South Ribble Community Safety Partnership

Domestic Suicide Review

Overview Report

'Joan'

Died June 2019

Chair and author: Ged McManus

Supported by: Carol Ellwood Clarke

Date: June 2021

INDEX

1 Introduction

1.1 This report of a Domestic Suicide Review (DHR) examines agency responses and support given to Joan[1], a resident of South Ribble, prior to her death. The panel would like to offer their condolences to Joan's family on their tragic loss. All names used in the report are pseudonym's.

1.2 Joan had a long and complex medical history. In some of her interactions with professionals, she complained that her husband, Brian[2], was aggressive and emotionally and financially abusive to her. In June 2019, Joan took her own life whilst alone at home.

1.3 In addition to agency involvement, the review also examines the past to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.4 The review considers agencies contact and involvement with Joan and Brian from 1 May 2018, until Joan's death in June 2019. This time period was chosen because the start date was several weeks before the first of several safeguarding alerts were made concerning Joan and the panel wished to capture the weeks leading up to that alert. Background information prior to 1 May 2018 is used in the report for context. The couple had an adult daughter who lived with them. She is not a subject of the review but is referenced in the report.

15. The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence abuse and suicide. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.8 **Note:**
It is not the purpose of this DHR to enquire into how Joan died. That is a matter that has already been examined during the coroner's inquest.

[1] A pseudonym agreed with the victim's brother.
[2] A pseudonym chosen by the DHR panel

2 Timescales

2.1 This review began on 29 July 2020 and was concluded on 1 June 2021 following a period of consultation with Joan's brother and later input from Joan's husband. More detailed information on timescales and decision making is shown at paragraph 5.2

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 A pseudonym was agreed with the victim's brother to protect her identity. Pseudonyms for the victim's husband and adult daughter were allocated by the DHR panel as they did not engage with the review.

4 Terms of Reference

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe Under Review

The DHR covers the period 1 May 2018 to Joan's death in June 2019

4.3 Case Specific Terms

Subjects of the DHR

Victim: Joan, aged 64 years

Joan's husband: Brian, aged 66 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[3] did your agency identify for Joan?

2. How did your agency assess the level of risk faced by Joan from Brian and which risk assessment model did you use?

3. What knowledge did your agency have that indicated Joan could be at risk of suicide as a result of any coercive and controlling behaviour?

4. How can your agency demonstrate that professionals understand what coercive and controlling behaviour is and the impact it has on victims?

5. What services did your agency provide for Joan and/or Brian and their daughter; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

6. Was a carer's assessment offered and/or completed? If not, should it have been offered and completed.

7. What signs of carer breakdown did your agency identify and what was done to address the issue.

8. How did your agency ascertain the wishes and feelings of Joan and Brian about her victimisation and his alleged behaviour and were their views taken into account when providing services or support?

9. What did your agency do to safeguard Joan from domestic abuse?

10. How effective was inter-agency information sharing and cooperation in response to Joan and Brian and was information shared with those agencies who needed it?

11. What did your agency do to establish the reasons for Brian's alleged abusive behaviour and how did it address them?

12. Was there sufficient focus on reducing the impact of Brian's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

13. Are there any examples of outstanding or innovative practice arising from this case?

[3] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

14. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Joan and Brian?

5 Methodology

5.1 Following Joan's death, a referral was initially made to the Lancashire Safeguarding Adult Board for consideration of a Safeguarding Adult Review. During this process, it was discovered that domestic abuse may have been a factor in the case and the case was referred to South Ribble Community Safety Partnership.

5.2 On 22 April 2020, South Ribble Community Safety Partnership agreed the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review [para 18 Statutory Home Office Guidance][4]. The Home Office was informed on 19 May 2020.

5.3 The start of the process was delayed as a result of agency work pressures in the Covid -19 pandemic with the first meeting of the DHR panel taking place on 29 July 2020.

5.4 In deciding who should be the subjects of the review the DHR panel also considered whether the couple's daughter should be a subject of the review. There was one incident involving Joan and her daughter in which Joan told Adult Social Care that her daughter had been verbally abusive. This issue was dealt with by Adult Social Care and is set out in the report at paragraph 13.2.17. The panel decided that in the absence of other information it did not wish to make the couple's daughter a subject of the review as this may distract from the main focus of the review i.e. the relationship between Joan and Brian. The panel did though decide that the information should be reported in the review.

5.5 Meetings took place using Microsoft Teams video conferencing and the panel met five times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final scheduled panel meeting took place on 23 February 2021, after which minor amendments were made to the report which were agreed with the panel by email.

5.6 The report was then shared with Joan's brother who was given the space of several weeks to read the report but did not wish to give any feedback after reading the report.

[4] Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it merges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

5.5 Paragraph 6 outlines contact with Joan's husband, Brian. This was achieved very late in the review process and led to a further delay. The panel met again on 1 June 2021 after the input from Brian.

6 Involvement of Family, Friends, Work Colleagues and Wider Community

6.1.1 The DHR Chair wrote separately to Brian, Kirsty[5] and Joan's brother inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[6] leaflet.

6.1.2 No reply was received from Brian or Kirsty. At the end of the process the independent chair again wrote to Brian and Kirsty informing them of the progress of the review and inviting them to get in touch. On this occasion Brian did contact the chair. His input is shown at paragraph 6.2.

6.1.3 Joan's brother agreed to speak to the chair and author of the review in order to make a contribution to the review. Although he was made aware of options for advocacy support, Joan's brother said that he did not need any support. He also received a copy of the report prior to finalisation and was given the opportunity to provide feedback although he did not wish to do so.

6.1.4 Joan's brother was able to provide background information which was not known to the review and is presented here but also used to inform other sections of the report.

6.1.5 Joan was born in Preston and was the eldest of three siblings. When Joan was about five, her father obtained employment working on the Concorde project in Bristol and the family moved south. When Joan was about eleven years old, the family moved back to the Preston area.

6.1.6 Joan did not pass the eleven plus exam that was in place in the area at the time and her brother felt that this affected her badly, as she was quite intelligent and was expected to pass the exam. During her teenage years her brother remembers that Joan was often in conflict with their father. When she left school at fifteen, Joan obtained work at a petrol station and continued to work there until she met Brian a few years later.

6.1.7 Joan's brother thought that Brian had a controlling influence over Joan. For example, she gave up her job and was not allowed to wear makeup or dress up in nice clothes. Both Joan and Brian enjoyed drinking alcohol but didn't go

[5] A pseudonym for Joan and Brian's adult daughter chosen by the DHR panel
[6] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

out to do so: largely staying at home. Brian brewed strong home-made beer and the couple would stay in and drink at home. Brian worked as an electrical contractor but gave that up after a fall out with his business partner. Joan assisted in the business.

6.1.8 Once Joan and Brian had their daughter, they reduced their contact with Joan's family and the family would only be in touch sporadically, for example by text messages and short telephone calls. Joan was invited to join her brother on trips to visit their mother, who by then lived on the south coast of England, but she never accepted the invitation. No reason was ever given, and Joan's brother was not sure if this was Joan's decision alone or if she was influenced by Brian. On one occasion, after inviting Joan, he was contacted by Kirsty who told him to leave Joan alone and stop bothering her.

6.1.9 Joan's brother recalled that as an adult, Joan had often been unwell. Most conversations with her were dominated by a discussion about how she was feeling and her medical conditions. He thought that some of the illnesses may have been due to her mental state as opposed to purely physical conditions and was aware that over the years the couple had spent significant amounts of money on private medical consultations.

6.1.11 Although Joan's brother described Brian's influence on Joan as being controlling, he was not aware of any other behaviour which he thought could be described as domestic abuse.

6.2 **Brian**

6.2.1 Brian spoke how he met Joan when she was 15 and he was 17. Joan was working in a local shop and he was an electrician who came in to do repairs. Joan stopped work in the shop after they got married so that they could spend weekends together. Joan then went to college to learn shorthand and typing, enabling her to obtain a secretarial job. They married when Joan was 21 and he was 23 and then 8 years later they decided to have children and Kirsty was born. Before Kirsty they had an adventurous life with lots of holidays.

6.2.2 After Kirsty was born, Joan gave up work as Brian preferred her to stay at home and look after their child whilst he worked.

6.2.3 In 1990 Brian started his own electrical business with a friend. Joan stayed at home but was involved with the paperwork. In 2000 Joan undertook some extra training and helped move the business to a computerised method of invoicing and clerical work. In 2008 Brian sold his share of the business, as he had struggled with the paperwork and described how it was making him ill.

6.2.4 For the last 3 ½ years of Joan's life, Brian said that he and his daughter, Kirsty looked after Joan and that she was effectively being cared for at home by them. He described how Joan had given up and would not do anything for herself. Kirsty was doing the cooking, which Joan constantly complained about. Initially it was arranged for carers to come into the home to help, but Joan did not want people in the house. Sometime when the carers came, Kirsty and Brian had already done the tasks they were supposed to do, on other occasions Joan was not ready for them to be in the house. This caused arguments with Joan challenging Brian and Kirsty as to why carers were needed, she often said – 'Why can't you two just do that and look after me'. Brian explained that to care for Joan he would have had to give up his work and he did not want to do that and did not want to be at home full time, he needed to work for the sake of his own wellbeing.

6.2.5 Brian described how he carried Joan up and down the stairs, bathed her, whilst at home and when she was in hospital. Brian paid for and fitted a stair lift to help Joan as well as an electrically assisted bed. Brian described how he adapted the bath by cutting a hole in the side and fitting a step so that Joan could get a shower as she struggled to get in and out of the bath. Brian erected handrails to help her in the bathroom. Prior to Joan's death Brian had removed the bath and fitted a shower, with the help of a friend. Brian was disappointed when Joan complained that the shower wasn't big enough.

6.2.6 The couple changed GP's five times, and this was because Joan was looking for different ways and hope that someone would be able to help her. This included Joan spending a lot of time on the internet researching different medicines and ways to deal with her illness. This included buying herbal remedies in excess from internet retailers.

6.2.7 Brian described how Joan's illness caused him stress. He said that after he had put Joan to bed he would sit downstairs and watch TV and drink until he fell asleep. This could be beers or spirits on some occasions. Brian denied that he was ever aggressive or physically violent towards Joan. He stated if he had ever hit her, Joan would have been the first person to have called the Police. He did not acknowledge the possibility that any of his behaviour could have amounted to controlling and coercive behaviour or emotional abuse. Brian also disagreed that there could have been financial abuse in the couple's relationship. He cited money he had spent on home adaptations and being the main provider for a number of years when he was working and Joan stayed at home. Brian categorically denied that there had ever been domestic abuse in his relationship with Joan.

6.2.8 Brian was asked about a safeguarding alert/enquiry and although not recalling the words safeguarding, he did recall two members of staff from social services coming to see Joan in hospital. Brian was not surprised with the visit due to the comments that Joan had been making in hospital. Brian believed Joan needed help with her mental health.

6.2.9 When asked about the help they had been offered, Brian said that having carers in the home was difficult as Joan didn't like it. They had been offered respite care, but Joan didn't want to go and it would have cost a significant amount of money in travel and car parking to visit. He could not remember being offered a carers assessment and was unaware what help a carers assessment may have been to him. He acknowledged that he had been drinking excessively whilst Joan was ill and said that he had sought help since her death and was now stable and back at work.

6.2.10 Brian agreed to the pseudonyms used in the report. He was offered the opportunity to read and comment on the report which he initially accepted. However, he later contacted the chair of the review to ask that the report not be sent to him as it would be too upsetting to read.

6.2.11 Brian's views are reported as he discussed them with the DHR chair. His narrative was not challenged.

6.3 Brian's friend

6.3.1 A friend of Brian's also asked to speak to the chair of the review. He had known Brian and Joan for many years and had sometimes worked with Brian. He had often visited their home and had been on a short holiday with Brian, Joan and his own wife.

6.3.2 Brian's friend described a situation which deteriorated gradually after Joan became ill. Joan required a lot of attention from Brian and Kirsty, for example Joan would often ring Brian at work every fifteen minutes or so making it difficult for him to concentrate.

6.3.3 Brian's friend said that Brian was devoted to Joan and tried to do everything that he could although he thought Brian was not well equipped for the caring role and knew that he found it very difficult and stressful. Brian's friend had never witnessed any behaviour which he could describe as domestic abuse. He

knew that Brian was drinking a lot when Joan was ill and thought that it was possible that this could affect his behaviour when he was intoxicated.

The friend thought that what could have made a difference was some form of respite care, which would have relieved the stress for both Joan and Brian, although he was aware that this had been offered and declined.

