Safer Wolverhampton Partnership

Caroline, February 2019- DHR 11

Chair and Report Author: Simon Hill

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1 Introduction

THE DOMESTIC HOMICIDE REVIEW (DHR) PANEL AND INDEPENDENT CHAIR, THE SAFER WOLVERHAMPTON PARTNERSHIP AND ALL PARTICIPATING AGENCIES WOULD WISH TO PLACE ON RECORD AN EXPRESSION OF SINCERE CONDOLENCES TO THE FAMILY, FRIENDS AND WORK COLLEAGUES OF CAROLINE.

1. This Overview report of a Domestic Homicide Review examines agency responses and support given to Caroline, a resident of Wolverhampton prior to the point of her death in February 2019.
2. Caroline, (who was 69 years old at the time of the homicide) died from head injuries in her home after a sustained physical assault at the hands of her son, Jonathon (who was 38 years old).
3. In addition to agency involvement, the DHR will also examine the past to identify any relevant background that may indicate the presence of domestic abuse as a relevant factor. The DHR will seek to establish whether Caroline or the perpetrator accessed support in the community but also whether there were any barriers to accessing that support.
4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person dies as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies in the future.
5. The DHR considered agencies contact with Caroline and Jonathon from 01/01/2017, (which from initial scoping, appeared to be the approximate point where Caroline's history of anxiety and depression caused by social stressors, began to lead to frequent episodes of self- harm), up to the date of the tragic homicide.
6. Independent Management Review (IMR) authors were asked to include any relevant background information held by their agency from outside this timeframe, if they believed it would shed light on either Caroline or Jonathon or assist in identifying the learning sought in the Terms of Reference.

2 Timescales

1. The Review began on 3 February 2019 and ended on 1 November 2020. From March 2020 meetings were held virtually due to the restrictions around the Covid-19 pandemic. The pandemic resulted in some delays to the completion of the review, this was largely down to those involved in the review having to respond to the pandemic and therefore, additional time being required to review reports and complete other actions relating to this DHR.

3 Confidentiality

1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. In the absence of family participation, the pseudonyms used were nominated by the DHR panel.
2. The names used in this report for the victim, perpetrator and family members are pseudonyms. In the absence of family participation, the pseudonyms used were nominated by the DHR panel.

Pseudonym	Relationship	Age at time of the fatal incident	Ethnicity
Caroline (Victim)	Mother of perpetrator	69 years old	White, British
Jonathon (Perpetrator)	Son of victim	38 years old	White British
David	Partner of victim		Not applicable
Adam	Son of victim		White, British

4 Terms of Reference

The over-arching intention of this review is to increase safety for potential and actual victims by changing future practice in line with lessons learned from the homicide review. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

- Objective, independent & evidence-based

- Guided by humanity, compassion and empathy, with the victim's voice at the heart of the process
- Asking questions to prevent future harm, learn lessons and not blame individuals or organisations
- Respecting equality and diversity
- Openness and transparency whilst safeguarding confidential information where possible

Specific areas of enquiry

The Home Office has indicated that a DHR should be undertaken. As such the Review Panel (and by extension, IMR authors) will consider the following:

- Information provided by family and friends
- GP Involvement (through the CCG) with the family
- Hospital visits (though RWT) for all family members
- Mental Health involvement (through BCFPT)
- Adult Social Care
- Dudley and Walsall Mental Health Trust (Contextual report only)
- West Midlands Ambulance Service

Establish what lessons are to be learned about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, with reference to:

a. Communication between services
b. Information-sharing between services regarding domestic violence
c. Community understanding of domestic abuse, awareness of how to identify domestic abuse, and routes for reporting domestic abuse
d. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator towards the victim
e. Whether the work undertaken by services in this case was consistent with each organisation's:

- Professional standards
- Domestic violence policy, procedures and protocols
- Safeguarding adult's policy, procedures and protocols

The response of the relevant agencies to any referrals relating to Caroline or Jonathon concerning domestic abuse, mental health or other significant harm. In particular, the following areas will be explored:

a. Whether there were any barriers experienced by the victim or her family/ friends/ in reporting any abuse, including whether the victim knew how to report domestic abuse should she have wanted to

b. Whether there were any warning signs and whether opportunities for triggered or routine enquiry relating to domestic abuse and therefore early identification of domestic abuse were missed

c. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards

d. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective

e. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

f. The quality of the risk assessments undertaken by each agency

g. Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the respective family members.

h. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

i. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

Agency specific questions

Question	**Organisation**
Do records show any indication that Caroline was asked about DA as per expectations of Routine Enquiry in NICE guidelines and WDV Protocol?	CCG, BCPFT, Dudley and Walsall Mental Health Trust, RWT
Did any assessment identify that the routine question was asked? If not, what steps has your organisation undertaken to ensure routine questioning takes place?	CCG, BCPFT, Dudley and Walsall Mental Health Trust, RWT
Has there been training in relation to Routine Enquiry and what has been the uptake? (1 January 2017 – present)	CCG, BCPFT, RWT, Dudley and Walsall Mental Health Trust
Please provide any protocols, procedures and guidance related to domestic violence and abuse and routine questioning. (1 January 2017 – present)	CCG, BCPFT, WMAS, RWT
Has the practice received GP training and support from WDVF/ IRIS? If so, has the follow-up session been completed?	CCG, Walsall and Dudley CCG
Did notes suggest problematic use of alcohol by Caroline and referral to alcohol services?	CCG
Please provide copies of any relevant assessment proformas.	CCG, BCPFT, RWT, Dudley and Walsall Mental Health Trust
Could the injuries that Caroline presented with on 15 April 2017, have been consistent with being hit by a lamp/ assault?	RWT
Following the arrest of Jonathon on 21 April 2017 were any onward referrals made to specialist agencies for support for Caroline?	WMP

Was a DASH risk assessment completed? If so, what were the findings and what was done with them? If not, why was this decision made?	RWT, WMAS, WMP,
Was a forensic investigation carried out on the lamp, and if so, was any evidence found? If a forensic investigation was not carried out, why was this decision made?	WMP
After Caroline chose not to pursue the complaint relating to Jonathon's arrest on 21 April 2017, was any safeguarding support offered to Caroline at this point?	WMP
Considering the frequency of calls made to WMAS relating to Caroline were there any missed opportunities for an adult safeguarding referral?	WMAS
What consideration was given to any need for support for Caroline at home on each occasion following her discharge?	RWT

5 Methodology

1. When notification was received of Caroline's death by Safer Wolverhampton Partnership from West Midlands Police, a wide range of agencies were contacted to understand the extent of contact with Caroline and her family. Agencies were asked to secure their records and provide a brief overview of any contact which they had had with Caroline or anybody within her household.
2. These responses were reviewed by Safer Wolverhampton Partnership multi-agency Domestic Homicide Review Standing Panel, who concluded that due to the extent of agency contact with Caroline, there are likely lessons to be learnt by her homicide therefore, a full DHR should be undertaken. This decision was signed off by the Chair of Safer Wolverhampton Partnership and the Home Office were informed of the decision to initiate the DHR process in February 2019.

3. Initial scoping of all agencies identified the level of engagement they had with Caroline or Jonathon and therefore, which agencies should contribute IMRs.
4. Seven Panel meetings were held to consider the Terms of Reference, review the IMRs, and identify learning, as well as agree the Overview report and recommendations, these occurred between June 2019 and 08/07/2020 (The DHR was not suspended during the COVID-19 'lockdown' and virtual panels were held. However, obtaining information from agencies experiencing re-deployment and unprecedented demand on staff, slowed down the DHR.)
5. A Learning Event was held in December 2019, involving some key frontline professionals who had worked with Caroline, including first line and senior managers. Members of the DHR panel also attended and contributed to the event.

6 Involvement of family, friends, work colleagues, neighbours and wider community

1. The DHR contacted Adam, Caroline's son, encouraging him to participate in the review. Similarly, Caroline's former partner, was written to at the start of the DHR and again by the Chair in May 2020 after key learning had been identified by the panel. Both family members were also provided with Home Office leaflets containing information around advocacy and support. A final opportunity to engage with the DHR was offered to Adam and David following the production of the Overview report, before submission of the DHR to the Home Office QA panel. No reply was received on any of these occasions.
2. Caroline's employer a major national retailer, was approached, and contributed to the DHR's understanding of how they supported Caroline and what they knew about her vulnerability.
3. Some of Caroline's friends were identified and approached through the Family Liaison Officer (FLO). A letter was provided explaining the DHR process and an invitation to participate in the review, they were also provided with Home Office information around advocacy and support. None have chosen to engage with the DHR.
4. Jonathon (the perpetrator) was also written to in order to invite him to contribute to the review however, no response was received.

7 Contributors to the Review

1. The following agencies contributed Individual Management Reviews (IMRs) to the DHR. The DHR received assurance from the senior managers signing off the IMRs that the authors had no involvement or management of the case and were entirely independent.
   Individual Management Reviews were requested from:

- Wolverhampton Clinical Commissioning Group (CCG)- GP's involvement
- Adult Social Care (regarding the Multi-Agency Safeguarding Hub-MASH)
- Black Country Partnership Foundation Trust- Mental Health (Since April 2020, Black Country Healthcare NHS Foundation Trust)[1]
- Royal Wolverhampton NHS Trust- hospitals
- West Midlands Police
- West Midland Ambulance Service
- Dudley & Walsall Mental Health Trust (Information report)

8 The Review panel members

Name of Panel member	Agency and role
Simon Hill	Independent Chair & Report Writer
Annette Lawrence	Wolverhampton Clinical Commissioning Group CCG Designated Adult Safeguarding Lead
Kathy Cole-Evans	Wolverhampton Domestic Violence Forum Chief Officer
Karl Fletcher	Public Protection Unit West Midlands Police Detective Inspector, Western Adult Investigation Team
Sarah Carter	Black Country Partnership Foundation Trust (Since 2020 Black Country Healthcare NHS Foundation Trust) Named Nurse Safeguarding Adults, Wolverhampton and Walsall
Julie Price	Black Country Partnership Foundation Trust (Since 2020 Black Country Healthcare NHS Foundation Trust) Head of Adult Safeguarding
Paula Morris	City of Wolverhampton Council Head of Service, Adult Safeguarding
Perri Minton	Royal Wolverhampton Trust Named Nurse, Safeguarding Adults
Clare Hope	Royal Wolverhampton Trust
Sharon Latham	Dudley & Walsall Mental Health Trust Head of Safeguarding
Lynsey Kelly	City of Wolverhampton Council

[1] The Black Country Partnership Foundation Trust and Dudley & Walsall Mental Health Trust merged in April 2020 to form the Black Country Healthcare NHS Foundation Trust.

	Head of Community Safety
Hannah Pawley	City of Wolverhampton Council Community Safety Manager
Janette Huntbatch	City of Wolverhampton Council Administrative Officer

All panel members had no involvement or management of the case and were entirely independent.

9 Author of the Overview Report

The Chair, Simon Hill, is a retired police public protection investigator with West Midlands Police, with twelve years' experience of child and adult safeguarding and major investigations. He retired from the service in 2013. Prior to leaving the police service he managed the Public Protection Review Team, responsible for writing the Force's IMRs and contributing to over thirty DHR and child and adult SCRs.[2] He has chaired numerous DHRs and adult SARs in the region. He has had no previous involvement with the case subject of this DHR.

10 Parallel Reviews

1. Her Majesty's Coroner conducted an inquest into the homicide.

11 Equality and Diversity

1. The DHR considered the nine protected characteristics under the Equality Act 2010 and felt that the age of the victim may have been a factor in failing to recognise risk of domestic abuse. This was considered in detail by the review panel and is detailed in section 16.1. The panel found no evidence that any other of Caroline's characteristics had an impact on agencies response to Caroline, nor her ability to access support.

[2] Child SCRs are now known as Child Safeguarding Practice Reviews (CSPRs) and adult SCRs are Safeguarding Adult Reviews (SARs)

12 Dissemination

1. The overview report will be disseminated to:
   - All panel members
   - Responsible Authorities group
   - One Panel
   - Wolverhampton Safeguarding Together
   - All agencies which contributed to the review
   - Home Office

13 Background information (facts)

1. Caroline lived in a privately-owned terraced house in Wolverhampton, that she moved to following the end of her marriage to the father of her adult sons, Jonathon and Adam. In information given to Police by Jonathon, it appears that Caroline experienced domestic abuse and controlling behaviours and his parents divorced when the boys were still at school. (Caroline herself described physical, psychological and sexual abuse by her ex-husband in a mental health assessment in 2012.) She also disclosed physical and psychological abuse by her mother, from the age of six years old. Caroline viewed her adverse childhood experiences, (ACEs)[3] as a significant cause of her mental health issues in adulthood.
2. Jonathon moved in with his mother, but Adam chose to stay with his father. In 2005, Caroline formed a relationship with David who lived with Caroline and Jonathon from December 2006 until around September 2017. After the relationship ended, Caroline lived with only Jonathon to support her.
3. David was invited to participate in this DHR but has not responded, therefore details of Jonathon and David's relationship and the family dynamic, were drawn from Police interviews and

[3] Adverse Childhood Experiences (ACEs) are stressful events occurring in childhood including:

- domestic violence
- parental abandonment through separation or divorce
- a parent with a mental health condition
- being the victim of abuse (physical, sexual and/or emotional)
- being the victim of neglect (physical and emotional)
- a member of the household being in prison
- growing up in a household in which there are adults experiencing alcohol and drug use problems.

statements and a psychologist's report, prepared for the court during the criminal proceeding relating to the homicide.

4. David and Jonathon apparently tolerated each other but it appears, had very little to do with each other. David described Jonathon as, '*an angry volatile character that often shouted and swore while on his gaming console. Jonathon was always on his gaming console and would at times get very angry. He would even throw the gaming CDs out of his window when he would get angry. Jonathon was never violent or aggressive to me and I never saw him be aggressive or violent to his mother Caroline. Jonathon was also reclusive and shy'.*
5. The Consultant psychiatrist who assessed Jonathon in prison stated that he, '*did not suffer from a mental illness. 'Jonathon' suffers from a recognised medical condition, namely an Autistic Spectrum Disorder (ASD). The most likely diagnosis is Asperger's syndrome. From his account and the account of his brother he has lived an extremely regimented life with little social interaction. He has major difficulties in understanding the motivation of others, a fixed routine, very few relationships from which he gained any benefits, (his brother seems to have been his sole confidante and by his brother's account he has a very strong relationship with his mother's cats). In my opinion this is a recognised medical condition and his lack of social interaction, rigidity of routine and almost absence of empathy constitute abnormalities of mental functioning.'*
6. This formal diagnosis of Jonathon's condition does not appear to have been made at any time in childhood, adolescence or adulthood prior to the homicide. There was no evidence presented to the DHR from any of the contributing agencies that his condition was known, or that he had received any support for his ASD.
7. Caroline experienced depression and anxiety for at least fifteen years. She told David her depression was caused by the abuse she suffered as a child. She had a history of self-harm that was first recorded in March 2012. There were eleven further episodes of self–harm, mostly involving prescription drugs, often combined with alcohol, from 2017 to March 2018, which appeared to the DHR to be a time of acute emotional and mental health crisis in Caroline's life.
8. Caroline apparently had a wide circle of friends, but it seemed to the DHR that she had become increasingly isolated by 2017. She had a thirty-year career as a catering assistant for a major High Street retailer but was signed off sick for a significant part of 2017.
9. From Jonathon's account of the homicide, which was accepted at trial, alcohol had become a significant problem for his mother and together with herself-harm. However, it appears he was an impatient and unsympathetic caregiver. It is clear that he found himself being unwillingly drawn into one crisis after another. The court accepted expert evidence that his lack of empathy and understanding for his mother's condition and his apparent lack of self-control were in all likelihood

due to his probable autistic spectrum disorder. (These features of the relationship will be examined in section 15 below.)