6.4 Joan's friends

6.4.1 The DHR panel were unable to identify any friends of Joan who could be contacted to invite their contribution to the review. It seems that in later years Joan had little contact with people beyond professionals and her immediate family.

6.5. Joan's employment

6.5.1 The DHR panel noted that there were differences in the sequence of events reported by different people, for example in relation to Joan's work history. The panel was unable to find other information to reconcile Joan's work history but accepted that the information had been genuinely given and discrepancies were as a result of differences in recollection over time.

7 Contributors to the Review/ Agencies Submitting IMRs[7]

7.1.1	Agency	Contribution
	Lancashire Constabulary	IMR
	Lancashire Adult Social Care	IMR
	Chorley and South Ribble CCG	IMR
	Lancashire and South Cumbria NHS Foundation trust [LSCFT]	IMR
	Lancashire Teaching Hospitals NHS Foundation Trust	IMR
	gtd Healthcare	IMR
	Victim Support	IMR
	North West Ambulance Service	Chronology

7.1.2 As well as the IMRs, each agency provided a chronology of interaction with Joan and Brian including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Joan or Brian, nor had any involvement in the provision of services to them.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the subjects of the review over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Joan and Brian; and, any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and, the actions taken or not taken. Where judgements were made or

[7] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Joan and/Brian.

actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 Each Domestic Homicide Review may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.1.6 The IMRs in this case were of good quality and focussed on the issues facing Joan. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.2 Information About Agencies Contributing to the Review

7.2.1 Lancashire and South Cumbria NHS Foundation Trust

Lancashire and South Cumbria NHS Foundation Trust was established in April 2002 and authorised as a foundation trust on 1/12/07.

The Trust provides a range of health and well -being services for children and adults and specialist secure, inpatient and community mental health services across a number of areas: Pan Lancashire, Sefton and Formby, Blackburn with Darwen and Cumbria.

The trust vision is to provide high quality care in the right place at the right time.

7.2.2 Lancashire Teaching Hospitals NHS Foundation Trust

The Trust provides a wide range of general hospital services to 370,000 people from the Chorley, South Ribble and Preston areas and several specialist services to around 1.5 million people from Lancashire and South Cumbria. Working together with other health services, local authority and private sector colleagues, the trust aims to provide joined-up services that meet holistic health and social care needs.

7.2.3 gtd Heathcare

gtd Healthcare (gtd) is a not-for-profit provider of primary and urgent care services. gtd was established as a GP out-of-hours provider in Oldham and Tameside & Glossop in 1997 and has since grown to provide a range of scheduled and urgent primary care services across parts of Greater

Manchester, Liverpool and Lancashire. The headquarters and clinical hub of the organisation are based in Denton in Manchester.

In 2016, gtd were awarded the contract for the provision of an Integrated Urgent Care Service (IUCS) for Preston and Chorley and South Ribble CCG. The service commenced in November 2016 and consists of:

- The traditional GP Out of Hours service, i.e. provision of advice and treatment when the patient's own GP practice is closed for patients who have contacted NHS111. Patients call NHS111 and if, following their assessment, it is deemed they need further clinical input either by telephone or face to face, the case is electronically transferred to our clinical hub based in Denton. A review is undertaken by a gtd clinician, which may be a GP, Advanced Practitioner, Pharmacist or Clinical Assessor. Patients are then provided with self-care advice, given an appointment, receive a home visit or referred to secondary care. Following assessment, those patients going on to receive further care are provided with a specific call-back telephone number to contact us should there be a change in their condition. These calls are initially managed by our care-coordinators (non-clinical staff) who can provide status updates to the patients or escalate any concerns to clinical staff.
- The community DVT service which receives referrals from Preston and Chorley GPs.
- GP/Clinical element of the Patient Alternative to Transfer Service (PATS) and Acute Patient Assessment Service (APAS) with Northwest Ambulance Service(NWAS). With the PATS service where patients have contacted 999 and following an assessment by a paramedic on scene, it has determined that they may not require conveyance to hospital but can receive further clinical and advice and management in primary care, the patient's care is transferred to gtd. For APAS, the service provides additional clinical input where a patient has contacted 999 and following assessment by NWAS, they are categorised as a category 3 or 4 where primary care management can be considered so the cases are passed to *gtd* for clinical review
- Two 24/7 Urgent Care Centres (UCCs), co-located within Lancashire Teaching Hospitals NHS Trust, Emergency Departments (ED) in Royal Preston Hospital and Chorley & South Ribble Hospitals. Patients are able to self-present at either UCC, or are booked an appointment following contact with NHS111 (direct booking from NHS111 or following further assessment at our clinical hub). On attendance, patients are assessed by a clinician (GP, Advanced Practitioner, Urgent Care Practitioner dependent on their presenting condition) and provided with appropriate treatment and

management, e.g. advice, provision of medication, referral to other specialties. On completion of the episode of care, a copy of the patient's clinical record is sent electronically to the patient's own GP by 8am the following morning to ensure continuity of record keeping.

- Direct calls from healthcare professionals, e.g. paramedics, district nurses, care home staff who require a primary care opinion for their patient. These calls are received during the daytime and out-of-hours periods

7.2.4 Victim Support

Victim Support is the commissioned provider of support services for victims of crime in Lancashire. Victim Support provides practical and emotional support to any victim of crime, regardless of whether they have reported it to the police or not. This includes specialised support for victims of domestic violence, sexual assault, hate crime, and children and young people.

7.2.5 Progress Housing

Progress Lifeline

Progress Lifeline is a personal, emergency alarm system that calls for help at the touch of a button. In the event of an accident or incident, it connects a customer with the control centre who can escalate to emergency services, a doctor, a family member or carer; ensuring safety and providing peace of mind.

7.2.6 Lancashire Adult Social Care

Lancashire County Council provides the Adult Social Care service across Lancashire. Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the government, local councils and providers of services to make sure that people who need care and support have the choice, flexibility and control to live their lives as they wish.

7.2.7 N-Compass

N-Compass adopts a person-centred approach to the delivery of carers provision and is seen as a leader in the fields of identifying, supporting and empowering previously hidden carers of all ages and from all backgrounds. N-Compass provides specialist support for carers to improve their health and wellbeing, and enable them to continue in their role for as long as they choose. They offer a blended approach of face-to-face support and a digital online offer to ensure carers always get the support of their choice.

This unique approach places carers at the heart of the service. N-Compass works directly with individual carers to discuss their concerns and needs, offer information and guidance, and design a bespoke support package for each carer. Co-production lies at the centre of all service delivery.

7.2.8 Guardian Homecare

Guardian Homecare provides leading live-in care services, helping people to live independently in the comfort of their own homes. Helping a broad range of people with a wide variety of needs and requirements, the company assists with live-in care services including:

- Elderly care, including dementia and Alzheimer's support
- Specialist care for adults, young people and children with physical and learning disabilities
- Respite care, for temporary relief of regular carers
- Reablement programmes to help with recuperation following hospitalisation, illness or injury
- Sleep-in and wake-in services
- End-of-life and palliative care

With a dedicated workforce encompassing highly trained care assistants and management teams in support, the company's primary aim is to provide care that upholds the dignity of clients through considerate, compassionate care.

The company's aim is to deliver services that vastly improve the life of clients and treating them, and their families, with the respect, dignity and compassion they deserve. We also believe that our services should not only comply with regulatory standards but exceed those wherever possible in promoting a client's overall well-being.

8 The Review Panel Members

8.1	Ged McManus	Chair and Author
	Carol Ellwood Clarke	Support to Chair and Author
	Heather Corson	Community Safety and Safeguarding Manager, South Ribble Borough Council, Qualified IDVA
	Damian McAlister	Review Officer, Lancashire Constabulary
	Lorraine Elliott	Designated Lead Nurse for Safeguarding Adults & MCA, Chorley and South Ribble Clinical Commissioning Group
	Liz Stanton	Refuge Manager, Clare House and Chorley Refuges
	Rebecca Maylor	Business Coordinator, Lancashire Safeguarding Adult Board
	Claire Powell	Area Manager, Victim Support
	Dawn Sewards	Director of Governance - gtd Healthcare
	Susan Porter	Specialist Safeguarding Practitioner, LSCFT
	Cherry Collision	Safeguarding and MCA Named Professional, LSCFT
	Rachel Holyhead	Named Nurse, Safeguarding Adults, Lancashire Teaching Hospitals NHS Foundation Trust

Bernadette Booth	Team Manager, Patient Safety and Safeguarding, Lancashire Adult Social Care
Pauline Bartholemew	Lancashire Adult Social Care
Laura Hudson	Lancashire Adult Social Care
Karen Simpson	Progress Housing [Lifeline]

8.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review chairs and authors. In this case, the chair and author were the same person.

9.2 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board [not in Lancashire or an adjoining authority] and has chaired and written previous DHRs and Safeguarding Adult Reviews.

9.3 Carol Ellwood Clarke retired from public service [British policing] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

9.4 Both practitioners served for over thirty years in different police services [not Lancashire] in England. Neither of them has previously worked for any agency involved in this review.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Joan's death. The inquest was concluded on 2 September 2019.

The medical cause of Joan's death was recorded as suffocation.

The circumstances of Joan's death were recorded as:

[Joan], who struggled with significant levels of pain, was found deceased at [address] on [date redacted] with plastic bags over her head, and having consumed a large quantity of her prescribed medications.

The coroner's conclusion, as to death, was suicide.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

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

11.2 Joan had a number of long-term medical conditions which limited her mobility and affected the things that she was able to do in her day-to-day life. The panel was in no doubt that she was disabled within the meaning of the Equality Act.

11.3 The panel acknowledged that research on domestic abuse and older people suggests that "older women's experiences of domestic abuse are markedly different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for"[8].

11.4 A report by Safelives, 'Safe later lives: Older people and domestic abuse[9]' highlights that women aged 61 [40%] or over are more likely to experience abuse from a current partner than younger women [28%]. They are also more likely to be living with the perpetrator after getting support. 32% for women 61 or over, 9% for younger women.

11.5 The Age UK report 'No Age limit The Hidden Face of domestic abuse, identifies that older victims face additional barriers to reporting

Older survivors of domestic abuse can face significant barriers when asking for help or when trying to leave an abusive relationship. These barriers can be severe for survivors who have been subject to years of prolonged abuse, are

[8] https://pubmed.ncbi.nlm.nih.gov/21040066/ McGary and Simpson
[9] https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

isolated within a particular community through language or culture, are experiencing long term health impacts or disabilities, or those who are reliant on their abuser for their care or money.

https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/id204298-domestic-abuse-a5-booklet.pdf

Research shows that older victims of abuse are likely to have lived with abuse for prolonged periods of time before seeking help. Physical health and dependency for others to care for them as well as isolation can all be factors in the decision made by older victims of abuse to remain.

SafeLives Spotlight #1: Older people and domestic abuse [online]
https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

Pg 13 of the Safelives report states –
An additional key barrier that can arise in this client group is the issue of dependency. Older people are statistically more likely to suffer from health problems, reduced mobility or other disabilities, which can exacerbate their vulnerability to harm. Problems with physical health and subsequent isolation can present barriers to victims being able to access community services, as they may be unable to easily leave their home.

11.6 There is evidence throughout the review that Brian was drinking alcohol excessively. He had been through residential detoxification programmes around ten years prior to the review period.

11.7 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.8 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.9 All subjects of the review are white British. At the time of the review, they were living in an area which is predominantly of the same demographic and

culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

12 **DISSEMINATION**

Joan's brother
Home Office
South Ribble CSP
South Ribble Clinical Commissioning Group
Lancashire Constabulary
Lancashire Police and Crime Commissioner
Lancashire Safeguarding Adult Board
Lancashire Teaching Hospitals NHS Foundation Trust
Lancashire and South Cumbria NHS Foundation Trust
Victim Support
gtd Healthcare
Lancashire Adult Social Care
Progress Housing
Clare House and Chorley Refuges

13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, and material gathered by the police during their investigation following Joan's death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1.1 Joan and Brian were married in 1974 and lived in their own home in South Ribble. For many years they jointly ran an electrical business but closed this in 2009. Joan told a medical professional that the reason for the sale was because of Brian's drinking. The couple both obtained other employment; Joan worked in a Sherriff's office dealing with debtors and Brian worked on the maintenance team at a school.

13.1.2 From November 2009 to June 2010, Brian suffered from severe depression, suicidal ideation and increased alcohol use requiring two voluntary inpatient admissions to support detox and alcohol management.