10. On the day of the homicide, Jonathon arrived home to find his mother had been drinking heavily and was in her bedroom. There had been a bedroom cabinet pushed up against the door, necessitating him to shove it open to get into the bedroom. He allegedly found his mother in the room with pills '*scattered around'*, repeatedly claiming she was drunk. He then flew into a rage, first kicking her in the head and then repeatedly punching her, before he picked up the bedside cabinet that had been blocking the door and struck her repeatedly around the head with it, causing it to fall to pieces.
11. By the time his alleged rage subsided, Jonathon believed he had killed his mother. He left the room and started to arrange his financial affairs knowing that he would not be coming home. He spent the night in the house and the following morning cared for and fed the family's cats and began to tidy in his mother's bedroom. He moved his mother's body to the bed and covered her with bed-clothes. There was no suggestion at his trial that he was attempting to conceal the homicide. He was clear he intended to surrender himself to police and face the consequences.
12. He later went on to return his car to work, before going in the early evening to his brother's home, where he confessed to the murder. He asked Adam to look after the cats, before, accompanied by his brother, he went to a local police station to hand himself in.
13. Jonathon was arrested and originally charged with the murder of Caroline, but was subsequently allowed to change his plea to guilty of manslaughter on the grounds of diminished responsibility. In the summer of 2019 he was sentenced to six years and eight months in prison.

14 Chronology

1. This chronology will describe Caroline's repeated incidents of self-harm. Some of these were accompanied by an apparent expressed intention to end her life. This DHR will adopt this definition of self-harm drawn from the Guidance by the National Institute for Clinical Excellence (NICE)[4]; '*Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act. It includes acts intended to result in death (attempted suicide), those without suicidal intent (e.g., to communicate distress, to reduce unpleasant feelings) and those with mixed motivation.'*

[4] Self-Harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care (Clinical Guideline 16). NICE.

2. Caroline's first self-harm episode occurred in January 2012 when her partner David, returned home to find that she had taken an unknown quantity of diazepam[5] and amitriptyline[6] and consumed sherry. She had placed a plastic bag over her head and stated she '*didn't want to be there'*. Assessed by a Clinical nurse specialist from the Psychiatric Liaison Team Caroline explained that since Christmas she had been unable to '*switch off'* and had taken to drinking brandy, port and sherry to '*aid sleep and alleviate anxiety.*' She was referred to the Wolverhampton Crisis Team.[7]
3. In April 2012, Caroline was taken to hospital experiencing lower back pain following a fall some days before. She presented with pain in her right knee after the fall. Apparent accidental falls were to become a common feature of Caroline's medical presentations.
4. From 2012 until 2017, Caroline was seen by her GPs at practice 1 for various medical conditions and was reviewed in relation to anxiety:

   2012- 8 attendances

   2013-3 attendances

   2014–4 attendances

   2016-1 attendance
5. It appears Caroline was prescribed sertraline[8] for anxiety for much of this period.
6. On the 09/01/17, Caroline's GP advised her to attend A & E after it became evident that she had taken an overdose. She disclosed she had drunk a ¼ of bottle of gin the night before and taken 10 10mg propranolol[9] tablets, she had apparently taken 28 tablets the day before. In a subsequent GP review the following day her prescription of diazepam was reduced to five days only, which was good practice. Caroline denied any recent drinking and said she was not having suicidal thoughts. There was no record of any attempt to discuss the reason for her overdose, nor to establish what

[5] Diazepam belongs to a group of medicines called benzodiazepines. It is 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

[6] Amitriptyline is an antidepressant medicine. It's used to treat low mood and depression.

[7] The Crisis and Resolution team aim to see a patient referred to them on the same day. One or two members of the team will meet the person, or their carer or family, to find out what the person's needs are. They will then decide whether the team is the best team to provide the support the person needs. If it is felt someone's needs can be better met by another team, they can help them get in touch with this team. If the team feel they can help the person through their crisis they will go about making a care plan with them.

[8] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

[9] Propranolol belongs to a group of medicines called beta blockers. It is used to treat heart problems, help with anxiety and prevent migraines.

support she had at home. She was however advised to contact the surgery, or the out of hours service or 999 if she felt suicidal.

7. Reviewed by the same GP a week later, Caroline said she was still not drinking and although she was not sleeping well, said she was not having suicidal thoughts. She was asked to consider Talking Therapies, which was good practice. However, two days later, she called an ambulance to her home having taken an overdose of diazepam, Nytol[10] and attempted to strangle herself with her bra strap.
8. Caroline was assessed and agreed to an informal admission on the 18/01/17 to a local psychiatric unit 1, where she stayed until the 05/02/17. This was one of only two voluntary admissions for assessment. In his statement to Police, David claimed neither Adam nor Jonathon visited her whilst in hospital and that he was 'the *one who supported Caroline at that time.*'
9. The discharge letter to the GP noted '*no concerns or issues were identified during the period of assessment on the ward. Caroline had a mild depressive disorder, low risk to herself or others*.' There was a recommendation that Caroline should be referred to the appropriate Older People's Community Team[11].
10. The mental health risk assessment undertaken at psychiatric unit 1 required 'current context of risk factors' to be described and Caroline explained that '*her sons have difficulty accepting her mental health.'* The same assessment records 'positive resources and materials' indicated Caroline did not see her sons as a positive resource. Caroline explained Adam was angry with her for taking an overdose. There is evidence that she was 'reassured', but the social history was not explored. The BCPFT IMR noted ten home visits by the Home Treatment team between the 02/02/17 and the 16/02/17 and concluded it would have been '*pertinent'* to explore her relationship with her sons and the impact it had on her wellbeing.
11. Within a week of being discharged from the Home Treatment team, Caroline was seen by another GP at practice 1 who responded effectively to her low mood and suicidal thoughts by arranging immediate access to the Wellbeing Team[12] a non-urgent mental health support service, which was a further example of appropriate mental health support.

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[10] Nytol is an over-the-counter antihistamine that has short term application for insomnia

[11] Service Description. Support is provided for individuals to carry on with their daily lives, Self-care, home tasks, and leisure activities. There are also group sessions at various venues in the community, 1:1 talking therapy sessions, anxiety management and relaxation. The team consist of psychiatric nurses, Occupational Therapists, technical instructors, support workers, psychiatrists and psychologists. Access: GP referral and other health professionals.

[12] Recovery nursing services and vocational services for clients with mild to severe mental health problems.

12. Soon after, on the 05/03/17, Caroline took an overdose of zopiclone[13] in her home and told the ambulance crew she was trying to kill herself. On admission to A & E she was noted to have bruising to both sides of her forehead and to her left eye. She explained that she had fallen some days before, hitting her head, first on a unit and then the floor. Her son Jonathon, in a Police interview a month later, described her injuries as '*massive black eyes that looked like she'd been beaten up.*' There was apparently no exploration of this account during the A&E presentation. The mechanism of the fall was not discussed, nor were any mobility issues explored as a possible risk. There was no recorded questioning of Caroline to establish whether she was experiencing domestic abuse. This seems poor practice. This missed opportunity will be considered in the analysis at section 16.2
13. In relation to her mental health, Caroline agreed to voluntary admission to psychiatric unit 2. [14]She presented with the visible injuries noted in A & E and was once more subject to a mental health risk assessment by the Home Treatment team. Although she indicated there was no risk of abuse by any party, she indicated she did not feel safe at home when her partner was at work and once more indicated that she did not see her sons as a positive resource because they were lacking understanding of her mental health. It is possible that Caroline did not feel safe alone because of her persistent desire to self-harm, or there may have already been an awareness of her vulnerability to physical abuse.
14. This disclosure apparently did not prompt more in-depth questions relating to the risk of domestic abuse, nor did the team explore why she did not feel safe at home. This is particularly disappointing given the facial injuries she presented with. It would not be unreasonable to question whether injuries to both sides of the head could be accidental and should have prompted much wider enquiry. This was another substantial missed opportunity.
15. A manual handling assessment carried out at psychiatric unit 2 made it clear that Caroline was able to move independently without assistance. It is worth noting that no agency provided any evidence of any physiological or biomechanical infirmity that could explain the falls Caroline claimed occurred and this with be developed as a safeguarding issue below in analysis at section 16.5
16. GP practice 1 at some point, thereafter, received a letter from a senior nurse practitioner attached to psychiatric unit 2, that included all the salient details in paragraph 13 above; that she did not feel safe at home, but also additionally included *'She has had arguments with her son which has caused her stress.'*

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[13] **Zopiclone** is a hypnotic agent that is non-benzodiazepine, the common drug used to treat insomnia. ... This type of drug is commonly prescribed by doctors for sleep problems and other conditions such as alcohol withdrawal **and anxiety**

[14] The Black Country Partnership NHS Foundation Trust provide mental health services in both Sandwell and Wolverhampton and the hospital in this case was in Sandwell

17. The letter was acknowledged by the CCG IMR to be on Caroline's patient records, but it is not possible to say how quickly it was entered on their electronic system. It seems quite probable the letter had not been seen and reviewed by a GP, when Caroline called GP practice 1 on the day of her discharge from Psychiatric unit 2 saying she was having suicidal thoughts. The GP she spoke to requested the Care plan from the hospital. She was seen again in surgery and reviewed on the 08/03/17.
18. Whilst the letter had possibly not yet been received at this point, it was received at the practice at some point thereafter and good practice would require a GP to screen incoming discharge letters for urgent medical advice or safeguarding concerns. It is therefore a substantial missed opportunity that this information was not addressed with Caroline at any subsequent presentations.
19. On the 14/03/17, Caroline once more self-harmed, taking an overdose of 12 zopiclone tablets, apparently purchased over the Internet. She had posted on Facebook her intention to kill herself, and a work colleague, who was alarmed, informed her manager who in turn called Police and mental health services for advice. Police and the ambulance service attended Caroline's home where she confirmed she had ingested an overdose. Jonathon was present, as was Caroline's friend who had raised the alarm, and Police updated David when he attended hospital.
20. GP practice 1 were informed in a subsequent letter that Caroline had asked for an informal admission to psychiatric unit 1, but that her *'presentation did not warrant it.'* This was apparently because she was '*no longer suicidal*.'
21. A letter from Psychiatric unit 2 to GP Practice 1, dated the 07/04/17, related to an in- patient assessment of Caroline, by a consultant psychiatrist from psychiatric unit 1 on 16/03/17. He referred to Caroline explaining she '*talks again about relationship problems with her son which definitely causes her low mood*.' Neither the psychiatric unit nor GP explored this further.
22. Two days later, on the 08/04/17, another self-harm incident occurred. However, the additional serious concern was that Caroline had suffered injuries; '*hand fractures to the right 5th metacarpal*[15] *and displaced fracture to the left 2nd metacarpal.'*
23. It is important to address events in detail, since it will be necessary to analyse later whether the facts, as they emerged in the following hours and days, prompted appropriate risk assessments and responses from agencies, correct adult safeguarding decisions and an adequate criminal investigation, when Caroline made an allegation against Jonathon concerning events that day.

[15] Metacarpals are the bones below the knuckle joints, that connect to the wrist. At the knuckles, the metacarpals attach to the phalanges (fingers) Metacarpals are numbered 1-5 starting at the thumb.

24. Jonathon was present during the whole day in question, but David was out. David's decision to visit family without Caroline was according to her, the reason she suffered low mood and took an overdose of seven 1 mg Lorazepam[16] tablets, together with 'a *large glass of gin'*.
25. Lorazepam has short-term application for anxiety. According to NICE guidance, the daily dose for an adult is between 1mg to 4 mg by mouth, in divided doses. For conscious sedation for procedures, a patient would take 4mg the previous night and 3mg 1-2 hours before the procedure. It seems reasonable to assume that taken at once, and coupled with alcohol, it is probable that Caroline could have become unsteady, drowsy and lacked full control over her movements. However, there is nothing in the ambulance log or hospital notes that indicate she was experiencing lack of balance, slurred speech or was unconscious at any point when they treated her.
26. Caroline told paramedics and staff in A & E at the hospital that as a result of the combination of drugs and alcohol she had fallen asleep and '*dropped off the sofa'*, then had fallen on her back in the kitchen, and also down the stairs, on her bottom. The RWT IMR relating to the A&E attendance makes it clear that there are no notes available to indicate whether Caroline received a full physical examination at this time. It seems therefore that on the first presentation to hospital, it is possible only the hand injuries were disclosed and recorded. WMAS are clear that their handover given to the Emergency Department described all the injuries.
27. It is clear therefore that the other injuries were in fact present. Jonathon himself would describe seeing an abdominal injury before the ambulance was called; '*she showed me later like there, there, like big blue patch on her side like you know yellowy swelling.*' It is questionable whether blue/ yellow bruising would be visible so soon after an accident; blue and yellow bruising only becoming visible after a few days.
28. From his statement to Police, it is apparent that David was phoned by Caroline and met her at the hospital. She apparently disclosed to David that following an argument, Jonathon had hit her on the hands and head with a table lamp from next to her bed. She was reluctant to report the matter to police, although she said later that David encouraged her to. David in his police statement claimed to have later challenged Jonathon about the assault but somewhat surprisingly, given the circumstances, claimed that he could not remember what Jonathon had said.
29. David confirmed that he had seen the damaged lamp that same day. The central support and shade were damaged, but he described it as '*intact'*.
30. Eight days after the incident, on Saturday 15/04/17, Caroline was once again experiencing suicidal thoughts. She called an ambulance, telling the crew she was suicidal. At the scene they recorded injuries; '*Caroline right arm in cast, multiple bruising on left arm and to left side of forehead from*

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been assaulted by son 7 days previously.' This was the first time that Caroline disclosed to a professional that the injuries had been caused in an assault. The crew appropriately sought her view on reporting the incident to police and she asked that this not be done.

31. In A&E, she stated that as well as the fractures, she had presented on the 08/04/17 with '*extensive injuries to the front and back of her body.*' Doctors reported bruises over the left lateral side of Caroline's abdomen. It seems that Caroline disclosed that she had in fact attempted to self-harm with paracetamol. She was reviewed by the psychiatric liaison team and disclosed the alleged assault by Jonathon to a senior nurse practitioner (SNP).
32. An adult Safeguarding concern referral (SA1) was completed on the 15/04/17. Caroline told the SNP that David was aware of the assault and had advised her to report the matter and she was '*thinking about it'*. She explained that the assault had been '*out of character'*, that her son was '*remorseful'* and that she did not want the matter reported to Police, because her son might lose his job over the alleged assault. She stated she felt safe at home. She did agree to a Safeguarding referral being made.
33. The referral was not submitted to the Wolverhampton Multi Agency Safeguarding Hub (MASH) until Tuesday 18/04/17. Given the serious nature of the domestic assault being disclosed, this seems an entirely inappropriate delay. It left Caroline at risk for an unacceptably long period.
34. The RWT IMR provided no reason for this delay, and it seems likely that over the weekend, the SA1 was treated as non-urgent and left for submission during the week. (The Mental Health Liaison Service (MHLS) also completed a referral on the 15/04, but it appears that it was not received at the MASH. When over subsequent days, the MHLS team made enquiries with the MASH seeking updates, they were assured the enquiry was being progressed. It was not until some weeks later that it was identified that MASH had been referring to the original referral not the MHLS that referred to the same concerns.
35. Once an Adult Social Care manager in the MASH reviewed the referral, safeguarding steps were immediate. Overriding public interest allows the sharing of information between agencies without consent; '*to prevent crime, or where a serious crime has been committed*' and therefore, the incident was reported to Police the same day and a crime of grievous bodily harm was recorded.
36. In the information gathering stage of the safeguarding enquiry, the MASH requested information from the Royal Wolverhampton Hospital Trust, Black Country Partnership Foundation Trust, Recovery Near You (drug and alcohol services), the Police and Wolverhampton Homes. There is no record of information being sought from Caroline's GPs and this seems an unfortunate oversight, given the amount of relevant information being held by GP Practice 1. It also meant there was no feedback after the enquiry to primary care, a significant oversight.