13.1.3 In 2010, Joan fell and hurt her back when the door of a dishwasher that she was opening developed a fault. Subsequently she suffered from a range of medical conditions which severely affected her day-to-day life and left her in severe pain. These included chronic back pain, osteoporosis, gout, asthma, spondylitis, sciatica, and depression. As a result of her medical conditions Joan had limited mobility and need assistance to complete some day to day tasks such as cooking, cleaning and washing. In her later years she did not leave home alone as she needed assistance. As a result of her medical conditions Joan had limited mobility and need assistance to complete some day to day tasks such as cooking. In her later years she did not leave home alone as she needed assistance.

13.1.4 The couple had an adult daughter who helped to care for Joan but also worked and had other commitments. Brian was Joan's main carer although he too worked for some of the review period.

13.1.5 The many complexities of Joan's medical conditions meant that she was often admitted to hospital, had many home visits from medical professionals and carers, and was prescribed strong painkillers throughout the duration of the review period.

13.2 Relevant Events with the DHR Timeframe

13.2.1 The DHR panel felt that the focus of the review should be on domestic abuse and safeguarding issues rather than the detail of Joan's medical conditions and appointments. Many medical issues are therefore not covered in the report with only those being directly relevant included. The following paragraphs summarise those issues affecting Joan and Brian within the timeframe of the DHR terms of reference which the panel felt were most relevant.

13.2.2 In April 2018, Joan was visited at home by a social care support officer [Adult Social Care] and a number of home adaptations and aids were agreed. A referral was made to N-Compass[10] for carer's assessments for Brian and their daughter. By early May, Joan and Brian had purchased and had fitted a stairlift.

13.2.3 On 16 May 2018, an offer was made by Adult Social Care to arrange for carer visits one hour per day to assist Joan. Joan personally declined the offer as she didn't feel comfortable with strangers entering the house.

13.2.4 On 22 May 2018, a lifeline alarm, together with other safety equipment, was installed at the family home. The alarm and a pendant worn by Joan allowed her to alert a help centre, provided by Progress Housing, if she was in immediate need of assistance.

13.2.5 On 6 June 2018, Joan was admitted to Royal Preston Hospital [Lancashire Teaching Hospitals NHS Foundation Trust]. Joan was anxious and stated that she couldn't cope and would kill herself. She said that she had previously tried to suffocate herself. A safeguarding alert was made to Lancashire County Council Adult Social Care. The alert stated that:

'Husband was refusing to accept care services and was refusing to give Joan her medication. It stated that Brian was alcohol dependent and controlling of all aspects of Joan's care. It was stated that Brian had declined a plan of care which had been requested. The frailty team were concerned about how the situation at home was affecting Joan's anxiety levels'.

13.2.6 On 29 June 2018, Joan self-discharged from hospital.

13.2.7 On 3 July 2018, a social worker telephoned Joan following her discharge from hospital on 29 June 2018 in response to a request for assessment. Brian answered and informed the social worker that the family were at crisis point and Joan had been discharged from hospital without any support. He said that both himself and his daughter were on the verge of a breakdown as their mental health was suffering

[10] https://www.n-compass.org.uk/our-services/carers/the-lancashire-carers-service

due to the lack of assistance. A care package of one hour visits each morning was agreed for the next two days. However, Brian later called an ambulance as Joan was in severe pain and she was admitted to hospital. During this admission, Joan said that Brian was drinking more and refused support. She was frustrated that a care package had not been resolved. Joan was discharged on 19 July 2018.

13.2.8 On 4 July 2018, Brian's employer contacted the police regarding a concern for his welfare. The police were told that he was under a lot of pressure as his wife struggled with her mental health. He was not receiving any help and couldn't cope. Brian was also thought to have issues with alcohol and had previously expressed suicidal thoughts. Police conducted a welfare check at Brian's home and found that he was safe and well in bed. No further action was taken.

13.2.9 On 6 July 2018, a third party contacted the police following a conversation with Brian who was concerned about his wife coming home from hospital. He had said that he couldn't cope and it would be better if he wasn't here. An officer attended at Brian's home and found he was safe and well. Brian stated that he was working with Adult Social Care and they were going to provide a care package. He also stated that he resided with his daughter who was supporting him. The officer did not identify any other additional support that was needed and no further action was taken.

13.2.10 On 24 July 2018, Joan was admitted to hospital. During this admission, she raised concerns about Brian's drinking. A referral was made to N- Compass for a carer's assessment.

13.2.11 Joan was discharged from hospital on 2 August 2018. She was to receive reablement support for four weeks from Guardian Homecare.

13.2.12 On 3 August 2018, Brian called Adult Social Care as there had been no contact from carers. There had been an internal problem relating to referral forms and a crisis care package was provided until 6 August when the reablement visits were started.

13.2.13 On 6 August 2018, Brian attended a GP appointment where he discussed that he was not coping well, was depressed and was drinking alcohol in excess.

13.2.14 Following the GP appointment, Brian was referred to LSCFT Minds Matter service. A 6-week course of talking therapy commenced 15 August 2018 to support anxiety and depressive disorder. At this time, Brian reported he was undertaking 2 jobs as well as caring for his wife, and although social care had arranged for carers to visit twice a day, Brian was struggling with this and was signed off work due to sickness. He felt down and miserable most days, he identified goals to get back to work, there

was evidence of good engagement: no alcohol or substance misuse were noted. This was a timely appropriate intervention.

13.2.15 On 4 September 2018, at a GP appointment, Brian was drunk and had been suspended from work. He attended the practice for a review the following day and said that he had drunk a whole bottle of gin the night before. At a further appointment of 26 September 2019, Brian said that he was drinking 80 units of alcohol per week and had now left work.

13.2.16 On 14 September 2018, Joan was visited by a senior social worker and occupational therapist. A social care assessment and assessment regarding appropriate equipment and adaptations to support Joan was undertaken. Joan, Brian and Kirsty all appeared to be content with the prospect of the package of care provided by a local care agency. However, Joan cancelled the visits on occasions and on 4 October the visits were suspended as Joan said that the carers who were coming were too young. On 12 October, Joan said that she didn't want to reinstate the care visits as Kirsty was now going to be her carer.

13.2.17 On 2 November 2018, Joan telephoned Adult Social Care [Emergency Duty Team]. As a result of the call, a safeguarding alert was recorded. Joan said that:

- Neither husband nor daughter were assisting her to go to bed.
- She tried to get into bed herself which resulted in her spraining her wrist.
- She stated that her daughter shouted at her, called her a burden, that she didn't love her, hates her and wishes she was dead.
- Joan stated she was frightened of falling and is living on a knife edge.

The Emergency Duty Team spoke to Kirsty who said that she was struggling and felt her support was 'never good enough' for her mother. Crisis Care was arranged, providing four visits over the weekend, finishing late on the Monday evening.

13.2.18 On 20 November 2018, during a telephone consultation with a GP, Joan was distressed about her family situation. The doctor documented that Joan appeared to be very controlling and demanded that her daughter be her main carer.

13.2.19 On 27 November 2018, during a GP visit to see Joan at home, Brian was drunk and abusive. The GP found his behaviour frightening and checked that Joan and her daughter were ok. They declined any further support at that point.

13.2.20 On 6 December 2018, Brian visited his GP. He said that he had been cutting down on alcohol but had then stopped suddenly and was experiencing some mild withdrawal symptoms.

13.2.21 On 7 January 2019, Joan activated her lifeline alarm and spoke to staff at the Progress monitoring centre. An ambulance was called and Joan was admitted to Preston Royal Hospital.

13.2.22 During the evening of 8 January 2019, an incident occurred when Brian was visiting Joan on a ward. Joan was visibly upset and told staff that Brian was an alcoholic and was not coping well. Brian was asked by staff if he needed help or needed to see a doctor but grabbed his bag and left before returning later. Joan told staff that Brian had grabbed her and made threats to hurt himself. She also told staff that Brian had previously said to her that she 'should just die'. Staff contacted the couple's daughter to check on Brian's welfare.

13.2.23 On 9 January 2019, the hospital safeguarding team was informed and a DASH[11] risk assessment was completed with Joan indicating a score of 10 – standard risk. The DASH noted ongoing emotional and verbal abuse. Joan said that she was hiding money in an attempt to curtail Brian's alcohol consumption and that she wanted him to leave the family home. A referral was made to Lancashire Victim Support.

13.2.24 Lancashire Victim Support called Joan the following day with an offer of support and assessment. Joan said that she was in hospital at the time so it was not convenient to do an assessment and she did not want any support. It was agreed that the worker would send her a text message with contact details should her circumstances change, or she changed her mind. The text message was sent and the case closed.

13.2.25 On 22 March 2019, both Joan and Brian moved GPs to another local practice [Practice B]. The new patient questionnaire, filled in by Joan, described her being severely immobile and relying on her husband and daughter as carers. Brian's new patient questionnaire omitted the fact that he was a carer or had alcohol problems.

The reasons for the change of GP practice are not known to agencies [there was no change of address] but the timing was just two days after Joan's GP from Practice A

[11] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC]

visited and agreed with Joan a plan to reduce her diazepam[12]. The panel were told that diazepam is prescribed with great caution these days, but many years ago it was not unusual for patients with anxiety and distress to be given enough to become dependent on it. Over time patients become "used to it" so it stops working and they often crave more. It is extremely time-consuming and challenging to help someone reduce and come off diazepam, but patients usually feel so much better afterwards and it was excellent care for Joan's GP to visit her at home to start the process. The planned diazepam reduction never happened.

Note. Brian told the chair of the review that the reason for the change in GP was because Joan did not like the plan to reduce diazepam.

13.2.26 On 10 April 2019, Joan was admitted to Royal Preston Hospital. Over the weekend of 13 – 14 April 2019, Joan made a number of disclosures to staff that Brian was emotionally and verbally abusive towards her and that he handled her roughly. She repeated her previous concerns about his alcohol consumption and said that she did not want him to visit her.

13.2.27 On 15 April 2019, Joan showed staff text messages from her daughter indicating that Brian was intoxicated. The information was shared with Joan's named social worker. A member of staff began completing a DASH risk assessment but was called away to a medical incident and the process was not completed.

13.2.28 On 25 April 2019, a safeguarding alert was made to Adult Social Care by staff at Royal Preston Hospital. The alert identified that:

- Husband, is being financially and verbally abusive
- Husband has never been violent but is becoming increasingly aggressive and out of control which is getting worse

13.2.29 On 26 April 2019, Joan was discharged from hospital. She had been reluctant to go home and extensive discussions took place about an appropriate care package. The hospital discharge letter to Joan's GP stated that the discharge had been delayed due to "husband's violent tendencies". Guardian Homecare, a care agency, was asked by Adult Social Care [CATCH team] to provide four visits per day to Joan until

[12] Diazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety, muscle spasms and fits (seizures). It's also used in hospital to reduce alcohol withdrawal symptoms, such as sweating or difficulty sleeping

1 May 2019. The purpose of the visits was to support Joan with washing, dressing and meals. This crisis provision is intended to be a short-term service until an appropriate care pathway can be identified by Adult Social Care.

13.2.30 On 28 April 2019, an out-of-hours GP provided by gtd Healthcare visited Joan at home. The doctor noted that Joan was highly anxious, continuously talking and complaining about numerous things, including hospital treatment, medication burning in her gullet, Brian spending all their money on drinking, family members leaving her alone and not coming to listen to her. Brian told the doctor that Joan was driving everyone mad with non-stop complaining. Joan was refusing medication for anxiety as she did not feel that this was a problem. The doctor noted that Joan was highly anxious but had no ideas of self-harm. Appropriate medication was prescribed and the doctor completed a consultation report which was sent to Joan's own GP.

13.2.32 On 29 April 2019, Guardian Homecare received a report from the attending care worker that Joan did not require any care support that morning, but that Joan had highlighted that she was anxious and upset because of her husband drinking and spending her money. She said he was always drunk. Joan also played the carer a recording of a conversation between Joan and her daughter the night before, and the conversation was quite abusive. The concerns were reported to Adult Social Care. Staff from Adult Social Care [CATCH team] visited the following day and carried out an assessment with Joan which resulted in a request for reablement care and a referral for a carer's assessment for Joan's daughter.

13.2.33 On 2 May 2019, Adult Social Care commissioned Guardian Homecare to provide reablement care four times per day for Joan until 14 May 2019. The aim of the reablement service is to enable people to maximise their independence.

13.2.34 On 10 May 2019, Joan was visited at home by a GP from Practice B and seen whilst Brian was present. The records note a marked change in Joan's behaviour.

13.2.35 On 12 May 2019, a safeguarding alert was made to Adult Social Care by Guardian Homecare. The alert stated that:

- Joan is scared of Brian, who is threatening violence.
- Joan is scared of disclosing abuse for fear of repercussions and scared to contact police in case Brian finds out.
- Joan's daughter drags her to bed.

This alert was made as a result of concerns that Joan raised directly with a care worker who was visiting to provide reablement care.

13.2.36 On 17 May 2019, Joan was taken to hospital following an intentional mixed overdose of oxycodone and diazepam. Brian was seen to have a bottle of vodka in his bag. He fell asleep in the emergency department relatives' room and was later found asleep in a corridor. He was verbally aggressive to staff and was escorted off site. Joan said, '*she didn't feel her family wanted her anymore and she would be better off dead'*. She was admitted to the hospital for assessment.

13.2.37 On 20 May 2019, whilst in hospital, Joan was assessed by a Mental Health Liaison Practitioner [Lancashire and South Cumbria NHS FT].
Joan said she was in pain, she felt a burden to her family and believed they did not want her at home. She described the relationship with her husband as strained and said that he became angry with her when he had consumed alcohol. Joan said she relied on her husband and daughter to provide her care.

The Mental Health Practitioner recorded the following assessment of risk:

Presenting Lead Risk – intentional mixed overdose leading to admission

Predisposing Factors – chronic pain, long-standing anxiety & depression

Precipitating Factors – on-going pain, relationship difficulties

Perpetuating Factors – chronic pain, fear of further falls and admissions to Lancashire Teaching Hospitals (LTH)

Protective Factors – limited, feels family do not want her

Joan was to be referred to the mental Health Home Treatment Team [HTT] on her discharge from hospital.

13.2.38 On 24 May 2019, Joan was to be discharged from hospital but did not want to go home. She went to the toilet, wrapped her mobile phone charger cable around her neck but then called for assistance. Joan was seen again by a Mental Health Liaison Practitioner. She said she did not want to go home describing Brian as an alcoholic. Joan denied that there was any violence and declined permission for a safeguarding alert to be made. Joan declined a follow-up from the Home Treatment Team [as per the plan made from assessment on 20 May] although she accepted their contact number should she change her mind. It was noted that Joan had capacity[13] to make these decisions.

[13] Mental Capacity Act 2005

The ward staff were advised there was no change in Joan's mental state and that she could be discharged home with the plan for community services as per her previous assessment.

13.2.39 On 31 May 2019, Joan was discharged from hospital.

13.2.40 On 3 June 2019, Joan was seen by a GP and Advanced Nurse Practitioner at home. Brian was present. A plan was made to expedite a psychiatry appointment and to arrange a multi-disciplinary meeting.

13.2.41 On the evening of Friday 7 June 2019, Joan was visited at home by an out-of-hours GP provided by gtd Healthcare. This followed a series of contacts with 111 and health professionals as Joan was unable to cope with the pain she was experiencing. She requested a change of medication and was prescribed oxynorm[14] liquid. The GP prescribed more than would be normally recommended by gtd Healthcare in order to ensure that Joan had sufficient medication to last over the weekend.

13.2.42 On 9 June 2019, Brian called the ambulance service. He said that he had been out for around two hours to pick his daughter up and came home to find Joan deceased. Paramedics arrived within a few minutes and confirmed that Joan was deceased.

13.2.43 Joan had two plastic bags tightly over her head secured with a Velcro type fastener. A postmortem examination confirmed that she had suffocated and also had multiple drugs in her system.

13.2.44 The police investigation into Joan's death included examination of her telephone and laptop computer. Joan's telephone contained a number of texts to her daughter, who was at that time away from the family home, stating that she was in a lot of pain. One example was:

"Yr father has been a pig today. Disyrict nurses were supposed to be coming by order of Gp but they havent come. Waited all day. Gonna have to drug myself up. If i cant stand pain. Ill have to ring 999. During night. Receptionist said [Brian] only rang at 1.20 today. If he had rung earlier they would of come no proplem. He is drinking still behind my back. He knows i cant check on him in conservatoy. Been in agony all day. Miserable gonna have to ring and go on my own. x why did he not just let me end it. I cant take this constant pain. Luv u so much"

[14] OxyNorm liquid contains oxycodone hydrochloride. Oxycodone belongs to a group of medicines called opioid analgesics. OxyNorm liquid is used to relieve moderate to severe pain.

13.2.45 On the day that Joan took her own life, she sent messages to her daughter saying that she was in agony and that she was dreading another night.

13.2.46 Internet searches on Joan's computer, under her username, showed that several suicide related websites had been visited on 7 June 2019: two days before her death. Searches included:
"can u kill yourself with oxynor",
"watch s to poison yourself",
"kill me quick" "im still here",
"help for suicidal thoughts"
"how many pain killers to kill yourself"
"injury profiles: suicide attempt (wrist lacerations)" "how do you slit your wrists" "is cutting your wrists the best way of suicide"
"how to support someone with suicidal thoughts"
South Ribble Crisis Team was also searched for along with advice on how to complain about your GP.

13.2.47 On 16 June 2019, Brian was interviewed by the police in relation to a suspicion that he had aided and abetted Joan's suicide. Brian answered all the questions that were put to him and the police found that there was no evidence to pursue a case against him.

13.2.48 The inquest into Joan's death was concluded on 2 September 2020. The full details are shown at paragraph 10.1

14 ANALYSIS

14.1 What indicators of domestic abuse, including coercive and controlling behaviour,[15] did your agency identify for Joan?

14.1.1 There were four safeguarding alerts during the time period of the review; all of which indicated elements of domestic abuse. They are summarised below.

6 June 2018, referred to Adult Social Care by Royal Preston Hospital;

- Brian was refusing to accept care services and was refusing to give Joan her medication.
- Brian was alcohol dependent and controlling of all aspects of Joan's care.
- Brian had declined a package of care which had been requested.
- There were concerns about how the situation was affecting Joan's anxiety levels.

2 November 2018, Joan phoned Adult Social Care (EDT) to request support;

- Neither husband or daughter assisting her to go to bed
- Joan tried to get into bed herself which she states resulted in her spraining her wrist
- Joan stated that her daughter shouts at her, called her a burden, that she doesn't love her, hates her and wishes she was dead
- Joan stated she was frightened of falling and is living on a knife edge

25 April 2019, referred to Adult Social Care by Royal Preston Hospital;

- Brian, is being financially and verbally abusive
- Brian has never been violent but is becoming increasingly aggressive and out of control which is getting worse

12 May 2019, referred to Adult Social Care by Guardian Homecare;

- Joan is scared of Brian, her husband, who is threatening violence
- Joan is scared of disclosing abuse for fear of repercussions. Scared to contact police in case Brian finds out

[15] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

- Daughter drags Joan to bed

The response to these safeguarding alerts is discussed at paragraph 14.5

14.1.2 Joan often spoke to medical professionals about concerns for her care and there were a number of times when she clearly indicated that she was suffering from domestic abuse. For example, an incident at Preston Royal Hospital on 8 January 2019, after which Joan said that Brian had grabbed her resulted in a DASH risk assessment being completed the following day. The risk was assessed as standard and therefore the action generated was a referral to Victim Support. A later incident on 15 April 2019, caused a member of staff to begin completing a DASH risk assessment but this was not finalised due to an urgent incident on the ward. The panel heard that the trust now has an Independent Domestic Violence Advocate who supports staff with complex cases. A recent audit has shown 96% compliance with processes once domestic abuse is recognised. No recommendation is therefore made on this point.

14.1.3 GP Practice A knew the family well having seen both Joan and Brian separately in the surgery, and also together at home over two years. They were aware of several risk factors for abuse. Joan was vulnerable due to her physical and mental health problems, and Brian was also vulnerable due to his own mental health and alcohol problems.

14.1.4 On 20 November 2018, Joan told a GP on the telephone that Brian "was very controlling". The GP went to visit her and shared this information with Joan's social worker. This was good practice. This episode in November 2018, is the only time Practice A identified that abuse was potentially happening to Joan from Brian.

14.1.5 On 2 November 2018, Joan had been seen with a wrist injury which the GP felt to be consistent with Joan's story of having hurt it whilst getting up out of her chair. The panel felt that in light of Joan's vulnerability it would have been good practice to make an enquiry about domestic abuse at that point. This is a learning point and leads to a single agency recommendation for the CCG.

14.1.6 On 27 November 2018, during a GP home visit, Brian was drunk and abusive prompting the GP to be concerned for Joan and Kirsty's welfare.

14.1.7 Joan's GP medical records were not flagged or coded to indicate concern about domestic abuse. GP Practice B took over the family's care in March 2019, less than three months before Joan's death, so did not know them as

well as Practice A. During this time, Joan was seen at home on several occasions though Brian did not have any consultations himself. As the records were not flagged or coded, Practice B were not aware of the previous concern regarding vulnerabilities or domestic abuse. This is a learning point and leads to a single agency recommendation for the CCG.

14.1.8 During visits by Guardian Homecare staff, Joan said that Brian was always drunk and that he spent her money. She also said whilst on the reablement service that she was frightened of Brian and wanted to go into a care home. These concerns were reported by Guardian to Adult Social Care.

14.1.9 During several hospital admissions, Joan shared with mental health practitioners her concerns about Brian's behaviour. The issues reported by Joan were known in part or full by Adult Social Care, Royal Preston Hospital, Lancashire and South Cumbria NHS Foundation Trust and GP Practice A.

14.1.10 Joan was reliant on Brian due to her care and support needs. She said that she felt like a burden to her family and had a strained relationship with Brian who could become angry when he consumed alcohol. It is clear that the couple's relationship was under great strain. Joan was sometimes resistant to having care provided from outside the family and at times Brian was unable to cope with caring for Joan. His reported excessive drinking may have been, in part, as a result of that although he had previously had two periods of alcohol detoxification ten years previously.

14.1.11 The DHR panel thought that, taken together, the information indicated a pattern of emotional abuse.

14.1.12 The panel considered whether there was evidence that Brian had subjected Joan to coercion and control and in doing so referred to the Crown Prosecution Service's policy guidance.

14.1.13 The Crown Prosecution Service's policy guidance on coercive control states:[16]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time

[16] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent

- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.1.14 The panel noted Joan's reports that Brian was threatening and abusive and that his behaviour was affected by alcohol consumption. The family's finances were affected by Brian's drinking and Joan confided that she hid money and bank cards to prevent him from buying alcohol. The panel saw that as Joan's primary carer, Brian had control or influence over some aspects of Joan's life and was responsible for intimate personal care routines. The panel also noted information from Joan's brother that she did not socialise and had not been able to dress up or wear makeup.

14.1.15 The panel thought that there was evidence of some elements of coercive control. The panel also acknowledged that some of Brian's behaviour was impacted upon by his caring role and may not have been purposeful.

14.1.16 The panel noted that Joan often complained that Brian spent the couple's money on drink. Brian told the chair that Joan had her own bank cards and often spent money internet shopping. He also provided examples of other money that was spent to support Joan.

The panel considered the definition of economic abuse contained within the Domestic Abuse Act 2021
"any behaviour that has a substantial and adverse effect on an individual's ability to:

- acquire, use or maintain money or other property (such as a mobile phone or car) or
- obtain goods or services (such as utilities, like heating, or items such as food and clothing)"

The panel noted that Joan had a computer, access to her own bank account and shopped on the internet. Brian undertook the day to day shopping, for food and other essentials. Although the panel did not have evidence of economic abuse beyond Joan's complaints that Brian spent money on drink, the panel acknowledged that Joan's medical conditions and her reliance on Brian for her care needs rendered her vulnerable to economic abuse.

https://survivingeconomicabuse.org/what-is-economic-abuse/

Economic abuse is a legally recognised form of domestic abuse and is now defined in the Domestic Abuse Act [post Joan's death]. It often occurs in the context of intimate partner violence, and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy.

1 in 6 women in the UK has experienced economic abuse by a current or former partner.

Economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

14.2 **How did your agency assess the level of risk faced by Joan from Brian and which risk assessment model did you use?**

14.2.1 LSCFT Electronic Care Records for all service users have a Standard Risk Assessment Tool and an Enhanced Risk Assessment Tool: all versions of completed risk assessments can be viewed in chronological order. Prior to use, staff are required to complete the relevant eLearning which explains the functionality of these new risk assessments. This risk assessment combines consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people.

14.2.2 A standard risk assessment completed with Joan in March 2018, did not identify any risks or domestic abuse either current or historic, as such no further analysis was undertaken that would have provided a formulation of risk and vulnerability to inform a risk management plan. The care records did however make clear references to Joan's vulnerabilities, her previous suicidal thoughts and concerns relating to the impact of her health needs on both her and her husband.