37. The Adult Social Care (ASC) IMR identified the police as leading on the Safeguarding enquiry. The police investigator attempted to contact Caroline but could not reach her. (With hindsight it appears that she and David went on holiday to North Yorkshire at the beginning of the week
38. Following a strategy discussion between a MASH manager and Police Public Protection Unit manager on the 21/04/17, the police arrested and interviewed Jonathon the same day. He denied assaulting his mother and described two successive accidental falls that he believed accounted for the injuries, although he had not witnessed any of them. He told the investigators that Caroline had apologised for accusing him of assault, but had explained that on the 15/04/17, when she felt suicidal, she had believed that this type of concern would gain her in-patient care.
39. Jonathon was bailed to stay away from Caroline, not to communicate with her and not return to the home address. There was no evidence provided in the Police IMR as to where Jonathon went. However, on the same day, Friday the 21/04/17, Adam called Caroline and told her of Jonathon's arrest. David explained in his statement that 'this *shocked Caroline as she did not want this to happen*.' They apparently returned from their holiday on the Saturday.
   Police placed a SIG marker on the address, (an electronic alert to the presence of domestic abuse and an offender on bail).
40. On the 24/04/17, Police spoke to Caroline for the first time. Caroline telephoned and said she had made up the claim of assault to get admitted to hospital. She had not expected police to be involved and apologised for '*wasting their time*.' On the 28/04/17, a statement was taken in which she retracted the claim and described her repeated accidental falls, culminating in her falling downstairs and punching the wall in frustration, causing the hand injuries. Consequently, Jonathon's bail was cancelled and both Caroline and Jonathon were informed there would be no further police action. Police did not complete a domestic abuse stalking and harassment risk assessment (DASH) because the claim of assault made to health professionals and to her partner David, had not been substantiated. In filing the case, the supervising officer considered the option of classifying the matter as 'no crime' (where following an investigation police establish that no recordable crime has occurred). However, the presence of injuries that were consistent with the accusation of assault that Caroline made to health professionals meant that this crime classification was not appropriate.
41. David made it clear in his statement that Jonathon moved back into the address shortly after bail was cancelled. He stated, '*during this period I wasn't happy that Jonathon was returning as I was concerned for Caroline's safety. I decided I could not live in the same house as Jonathon after he assaulted Caroline. I found myself some shared accommodation in Birmingham I could stay whilst continuing my relationship with Caroline. Caroline accepted this*.' (Although David's statement

appears to suggest this decision was contemporaneous with the assault, it would appear that David did not fully move out until around 30/07/2017).

42. David went on to say that before he left, he spoke to Jonathon, who disclosed '*he had never wanted me to live with Caroline…I felt that to be strange thing to say as he had never mentioned anything like that before in 12 years I had previously lived at the address. He did not go into detail for the reasons why he didn't want me there, but I suspect he wanted Caroline to himself as he was very controlling.*'
43. The events between 08/04/17 and the 28/04/17 represented, with hindsight, a significant opportunity for both ASC, Police and partner agencies to evaluate the adult safeguarding risks posed by Caroline's repeated self-harm, and to take into account the protective factors, but also the risk from anyone within the home. This area is analysed below in section 16.2
44. On the 07/05/17, the officer in the case (OIC) having missed an earlier call, returned a call to Caroline. She disclosed she had taken '*10 100mg Sertraline, 45 herbal sleeping tablets and 3 shots of gin, with the intention of killing herself* '. Apparently, David was in the garden, and he was called to the phone, the circumstances explained to him, and he was asked to monitor Caroline, whilst awaiting an ambulance. She was taken first to A & E, but then to psychiatric unit 1, where she was assessed. It is of note that Caroline was offered voluntary admission to psychiatric unit 2, because there were no beds available at psychiatric unit 1. It is unclear why it was felt that voluntary admission would be helpful, when in similar circumstances it had been refused. It appears Caroline did not want to go to psychiatric unit 2 and she refused voluntary admission. Caroline was discharged to her GP and wellbeing services and the Community Home Treatment team.
45. The next day a Social Work manager in MASH started the process of closing the adult safeguarding referral relating to Caroline. The manager requested contact be made with Police and potentially Caroline, as well as a named member of the Psychiatric Liaison team (the nurse who in early March, had described in the letter to agencies (paragraph 16 above) that '*Caroline did not feel safe at home*.')
46. It is unclear whether the allocated social worker was aware of the most recent self-harm episode (07/05/17), or what impact, if any, this would have had upon a decision to close the adult safeguarding referral related to domestic abuse. MASH records show several attempts to contact the Mental Health Liaison team over the next ten days, but there is no evidence that the conversations requested by the MASH manager actually occurred before closure of the case. If Caroline was contacted and her safeguarding and wellbeing discussed, no record apparently exists. The MASH referral was finally closed on the 17/05/17.

47. In May and June, Caroline was reviewed by her GP and her medication altered on the advice of psychiatric unit 1. On the 25/05/17, the psychiatrist sent a discharge letter to GP practice 1 concerning the short admission to the unit earlier in the month, in which Caroline was described as having *'emotionally unstable borderline personality traits[17].'* There is no suggestion that Caroline's care plan was modified as a result of this diagnosis.
48. Towards the end of June 2017, Caroline sought help from her GP and psychiatric services. She was feeling suicidal and unable to cope. The reason appeared to be that she was breaking up from David, her partner of over twelve years. The surgery was sufficiently anxious after a phone consultation on 21/06/17, in which Caroline reported; '*mood deteriorating, can't get out of bed, hopes not to wake feels suicidal, tells GP she wants to end her life.*' that they contacted psychiatric unit 1 who advised them to get Caroline to A &E.
49. This she duly did and was she admitted briefly to psychiatric unit 1,but discharged home the same day. The discharge letter stated, '*depressed since taking Mirtazapine tablets increase anxiety and having suicidal feelings, currently separating from partner and children not talking to her.'*
50. Caroline took further overdoses on the 25/06/17 and the 15/07/17 (her 9th and 10th self- harm) and her treatment on both occasions followed a now established pattern, with admission to A&E, mental health assessment by the Mental Health Liaison team following by discharge home to the home treatment team. Caroline told professionals that she had broken up with David and was now living alone with her son.
51. In David's statement he explained that the relationship ended on 30/07/17. He stated he and Caroline went on a holiday to Suffolk and then on the Sunday; *'out of the blue she said the relationship wasn't working and she wanted me to leave. This was a total shock to me, and I did not see this coming.'* David explained he left and collected his belongings over the next few weeks. He last saw Caroline on the 01/09/17.
52. From July to October 2017, Caroline was seen by GPs for medication and mood reviews about ten times, and although there were dips, generally she reported to be broadly stable. She was seeing a psychiatrist from Older Age Mental Health services, who reported a history of 'domestic abuse' in two letters to the GP. However, having been contacted by the BCPFT IMR author, the psychiatrist could not recollect any details of the abuse, and none were recorded in records. The information passed to the GP was therefore not helpful, but also did not prompt exploration of the letters at any of the reviews at the surgery.

[17] Borderline personality disorder (BPD), also known as emotionally unstable personality disorder (EUPD), is a mental illness characterized by a long-term pattern of unstable relationships, a distorted sense of self, and strong emotional reactions. There is often self-harm and other dangerous behaviour (MIND UK)

53. In November 2017, Caroline presented at the GP with back and leg pain following a tripping injury. This does not appear to have been considered from the viewpoint of possible domestic abuse and apparently no relevant questions were asked to rule out this possibility.
54. In Late November 2017 Caroline re-registered at GP practice 2. There is no information available to explain why Caroline chose to end a relationship with GP practice 1 after such a long time. She had not moved, and both surgeries were close to her home address.
55. In January 2018, the new surgery received the Mental Health Care plan from psychiatry. It included information that Caroline had a *'a history of experiencing abuse Physical /emotional /sexual by ex – husband'*. This was one of the very few examples of Caroline's lived experience having been shared between professionals, however, it seems strange that this background from decades before, was apparently considered more relevant than the immediate antecedent history from the preceding 18 months.
56. Caroline took two further overdoses of her prescribed medication and alcohol on the 18/01/18 and again on the 12/03/18. She was being reviewed and seen by psychiatry on a regular basis, having at least nine reviews with a psychiatrist on either side of these two episodes.
57. In April 2018, Caroline was admitted for surgery to her hand for decompression of carpal tunnel syndrome[18]; this was necessary because of the damage to her hand she had sustained in the incident on the 08/04/17. She required time off work, as well as several weeks of physiotherapy.
58. On the 29/06/18, in a return to work 'fact finding interview' with her employers, Caroline described the incident, how the injury had occurred which resulted in the need for surgery and the consequent absence from work, over a year later. Caroline stated it was the result of putting her hands up to protect her head after her son '*picked lamp up'*. She described her son being arrested, released and the charges being subsequently dropped.
59. By July 2018, Caroline was self-reporting as; '*back to being me'* in a discharge letter to the GP surgery from the Older People's Community team psychiatrists.
60. However, by late September 2018, she reported to her GP she was anxious, and her mood was slipping a little. In a report from the Home Treatment team on the 01/11/18 it was noted; '*Caroline reports having an argument with her son over birthday cake; states relationship fragmented at times.'*
61. In November and December 2018, Caroline spoke to her GP about two issues impacting on her emotional wellbeing. It appeared a friendship made on Facebook was considered to be a '*financial scam*' and Caroline '*blocked'* this person. Then she reported anxiety at work because she was being

[18] Carpal tunnel syndrome causes weakness of grip, tingling and 'pins and needles' and aching in fingers, wrist or arm. It can usually be treated by a GP and with time rights itself. In more severe cases surgery will be required to decompress the nerve. It could be caused by a wrist/hand injury.

moved from catering to the tills about which she was very anxious. Her GPs supported her with a letter to the employer that seemed to the DHR to be good practice. (It is not clear how long Caroline had been back in work, since she was signed off for most of 2017).

62. There were no further indications that Caroline may be in crisis, before the tragic events in February 2019 and her homicide by Jonathon.

15 Overview

1. This DHR has concentrated upon the information known about the victim, the perpetrator and her family and shared between the agencies and professionals involved throughout the period under review, particularly during the safeguarding enquiry resulting from the April 2017 domestic abuse safeguarding referral. This was the only such allegation Caroline ever made, but it appears to be one which has great resonance, given the similar facts of the homicide. If the opportunity to understand Caroline's lived experience was not fully realised in the investigation of this incident, did professionals who were trying to support Caroline, nonetheless understand her needs?
2. This DHR therefore sought to identify the strengths and shortcomings of safeguarding responses in relation to Caroline's significant vulnerabilities, drawing learning from the interrelation in this case between domestic abuse, mental health, self-harm and substance misuse. As an older person, the joint investigation of domestic abuse by Police and Adult Social Care should have started with a risk assessment and concluded with a further risk assessment to identify any unresolved risk.
3. This led the DHR to identify that there appeared to have been very limited shared understanding of Caroline's social and environmental history. The importance of adopting a 'Think Family' became a central theme at the Learning event held on 05/12/19 and developed at various points in the analysis and lessons learned sections. This DHR identified multiple missed opportunities to explore areas crucial to understanding Caroline's needs and vulnerabilities and ultimately her risk of domestic abuse.
4. Adult safeguarding should primarily be about prevention. The DHR sought to identify how as a result of the Learning from the DHR, professionals in Wolverhampton could be better equipped to identify the needs of an adult like Caroline, who was particularly vulnerable, and through early identification, provide access to support and self-help options to prevent her becoming more vulnerable or developing care and support needs.
5. This DHR would argue that in the absence of compelling evidence to indicate that these shortcomings were particular to this case, then these have to be viewed as systemic and likely to still be occurring in similar cases. Agencies were therefore invited to identify any changes in policy,

practice or procedure already implemented or planned, that would make these adverse outcomes less likely in 2020.

16 Analysis

16.1 The Effectiveness of the joint Adult Social Care and Police investigation of the Domestic abuse allegation (April 2017)

1. This DHR involved a perpetrator whose own vulnerability was apparently unknown to professionals involved with Caroline. After the homicide, it was identified in two separate psychiatric assessments, that Jonathon had a developmental disorder, a form of autism, Asperger's syndrome. With the benefit of this crucial hindsight, it is clear that he would have been singularly ill equipped to provide support for his mother or empathise with her condition. Whilst he did assist with practical tasks; giving her lifts or taking her shopping, he was apparently unable to respond appropriately when she experienced suicidal thoughts or self-harmed.
2. In his psychiatric interview and police interviews, he demonstrated his incomprehension of his mother's failure to adhere to treatment plans in relation to anti-depressants. He saw her self- harm episodes as '*making a fuss'* and '*attention seeking.*'
3. He admitted to seeing his mother with serious facial injuries as a result of alleged falls, whilst also saying he was dubious when she claimed to have fallen on other occasions. He showed no empathy, only frustration. In the pre-sentence psychiatric report, Jonathon was described as being '*incapable of empathising with the difficulties which his mother was experiencing and he would have seen them only in terms of their manifesting in her drinking and presenting herself in a chaotic and disorganised fashion.*'
4. With hindsight, the circumstances of the homicide bore a very close resemblance to the allegation made by Caroline in April 2017. In both episodes apparently, Jonathon went to remonstrate with his mother in her bedroom, because she was apparently drunk, and acknowledged he had flown into a rage on both occasions. He admitted to picking up objects to hand; a table lamp in April, and a bedside cabinet with which he repeatedly struck his mother during the homicide. In the April 2017 incident however, he claimed to have thrown the lamp at the wall (an explanation that Caroline corroborated in her retraction statement). During the homicide, he repeatedly kicked and punched his mother. Caroline's injuries to the abdomen, back and arms in April 2017, could have as likely been caused by such an attack as an accidental fall. Jonathon denied this was the cause.