14.2.3 An enhanced risk assessment completed in May 2019, was comprehensive and reflected Joan's presenting risks in terms of physical and mental health, her care and support needs and her husband's alcohol use and behaviour toward her when providing support. Joan disclosed that she felt like a burden (also considered within the assessment), resulting in a formulation and specific plan of support detailing measures that would help to reduce the caring responsibilities for Brian. The impact of Brian's behaviour on Joan was

also considered, however it would appear that these issues were not recognised as possible domestic abuse and referrals to specialist victim support services or DASH risk assessment does not appear to have been considered. Since this time, targeted initiatives have commenced to raise awareness of what would constitute good practice in relation to adopting routine enquiry, signposting to appropriate support agencies and undertaking appropriate risk assessment. This is an area that will be further evaluated within a Trust audit in Quarter 3 2021.

14.2.4 Following the incident on 24 May 2019, when Joan wrapped a telephone charger cable around her neck, the risk assessment was not updated. A post incident review completed by LSCFT 15 November 2019, identified that the risk assessment was not updated at this time to reflect the incident and this has been addressed in the Post Incident Review-learning Brief and subsequent practitioner engagement activity. No further recommendation on this point is therefore made.

14.2.5 Two formal risk assessments were completed in the MASH strategy discussions for the 2nd and 3rd alerts. The risks were discussed in all 4 alerts between MASH, Safeguarding Enquiry Service and partner agencies. For the second alert, in which a full safeguarding enquiry was undertaken, the risk assessment was not reviewed. Formal risk assessments were completed following the alerts of 2 November 2018 and 25 April 2019.

14.2.6 The risk assessments are called 'Safeguarding Risk Assessment' and 'Risk Management Plan'. They are stored within the safeguarding module on the Adult Social Care 'Liquid Logic' computer system.

14.2.7 Following the alert of 2 November 2018, a Risk Assessment/Risk Management Plan was completed by a 'MASH' (multi agency safeguarding hub) worker on 6 November 2018. This is discussed in detail at paragraph 14.5.5

14.2.8 Following the alert of 25 April 2019, a Risk Assessment/Risk Management Plan was completed the same day. This is discussed in detail at paragraph 14.5.10

14.2.9 The only formal domestic abuse risk assessment [DASH] in the case was completed by Royal Preston Hospital on 9 January 2019, following an incident at the hospital on 8 January 2019. The risk was assessed as standard and therefore the action generated was a referral to Victim Support. As outlined at

paragraph 14.1.2, a later incident on 15 April 2019, caused a member of staff to begin completing a DASH risk assessment but this was not finalised due to an urgent incident on the ward.

14.2.10 Lancashire Constabulary had no involvement in the case which gave an opportunity to conduct a DASH risk assessment.

14.3 **What knowledge did your agency have that indicated Joan could be at risk of suicide as a result of any coercive and controlling behaviour?**

14.3.1 On 6 June 2018, Joan attended at Preston Royal Hospital following a fall. Whilst at the emergency department, she told staff that she was anxious, unable to cope and would kill herself. She added that she had previously tried to suffocate herself. The medical notes record that Brian was an alcohol user who was verbally abusive and had been refusing to give Joan care. A referral to mental health services was made but this was declined as Joan had no active suicidal ideation and was not medically fit. [This is further discussed at paragraph 14.5.20]. Joan was admitted to hospital and this admission prompted the first safeguarding alert to Adult Social Care. The panel discussed whether this information should also have prompted a DASH risk assessment to be conducted and concluded that a DASH should have been completed. This would have better informed the safeguarding alert to Adult Social Care.

14.3.2 On 2 November 2018, Joan told the Emergency Duty Team [ASC] that she felt like such a burden to her family that she did not wish to be here anymore. She said her daughter would say things like "I wish you weren't my mum", I wish you were not here". Joan disclosed that she felt depressed and didn't "want to be here anymore" because she was a burden to her family and they were so nasty towards her.

14.3.3 On 7 January 2019, Joan activated her lifeline alarm and spoke to staff at the Progress monitoring centre. Joan said that she was all alone and stuck in the chair. During the call she stated that she wished to kill herself and was very distressed saying she needed more help as she was not getting anywhere and was in a lot of pain. She stated that her husband and daughter were also at the end of their tether with the situation. Due to the nature of the call, an ambulance was called to the address and Joan was ultimately admitted to hospital. The panel thought that the actions of staff at the monitoring centre,

in calling an ambulance, were appropriate and had the immediate effect of safeguarding Joan at that time.

14.3.4 On 17 May 2019, Joan was admitted to hospital following an intentional mixed overdose of oxycodone and diazepam. Joan was in hospital until 31 May 2019, and throughout that time made professionals aware of the challenges in her relationship with Brian. An enhanced risk assessment, recorded by a mental health practitioner, stated:

Protective Factors – limited, feels family do not want her
[full details at chronology entry 20 May 2019 paragraph 13.2.7]

14.3.5 Joan was discharged from hospital on 31 May 2019. She was seen at home by a GP and Advanced Nurse Practitioner on 3 June 2019, by way of a follow-up from her hospital discharge. Plans were made to expedite a psychiatry follow-up and arrange a multi-disciplinary meeting. Given that she had overdosed, Joan's medication was closely monitored by the GP. She told the GP on the following day, on the telephone, that she did not like the taste of oxycodone [oxynorm], so oramorph was prescribed instead.

14.3.6 On 7 June 2019, Joan was seen at home by an out-of-hours GP provided by gtd Healthcare. Due to her uncontrolled pain, she was issued with another bottle of oxynorm liquid. As it was a Friday evening the GP prescribed more than would be normally recommended by gtd Healthcare in order to ensure that Joan had sufficient medication to last over the weekend. gtd Healthcare doctors do not have full access to GP records and would not have known Joan had recently taken an overdose unless the GP practice had specifically told them. This consultation was the last time that Joan was seen by a medical professional. The panel heard that there is an existing mechanism for putting special patient notes on the computer system which could have informed gtd Healthcare of Joan's recent overdose. Currently the system tends to be used only in cases where palliative care is ongoing but there is the potential to expand it to other cases. This is a learning point and leads to a single agency recommendation for the CCG.

14.3.7 It is clear that Joan disclosed her feelings to health professionals and sometimes others. The actions of staff at Preston Royal Hospital in making safeguarding alerts, were appropriate and recognised the risks that Joan was facing. Mental health practitioners [LSCFT], who saw Joan at the hospital, completed appropriate risk assessments [although an update was missed, see paragraph 14.2.4].

14.3.8 A significant response of agencies was to pass their concerns to Adult Social Care by making a safeguarding alert. The alerts were appropriately made and the response to those alerts is discussed further at paragraph 14.5

14.3.9 The panel were aware that research has indicated a significant number of domestic abuse victims suffer from suicidal ideation. A study[17] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. Whilst noting that there were other significant factors in this case, for example, Joan's chronic pain, panel members thought that the research should be widely shared in domestic abuse training. This is a learning point. [Multi-agency learning 1]

14.4 **How can your agency demonstrate that professionals understand what coercive and controlling behaviour is and the impact it has on victims?**

14.4.1 **Lancashire Constabulary**

Lancashire Constabulary has a comprehensive training package for their new recruits on all aspects of domestic abuse, including coercive control. When coercive control offences were first introduced, Lancashire Constabulary didn't have any form of formal training for current staff; although numerous training/notification documents were circulated via Sherlock (Lancashire Constabulary's IT Information System).

Subsequently, presentations on coercive control were given to officers and communications staff.

Whilst the constabulary believes it has provided adequate training on this subject, as part of its action plan for this DHR it will consider an audit of webstorm logs with a domestic abuse classification. It can then be established that officers within the constabulary have an understanding of the issues of coercive control and that they are being dealt with appropriately.

14.4.2 **Victim Support**

Victim Support is the commissioned provider for Lancashire Victim Services and a significant proportion of referrals to the service are the result of

[17] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse[17] [*Vanessa E. Munro & Ruth Aitken]*

domestic abuse [around 16,000 per annum]. No member of the team is permitted to work with victims of domestic abuse without undertaking in-house domestic abuse training that covers coercion and control. In addition, all of IDVAs who work with high-risk victims of domestic abuse complete accredited training by Safelives in order to recognise and address risks and the impact of DV on victims.

14.4.3 **gtd Healthcare**

gtd *Healthcare* has comprehensive safeguarding vulnerable adults' policies and procedures.

All staff within the organisation are required to be trained to the appropriate level dependant on their designation.

Significant efforts are being made in terms of raising awareness of relevant safeguarding themes, including domestic abuse, and providing guidance to staff members across the organisations via a range of communication channels i.e. staff intranet, weekly organisational briefings.

14.4.4 **Adult Social Care**

Safeguarding senior social workers, social workers and SCSOs undertake ongoing training as part of their roles within the Safeguarding Enquiry Service. Essential training for staff includes Safeguarding Adults E Learning training, Safeguarding for All classroom training and Safeguarding Level 2 classroom training.

Senior social workers, social workers and SCSOs are kept up to date with current training opportunities (classroom, webinars, and presenters at team meetings) and are encouraged to apply for training applicable to their specific roles. Senior social workers attended domestic abuse training in May 2020 around signs of abuse, safety planning and signposting. The Safeguarding Enquiry Service encourages a culture of sharing and learning from training events workers have attended. In-house monthly CPD sessions are also held so that safeguarding staff can share their learning from courses they have attended, practice experiences, reading, etc.

Although staff are encouraged to attend training around domestic abuse and coercive and controlling behaviour, there is no specific training identified in the 2020-21 Adult Social Care training plan.

Further to this, Lancashire County Council have an academy that forms part of an induction as well as on-going training for new employees, with and

without professional qualifications. For social workers, there is the further commitment to their Continuous Professional Development that is a requirement of their professional registration. Learning needs may also be identified through regular supervision.

There will be training specifically available for those working in safeguarding. Learning and Conclusions from Safeguarding Adults Review Board are also made available for the most recent safeguarding reviews through the Lancashire Safeguarding Adults Board.

Social workers and social care staff in the hospital have discussions with service users separately if they have any concerns that they may be being coerced or controlled in any way and ward staff ensure that they document any concerns on ward notes and social care electronic records if they have concerns. There is safeguarding e-learning available for staff and the culture of the team was one of openness and had daily discussions regarding patients where safeguarding issues were often raised. The Principle Social Worker and Community Operations Safeguarding Manager also circulate regular documents relating to domestic violence.

14.4.5 **Clinical Commissioning Group**

All practitioners have undergone training on domestic abuse and both GP practices have up-to-date Safeguarding Adult and Domestic Abuse Policies as recommended by the CCG Safeguarding Team.

Practice members demonstrated that they know where to get help and advice for victims when spoken to by the IMR author.

14.4.6 **LSCFT**

LSCFT have mandatory training requirements in place to support safeguarding: a training matrix identifies the minimum competencies of all staff within the organisation dependant on role. This consists of: Safeguarding Adults (SGA) and Children (SGC) training at levels 1, 2 and 3; Mental Capacity Act (MCA) levels 1 and 2; and, WRAP reflective of the intercollegiate document. Adult and children's safeguarding training includes: domestic abuse; explores the wider determinants of domestic abuse; impact on children and victims; and, what would constitute good practice.

In future, all safeguarding level 3 training will be delivered face-to-face: a strategy has been developed to support the implementation.

	SGC Level 1	MCA Level 1	SGC Level 2	SGC Level 3	SGA Level 2	MCA Level 2	WRAP
Professionally registered staff	**N/A**	**N/A**	**N/A**	**RQ'D**	**RQ'D**	**RQ'D**	**RQ'D**
Non-professionally registered	**N/A**	**RQ'D**	**RQ'D**	**N/A**	**RQ'D**	**N/A**	**RQ'D**

The issue of domestic abuse (DA) and the promotion of routine enquiry (RE) has been a key focus within quality improvement activity within LSCFT and is a key organisational priority; the focus being to promote use of routine enquiry in practice and to develop staff confidence in knowing how to respond to domestic abuse.

This has involved: focussed workshops; training initiatives and awareness raising sessions across the networks; sharing domestic abuse pathways and resources to support staff's understanding of the key features and indicators of domestic abuse; and, to promote good practice.

IT developments will also be implemented within Rio (Mental Health Case Records) in November 2020, to better capture the adoption of routine enquiry, aiding audit and will also provide practitioners with a prompt.

The trust also has a MECC2 (Domestic Abuse; making Every Contact Count) e learning module which has been promoted through LSCFT Safeguarding Champions. This training will become essential for registered professionals.

Other initiatives undertaken by LSCFT include securing the services of AFTA Thought, an organisation delivering training through drama to bring issues, policies and legislation to life. They were commissioned to deliver 3 half-day sessions on DA and RE. These were open to all staff, with 117

attending. Feedback from attendees included:

> ***"Absolutely hits the spot"***
> ***"excellent"***
> ***"Powerful, emotive, upsetting - really brought home the reality of DA"***
> ***"Good helpful, powerful forum to reflect on practice - the Q&A session was very good"***

Practitioners also reported that confidence had increased when adopting RE:

> ***"Yes and will feedback to my colleagues"***
> ***"Supported and strengthened understanding"***
> ***"Very much so - I hope should a situation arise I could deal with and support with confidence"***
> ***"Yes definitely, I understand the difficulties people face in speaking out about DA and how we can help in supporting them"***

In January 2020, LSCFT hosted a safeguarding conference, Encouraging Empowerment in Safeguarding Domestic Abuse Victim Support Services. This was presented to the 125 multi-disciplinary attendees as part of the agenda, they also supported a survivor of DA to share their experiences of contacts with services, again providing a valuable learning opportunity.

As part of the LSCFT Professional in Practice Preceptorship Events for newly professionally registered practitioners within the organisation, the safeguarding team used DA scenarios to promote the wider determinants of DA, LSCFT policy, procedure, RE and good practice: there were 111 attendees over 3 half-day sessions.

LSCFT have a Domestic Abuse Operational Group led by the safeguarding team to ensure interface with network leads in relation to this agenda, to educate and disseminate information and to respond to strategic and legislative developments. Additionally, this group has also coordinated key audit activity in relation to domestic abuse to evaluate practice standards in this area and to support the quality improvement journey.

14.4.7 LTHTR [Preston Royal Hospital]

The Trust has recently reviewed all of its safeguarding training packages and now includes comprehensive education on all aspects of domestic abuse. A recent audit identified positive response in relation to recognising and responding to domestic abuse incidents and appropriate DASH risk assessments were undertaken alongside necessary signposting to services for both the adult victims and their children.

14.4.8 **Guardian Homecare**

All staff are trained in safeguarding of vulnerable adults, which includes the signs and symptoms of domestic abuse including coercive and controlling behaviour. This is covered during the induction process as well as during annual refresher training.

14.4.9 The panel acknowledged that some responses were generic in relation to domestic abuse training and that specific training to recognise the signs of coercion and control was not consistent across agencies. This is a learning point [Multi-agency learning 2].

14.5 **What services did your agency provide for Joan and/or Brian and their daughter; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?**

14.5.1 Victim Support responded to a referral from Preston Royal Hospital after a DASH risk assessment had been completed by telephoning Joan the following day to offer support. Joan said that she was in hospital, it was not convenient to do an assessment and she did not want support. It is not clear whether reasonable enquiries were made to understand the circumstances for Joan i.e. was she in hospital because of domestic abuse or unrelated matters, had she sustained injuries, was she frightened? It would also have been good practice to advise the referrer that support had been declined. Joan was still in hospital at this point and had staff there known Joan had declined support, it would have given another opportunity for a supportive discussion. The Victim Support representative on the panel acknowledged that good practice would be for the hospital, as the referrer, to be contacted. This learning point leads to a single agency recommendation for Victim Support.

14.5.2 Adult Social Care recorded four safeguarding alerts for Joan as outlined at paragraph 14.1.1

14.5.3 First safeguarding alert

Opened: 06/06/2018 – Closed: 08/06/2018

No risk of suicide was recorded during this period of safeguarding intervention. The MASH worker attempted to liaise with Joan via a staff nurse, but Joan felt too tired to speak about 24-hour care provision. The approach from MASH centred round carer breakdown in which Brian was contacted first. Discussions at MASH centred round finding the most appropriate support to meet Joan's needs and address carer breakdown. The safeguarding response was timely; however, the specific safeguarding concerns within the alert around controlling behaviour, refusing to give medication and declining formal support, do not appear to have been addressed on their own merit and Joan was not directly spoken to about this in terms of her desired outcomes. It also does not appear that attempts were made to contact the allocated social worker as part of the strategy discussion. The MASH strategy stated that the alleged neglect wasn't intentional; however, it is not clear what the rationale was in determining this.

14.5.4 The DHR panel discussed whether the appropriate approach had been taken in contacting Brian to discuss Joan's support needs. The panel thought that whilst a conversation with Brian about Joan's support needs was necessary, this safeguarding intervention failed to address domestic abuse in any way and was therefore not appropriate. A DASH risk assessment should have been completed or advice sought from a domestic abuse professional. This is a learning point for Adult Social Care.

14.5.5 Second safeguarding alert

Opened: 02/11/2018 – Closed: 09/01/2019

A case note is incorporated into the Strategy which states 'she said that she is depressed and doesn't want to be here anymore because she is a burden to her family and they are so nasty towards her.'

The MASH worker who made contact with Joan on 6 November 2018, stated she was in too much agony to speak. The case was progressed to the Safeguarding Enquiry Service on 6 November 2018. A joint visit to see Joan at home was then undertaken with Safeguarding Enquiry Service and the Screening and Initial Assessment Service on 14 November 2018. The Safeguarding Enquiry Service worker formulated the following safeguarding plan on 20 December 2018:

-GP pain management/mental health needs to be assessed.
-referral to welfare rights.

-Direct Payment for Personal Assistant option to be explored.
-Carers assessment and support for daughter.
-Brian social care needs to be assessed, referral to discover.
-referral to ASC for long term intervention.
-care line in place.
-Joan provided with safeguarding information and advice verbally and in written form. to press care line, call 111, call social services, call police.
-Daughter to call for an ambulance for [Brian] if he sustains injury due to alcohol.

The safeguarding plan was designed around meeting Joan's health and social care needs, addressing carer breakdown and offering support around Brian's alcohol dependency. Screening and Initial Assessment Service were tasked with the responsibility for following up these actions. Safeguarding advice was given.

14.5.6 On 9 January 2019, the hospital discharge team contacted Screening and Initial Assessment Service about whether it was safe for Joan to return home following a hospital admission. Screening and Initial Assessment Service advised that the safeguarding enquiry had been concluded. There is a record of a safeguarding enquiry outcome letter addressed to Joan but it does not appear that the letter was sent. This appears to have been an administrative error.

14.5.7 While Joan was in hospital, from 7 to 10 January 2019, a window of opportunity was missed to have a discussion about the safeguarding and domestic abuse concerns. This was at a point where hospital staff felt it appropriate to complete a DASH risk assessment.

14.5.8 This safeguarding concern was finalised as unsubstantiated. Joan was not involved in reviewing the safeguarding actions and it is not clear if she was asked whether her desired outcomes were achieved. No discussion was held with Joan on closing the case. In accordance with Making Safeguarding Personal[18], Joan should have been consulted at the beginning, the middle and the end of the episode.

14.5.9 The DHR panel noted that in common with the first safeguarding episode, whilst work had been undertaken to review Joan's care needs and attempts

[18] Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. The work is supported by the Local Government Association with the Association of Directors of Adult Social Care and other national partners and seeks to promote this approach and share good practice.

made to address possible carer breakdown, there is no evidence of actions taken directly to address allegations of domestic abuse.

14.5.10 Third safeguarding alert

Open: 25/04/2019 – Closed: 29/04/2019

On 26 April 2019, the MASH worker liaised with the discharge coordinator at Preston Royal Hospital who was able to establish that Joan did not wish to pursue a safeguarding enquiry and that she was more concerned about her medical needs being met when returning home. A discussion should have taken place with the Adults Safeguarding Team within Royal Preston Hospital in order to gather additional information and contribute to a risk assessment. The MASH worker agreed to send a letter through the post with useful numbers and ask the discharge coordinator to ask Guardian Homecare [reablement] to raise any future safeguarding concerns. The Adult Social Care representative on the panel indicated that they would expect to see a record of the mental capacity of the person making such a decision and there is no record of this within the notes of the case. This is a learning point for Adult Social Care.

14.5.11 Due to the nature of the allegations of abuse, the MASH worker liaised with police to request intelligence around domestic abuse at the property. Police advised that no concerns were noted in the last 12 months, but a Vulnerable Marker was placed on the property.

14.5.12 On this occasion, Joan's views were considered. The panel noted that the MASH worker appeared to be reassured by the fact that the police reported there had been no incidents reported at the family property. However, given the well-established evidence that domestic abuse is widely underreported, the panel felt that little weight should have been given to the information when Joan had made several allegations of domestic abuse to health professionals over the preceding months.

14.5.13 Fourth safeguarding alert

Open: 12/05/2019 - Closed: 06/11/2019

The panel noted that this alert was made by Guardian Homecare who were asked by the hospital discharge coordinator on 26 April 2019 to raise any future safeguarding concerns. Guardian had been providing care to Joan since 26 April 2019. The care had been cancelled on a number of occasions by Brian and Guardian had reported a concern for Joan's welfare to Adult

Social Care on 29 April 2019. Care staff, having visited Joan on 12 May 2019, were so concerned that their concerns were raised as a safeguarding alert.

14.5.14 The nature of the allegations [threats of violence and fear of repercussions from husband and daughter dragging her to bed] appeared to demonstrate an escalation from the previous safeguarding alerts. The case was categorised as '3' (cases are to be allocated out to workers within a 2-week period.) by MASH and thus a low priority. It was noted that Brian's intoxication was a result of caring responsibilities. Whilst those responsibilities may have placed pressure on Brian, the panel noted that his use of alcohol was long standing and that information would have been available if it had been sought.

14.5.15 The record noted that Joan had capacity and could call the police for assistance, however this failed to address the concerns within the alert that Joan feared repercussions from Brian if she was to disclose anything. There was no intervention from MASH between 12 May 2019 and the date of Joan's death; although a request was made on 29 May 2019 to review the package of care. It is recorded that on 29 May 2019, a MASH worker received a phone call from the Hospital Discharge Team. Following receipt of the phone call, the worker should have liaised with the duty team. This should have been rescreened as a higher priority as MASH had received notification that Joan was in hospital and the case would then have received a more urgent response. The panel thought that the response to this safeguarding alert was inadequate. This is a learning point for Adult Social Care.

14.5.16 Each safeguarding alert appeared to the panel to have been dealt with in isolation and the potential escalation between the alerts was not recognised or acted upon. A number of actions were taken to address Joan's care needs, but the panel could not see any evidence of actions taken to directly address the specific domestic abuse concerns. This is a learning point for Adult Social Care.

14.5.17 The Association of Directors of Adult Services publication, 'Adult safeguarding and Domestic Abuse, a guide to support practitioners and managers 2015', contains the following information on the impact of domestic abuse on people with care and support needs.

What might be the additional impacts of domestic abuse on people with care and support needs?

- increased physical and/or mental disability

- reluctance to use essential routine medical services or to attend services outside the home where personal care is provided
- increased powerlessness, dependency and isolation
- feeling that their impairments are to blame
- increased shame about their impairments (for example in relation to needs for personal care.

Research has mainly been carried out with women, and this has shown that: being disabled strongly affects the nature, extent and impact of abuse. Research has shown that people's impairments are frequently used in the abuse. Humiliation and belittling were an integral part of this and were particularly prevalent. Many abusers deliberately emphasise and reinforce dependency as a way of asserting and maintaining control. Sexual abuse appears to be proportionately more common for disabled than for non-disabled women, perhaps reflecting particular vulnerabilities. The impact of domestic abuse is often especially acute where the abusive partner is also the carer: the carer has considerable power and control and the victim relies on them. Perpetrators often use forms of abuse that exploit or contribute to the abused person's impairment.

14.5.18 The Lancashire Safeguarding Adult Board 'Domestic Abuse Guidance November 2018' contains extensive guidance for practitioners which builds on the ADAS guidance and, in addition, contains information for practitioners on safeguarding enquiry and the need to use the DASH risk assessment.

14.5.19 The panel recognised some of the features described by the publication in Joan's consistent reports to professionals. The panel thought that these impacts could reasonably have been expected to be recognised by professionals in Adult Social Care who dealt with Joan's case.

14.5.20 Lancashire and South Cumbria NHS Foundation Trust

On 6 June 2018, a referral was made to the LSCFT Mental Health Liaison Team [MHLT] after Joan had attended A & E following a fall at her home, she was presenting as very anxious. Mental Health Liaison Team felt that as Joan was not medically fit at that time, it was not appropriate to undertake a mental health assessment. This is in keeping with expected practice. Joan was discharged before an assessment was completed and she was not referred to a community mental health team for a follow-up assessment. This

would have been of benefit and appropriate as she had reported to have been expressing suicidal thoughts. Joan was not referred to the Community Mental Health Team as she was on a waiting list to see a consultant psychiatrist. This learning point was identified by LSCFT during an internal review in November 2019, as a result of which a learning briefing was developed and circulated to all relevant staff. There is therefore no recommendation made on this point.