5. The MASH decision to report the domestic abuse allegation to Police on the 18/04/17, was appropriate in the context of an adult who may have care and support needs at risk of abuse or neglect. In the decision-making stage, where evidence of a concern is gathered and care and support needs are considered, information can be shared without consent where there is an overriding or vital public interest to '*prevent crime or where a serious crime has been committed.*'[19] The DHR would concur with the MASH manager's view that there was a duty to inform Police. They in turn, recorded a section 20 Offence Against the Person Act wounding crime report.
6. It was recorded in the Safeguarding Referral that Caroline did not want the Police involved, and had they been able to reach her, available evidence suggests that she may have refused to cooperate. That she was away on holiday, and could not be contacted, meant that in a strategy discussion on the 21/04/17, the PPU supervisor and MASH agreed Police would lead and investigate the domestic abuse allegation by way of arrest and interview of Jonathon. Arrest of an abuser is a '*positive action'* recommended in the Guidance[20] to officers provided by the National Policing College.
7. It can be argued that whilst police led on the investigation of the crime in this case, the Local Authority (Adult Social Care) remained the 'lead agency' for the overall safeguarding decisions, particularly since during the decision-making stage, the Local Authority became aware of Caroline's mental health vulnerability and history of repeated self-harm.
8. This was therefore a domestic abuse allegation, involving an alleged serious assault of an older person, who was experiencing chronic mental health concerns[21], and was potentially dependent upon the abuser for support with that mental health vulnerability. Both key agencies would acknowledge that West Midlands Adult Safeguarding Policy and procedure states; '*In most circumstances, the Local Authority is the "Lead Agency" and will receive and deal with Adult Safeguarding concerns directly*. '(Paragraph 9.3)
9. Caroline's disclosure had to be risk assessed by safeguarding professionals, whether from the Police Public Protection Unit or the MASH, in the context of her evident mental health vulnerability. Ideally the police investigators would also be alert to concerns relating to adults at risk in a household where domestic abuse is perpetrated.
10. During the resulting police interview on the 21/04/17, it became clear Jonathon already knew that some professionals had an awareness of at least a significant previous argument between him and his mother. Jonathon said his mother had apologised for making the allegation. If this was true it may have been because she believed he would eventually find out about the allegation. In any case,

[19] West Midlands Adult Safeguarding Policy and Procedures

[20] Authorised Professional Practice: Major investigations and public protection (2015)

in the police interview, he seemed unaware of what she later said was her motivation for the allegation; to secure hospital admission.

11. During the interview the police investigators appear to have been only aware of Caroline's injuries to the extent that they were described in the safeguarding referral; '*multiple metacarpal fractures and bruises over the left side of the abdomen.*'
12. The police/MASH strategy decision had been to proceed to early arrest and interview of Jonathon and because Caroline was unavailable, there was no victim statement or consent obtained for her medical records being released.
13. It remains unclear whether a clinician conducted a full medical to record all of Caroline's injuries on the 15/04/17; this would be correct practice during an investigation of a domestic assault. A consultant from the mental health team made the Safeguarding referral, therefore it is quite possible no overall record of injuries present was made.
14. An interviewer for a serious assault should take into account all the presenting injuries and their aetiology. In the absence of such detail, obtained from speaking with the victim and taking their witness statement and gathering medical[22] or witness evidence, a first interview can only ever be an opportunity to get on record an account from the offender, or allow him the opportunity to admit an offence. The suspect would then be bailed with a view to gathering further evidence and re-interviewing if necessary.
15. When Caroline retracted her allegation, first on the phone and then in a statement she gave an account of three concurrent drugs and alcohol induced falls. One was from a sofa where she fell onto a china bow. She then spoke of a backward fall but did not describe any resulting injuries but claimed to have also fallen down the stairs on her back. Whilst this may account for bruising of the back, (that she reported on the 15/04/17) there is no clear explanation for the presence of abdominal injuries. It was at least arguable that the injuries were more consistent with a physical assault than an accidental fall. It would be good practice to review inconsistencies in the victim's and alleged perpetrator's accounts; the exact cause of the serious hand injuries being a case in point. Caroline said in her retraction statement that she had been so angry at falling down the stairs that she had lashed out and struck the door frame. The injury to her hand was also consistent with a hand raised to protect the head from blows with a lamp.
16. The most compelling evidence that Jonathon had indeed assaulted her was the apparent contemporaneous disclosure of this that she made to David, when she called him to come home after the incident. The police investigator was apparently not aware of this when interviewing Jonathon, asking him whether David had been aware of the incident? Seeking evidence from

[22] Police would be able to apply Caldicott principles (the rules governing disclosure and confidentiality of medical records) and seek medical evidence without the patient's consent, in certain circumstances

members of the household should have been viewed as a routine part of a domestic abuse investigation. Caroline's early complaint to David was important in assessing the credibility of the allegation and subsequent denials by Jonathon. The DHR was not provided with any evidence that this had been considered or pursued, as a line of enquiry, and it appears to be a significant oversight.

17. The West Midlands Police IMR pointed to this absence of third-party witness statements as a reason for not proceeding to an evidence-led prosecution;' *without a third-party witness or other evidence to suggest an assault had indeed occurred, there was nothing with which to pursue any prosecution.'* However, before this stage can be reached all available evidence should be gathered and her retraction, when she discovered Jonathon had been arrested, needed to be assessed against the possibility that she had been coerced or persuaded to retract. When a victim changes an account and gives a new explanation to police, they should not accept without question the new account.
18. Two key documents guide police and CPS in the conduct of domestic abuse investigations. The College of Policing Authorised Professional Practice on Domestic Abuse and The CPS Domestic Abuse Guidelines for Prosecutors. Both give direction on building an evidence-led prosecution contemplating the possibility that a victim may be unwilling or hostile to an investigation (often due to coercion or control).
19. The guidance in what the College of Policing call a 'Crib-sheet for evidence led prosecutions', states; '*ensure that ALL evidence that is capable of corroborating an earlier 'truthful' account from the victim has been secured and accurately documented for presentation to the CPS. If this other evidence corroborates the victim's original 'truthful' version of events, then it is possible that a prosecution could be evidentially viable.'*
20. The CPS guidance describe re gestae statements in evidence-led domestic abuse prosecutions; *'res gestae - statements made by the complainant or a witness to a third party, or around the time that the offence was allegedly committed, that are so directly linked to the events occurring at the same time, so as to make it unlikely that they were distorted or concocted may be admissible other than as hearsay.'*
21. On this basis, the circumstances surrounding the first complaint on the 15/04/17 to the ambulance crew and then to the Senior Nurse Practitioner should have been investigated to establish whether there was any validity to Caroline's new account, which suggested it was an attempt to 'force' a Mental health admission. (This seems all the more relevant given she was discharged home the same day).

22. It is very significant that no account or statement was sought from Caroline's partner. It may not have been judged as a res gestae statement by CPS, but it proved that the assault account existed well before Caroline apparently thought of it, as a form of leverage, to gain a hospital admission. At the time it was made it served no purpose other than to alert her partner to a traumatic incident leading to serious injury. (With hindsight, the fact that Caroline described the hand injury to her line manager over a year later, in June 2018, as being the result of a domestic assault by her son also seems compelling. She had no need to disclose domestic abuse; in fact, an accidental explanation would have less repercussions. It was possible that she was now seeking help or support by mentioning domestic abuse to her manager.)
23. It was the view of the WMP DCI on the DHR panel that had statements been taken from David and the SNP who had received the disclosures the matter would have been passed to CPS for a decision.
24. . The CPS and National Police College advise police officers on key elements of a withdrawal statement. These include:
    - Whether the victim has been put under pressure to withdraw
    - The nature of the original allegation (if not fully covered in a previous statement)
    - Victim's reasons for withdrawing the allegation
    - With whom they have discussed the case – particularly anyone who has advised them (a solicitor, for example)
25. It appears that Caroline's retraction was accepted without considering the very real possibility that Caroline was being coerced or persuaded to confirm Jonathon's account, as often happens in domestic abuse allegations.
26. Had investigators spoken to David, and if he had described the early complaint, it probable that investigators would have felt the need to obtain full medical evidence and re-interview Jonathon with a view to an evidence-led prosecution. (Where a domestic abuse victim declines to give a statement and a prosecution is based on all other available evidence.)
27. In the police interview, Jonathon stated he seldom argued with his mother; David in his statement corroborated this; '*he had not ever seen Jonathon argue before let alone assaulting her.*' However, he clearly felt as a result of the assault, that Jonathon posed a risk to Caroline. This DHR would argue that a coercive and controlling abuser would not necessarily resort to frequent violence and its' apparent absence is not a good indicator of the level of risk.
28. Whilst it could not have informed the police enquiry a year before, the fact that Caroline again accused Jonathon of causing the injury, in a return-to-work interview in June 2018, was felt by the DHR panel to 'tip the balance'. It was the view of the panel that taking into consideration the 'early complaint' to David, the several occasions that Caroline accused Jonathon of the assault and the

striking similarity between the homicide and the earlier assault, it is more likely than not that Jonathon had assaulted his mother.

29. Although the BCPFT had alerted colleagues and GPs in the weeks before the allegation to highly relevant safeguarding information, there was no evidence presented that this was taken into account in the joint Police and Adult Social Care safeguarding investigation. If available partner agencies information had been shared with the police as part of a safeguarding enquiry, they would have been aware the part Jonathon played in Caroline's low mood. Her sense of not being safe when David was not present and that, even if David did not witness them, arguments with Jonathon had occurred in the past. It seems that because the safeguarding enquiry was Police led, it was seen as a domestic abuse crime investigation and not a broader safeguarding enquiry and this information was not passed or obtained by Police. This was poor practice.
30. When the MASH concluded that Caroline had no care and support needs, the criteria for a Local Authority led safeguarding investigation had not been met. It was argued at panel that Adult Social Care by reporting the crime allegation to police, had complied with their statutory obligations. The investigations that occurred in a safeguarding context, went beyond their strict statutory duty. Responsibility for any safeguarding responses thereafter fell to the police, as they would in any investigation of domestic abuse, where the victim was not believed to have care and support needs.
31. It does seem however that Caroline's precarious mental health may have caused investigators to too readily accept the claim that this was a false allegation. It is far from certain that David's evidence alone would have satisfied the evidential test applied by the Crown Prosecution Service (CPS) for an evidence-led prosecution. However, a continued enquiry may have reached a more nuanced understanding of risk.
32. No Domestic Abuse Stalking and Harassment (DASH) risk assessment was completed because of the retraction. A crime was recorded, (usually a trigger for a DASH) but the relatively rapid retraction meant the officers assessed the DASH as unnecessary. The West Midlands Police IMR pointed out; '*In the domestic context, change in policy which removed discretion from officers in respect of DASH has taken place since our most recent contact in 2017 and the use of DASH when attending domestic incidents, regardless of whether there are substantive offences or not, is now mandatory.*'[23]

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[23] Since early 2019, West Midlands Police use the Domestic Abuse Risk assessment (DARA) that is more focused upon coercive and controlling behaviour than DASH

33. West Midlands Police now complete a Domestic Abuse Risk Assessment, (DARA) that places greater emphasis upon the coercive and controlling elements of domestic abuse than was the case with DASH.
34. The officer investigating the case explained to the DHR that '*because of the mental health of the victim, I did not know if the victim had actually been assaulted or if she had said this as a cry for help.'* The DHR acknowledged the challenges that professionals often have to weigh up conflicting evidence. However, at the end of a safeguarding enquiry, if the investigator themselves was uncertain, then domestic abuse remained at best, an unresolved risk.
35. This DHR has identified the absence of safety planning with Caroline and in relation to this criminal investigation safeguarding enquiry, it is far from clear that health professionals (GPs and mental health teams) or Adult Social Care had an understanding that domestic abuse remained unresolved.
36. The closure of the Safeguarding Enquiry demonstrated what appears to be a systemic failing in domestic abuse enquiries where an adult at risk of domestic abuse is deemed not to have care and support needs, therefore, no section 42 Care Act investigations occurs. It also indicates that where there is a single agency enquiry, responsibilities may become blurred, which is why this DHR stressed that Adult Social Care remained the 'lead agency'.
37. The MASH considered that police would carry out any necessary safeguarding measures at the end of their investigation. The MASH closure report recognised '*what happened to cause the injury was not conclusive'.* It recorded that;' *Caroline had told Police she would report any further incidents with her son to police.'* This DHR would suggest that on the evidence of the incident being investigated, this was overly optimistic. There is no evidence that Police or Adult Social Care had discussed the case with Caroline or helped her to develop a robust safety plan if she was still at risk from Jonathon.
38. It does not appear that any agency had discussed with Caroline her sources of support, because if they had, they would have been told that her sons were unsympathetic and not a protective factor. If they had also spoken to David, her partner, he would have probably expressed anxiety about Jonathon returning to the home following cancellation of bail.
39. Police officers are advised to carry out a detailed safety plan with a victim who stays with an abuser. CPS domestic abuse guidance suggests they should include *'have the complainant's specific circumstances and vulnerabilities been identified and addressed to assist them (for example, in cases of familial abuse, or where the complainant has a disability)? Does the complainant have any individual needs requiring specialist support (for example, cultural or language barriers, alcohol or drug dependency, disability, physical or mental illness)?'*

40. It could be argued that Caroline's alcohol misuse, apparently central to her alleged falls, but relevant, whatever explanation was accepted, were neither identified nor addressed. This seems partly because of the peripheral part played by ASC.
41. This DHR acknowledges that Caroline may have had little or no insight into her son's Asperger syndrome. However, a more comprehensive safeguarding enquiry may have allowed this to come to light.
42. The officer in the case had called Caroline and been told she was receiving mental health support twice daily, providing the officer with some reassurance that her mental health vulnerability was being addressed. However, the DHR would argue that this alone was insufficient. The referrals had come from A & E and a BCPFT psychiatrist and the service were entitled to expect feedback from that enquiry. The West Midlands Adult Safeguarding Policy and procedures section 9.5.6. state that the Lead Agency; should ensure; '*The person or agency who raised the concern should be notified of the decision and outcome wherever appropriate and safe to do so.'*
43. The MASH manager had instructed this information be shared with the Mental health Liaison Team and it was recorded as having been shared on closure. The BCPFT IMR suggested that this was not the case, or at least the outcome had not been recorded. If mental health professionals were unaware of the result of the enquiry, then subsequent support of Caroline was compromised.
44. This DHR noted section (13 paragraph 34) that CCG (GPs at GP practice 1) were not spoken to in relation to the enquiry. They did however learn about the allegation in letters from the Mental Health Liaison Team. They similarly were not informed about the outcome and were not aware of a retraction. The CCG IMR notes that there was no discussion of domestic abuse with Caroline during subsequent presentation prompted by the MHLS letter.
45. When Caroline moved to GP practice 2 in November 2017, there was no domestic abuse flagged on her electronic records. The absence of 'read codes' relating to domestic abuse and adult safeguarding meant that only a review of all of Caroline's record would reveal to her new physicians the domestic abuse allegations from the past. It could be argued that in a comprehensive new patient health check, previous domestic abuse concerns should come to light, particularly in the context of repeated self -harm.

16.2 "Asking the question': routine enquiry by health professionals in relation to Domestic Abuse

1. The DHR identified that during the period under review, in relation to Caroline's presentations to Primary and Secondary Health services, there was an almost total absence of recorded evidence of routine questioning in relation to domestic abuse. This seemed to be the case even where

Caroline's engagements were with Mental Health Staff who should be routinely 'asking the question' concerning domestic abuse, (regardless of whether there are the indicators of abuse present). There appeared to be a similar absence of questioning or recording of questioning by General Practitioners or Hospital A & E staff when questions should be asked when the 'indicators' of domestic abuse are present.

2. It is concerning that even where Caroline presented to professionals with injuries that should prompt enquiry regarding domestic assault (for example section 14 paragraph 12) or professionals were told of 'problems' with her adult son, they did not make safe enquiry, or at least made no written record of such enquiry.
3. The National Institute for Clinical Excellence (NICE) had introduced Guideline for Health Providers in 2014 in relation to 'asking the question';[24] '*Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence and abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe and, in a kind, sensitive manner*.'
4. Although these guidelines are not compulsory, Trusts accept that they represent best practice. They were followed up in 2016, with The Quality Standard on Domestic Violence and Abuse.[25] It has been the experience of the Chair, drawn from previous DHRs that many CCGs and Mental Health and Hospital Trusts have been slow to respond to the guidance and cannot provide evidence that the guidance and quality standards had been embedded by 2017-2018. This was the panel's finding in this DHR.
5. There are numerous examples of missed opportunities described in section 14 of this DHR, where Mental Health professionals should have been making routine enquiry relating to domestic abuse on each new presentation. There was no evidence presented that such enquiry occurred because it appeared risk assessments were not sufficiently explicit about the need to investigate domestic abuse.
6. The Black Country Partnership Foundation NHS Trusts, Wolverhampton CCG and the Royal Wolverhampton Hospital Trust point to considerable efforts in the last 18 months to ensure employees are now trained in Adult Safeguarding to the Standards required in the Intercollegiate document [26] and have mandatory domestic abuse awareness training available. (These steps are

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[24] National Institute for Health and Care Excellence (NICE) public Health Guidance 50 (Feb 2014) Domestic abuse: how health services, social care and the organisations they work with can respond effectively

[25] NICE: Domestic violence and abuse QS 116 published 29 February 2016

[26] Adult Safeguarding: roles and responsibilities for health Care Staff (August 2018)

described at the end of this section.) They express confidence their staff are aware of domestic abuse and when to refer.

7. It is harder to demonstrate a significant change in practice in relation to 'asking the question', without specific direction to all staff. Some professionals will use their new knowledge of domestic abuse to be more 'professionally curious' or may have a good idea of the kind of framing questions that prompt disclosure. However wider changes in practice by Health agencies' professionals requires clear instruction from the Trust or CCG as well as risk assessment and supporting documentation with prompts. The impact of these systemic changes can be demonstrated through auditing to prove change is embedded.
8. It is important that providers explicitly train professionals 'to ask questions' about domestic abuse and indicate the types of framing questions to be used. Good practice requires evidence of such questioning to be recorded (both positive and negative responses) and referral pathways to be well established.
9. The apparent lack of recorded evidence of 'asking the question' in Mental Health Trusts is sometimes because such enquiry is already expected to occur as part of a wider consideration of risk in mental health assessments but has not been subject to specific training that, for example, explores coercion and control.
10. The DHR was provided with copies of the Black Country Partnership Foundation Trust's key assessment documentation including their: Mental Health Joint Risk assessments, Wellbeing assessments, Psychiatric Assessments, Older Adult Care Plan, Older Adult Risk Assessment.
11. The specific areas of risk addressed that relate to domestic abuse (but could occur in a non-domestic context) are those listed in the framing question below. The documents make no mention of 'domestic abuse' and do not include controlling or coercive behaviour. They are therefore general and do not confine enquiry to abuse from a partner or family member. The only framing question suggested appears on the wellbeing assessment; *'have you ever experienced physical, sexual, emotional, or financial abuse at any time in your life?'* It could be argued this wording is more likely to prompt disclosures of historic rather present abuse.
12. This suggests that although the BCPFT may feel present risk assessment questioning meets NICE guidance, it is unlikely to be effective. The absence during the period under Review of clear policy or best practice guidance or of direct prompts relating to domestic abuse on the assessment modules, make routine questioning less likely to be well embedded relying instead upon professional best practice.
13. Caroline attended GP practice 1 from before 2012 until November 2017 and then registered at GP practice 2 from November until her homicide in February 2019. Her numerous presentations

included mental health 'mood' and medication reviews. On several occasions she saw a GP shortly after discharge letters from Mental Health services or A & E reported concerns about her relationship with her adult son, or when injuries or falls had occurred. Her general health presentations included urinary tract infections. All of these types of presentations are included in the list of NICE 'health indicators', that should prompt questioning about domestic abuse. Within the period under review changes in practice should have been evident in GP awareness of questioning around domestic abuse. Unfortunately, neither practice demonstrated that they knew when to 'ask the question' and record positive or negative outcomes.

14. The CCG would accept that routine questioning by GPs when a patient presented with one of the health indicators of possible domestic abuse was not embedded across Wolverhampton at the time under review. The two GP's practices were not therefore exceptional in not recording routine questioning and exploring Caroline's experience of domestic abuse. GPs represent the professionals with the most frequent opportunity to 'ask the question'.
15. Caroline presented around 11 times to A & E, however, was only asked about her experience of domestic abuse, leading to an adult safeguarding referral, when she made an unprompted disclosure of abuse (section 14, paragraphs 29 onwards).
16. The Royal Wolverhampton Trust acknowledged that during the period under review in relation to routine questioning, they had failed to meet the West Midlands Domestic Violence & Abuse standards (2015). This required the RWT to have in place:
    - *A workplace domestic violence policy*
    - *Routine questions about domestic violence on service user referral forms*
    - *To train staff in domestic violence to an appropriate level depending upon their role*
    - *When domestic violence is disclosed be able to undertake a DASH risk assessment or have in place an agreed referral pathway for a DASH risk assessment to be undertaken*
17. It is unfortunate that in 2017, the Trust had not complied with the DV Standards that had been best practice for several years before the incidents included in the timeframe under review.
18. It is encouraging that remedial steps have been taken by all three agencies, however the Safer Wolverhampton Partnership would seek assurance from these partners that they have audit processes in place that allow them to measure the effectiveness of routine questioning or questioning where medical indicators of domestic abuse are present.

16.2.1 Changes implemented by the Black Country Partnership Foundation NHS Trust

1. The Trust brought in a new Domestic Abuse Policy in June 2017, which includes instruction in relation to routine questioning. Domestic Abuse training from 2018 onwards incorporates this area of practice. Safeguarding Link meetings held quarterly also consider domestic abuse and coercive

control and consider how to seek and support disclosure. In addition, participants are given updates of new and amended legislation.

2. It is possible that routine questioning was becoming more widespread across the Trust in the period under review, but that professionals were not recording it had taken place. The DHR would recommend that the Trust reviews risk assessment documents to include prompts relating specifically to routine questioning. They should consider how present auditing process would allow them to demonstrate when routine questioning is carried out and its' impact.

16.2.2 Changes implemented by Wolverhampton Clinical Commissioning Group

1. The CCG provides mandatory training open to GPs on aspects of domestic abuse through the Wolverhampton Domestic Violence Forum (WDVF). Mandatory Level III Safeguarding Adult training is provided bi-annually: highlighting domestic abuse, domestic violence and coercive control.
2. The CCG also has a project (GP Domestic Violence training and Support Project) that has been running 18 months, which provides bespoke training and support for GP practices provided by WDVF.
3. It is important that the CCG is able to demonstrate that practices across the city are aware of 'asking the question' and that this is demonstrated by more referrals to support. In the first instance they should consider appropriate flagging on electronic medical records.

16.2.3 Changes implemented by the Royal Wolverhampton Hospital Trust

1. As of 2019, routine questioning concerning domestic abuse has been included in mandatory documentation in Accident and Emergency. Training in relation to framing questions and skills was offered in 8 sessions, and 65 members of staff took up the training. (The DHR would suggest this uptake seems low for a large A & E department and the Trust should work with some urgency to improve this situation.)
2. Adult Safeguarding level II training has 92% compliance and level III is at 85%.

16.3 Health Professional responses to self-harm and safety planning in relation to depression and suicide risk

1. The DHR was struck by the apparent absence of in-depth exploration of the reasons for Caroline's self-harm. It was probably the most significant and concerning presenting feature but was viewed simply as a manifestation of her broader mental health concerns. It seemed GPs were waiting for guidance on how to approach self-harm from the Wellbeing service or Community Mental Health teams, whilst they in turn perhaps assumed the GP would address these concerns in primary care.

2. It is possible that had Caroline's GPs had access to a specialist support service in relation to self-harm, it may have prevented the cycle of self- harm episodes. As well as supporting an adult with repeated self-harm and suicidal ideation, such services can advise and support a client's family as well as providing guidance to GP practices on positive work with self-harm. There are, unfortunately, no such services in Wolverhampton, targeting suicide prevention.
3. Where such services do exist in neighbouring Local Authority areas, (provided by Papyrus and Kaleidoscope), they are often aimed at under 25s.This DHR would recommend that commissioners of services in Wolverhampton look to provide self-harm/suicide prevention counselling regardless of age, as part of the Adult safeguarding offer GPs should be able to access for patients.
4. This DHR identified a very concerning lack understanding of Caroline's level of support at home and her growing social isolation and threw into question the quality of mental health risk assessments being carried out after each presentation.
5. The DHR panel and many mental health professionals at the Learning event were concerned by the apparent absence of safety planning both on discharge and within the care plan. There was no evidence presented to the DHR of a clear plan to break the cycle of repeated self- harm episodes. Rather each incident was dealt with in isolation, in a frustrating pattern of admissions and discharges.
6. The DHR concluded that at the heart of Caroline's depression and metal health concerns may well have been her unhappiness concerning her relationship with her sons and in particular the demands placed upon her by Jonathon. He was controlling and had a sense of 'male entitlement' in relation to his mother. His Asperger's syndrome meant he had very little empathy and was likely to resent Caroline's mental health vulnerabilities because they impacted upon his need for order and structure. This made him a poor carer.
7. In his police interview relating to the domestic assault, Jonathon demonstrated little understanding of the risks associated with his mother's self- harm episodes and made it clear that he felt they represented '*attention seeking'* and that she was making a '*fuss'*. He pointed to the fact that Caroline was frequently discharged from hospital within hours of being taken in by ambulance to minimise their significance. The act of calling for an ambulance meant in his eyes, she had no '*real'* suicidal intent. He saw the episodes as an annoyance; his primary concern appeared to be how they inconvenienced and impacted upon him.
8. By any standards, Jonathon did not represent a family member who could support Caroline with her depression and recognise the risk from self -harm. David unfortunately chose not to engage with the DHR, but in his police statement he claimed he was the 'only person' supporting Caroline. The only mental health assessment the DHR was made aware of that showed any detailed

consideration of the network of family support, was conducted at Walsall Manor Hospital in 2012. It noted David was supportive and was '*very concerned about her risk of suicide*.'

9. Best practice in the treatment of patients with acute Mental Health needs is represented by a 'triangle of care'[27]; a partnership between the patient, the carer[28] and mental health staff.
10. Mental health professionals at the learning Event noted with concern the apparent absence of family involvement in discharge planning.
11. The starting point of this process would be to establish with Caroline whether anyone was fulfilling the role of carer and the level of support provided? Although Caroline could live independently, it seems the case that when in crisis, (a situation that reoccurred frequently in the period under review) she needed support from David or Jonathon.
12. It is hard to identify the level of care they each provided, or the degree to which Caroline accepted help from them, if it was offered. It is a concern that particularly in relation to the GPs and Mental health staff, IMR authors identified a lack of awareness of who was providing support to Caroline.
13. The effective treatment of chronic[29] depression[30] requires professionals to consider, with the patient's consent, working with families and carers. Caroline had a history of depression extending over many years. The NICE guidance suggests[31]: '*When families or carers are involved in supporting a person with severe or chronic depression, consider:*

- *providing written and verbal information on depression and its management, including how families or carers can support the person*
- *offering a carer's assessment of their caring, physical and mental health needs if necessary*
- *providing information about local family or carer support groups and voluntary organisations and helping families or carers to access these negotiating between the person and their family or carer about confidentiality and the sharing of information.'*

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[27] The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England

[28] A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who couldn't manage to live independently or whose health or wellbeing would deteriorate without this help. This could be due to frailty, disability or serious health condition, mental ill health or substance misuse. (RCGP)

[29] Depression is described as 'chronic' if symptoms have been present more or less continuously for 2 years or more (NICE CG 90)

[30] NICE Clinical Guidelines CG90 Depression in adults: recognition and treatment

[31] NICE CG 90 1.1.3.1

14. This level of engagement with David and Jonathon does not appear to have been achieved, since if it had, professionals would surely have noted concerns about the family dynamic and the lack of carer support, beyond David.
15. In his Police interview, Jonathon made it very clear that he lacked empathy and was frustrated by his mother's behaviour. Although he described taking his mother to psychiatric unit 1 to seek help, or took her on shopping errands, the predominant sense from his interview was his anger and frustration with her.
16. The police officer in the case (OIC) explained to the DHR that when the criminal and safeguarding enquiry into the assault ended and Caroline expressed apparent satisfaction with the outcome, the OIC was nonetheless '*glad'* that the CHTT were visiting twice daily. There is no evidence that the OIC discussed wider safeguarding with the mental health team, even though the officer recognised there was a distinct possibility there had indeed been an assault by Jonathon. It seems likely that the officer had some misgivings about Jonathon's role in Caroline's care.
17. When professionals were aware that Caroline's self-harm was now linked to her relationship breaking down, (section 14 paragraph 47) they should have understood the degree of isolation Caroline would now experience.
18. It is hard to avoid the conclusion that professional's decision making in relation to safeguarding was not informed by an understanding of all the factors that should have been taken into account.
19. It is in this context that the DHR considered appropriate safety planning after the repeated self-harm episodes. Chronic depression was likely to leave Caroline vulnerable but self-harm increased the adult safeguarding risk significantly. In addition, the diagnosis of borderline personality disorder in May 2017 required a response from professionals.
20. At the heart of NICE guidance[32] on self-harm is '*a full assessment of the person's family and social situation.*' (Paragraph 1.34 NIC CG 133). Professionals should find out about '*significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk.*' This DHR would suggest that prior to the abuse allegation made against Jonathon by Caroline, there was insufficient understanding of Caroline's social situation, despite clear disclosures that should have caused concern.
21. Of concern to the DHR was that there appeared to be no discernible change in Mental Health practice or risk assessments after the domestic abuse allegation. The BCPFT IMR writer was clear there was no record held by the Trust of the outcome of this crucial safeguarding enquiry. Although a Care plan from Older People's service was shared with GP practice 2 in April 2018, it appeared to only identify one risk '*a history of experiencing abuse Physical /emotional /sexual by ex –husband.'*

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[32] NICE Clinical Guidelines 133 self-harm in over 8s: long term management

In the context of what should have been known, it seems extraordinary that this historic abuse was the only risk mentioned. The DHR concluded that there was no evidence that the professionals in primary and secondary care had been involved in any multi-agency discussions that considered the risk posed to Caroline from self-harm, domestic abuse and an almost complete absence of support and community engagement.

22. The multiple self-harm episodes therefore represented multiple missed opportunities. NICE guideline stress: *'each episode of self- harm should be treated in its own right and a person's reasons for self –harm may vary from episode to episode*.' Each occasion that Caroline self-harmed was a new opportunity to consider; '*what is at the root of this behaviour*?' Regrettably, it appears these opportunities were largely missed. This appeared to be the result of practice that relied upon self-harm and suicidal ideation being addressed as part of the broader mental health presentation. Whilst the new BCHFT have addressed mental health risk management and self-harm with new approaches, outlined below, it does seem that pathways to specific self-harm/suicide prevention services that could assist adults as these thoughts first start to manifest themselves (regardless of their age), may have helped.
23. In relation to the assessment of risk associated with mental health and self-harm, the DHR sought reassurance that in future, BCHFT assessments would identify a patient's social and environmental factors, their known history, as well as take into account both the patient's strengths and the level of support offered by carers and family. The DHR felt assessments should always identify changes in circumstances likely to have either a positive or negative impact upon a patient's mental health.
24. The Black Country Healthcare NHS Foundation Trust (BCHFT) provided helpful insights on progress in these regards. The Trust now use the Steve Morgan 'Working with Risk' tool[33], a strengths-based approach. In an article in 'Mental Health Today',[34] Morgan stressed a good assessment should be a '*genuine enquiry into the experiences and specific context of the individual service user, their abilities and limitations, and how they might be helped to stretch the self-imposed and service -imposed boundaries to a life constrained by mental distress.'* Morgan highlights the emphasis upon collaboration with carers, recommended in the Department of Health guidance[35]. (The apparent absence of collaborative safety planning was a concern for the DHR and is addressed below.) The Morgan risk tool should be rolled out by September 2020 and signed off at the Trust's Quality and Safety Group in October 2020.