14.5.21 On 20 May 2019, Joan was referred due to an intentional mixed overdose of diazepam and oxycodone. An enhanced risk assessment was completed in line with expected practice.

14.5.22 Clinical Commissioning Group

Brian was known from 2009 to have problems with alcohol excess. He was noted on several occasions by GPs and Practice staff to smell strongly of alcohol. On each occasion [5 June 2018, 6 August 2018, 4 September 2018, 26 September 2018] he was offered support and advice regarding alcohol services. On 6 December 2018, he told the GP that he was cutting back on his drinking and was suffering with some withdrawal symptoms. After changing GP practices to surgery B in March 2019, Brian was not seen in his own right for a consultation. He did not declare any problem with alcohol on his new patient registration form.

14.5.23 In addition to her physical ill health, Joan also had complex long-standing mental health problems. There is mention within her GP records of agoraphobia, depression, anxiety and panic. She had intermittent involvement with mental health services but there is no clear definite diagnosis within her GP records.

14.5.24 In the view of the CCG IMR author, Joan's level of care from both GP practices was excellent. There is evidence throughout of thorough holistic care and all practitioners looked further than the physical problems and into the entwined psychological and social difficulties. When patients have complex needs it is advisable to maintain continuity of care; this was achieved by both Practice A and B. It was unfortunate that Joan and Brian moved GP practice in March 2019, as this continuity was interrupted. The reasons for the move of GP practice are not known – see paragraph 13.2.25 for further information.

14.5.25 The complexity of Joan's problems - physical, psychological and social - appears to have been overwhelming; though an enormous amount of effort and time were spent by both practices, no progress was ever really made. In hindsight, it can be seen that the family's pattern of behaviour was to seek urgent help at times of crisis. The advice they were given was often not followed through. Recurrent and multiple referrals were made, with good intention, to other services with subsequent non-attendance and therefore discharge. Looking at the reasons for non-attendances would have been helpful. Joan was largely immobile and to a great extent reliant on others to take her to any appointments. The panel identified this as a learning point and was then provided with guidance recently issued to GP practices as a result of a DHR in an adjoining area which deals with the same issue. There is therefore no separate learning or recommendation on this aspect of the review.

14.5.26 GP Practice B monitored Joan's medication closely after the overdose she had taken on 17 May 2019. The GP and Advanced Nurse Practitioner visited just after her discharge on 31 May and had planned to arrange a multi-disciplinary meeting. There had not been time to do this before Joan's sad death.

14.5.27 On 7 June 2019, Joan was seen at home by an out-of-hours GP provided by gtd Healthcare. Due to her uncontrolled pain, she was issued with another bottle of oxynorm liquid. gtd Healthcare doctors do not have full access to GP records and would not have known Joan had recently taken an overdose unless the GP practice had specifically told them. This learning point has already been discussed at paragraph 14.3.6.

14.5.28 Lancashire Constabulary had limited contact with Brian on two occasions in July 2018, when concerns were raised about Brian's mental health and possible suicidal thoughts. The response by the constabulary was prompt and his safety and wellbeing were established. Officers attending ensured he had support and addressed the concerns raised.

14.5.29 Lancashire Constabulary has looked to increase awareness around mental health. They have access to the Mental Health Advice Line (MHAL) 24hrs a day. This is a service for police officers and staff only, where they can obtain information and advice from a mental health professional, relating to individuals they are dealing with who present as being mentally unwell.

14.5.30 Officers also now have access to the Lancon Mental Health App via hand-held Samsung devices. This specific application has been compiled and designed with frontline policing in mind, to assist in dealing with the ever-increasing

mental health demand being placed on the police. There is a section relating to useful contacts, detailing the Mental Health Access Line, Bed Hub, Designated Places of Safety, AMHP Services, Community Mental Health Teams, etc. Letting officers know who they are and how to contact them.

14.5.31 Access to these services, which have been introduced within the last twelve months, may have provided officers attending both of these incidents with further options when assisting Brian.

14.6 **Was a carer's assessment offered and/or completed? If not, should it have been offered and completed.**

14.6.1 Adult Social Care records indicate that a carer's assessment was requested on four occasions and noted as an action on a fifth.

26 April 2018, following a home visit by Adult Social Care staff, it was noted that a referral for a carer's assessment would be made to N-Compass for both a carer's assessment and a welfare assessment regarding benefit entitlement.

24 July 2018, during a hospital admission, Adult Social Care records indicate that a referral was made to N-Compass for a carer's assessment.

14 November 2018, following a visit to Joan at home by Adult Social Care staff as part of a safeguarding enquiry, the plan drawn up included an action to request a carer's assessment. [no evidence this was progressed]

4 April 2019, a request for a carer's assessment for Brian and the couple's daughter was made by Adult Social Care [South Ribble East Community Team]

19 April 2019, a request for a carer's assessment was made by Adult Social Care following a hospital admission.

14.6.2 N-compass provides the Lancashire Carers Service. The Lancashire Carers Service is funded by Lancashire County Council to provide information, advice and a wide range of specialist support services designed to help carers continue in their caring role for as long as they choose and reduce the impact the caring role can have on their own health and wellbeing. This can include accessing a carer's assessment and other support services.

14.6.3 The panel were told that N-Compass had received one request for a carer's assessment from Adult Social Care in this case. Their records indicate receipt of a referral on 9 April 2019 [request recorded by Adult Social care as 4 April 2019]. N-Compass then spoke to Brian on 24 April 2019, explained the service and offered an assessment. Brian said that he didn't want any support and didn't want a carer's assessment. N-Compass also spoke to Joan and Brian's daughter who also declined support.

14.6.4 There is no evidence to indicate whether Brian or the couple's daughter understood the significance of the support being offered to them or whether the value of a carer's assessment had been discussed with them during any of the contacts with Adult Social Care.

14.6.5 Carer breakdown was identified as a feature in the case during the first safeguarding investigation in June 2018, when Adult Social Care indicate that their approach to managing the case was to focus on carer breakdown. It is therefore remarkable that of the requests for a carer's assessment recorded by Adult Social care, only one was ever received by N-Compass. This is a learning point for Adult Social Care.

14.6.6 Brian did not have a carer's health assessment, which should be offered as part of the GP Quality Contract, at either practice.

Practice A knew he was a carer, offered help and support within consultations and knew that Adult Social Care was involved. He was not formally "coded" as a carer within the GP records which meant that he was not on the official practice Carer's Register. It is this list which is used to invite patients for their carer's assessment.

As there was no coding from Practice A, and the new practice did not know the family, (Brian said he was not a carer when asked on the New Patient registration form) the fact that Brian was a carer was "lost" to Practice B.

The assessment aims to identify any unmet needs and refer or signpost the client to appropriate services. This is a learning point and leads to a single agency recommendation for the CCG.

14.7 **What signs of carer breakdown did your agency identify and what was done to address the issue.**

14.7.1 Joan raised issues that were symptomatic of carer breakdown during her hospital admissions on a number of occasions. These included Brian's drinking, refusing to give her medication or assist her in and out of bed. The concerns raised were appropriately referred to Adult Social Care as safeguarding alerts.

14.7.2 Over the course of the four safeguarding enquiries, carer breakdown was confirmed. The safeguarding plan from the second enquiry [2 November 2018 – 09 January 2019] emphasised the need to meet both Joan's needs as well as Brian and Kirsty's carer needs.

14.7.3 There is documentation within individual consultations at GP Practice A that practitioners were fully aware of Brian's caring responsibilities and struggles. He was offered help and support with his alcohol excess and low mood on several occasions. This is good practice.

14.7.4 As the extent of his alcohol problems became more severe, [by September 2018 he admitted to drinking 80 units of alcohol per week, was attending surgery drunk and had lost his job] a "Think Family" approach should have been used and Joan's welfare considered. On looking at Brian's records alone, there is no reference to this, but Joan's records show that liaison with Adult Social Care and Safeguarding did take place.

14.7.5 The NHS[19] provides the following information on managing health risks from alcohol.

To keep health risks from alcohol to a low level if you drink most weeks:

- Men and women are advised not to drink more than 14 units a week on a regular basis.
- Spread your drinking over 3 or more days if you regularly drink as much as 14 units per week.
- If you want to cut down, try to have several drink free days each week. 14 units is equivalent to 6 pints of average strength beer of 10 small glasses of low strength wine.

14.7.6 On 3 April 2018, a Social Care Support Officer with Screening and Initial Assessment Service spoke with Brian. He stated that he was managing but

[19] https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/#:~:text=men%20and%20women%20are%20advised,as%2014%20units%20a%20week

was having to cancel work in the mornings to support Joan. He thought a package of care might be suitable but wanted to speak to Joan first. Referrals were made for the Wellbeing Service, the Falls Clinic, EQR (low level adaptations and equipment that can be prescribed by SCSOs within SIAS). This was the earliest indicator that the carer role may not be sustainable. The support officer arranged to contact Brian on her return from leave. There is no record of that contact being made. Further contacts with Joan, Brian and Kirsty with Adult Social Care, indicated carer breakdown and are reflected in the safeguarding alerts that were raised.

14.8 **How did your agency ascertain the wishes and feelings of Joan and Brian about her victimisation and his alleged behaviour and were their views taken into account when providing services or support?**

14.8.1 Over the course of the four safeguarding enquiries, the main focus of Adult Social Care was on addressing Joan's health and social care needs and carer breakdown. There is no evidence of specific conversations with Joan or Brian around the allegations of abuse made by Joan.

14.8.2 An example of this approach was on 2 November 2018, when Joan rang the Emergency Duty Team. This call, which alleged emotional abuse from Kirsty, resulted in the second safeguarding alert being raised. EDT spoke to Kirsty who admitted that she was struggling to cope with caring for her mum. EDT responded by placing Crisis Care visits four times a day over the weekend to provide personal care and welfare support.

14.8.3 Much of the relevant information around the four safeguarding alerts and how they were dealt with, has already been discussed at paragraph 14.5. In summary, the focus was on Joan's health and care needs and although she raised the issue of abuse on a number of occasions this was not directly addressed.

14.8.4 As discussed at 14.1.2 and 14.5.1, staff at Preston Royal Hospital did listen to Joan's concerns and as a result, a DASH risk assessment was completed. Joan did not follow up on the offer of support from Victim Support which would have been an opportunity for her to further express her wishes and feelings.

14.9 **What did your agency do to safeguard Joan from domestic abuse?**

14.9.1 As a result of the four safeguarding alerts, as discussed in previous paragraphs, the focus of the action by Adult Social Care was around Joan's health and social care needs and carer breakdown. There is no evidence of specific actions to deal with domestic abuse. The panel thought that it may have been helpful if the advice of a domestic abuse professional had been sought during the course of the safeguarding enquiries.

14.9.2 All agency IMRs are clear that Joan had capacity to make her own decisions and that those decisions were respected.

14.9.3 The Mental Capacity Act 2005 has the following principles which they felt did not require them to complete a mental capacity assessment:

Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case". [Mental Capacity Act Guidance, Social Care Institute for Excellence]

The panel thought that agencies had followed the principles within the act.

14.9.4 On 21 May 2019, whilst Joan was in hospital, an enhanced risk assessment was completed by Mental Health Liaison Practitioner. [LSCFT] This identified Joan as being vulnerable to domestic abuse, however there is no evidence that any adult safeguarding referral was discussed with Joan or signposting to Victim Support. The practitioner was aware that a safeguarding referral had already been made and the panel thought it possible that this deflected the practitioner from further addressing domestic abuse.

14.9.5 Later in May, when Joan was due to be discharged from hospital, she was seen by a hospital-based social worker. Joan had capacity and the social worker did not feel that there was any undue influence on her. Joan's decision was to return home with support from Brian. The panel discussed what Joan's realistic options were at this time. She was unable to stay in hospital indefinitely and although there was some discussion about sheltered housing, it was unlikely that this could have been resolved quickly. In effect, Joan's only choice was to return home.

14.9.6 The panel thought that Joan's disclosures of abuse had largely been overwhelmed by the complexity of her medical and social care needs. Decisions were made to focus on those needs and attempts were made to relieve the burden of care by ensuring that Joan was provided with appropriate support at home. For example, she received four care visits per day following her discharge from hospital in May 2019.