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[33] An evidenced based initial risk assessment screening tool to develop an initial risk management plan from and highlight further areas that may require more in- depth risk assessment.

[34] Working with Risk. Steve Morgan Mental Health Today Sept 2007

[35] Department of Health. Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services. London: Department of Health, 2007.

25. The Trust explained that this risk assessment tool aligns most closely with their self-harm and suicide prevention ‘Connecting with People’ training provided by the National Suicide Prevention Alliance.
26. The Trust currently have an approach to self-harm and suicidal ideation that concentrates upon the distress, emotion and trauma behind the presenting behaviours and encourages a patient to engage with Cognitive Behavioural Therapies (CBT), Dialectic Behavioural Therapies (DBT)[36] and Eye Movement Desensitisation Reprogramming (EMDR)[37].
27. At the Learning event mental health professionals pointed to the benefits of the ‘Connecting with People’ SAFE Tool.[38] It does not set out to grade the level of risk or predict the risk of suicide, because there is considerable evidence that such approaches are unreliable. In a 2018 study,[39] researchers at The University of Manchester pointed out that clinical risk assessments have in the past demonstrated the ‘*low risk paradox*’; that although many people who die by suicide have associated high risk factors; self-harm, substance misuse, economic problems, 88% had been assessed as low or no risk of suicide at their final service contact. The National Institute for Clinical Excellence (NICE) give guidance that risk assessment tools should not be used for that purpose but should be used as a ‘*prompt or measure of change*’[40]
28. The SAFE tool develops an understanding of a person’s current experiences and background history to develop a’ person-centred intervention to mitigate risk.’ BCHFT ‘Connecting with People’ training in relation to suicide and self-harm emphasises the importance of the multi-faceted risk assessment. The training has continued during the COVID-19 pandemic using virtual training sessions which is good practice.

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[36] Dialectical behavioural **therapy** (**DBT**) is a type of cognitive behavioural **therapy**. Cognitive behavioural **therapy** tries to identify and change negative thinking patterns and pushes for positive behavioural changes. **DBT** may be used to treat suicidal and other self-destructive behaviours

[37] **EMDR therapy** is a phased, focused approach to treating traumatic and other symptoms by reconnecting the client in a safe and measured way to the images, self-thoughts, emotions, and body sensations associated with the trauma, and allowing the natural healing powers of the brain to move toward adaptive resolution.

[38] The Connecting with People SAFE Tool is a framework to support a compassionate and structured assessment of someone at risk of suicide. It is based on principles derived from research and has been extensively peer-reviewed by international experts in self-harm and suicide prevention, people with lived experience, practitioners and third sector (NGO) experts. It is NOT a risk prediction tool as ALL patients receive a clinically appropriate response based on a person-centred assessment. The tool guides a practitioner through the process of identifying, capturing and evaluating relevant aspects of a person's current experiences, past history, background factors, risk factors and details of their suicidal thoughts in order to design a person- centred intervention to mitigate risk of suicide. The SAFE Tool assessment culminates in identifying and maximising strengths, assets and protective factors with the co-production of a Safety Plan for every patient and not just those at an elevated risk of suicide. The completion of the SAFE Tool as part of a mental state assessment, provides documentary evidence of the assessment and a Safety Plan that underpins the risk assessment. The SAFE Tool assessment can be printed to facilitate effective referral, with consistent communication for specialist services and the patient takes home a printed copy of their Safety Plan.

[39] The University of Manchester and Healthcare Quality Improvement Partnership: The assessment of clinical risk in mental health services (2018)

[40] NICE Clinical Guidelines 133 self-harm in over 8s: long term management

29. The Trust are identifying Connecting with People Champions to build practitioner confidence in completing crisis and safety plans.
30. It does appear to the DHR that the BCHFT have been open and honest and have acknowledged the shortcomings in the care of Caroline. They have described changes made to risk assessment and the care of patients who self-harm. The DHR recommendations will seek assurances of the effectiveness of these changes.
31. The BCHFT have also introduced a new database system Rio[41] which will ensure that professionals across the Trust have the right access to patient information. This will rely upon effective information sharing by partner agencies; a weakness recognised in this DHR.

16.4 The identification of the part alcohol abuse played in Caroline's mental health deterioration during the period under review

1. In the context of self-harm, NICE recommend; '*consider the possible presence of other co-existing risk-taking or destructive behaviours…such as engaging in harmful or hazardous drinking.'*
2. It is hard to draw any firm conclusions concerning the extent to which harmful or hazardous drinking played a part in Caroline's mental health deterioration. David claimed to be unaware of any excessive drinking by Caroline. (However, he did not see her after September 2019.) Nonetheless many episodes of Caroline's drugs and alcohol overdoses occurred before that point, and he did not apparently identify it as an issue.
3. If Jonathon is to be believed, Caroline was often collapsed, drunk. He stated her drinking had spiralled out of control in 2017. It was by his own admission a major reason for his anger with his mother. (It was another concerning feature of her vulnerabilities that may have been a response to domestic abuse.)
4. The DHR noted that the BCPFT IMR, whilst it listed the drugs used by Caroline to self- harm, did not mention the part that significant amounts of alcohol had played in many of these crisis situations. (In contrast with A & E and WMAS records).
5. In additional questions to the Trust, the DHR asked whether secondary and community mental health teams had note hazardous drinking or had considered referral to alcohol services. (It would have been possible for a psychiatric consultant to make a direct referral with a patient's consent, to Recovery Near You, who provide substance misuse services in Wolverhampton.)

[41] Rio supports the vision of every patient having one, fully integrated, electronic health record (EHR) to enable the very best and most efficient healthcare. A leading electronic patient record system for secondary care, it operates across mental health, child health and community care settings and interoperates easily with other systems.

6. The response received suggests that alcohol was not considered to be a co-existing presenting problem. This was based on Caroline's own assessment that alcohol was not a significant issue. It does seem with hindsight that this was possibly an overly optimistic analysis. It does not take into account the physiological impact of alcohol and medication. Medical records included several references to injuries caused by falls as a result of drugs and alcohol. Given the nature of these alleged accidents, then at the very least, it could be argued there was hazardous drinking. (Clearly Caroline would have needed to want to engage with alcohol services and there is no evidence this was the case.)
7. Similarly, the GPs at both practices recorded in patient notes about alcohol consumption eight times between January 2017 and September 2018. Often it was to record Caroline's self-reported alcohol use; generally, she claimed to have had little or none since the last review. Professionals were however, apparently aware of the part alcohol played in many of the self-harm episodes and as late as September 2018 Older People's Mental Health Services a letter reports '*patient has been in low mood resorted to drinking a bottle of wine each day and self-prescribing'*
8. There is no record of any attempt made after September 2018, to address this apparent increased alcohol consumption with Caroline. It does not appear that the potential negative impacts upon Caroline's mental health were recognised in primary care.
9. It is the view of the DHR that this failure to address a dual diagnosis remains too frequent in safeguarding cases reviewed as DHRs or SARs. All agencies should review the awareness of their professionals to this risky comorbidity.

16.5 Investigation of possible non-accidental injuries in this case.

1. The DHR felt considerable unease with the apparent tendency of professionals to accept Caroline's claim that accidental falls were the cause of her numerous injuries. She had no medical condition that would account for such falls however she was frequently under the influence of alcohol and prescription drugs.
2. There was no recorded professional consideration of the likelihood that the drug and alcohol combinations could account for such serious fall injuries. In any event, during the period under review, a person presenting to health professionals with these injuries should have been viewed as a possible victim of domestic abuse.
3. It could be argued that the OIC in the only domestic abuse allegation involving Caroline and Jonathon, should have at least enquired about previous injuries that Jonathon himself said looked as though his mother had been '*beaten up*.'

4. Opportunities occurred to understand the actual risks in Caroline's life, and it is very regrettable that there was a general naivety and over optimism about the cause of these injuries.
5. Particularly within Health providers, the Safer Wolverhampton Partnership would seek reassurance that professionals have received appropriate training on investigation potential non -accidental injuries in adults.

16.6 Workplace Support for victims of domestic abuse

1. Caroline worked for many years for a major UK High street retailer. She underwent a return to work 'fact finding' interview with her line manager in June 2018, in which she disclosed that her hand injury that had required surgery and a period of absence, was the consequence of a domestic assault.
2. The employer described to the DHR the Employee Assistance Provider (EAP) "Live Well, Work Well', that was in place at the time the review took place and offered 'confidential support for mental and emotional wellbeing.' This was a confidential service, available to Caroline if she wanted to use it. Her employers stated that for this reason they were unable to say whether Caroline availed herself of it. This in itself did not reassure the DHR panel. Domestic abuse is so widespread in the community we would have hoped that the employer would have been able to describe the frequency with which employees sought assistance with domestic abuse.
3. Recording that an employee who has disclosed or been identified as a victim of domestic abuse has been made aware of a EAP service has several benefits for the individual and the organisation. It allows an employer to demonstrate that employee's wellbeing is being actively promoted. It also allows the organisation to monitor their manager's safeguarding decision- making. Recording a request to be referred to a service, is not a breach of confidentiality, so long as personal records are secure and are only accessed appropriately. The absence of any note on Caroline's record makes it impossible to tell whether she was aware of this option.
4. Caroline's employers now use a different EAP, PAM Assist, who are able to provide confidential support relating to domestic abuse and mental health, as well as other issues likely to impact on an employee's wellbeing. A manager would be expected to explore an employee's support network and offer the assistance of PAM Assist.
5. In addition, a Line Manger Advisory Service was the pathway to the identification of an employee at risk requiring referral to a MASH. The Company does not have a current Domestic Abuse policy and indicated that their OT and EAP provision was felt to provide adequate support.
6. The DHR Chair wrote to the employer and asked them to consider augmenting the level of domestic abuse support offered to employees, by bringing in a clear domestic abuse policy as suggested in the October 2019

Public Health England: ‘Domestic abuse- a tool kit for employers.’; ‘*An effective workplace policy/guidance is critical to raise awareness, identify responsibilities and ensure provision, support and safety*.’

17 Conclusions

1. Caroline was at high levels of safeguarding risk throughout the period under review. Her repeated self-harm episodes could at any time have ended in tragedy. It seemed to the DHR that little progress was made in understanding Caroline’s needs as a vulnerable adult and consequently each episode was dealt with in apparent isolation.
2. There appeared to be a similar lack of understanding of the possible risk of ongoing domestic abuse; even where for a short period, Caroline made a clear allegation of a serious domestic assault. In spite of her later retraction, it is reasonable to conclude that it is more likely than not, that she was the victim of domestic abuse at the hands of her son, in April 2017. The circumstances of that incident and the homicide were chillingly similar. The homicide therefore was probably not a tragic lone event but represented an escalation of a pattern of control and abuse.
3. At his trial, it was accepted that due to Asperger’s syndrome, Jonathon lacked empathy, apparently was unable to cope with his mother’s repeated self-harm episodes disrupting his need for a regimented life. The circumstances on the day of the homicide were portrayed as the ‘final straw’ after years of similar episodes, which the defence claimed ultimately triggered an unpremeditated and frenzied attack. There appears to have been no mention, despite the similar facts, in either the police murder interview, or during the trial, of the alleged assault in April 2017.
4. From the perspective of this DHR, informed by detailed consideration of all known agency involvement with the victim and perpetrator over several years, and with the benefit of hindsight, it is hard to avoid the conclusion that the narrative accepted at trial appeared to ‘blame’ Caroline for her own homicide.
5. It seems Jonathon was afforded more understanding and sympathy than the victim herself. Jonathon had apparently worked quite effectively in a job as a delivery driver, and whilst he may not have developed close relationships with colleagues, there is no compelling evidence that Asperger’s syndrome caused him to argue or fall out with colleagues or customers. The trial seemed to argue that Caroline placed unbearable pressures on Jonathon; ones that he did not encounter in life outside the home.

6. The DHR is not compelled to follow the account accepted at trial, but can advance an equally plausible narrative, based upon an understanding of the nature of domestic abuse and learning from other DHRs.
7. Caroline had suffered domestic abuse as an adult and childhood abuse from her mother, which may have played some part in her anxiety, low mood and depression in adult life. These may also have been some of the reasons she self-harmed. However, it is also very possible that she was coerced and controlled by Jonathon who believed he was entitled to a 'quiet life' and reacted sometimes violently, when 'provoked' by Caroline.
8. Caroline blamed herself, like so many victims, for the perpetrator's abuse, not recognising that many of her vulnerabilities were actually caused by Jonathon. This mindset allows perpetrators to blame the victim for their violence; *'I wouldn't get violent if you didn't keep drinking and trying to kill yourself.'*
9. During her employee welfare interview at work in June 2018, she said that she had been, *'silly with drink and drugs'*, implying that she had been assaulted and suffered broken bones because her drinking and self-harm 'provoked' Jonathon and triggered violence. On the day of the homicide, Caroline had 'barricaded' herself in her room by wedging the bedside cabinet against the door. It seems fair to conclude this was to protect herself from the kind of severe violence she had already experienced from Jonathon.
10. Her self-harm may have been a conscious or unconscious attempt to draw attention to her plight. Even when, on several occasions, she disclosed the tensions in her relations with Jonathon, Caroline appeared to be failed by professionals, who never asked further exploratory questions to identify domestic abuse or sought to understand the cause of her self-harm, in any meaningful way.
11. The agencies contributing to this DHR have pointed to improvements in guidance and policies that they believe should reduce the risk of similar poor practice. However, these issues are so central to effective safeguarding that it is vital that all Wolverhampton agencies contributing to this Review ensure they audit practice to ensure that changes are properly embedded and remain so.
12. The DHR has identified that there remains a gap in responses where an adult like Caroline is deemed to be highly vulnerable but may not have care and support needs as defined by the Care Act. It is clear that domestic abuse is often one of several risks that are identified where adults have significant needs. It cannot be stated often enough how frequently domestic abuse and coercive control are found to be at the root of depressive conditions, self-harm and suicides in women.
13. The challenge in safeguarding adults is understanding all relevant factors and this requires multi-agency working. As crucial as a timely safeguarding referral may be, professionals should not place

an over reliance upon adult social care to be the lead professionals, as a result of a section 42 enquiry, to identify whether that adult is at risk of harm.

14. Instead, vulnerable adults with significant needs should be identified early and pathways and support be provided to prevent the risk of abuse or neglect. This emphasis on prevention is clearly at the heart of current thinking across Wolverhampton agencies, and it should be enhanced to prevent safeguarding concerns reaching the level that require Adult Social Care intervention.
15. Wolverhampton agencies with adult safeguarding responsibilities have recognised that there are many vulnerable adults, like Caroline, who may not respond to the support offered by professionals and go on to be at a high level of concern but may not have care and support needs.
16. In cases where early intervention may not have reduced risk and concerns remain high, the agencies in Wolverhampton contributing to this Review have acknowledge that a solution may be found in dynamic and thorough risk assessment informed by confident information sharing, backed up by multi-disciplinary team meetings and action plans led by an identified key worker.
17. The Learning in this DHR concentrates upon the processes already in place in Wolverhampton to improve practice and suggests additional measures informed by the learning from Caroline's tragic homicide. The DHR Chair was heartened by the willingness of safeguarding leads and managers from agencies including the MASH, to innovate and respond in a flexible way.

18 Lessons to be learnt

18.1 Raising Awareness of Elder Abuse and domestic abuse.

1. There is a growing awareness of the risk, particularly to parents, of parricide; domestic homicides perpetrated by an adult son or daughter. A study [42]by Hannah Bows from Durham University cited Benbow and others who had considered evidence from across DHRs. At present there is a lack of firm evidence that is strongly indicative of risk, although there is some evidence that older women (in the age group 60+) are more at risk from adult sons particularly where they display the vulnerabilities such as mental ill health) than from intimate partners or former partners.
2. The DHR recognised a number of closely interconnected reasons why Caroline's vulnerability may not have been properly identified and the safeguarding consequences around domestic abuse not properly addressed. These seem to stem from a combination of commonly held societal attitudes and perceptions linked to age, that may have meant that not only was Caroline less likely to have

[42] Domestic Homicide of Older People (2010-2015): A comparative analysis of intimate-partner homicide and parricide cases in the UK

identified herself as a victim of abuse, but also that some professionals may not have recognised her as a potential victim of abuse. An additional relevant factor appeared to be that whilst many professionals recognise domestic abuse when it is occurring between intimate partners, they are sometimes less quick to identify the signs of abuse when it involves family members particularly if the victim is an older person.

3. In a July 2019 report, HMICFRS and HMCPSI[43] noted that; '*There is no agreed age or definition across the criminal justice system (or indeed society) for what constitutes an 'older person'. For example, Age Concern defines old age as starting at 50 years; the CPS at 60 years; and different forces have chosen their own lower age limits (for example, one force inspected for this report had chosen 60)*.' In the UK, according to NHS England, this term describes a person over 65.
4. Caroline, who was 67 years old in January 2017, and was 69 at the time of her homicide in February 2019, would be considered an older person. Some (but by no means all) older people become more vulnerable with age, due to frailty or other needs. 'Action on Elder Abuse'[44] have identified through their work that older people are at greater risk if they also experience other vulnerabilities such as poor mental health, alcohol and substance misuse, isolation, poor quality long- term relationships and dependency.
5. Until recently, work and studies to identify risk of elder abuse were rare. Similarly, little distinction was made between the investigation of crimes against older people and younger adult victims. In a recent study it was suggested '*It is only in last few years that that this has been the subject of rigorous scientific study and specialised health and criminal justice attention and intervention*'[45] This has allowed conclusions to be drawn related to risk from perpetrators and the vulnerability factors in victims.
6. In Caroline's case, although she had no recorded physical ailments that would have accounted for her apparent accidental falls, it is clear that she experienced chronic depression, frequently experienced suicidal intent and it seems likely that by 2017, she was drinking alcohol at hazardous levels. She had had a long-term relationship with David that appeared to be at risk and had lost contact with her circle of friends. On sick leave from work for much of 2017, she was increasingly isolated from sources of support.
7. Caroline had lived with her son his entire life and probably had an awareness and had been experiencing the consequences of his apparently undiagnosed ASD, for much of that time. This DHR

[43] Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Her Majesty's Crown Prosecution Inspectorate (HMCPSI) The Poor relation: The Police and CPS response to Crimes Against Older People

[44] Action on Elder abuse is a UK charity working to end harm, abuse and exploitation of older people.

[45] Aggression and Violent behaviour 50(2020) Risk factors for elder abuse and neglect: a review of the literature. (Jennifer E. Storey Department of Law and Criminology Royal Holloway University of London)

would argue that he exhibited many of the known factors making him likely to commit elder abuse and this manifested itself in his coercive and controlling behaviours.

8. Elder abuse can involve; '*a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person'*[46] Elder abuse can involve any of the behaviours recognised as domestic abuse; physical, emotional, sexual, financial abuse or coercion and control. Although most common in the over 70's, (an Action for Elder Abuse study identified that 78% of victims of such abuse were over 70 years old,) 18% were in the 65 to 69 age group.[47] Women were significantly more likely than men to report as victims; 67% were female. Family members were the perpetrators of elder abuse in 33% of reported cases. Victims most often experienced abuse at home, 64% of the cases occurred there.
9. This is borne out in a 2020 Review by Jennifer Storey from the University of London, of available literature and worldwide research on elder abuse.[48] She describes the key risk indicators in perpetrators of elder abuse. Many are highly relevant to assessing risk posed by Jonathon:

- *Problems with Mental Health- personality functioning and cognitive impairment*
- *Dependency- relating to housing and finance but can be emotional and functional in nature.*
- *Problems with stress and coping-serious problems with stress related to an inability to cope with life problems. Problems may be a reaction to unusually stressful life events, inadequate coping with normal or day to day life stresses, or inadequate coping with caregiving responsibilities.*
- *Victimisation- previous abuse experienced or witnessed during childhood or adolescence*
- *Problems with attitudes- Serious problems with attitudes relating to caregiving, older persons, and the rights of others.*

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[46] Definition adopted by the World health Organisation (see Action on Elder abuse (1995) 'New Definition of Abuse', London: Action on Elder Abuse Bulletin (May-June 1995, issue no. 11).

[47] Action for Elder abuse UK Study of Abuse and Neglect of Older People - 2007

[48] Aggression and Violent behaviour 50(2020) Risk factors for elder abuse and neglect: a review of the literature. Jennifer E.Storey Department of Law and Criminology Royal Holloway University of London

- *Problems with relationships- serious problems establishing or maintaining positive, prosocial intimate (romantic) and non-intimate relationships. Includes conflictual relationships, feelings of social isolation and a lack of social support.*

10. Jonathon's life was dictated by his ASD. He demanded structure and the security of his home. He had no close friends, struggled to develop relationships and was poorly equipped to deal with life events and everyday stresses. He was not suited to care giving, lacking empathy or understanding. He may well have witnessed or been a victim of domestic abuse in his childhood. There is some evidence of controlling behaviour, and he may well have felt entitled to demand that his mother provide an environment that met all his needs. When this was not fulfilled, Caroline became even more vulnerable to abuse.
11. Caroline was therefore probably at great risk of elder abuse, but it seems likely that she may not have considered herself a victim of elder abuse or domestic abuse for several reasons.
12. Some studies have suggested that older people are the least likely age group to identify their experiences as domestic abuse and report it. "*Older women are far less likely to identify their situation as abuse*"[49],
13. The study by Safe Lives, a domestic abuse support charity[50] points to the fact that many studies, including the Crime Survey for England and Wales exclude from consideration victims of domestic abuse beyond 60 years old which serves to' *to reinforce the false assumption that abuse ceases to exist beyond a certain age*.'
14. Because older people are less likely to report and access domestic abuse services, there is a perception amongst some health professionals that they do not really experience domestic abuse. The study suggested that;' *these assumptions may encourage health professionals to link injuries, confusion or depression to age related concerns rather than domestic abuse. An Independent Domestic Abuse Adviser (IDVAs) with specialist experience in working with older victims, emphasised that "sometimes professionals [social workers and doctors] only see medical conditions with older people and they're […] not trained to see domestic abuse."*
15. At the Learning Event professionals identified that often when colleagues think of domestic abuse, they envisage abuse between intimate or formerly intimate partners and do not so readily identify abuse by family members as domestic abuse.

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[49] Scott, M., Mckie, L., Morton, S., Seddon, E., and Wosoff, F. (2004) Older women and domestic violence in Scotland…and for 39 years I got on with it, NHS Health Scotland, Edinburgh. page 28

[50] Safe Lives Older people and Domestic Abuse

16. It appeared to the DHR that these factors may well have accounted for the missed opportunities to explore why Caroline reported feeling unsafe at home, or to identify problems in her relationship with her son.

18.2 'Think Family' – achieving a cultural change within agencies and the need for Think Family 'prompts' in assessment tools

1. Caroline's situation was one which regrettably appeared not to prompt a 'Think Family' approach on the part of professionals. It led the Review to conclude that professionals still do not generally recognise that 'Think Family' has an application for adults who have complex needs such as chronic health issues, mental health concerns, alcohol and drugs dependency, but who may not have children with recognised needs, to prompt the 'Think Family' approach.
2. Many Adult and Child Safeguarding Partnerships have 'Think Family' protocols. This DHR acknowledges that the original 'Think Family' and 'Whole Family' models were and remain, aimed at securing better outcomes for children by recognising the impact of the complex needs of the adults and addressing them. They recognise that an adult's parenting capacity may be affected by their vulnerabilities, increasing the needs of children. They encourage a holistic view of a family, to understand strengths and weaknesses in order to better evaluate the child's needs. However, the DHR concluded that work needs to be done by all agencies to help professionals appreciate these principles can have wider application.
3. In recent years, Health Trusts and CCGs have promoted 'Think Family' principles to their professionals, but it does not appear they have been clearly enough stated so that they are seen to have the same relevance where there are no children at risk. This DHR would argue that an adult's complex needs often impact upon their family and friends and carers, so it becomes crucial to understand the person's social and environmental factors.
4. The guidance on the application of a 'whole family' approach which accompanies the Care Act[51] puts it in these terms; 'a vital aspect in considering an individual's wellbeing is the context in which they live, their domestic and family relationships and the importance of achieving a balance between their wellbeing and that of any family or friends who are involved in caring for them.'
5. An additional complexity is that adult safeguarding under the Care Act and related guidance, relates to adults with 'care and support needs.' This DHR illustrates the extraordinary vulnerability of adults with complex needs even when they do not meet the threshold of the Care Act because they are able to live independently.

[51] The Care Act and Whole Family Approaches Department of Health (2015)

6. The 'Whole Family' approach in its' essence is about the need for professional curiosity. To be effective, professionals should establish the social and environmental factors impacting upon Caroline's emotional and physical wellbeing. This included having a clear understanding of her 'lived experience.' Most importantly, they should have sought to identify the strengths in her family and community support, but also the things that might foster a sense of wellbeing.
7. In order to safeguard effectively there needed to be conversations to find out how they could support Caroline to feel safe. Information should be shared between agencies for many of the reasons that are at the heart of adult safeguarding:

- Prevent death or serious harm
- Coordinate effective and efficient responses
- Enable early interventions to prevent the escalation of risk
- Prevent abuse and harm that may increase the need for care and support
- Reveal patterns of abuse that were previously undetected and that could identify others at risk of abuse
- Identify low-level concerns that may reveal people at risk of abuse
- Help people to access the right kind of support to reduce risk and promote wellbeing
- Help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour.

8. At its' most basic level, this required practice to recognise the need for professional curiosity going beyond a consideration of an incident, to look at root causes. It needed all professionals to resist silo-ed working and see the wider picture. There are practice models already in existence that could help.
9. The chronology described agency involvement with Caroline over a period from the start of 2017 until her tragic homicide in February 2019. The DHR has listed eleven separate self-harm episodes in that period, and repeated contacts with the Emergency Departments of two local Hospitals, GPs and primary care, Mental Health Liaison services, CRISIS and Older People's Community Mental Health teams, Adult Social Care and West Midlands Police. The DHR would hope to find evidence of a Care plan or safety plan in place that was properly informed by an understanding of Caroline's support at home, and an accurate understanding of the risk from domestic abuse, following the information gathering stage of the joint police and adult social care investigation in April and May 2017.
10. It is a matter of concern to this DHR that these agencies appeared to have very little shared understanding of Caroline's social circumstances. The names of Jonathon (son) and David (partner)

are apparently not mentioned at all in the records from either of the GP surgeries caring for Caroline in the period under review. The chronologies submitted to the review contain no detailed discussion between Caroline and GPs or their nursing staff, about home circumstances and support, even though health records list dozens of reviews during the period under consideration. There was very little evidence presented to the DHR that agencies had a clear and detailed understanding of the family composition, or the level of support that these key adults could provide Caroline in responding to her frequent mental health crises. Caroline was increasingly isolated from friends and family and was on sick leave from work for a large part of the period under review.

11. The BCPFT IMR was honest in describing this weakness in practice. The author acknowledged that even where Caroline stated that she did not feel safe at home when her partner was not present, there were no recorded attempts by their professionals to explore the reason for this.
12. This apparent failure to identify risk was mirrored in a failure to explore the reasons behind the repeated self -harm episodes. The BCPFT IMR author stated *'there is no evidence that the reasons for these incidents were investigated further than what was reported by Caroline at the time on taking the overdoses. Follow up work on the issue of her overdosing is not evidenced in available documentation apart from evidence of changes in medication regime and support with anxiety and depression offered by Healthy Minds, Wolverhampton. The IMR author suggests that the opportunity to examine the possibility of a root cause for why Caroline was making attempts to take her life should have been considered in more depth and this opportunity to support Caroline's wellbeing from available information was not afforded to her.'* These shortcomings are being addressed by the Black Country Healthcare Foundation Trust; a '7 stage briefing' about the Think Family approach was issued to practitioners in March 2020 and this forms part of a wider effort to embed 'Think Family' in mental health practice and in risk assessments.
13. In repeated Mental Health engagements and assessments, GP appointments and reviews of medication and presentations in the Emergency department of Hospitals, professionals failed to go beyond Caroline's immediate presentation to discover her social circumstances or identify factors that contributed to the actual level of risk she was experiencing.
14. The challenge posed by ten-minute appointments with a GP is, understandably, advanced as a reason that there appears to be a lack of professional curiosity in some primary care settings. This DHR would argue that time spent 'Thinking Family' would actually reduce repeat presentations and reduce the risk of worsening health and mental health conditions. The CCG point to the fact that a GP could bring a patient back for a double appointment to explore the concerns and this seems a more realistic goal than waiting for a nationally agreed change to the length of GP appointments.

15. This DHR would recommend that agencies concentrate upon embedding "Think Family' approaches and could use existing models to encourage the greater professional curiosity that this approach would require. One such model exists within Adult Social Care, but it could have application in any safeguarding situation.
16. The emphasis upon 'three conversations'[52]in adult social work is well established. It seems to the DHR panel to have relevance in promoting understanding of an adult with significant needs and could be used by professional from any agency with safeguarding responsibilities. Under this model, before there is any consideration of eligibility for care and support (a threshold that in any case may exclude many adults with significant needs and vulnerabilities), conversations take place designed to discover a family's strengths and their support in the community.
17. The first conversation asks, '*How can I connect you to things that will help you get on with your life – based on your assets and strengths, and those of your family and neighbourhood? What do you want to do? What can I connect you to?* The professional would not move onto the second conversation, until there is a good understanding of these strength-based factors.
18. The second conversation looks at risk; '*what needs to change to make you safe and regain control? How can I help make that happen?'* (In Caroline's case, it was the apparent absence of these two areas of investigation that left her so vulnerable and unsupported, in spite of frequent involvement with professionals.)
19. Only then, would long term care and support needs be considered in a third conversation. By using this approach, professionals would gain an understanding of the wishes of a person with significant needs before even going on to consider whether that person has care and support needs.
20. It appears that there needs to be a significant cultural change within agencies to embed 'Think Family' in the minds of their professionals. Briefing sheets and a review of training may provide some answers. The wider use of genograms was felt by many of the participants at the Learning Event to be helpful. All agencies should consider whether their 'Think Family' guidance is sufficiently explicit to emphasise its' application to vulnerable adults with complex needs who may have neither children nor care and support needs.
21. Agencies should actively review assessment tools to ensure that the right questions prompt the 'Think Family' approach. This is particularly important in the case of the Wolverhampton CCG and the Black Country Healthcare Foundation Trust and will be a recommendation from this DHR.