14.9.7 This approach did not take into account the possibility of domestic abuse preceding the development of Joan's care needs and effective steps to monitor and deal with any further domestic abuse were not put in place; instead, reliance was placed on the fact that Joan was able to contact the police and other services should she need to.

14.10 How effective was inter-agency information sharing and cooperation in response to Joan and Brian and was information shared with those agencies who needed it?

14.10.1 There is good evidence that agencies shared information, for example, information was shared between Preston Royal Hospital, LSCFT and Adult Social Care. Information was sought by Adult Social Care from the police and was appropriately shared. Guardian Homecare raised their concerns about

Joan and shared information with Adult Social Care appropriately. There is evidence of GP Practice A sharing information with Adult Social Care.

14.10.2 Although there is evidence of information sharing there are also examples where information was not shared. These include:

- 6 June 2018, GP Practice A received an A+E discharge slip saying Joan had attended with anxiety. No information was shared with regards to the safeguarding referral and MASH assessment which took place.
- On 2 November 2018, the GP was not informed that a safeguarding enquiry was underway.
- The GP was not contacted by any other services about Brian's behaviour or warned about any potential dangers of lone working. This was just a comment in the brief A+E discharge slip.

14.10.3 The gtd Healthcare Service specification requires that the patient's GP practice receives a copy of any consultations via an electronic post event messages by 8am the following day. An audit trail from the clinical system has confirmed that this was completed following all visits to Joan by out-of-hours GPs.

14.10.4 Whilst information was shared between agencies, it did not lead to effective action to tackle the allegations of abuse that Joan made on multiple occasions. Neither the Adult Social Care MASH nor Safeguarding Enquiry Service spoke to Joan in relation to the specific concerns around domestic abuse. Had these interactions taken place, the social workers may have been able to offer guidance on her options and offered a further DASH risk assessment; which could have led to a referral to an IDVA.

14.10.5 Several IMR authors in this case concluded that a multi-agency meeting to share information, risk assess and formulate a cohesive plan would have been helpful. The DHR panel agreed that such a meeting could and should have taken place. The appropriate forum for such a meeting is a Risk Assessment and Planning meeting [RAP]. Adult Social Care could have organised such a meeting and that they did not is a learning point.

14.10.6 On 3 June 2019, after Joan's discharge from hospital following an overdose, GP Practice B documented plans to arrange a multi-disciplinary meeting. This had not happened by the time Joan sadly died a few days later. The MDT meeting would typically include representation from professionals involved in Joan's care such as social worker, GP, etc. The meeting would include a

discussion around presenting medical issues and actions to be taken around potential identified risks with a holistic response to those risks including liaison and referral to relevant agencies. One potential outcome from the MDT would be for Adult Social Care to arrange a Risk Assessment and Planning meeting to address wider risks.

14.11 **What did your agency do to establish the reasons for Brian's alleged abusive behaviour and how did it address them?**

14.11.1 Information seen by the review shows that Brian's behaviour was treated as a symptom of carer breakdown. An assumption was also made that his excessive use of alcohol was a symptom of carer breakdown. A multi-agency meeting, as suggested at paragraph 14.10, would have established that Brian had long-standing issues with alcohol.

14.11.2 A result of the assumptions made was that no further efforts were made to establish the reasons for Brian's behaviour or to address it.

14.11.3 GP Practice A, though not realising that abuse was happening, offered Brian support and referrals regarding his alcohol problems on several occasions. Local support agencies have no record of Brian contacting them.

14.12 **Was there sufficient focus on reducing the impact of Brian's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**

14.12.1 The allegations about Brian's behaviour were never reported to the police. Adult Social Care did ask the police on one occasion if there had been any reports of domestic abuse at the couple's address, but allegations of abuse were not reported to the police.

14.12.2 Had Joan's allegations of domestic abuse been followed up, the possibility would have existed of a referral to a domestic abuse perpetrator programme for Brian, but this was never considered. The Lancashire Domestic Abuse Perpetrator Programme [LADAPP][20] is delivered by The Wish Centre and is suitable for people who are not in the criminal justice system.

14.12.3 The panel noted that Joan had reported to Adult Social Care concerns around Kirsty's behaviour. This was in part addressed by a referral for a carer's assessment which, if successful, could have provided additional support.

[20] https://lancastercvs.org.uk/wp-content/uploads/2020/06/Lancashire-Domestic-Abuse-Perpetrator-Programme-Make-The-Change-A5-2pp-2.pdf

14.12.4 Brian had also been referred for a carer's assessment on several occasions but, as discussed at 14.6, this was ineffective.

14.13 **Are there any examples of outstanding or innovative practice arising from this case?**

14.13 The panel did not identify examples of outstanding or innovative practice.

15 CONCLUSIONS

15.1 By the time of her sad death, Joan had suffered from multiple medical conditions which resulted in severe pain for many years. The complexity of her physical and mental health was challenging for professionals and she had many contacts with medical and social care professionals.

15.2 During the course of Joan and Brian's long marriage, there had never been a report of domestic abuse to the police. Brian was visited by the police on two occasions in 2018, as a result of welfare concerns raised by third parties, but other than that he was not known to the police and had no criminal record for any matter.

15.3 The DHR panel were mindful of information from Joan's family that Brian may have had a controlling influence on Joan and recognised that many domestic abuse incidents are never reported. One report for example states:

'On average victims experience 50 incidents of abuse before getting effective help'[21]

Nevertheless, agencies were not aware of allegations of domestic abuse until June 2018, when Joan first alleged abuse whilst in hospital.

15.4 Prior to that time, Brian had appeared to be supportive, for example earlier in 2018 he had obtained a stairlift so that Joan could more easily move around the house. Joan's brother told the chair of the review that the couple had spent thousands of pounds on private medical assessments over the years.

15.5 Once Joan began making disclosures of domestic abuse during 2018 and 2019, the main response of agencies was to make safeguarding referrals to Adult Social Care. This was a reasonable response from Preston Royal Hospital on two occasions. In addition, hospital staff conducted a DASH risk assessment on one occasion which did not result in further action beyond a referral to Victim Support. A call from Joan herself, to Adult Social Care, resulted in a third safeguarding alert and a fourth was raised by Guardian Homecare, a care agency which had been asked only a few days previously to be alert to the possibility of abuse.

[21] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

15.6 The response of Adult Social Care across the four safeguarding alerts was to focus on Joan's health and social care needs. The allegations of abusive behaviour were assumed to be caused by the pressure brought about by Joan's medical needs. Brian and to some extent the couple's daughter Kirsty, were caring for Joan and the allegations were seen as signs of carer breakdown.

15.7 Adult Social Care focussed on relieving the perceived carer breakdown. In the course of the first safeguarding investigation, Brian was spoken to about the issues but Joan was not. Across all four safeguarding alerts there was no direct action to deal with allegations which amounted to domestic abuse and each alert was dealt with in isolation. There was no referral to a domestic abuse agency and there is no evidence that a domestic abuse professional was consulted at any time.

15.8 Assumptions were made that Brian's excessive alcohol consumption was as a result of the stress of the family situation. Whilst this may have exacerbated his use of alcohol, Brian had long-standing issues with excessive alcohol consumption and this information would have been available if sought. Similarly, no thought was given to the possibility of domestic abuse pre-existing the development of Joan's care needs.

15.9 The need for carer's assessments was recorded on five occasions and is said to have been actioned by making a referral on four of them. Only one referral was received by the organisation responsible [N- Compass] and when contacted by them, Brian and Kirsty declined support. Given that the approach to managing the four safeguarding alerts in relation to Joan's circumstances was said to be around carer breakdown, it is remarkable that so little was done to ensure that Brian and Kirsty had support to enable them to be effective carers.

15.10 Several agencies contributing to the review concluded that a multi-agency meeting would have been helpful in addressing the complexities of the family situation. The panel agreed with that assessment and also thought that the input of a domestic abuse professional into the case would have been helpful.

15.11 The panel reflected on the differing information it had reviewed, with reports of domestic abuse from Joan, which were completely denied by Brian. The panel had no way of reconciling the differences, but noted that Joan's voice was clearly seen in contemporaneous records which the panel thought were an accurate reflection of Joan's views.

15.12 The panel could not draw a direct line between Joan's reports of abuse and her death. Joan clearly had a complex set of conditions that meant that she suffered intolerable pain despite being prescribed appropriate medication. Her texts and internet searches in the days prior to her death indicated that she was in pain and may have researched ways of taking her life. The panel did however recognise the impact on Joan due to the behaviour by Brian that she complained of and thought that had that behaviour been addressed, Joan may have been able to feel more positive about her life.

16 LEARNING

This multi-agency learning arises following debate within the DHR panel.

16.1 Narrative

The panel thought that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

Learning

Professionals will be better able to manage risk if they are familiar with research linking domestic abuse and suicide

Panel recommendation 1

16.2 Narrative

The panel thought that there was evidence of elements of coercive and controlling behaviour in the case that had not been recognised by practitioners.

Learning

Practitioners need to be provided with appropriate support and training in order to be able to recognise and act upon signs of abuse. Evidence provided by contributing agencies of training on coercion and control is inconsistent.

Panel recommendation 2

17 RECOMMENDATIONS

DHR Panel

17.1.1 Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.

17.1.2 Agencies contributing to the review should provide South Ribble Community Safety Partnership with detailed information on their plans to train staff in the coercion and control elements of domestic abuse.

17.1.3 The learning from this review should be shared with Lancashire Safeguarding Adult Board.

17.2 Single Agency Recommendations

17.2.1 All single agency recommendations are shown in the action plan at appendix A

17.2 It should be noted that all learning points for Adult Social Care are to be taken forward in a single action.

Appendix A Action Plan Joan DHR South Ribble Community Safety Partnership

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
South Ribble Community Safety Partnership							
1	Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.	Local					
2	Agencies contributing to the review should provide South Ribble Community Safety Partnership with detailed information on their plans to train staff in the coercion and control elements of domestic abuse.	Local					
3	The learning from this review should be shared with Lancashire Safeguarding Adult Board.	Local					

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
Single Agency recommendations							
Clinical Commissioning Group							
	Robust use of Carer's Register and "Think Family" approach.	Local	Practices to be reminded about the importance of coding of medical records to clearly identify vulnerabilities.	CCG	All practices are reminded to keep problem lists uncluttered for clarity of thought. Coding of records will be undertaken in a staged approach with priority patients coded.	April 2021 To commence April 2021 due to mass vaccination programme	
	Domestic abuse enquiry, use of professional curiosity.	Local	Routine enquiry about domestic abuse, in a safe environment to be carried out by clinicians in primary care as per NICE Guidance PH50. Utilise key messages from a recent DHR to avoid duplication of efforts.		Recirculate the Sample DA policy to all practices. Practices will receive a training update session from Lancashire Victim Support Service to support routine enquiry being embedded in primary care.	April 2021 April onwards 2021	
	Management of complex cases and use of multi-disciplinary meetings.	Local	Access to case supervision from GP Lead/ CCG / LSCFT safeguarding professionals.		Circulate LSCFT Safeguarding duty line number to support in the management of complex cases in children and adults.	April 2021	

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					LSCFT Safeguarding team requested to provide presentation update to primary care teams regarding their role.		
	Guidance for non-attendance where vulnerability is a feature.	Local	Utilise key messages and learning from previous DHR Adult E.		Was not brought policy is reviewed and circulated to Primary care.	April 2021	
	Safety of practitioners when lone working.	Local	Use of Flag or Special Alerts in medical records to be embedded across primary care to identify risk factors.		Lone working policy to be reviewed to establish if information sharing is included. Circulation of lone working policy to remind practices regarding safety of practitioners and information sharing.	April 2021	
	Effective responses to communication and information sharing between Primary Care and gtd via use of special patient notes.	Local	Primary Care and gtd to work together to ensure that gtd have access to all relevant information where appropriate to support information sharing and response to safeguarding and domestic abuse.		Information sharing in response to safeguarding and domestic abuse is strengthened by new information sharing process.	April 2021	
Victim Support							

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
	Victim Support will review its policy and processes to ensure that where appropriate a referrer is notified when a victim declines support.		Policy to be amended.	Victim Support	Staff are trained in new policy.	June 2021	
Adult Social Care							
	Adult Social Care should review its policy and processes in relation to cases where domestic abuse is disclosed and produce a new pathway and guidance for staff dealing with such cases. The introduction of the new pathway should be supported by case audit to ensure that appropriate progress in implementing the pathway is maintained.		New pathway written and agreed.	Adult Social Care	Staff are trained in new pathway. Audit plan in place.	July 2021	

End of overview report 'Joan'