[52] Asset-based places: a model for development SCIE July 2017

18.3 Social Prescribing and Wolverhampton's approach to Prevention of abuse or neglect in adults at risk

1. The CCG representative on the DHR identified Social Prescribing as an innovation that may have benefited Caroline by reducing her depression and isolation, had it been more widely available. It is a non-medical approach to improving health and wellbeing and is a link between primary care services and the voluntary and community sector and aims to help people with non-clinical needs access a wide variety of services and activities in Wolverhampton to support their health and wellbeing.
2. The University of Wolverhampton's Institute for Community Research and Development carried out an evaluation of the city's pilot social prescribing project.[53]They reported there was a '*statistically significant improvement*' in service users' reported wellbeing following contact with the social prescribing service; they reported a decrease in feelings of loneliness. In addition, a reduction in primary care health use was statistically significant for those service-users who were the highest utilisers of GP/practice nurse appointments (6+ appointments in six months).
3. Social prescribing is now firmly established across the Wolverhampton CCG in all GPs practices. The DHR concluded that had GPs had this non-medical model available as an addition to their traditional responses, when Caroline first identified depression and anxiety, it is possible that it could have helped to prevent her worsening mental health.
4. Whilst social prescribing will assist GPs in future, it is also important to acknowledge that it will not provide the answer for every adult identifying their isolation and anxiety. For this reason, the DHR was clear that in a case like Caroline's, identifying needs and obtaining help early, is critical to improving health and wellbeing and reducing risk.
5. Although the concept of 'Early Help' is firmly embedded in child safeguarding, there is not as yet, the equivalent emphasis upon early prevention of harm and abuse, in Wolverhampton. The Head of Safeguarding for Adult Services attended the Learning Event to discuss how a preventative approach could have impacted upon Caroline's needs, reducing the likelihood of her becoming an 'adult at risk'.
6. There can be no doubt that early identification of Caroline's escalating risk could have led to a better understanding of Caroline's social circumstances. There was no holistic understanding of her needs and in particular, the support she wanted and would engage with. It is, for example, clear that on several occasions, Caroline wanted in-patient mental health care but was considered ineligible. This must have caused her to disengage to some extent.

[53] An evaluation of Wolverhampton's Social Prescribing Service: A New Route to Wellbeing Dr Rachel Massie and Dr Nahid Ahmad (February 2019)

7. The DHR has welcomed the assurance that the Wolverhampton Safeguarding Together[54] (WST) and Public Health colleagues have prioritised a review of the City's Adult pathways to services and support from the statutory and voluntary sectors that better reflect the harm prevention duties upon Local Authorities under the Care Act, in order to prevent harm and abuse. The DHR will recommend that the Safer Wolverhampton Partnership (SWP) seek assurance from WST that once the Review has identified improved services and structures, that a suitable proportionate audit of its' impact is undertaken.

18.4 The use of Concerns Meetings and practice-based Multi-disciplinary Team meetings

1. The DHR was clear that Social Prescribing and Adult Early Help provide hope that adults who because of their physical or mental health, or social circumstances are vulnerable to abuse or harm, may in future be offered a range of choices and support that was simply not available in this case. It is also clear that there will be adults who go onto develop more complex needs that go beyond these pre-emptive responses.
2. The DHR and Learning Event identified that in spite of Caroline's presentation to her GPs, Hospital Emergency Departments, Mental Health services, Police, there was a clear lack of joined-up working by agencies, with a tendency to address the presenting problem without taking into account Caroline's previous history.
3. The DHR and professionals at the Learning Event were clear that the absence of a co-ordinated, multi-agency approach was a contributory reason that Caroline remained at such high levels of risk for so long. The over reliance upon a Safeguarding referral as the only 'trigger' for co-ordinated action may lead professionals to incorrectly assume that 'someone' is doing 'something.' This in turn sometimes fosters the view that they may no longer have a primary role.
4. This DHR illustrated how a safeguarding referral may lead to an investigation of a potential incident of abuse (which may involve a criminal investigation), but does not necessarily put in place a safeguarding plan if thresholds are not met. It also does not necessarily bring together a multi-agency team to look holistically to identify root causes and suggest support that the adult at risk finds acceptable.
5. The Review and Learning event were in agreement that far too little of the context of Caroline's life was understood by professionals trying so hard to support her, often too little effect. It was widely felt that had a multi-disciplinary meeting shared what was known, gaps in understanding of Caroline's strengths, risk and vulnerability would have been identified. The absence of a co-ordinating lead professional was seen by the DHR to be one of the main reasons professionals worked in silos.

[54] The name for the combined Wolverhampton adult and child safeguarding partnership arrangements

6. The DHR Chair was assured at the Learning Event by the Wolverhampton CCG, the Head of Adult Services and the Senior Social Work Manager responsible for the Wolverhampton MASH, that the city has put in place two pathways for multi- disciplinary meetings, either of which could offer more effective working in cases like Caroline's. There was a very encouraging willingness displayed by these senior managers at the Learning Event to learn from this case and adapt Guidance and Protocols to make the two processes even more responsive and effective.
7. The Wolverhampton CCG provided details of the practice-based GP-led Multi-Disciplinary Team (MDTs) meetings. They bring together GPs, Practice nurses, Occupational and Physiotherapists, Mental Health professionals, District nurses and Community matrons, Voluntary sector and Social workers. They are able to access community assets to address fundamental wellbeing, social isolation and depression. The MDT coordinator is crucial, collating information to be presented, ensuring appropriate representation for the MDT to be effective and most importantly identifying a keyworker for each case. A care plan is agreed with actions, with named professionals responsible for those actions.
8. Wolverhampton CCG has developed six Primary Care Networks across the Local Authority area. Groups of GP practices working with community, mental health, social care, pharmacy, hospital and voluntary services so patients can receive the right help they need from local health and social care services.
9. There are 2 to 3 MDTs on each PCN (covering a population of 30-50,000). The DHR has been told that as of March 2020, all but around 12 practices are engaged with the MDT process.
10. In addition to the GP led MDT, and as a result of Learning from SARs and Learning Reviews, SWT have developed a pathway for Concerns meetings. Any professional can call a meeting and they become the single point of contact (SPOC). These meetings are currently to discuss adults with care and support needs who may have not met the threshold for a section 42 enquiry but have unmet needs and vulnerabilities and are consequently at risk.
11. However, there was willingness from adult services and MASH to extend the process to cover adults deemed to be very vulnerable and at risk, who are not assessed to have care and support needs. This is in line with the Care Act Statutory Guidance Chapter 14 paragraph 44.[55]
12. The Review was clear that such meetings could have helped formulate a response to Caroline's self-harm episodes, anxiety and depression and isolation by bringing professionals together to share information and perhaps identify gaps in their understanding of Caroline's lived experience.
13. Our recommendation is that WST and partners refine the current system, guidance and protocols to extend its' remit to any adult at risk who is deemed highly vulnerable. The DHR were informed that the WST

[55] 'In any Organisation that comes into contact with adults at risk, there should be adult safeguarding policies and procedures. These should reflect this statutory guidance and are for use locally to support the reduction or removal of risk and securing any support to help the individual recover.'

Scrutiny & Assurance group are currently setting up a 'Survey Monkey' to gauge awareness of the current process and number of meetings that have occurred. The SWP should seek assurances from the WST Scrutiny & Assurance group that the Concerns meetings are identifying the right cases and having a positive impact.

18.5 Safeguarding referrals and shared assessment of risk

1. The DHR considered how the outcome of the Safeguarding referral in April 2017 was fed back to referrers and to those agencies actively working with Caroline. The conclusion was that the existing process was not effective in achieving a shared understanding of Caroline's ability to protect herself, nor did it identify clearly and unambiguously the on-going unresolved risks. The social worker was tasked with feedback and for reasons described above, the process was fragmented. There is nothing to indicate that this was an unusual occurrence and professionals at the Learning Event felt that in their professional experience they often considered that feedback after referrals was ineffective or partial. The DHR acknowledged that many referrals find no risk or are able to offer support to remove risk. We therefore concentrated on the much smaller category of referrals, where risk was unresolved.
2. West Midlands Adult Safeguarding policy explains: '*Feedback: at each stage of the adult safeguarding process. It is important to ensure feedback is given to the adult, people raising the concern and partners. People who raise adult safeguarding concerns are entitled to be given appropriate information regarding the status of the referral they have made. The extent of this feedback will depend on various things (e.g., the relationship they have with the victim, confidentiality issues and the risk of compromising an enquiry). At the very least it should be possible to advise people raising the concern that their information has been acted upon and taken seriously. Partners in provider organisations require feedback to allow them to continue to provide appropriate support, fulfil employment law obligations and make staffing decisions.'*[56]
3. The Learning event also identified that some agencies, for example the Wellbeing service, were not aware of the outcome of the referral but had not 'chased it up' through case management processes. This was mirrored within other departments of the BCPFT, for example Older Adult services, who worked with Caroline after the referral, but were unaware of the referral and the unresolved risk.
4. The Trust's safeguarding lead was clear that where a patient was still 'open' to the Trust irrespective of service, risk assessments need to be reviewed; at admission, at the point of change to a new team, if there is a change in presentation, or at very least on a 6 monthly basis and on discharge. These assessments must be informed by the outcome of safeguarding referrals.

[56] section 7.5 West Midlands Adult Safeguarding Policy and Procedures

5. It could be argued that whilst not wishing to hinder direct conversations between professionals, which will always promote safeguarding, the most effective feed-back method where risk remained unresolved would be a decision document, completed by a manager and shared electronically with the referrer and agencies actively engaged with the adult. It is vital to reduce the risk of 'start again' syndrome, where the risk assessment of a new concern is not informed by historic concerns. A shared feedback document could identify resolved and unresolved risk, the 'unknowns' in the case as well as the strengths. Importantly it could ensure that an adult's stated wishes at the time of the concern are known to all agencies. The DHR felt strongly that the technical or resourcing implications of entering the information on agencies' systems should not be used as a reason for not improving safeguarding.
6. The DHR was encouraged by assurances that the MASH and Adult Social Care managers and Safeguarding Leads met in May 2020 to consider how best to share relevant information following a referral, where there remains unresolved risk. It is recommended that WST, The MASH and Adult Services should continue this reassessment of the process for feedback after a safeguarding referral. It would also be helpful to consider how the MDTs and Concerns Meeting action plans and assessments are shared with participants. Whilst it seemed to the Chair that some form of electronically shared summary documentation, shared with participating agencies, would be the best solution, the process chosen should not be so bureaucratic or difficult to implement that it actually inhibits information sharing or prevents rapid implementation of improvements.

19 Recommendations

Learning: the DHR identified a general absence of detailed questioning about potential domestic abuse by general practitioners, hospital staff (E.D) and community and secondary mental health when the victim presented with health indicators that should prompt such questioning, in line with current best practice drawn from NICE guidance

1. **The DHR recommends that the Safer Wolverhampton Partnership seek assurances from the Wolverhampton Clinical Commissioning Group (CCG), the Black Country Healthcare Foundation Trust (BCHFT) and the Royal Wolverhampton Trust (RWT) that appropriate and safe questioning of patients around risk of domestic abuse (in-line with current NICE guidance) is now taking place and that a record confirming questioning has occurred is made on patient notes, regardless of outcomes**.

Actions

To demonstrate the effectiveness of changes described in this DHR the above-named agencies should:

i) Provide evidence of a robust auditing process that demonstrates that enquiries are taking place and being recorded (CCG to consider the feasibility of flagging of enquiries on records)

ii) Provide evidence of any increase in referrals made and whether the agency considers referral levels to be appropriate

iii) Provide copies of any improvements/changes to agency policy and procedures, paperwork, or proformas aimed to prompt such questioning

Learning: the DHR revealed a widespread absence (by most of the health professionals involved in this case) of enquiry to understand the victim's family history and social situation. The absence of a recognisable 'Think Family' approach suggested that agencies in Wolverhampton need to reinforce with their professionals that the principles behind 'Think Family', to obtain an understanding of a person's environmental and social factors, is as important in relation to vulnerable adults as it is to children.

2. **The DHR recommends that the CCG, BCHFT, Adult Social Care and the RWT review policy and procedures and guidance and training to ensure that they can demonstrate that 'Think Family' principles inform practice and that professionals obtain where appropriate a detailed family history and explore a patient's social situation.**

Action plan:

i) To demonstrate the impact of any changes in this regard, the Safer Wolverhampton Partnership should seek from the above-named agencies an account of changes made to guidance and training as well as to paperwork and assessment processes which should include prompts to encourage best practice

Learning: the DHR noted that establishing and mapping pathways to support (including social prescribing) together with earlier identification of adults with complex needs who may be at risk, are crucial steps in meeting the statutory duties under the Care Act to prevent harm

3. **The DHR recommends that the Safer Wolverhampton Partnership should seek an account from Wolverhampton Safeguarding Together and Public Health of their Review of service provision and pathways (both statutory, voluntary and third sector), which is aimed at improving early identification of need and preventing harm to vulnerable adults who may otherwise develop care and support needs and be at risk of abuse or neglect**

Action plan:

i) WST and Public Health provide the Safer Wolverhampton Partnership with details of their on-going Review
ii) WST and Public Health should ensure suitable audit methods are in place to demonstrate the impact changes brought about by the Review have, upon access to services and up-take of these services

Learning: the DHR identified that the absence of a ‘key worker’, working to an agreed action plan with partners to address complex needs (where an adult may or may not have care and support needs) was a factor in the escalation of concerns in this case. The DHR recognised the potential benefits of multi-disciplinary meetings and concerns meetings upon both the wellbeing and safeguarding of adults who may be vulnerable or at risk (regardless of whether or not they have care and support needs).

4. **The Safer Wolverhampton Partnership should seek assurances from the CCG and WST that the protocols for multi-disciplinary and concerns meetings would allow a professional to convene a meeting where an adult presented with similar needs to those of the victim in this case.**

Action plan:

i) The Concerns Meeting protocol should be amended to ensure that the process meets the needs the DHR was assured it was designed to address and is no longer confined to only those adults at risk who have care and support needs. (Chair’s note: new protocol broadening the scope of Concern Meetings was completed and circulated in July 2020)
ii) Adult Social Care should share with the Safer Wolverhampton Partnership the outcome of the ‘Survey Monkey’ of uptake and awareness of the concerns meeting protocol amongst professionals
iii) The CCG should provide an update (to a timescale agreed with the SWP) detailing the impact upon outcomes of the MDT process.

Learning: this DHR identified a concern that following a safeguarding enquiry prompted by a referral, there was an absence of a shared understanding amongst professionals working with that adult, of risk assessments, outcomes and that adult's stated wishes and choices

5. **The DHR recommends that the Wolverhampton MASH and Adult Social Care should identify how, following a safeguarding referral, an accurate understanding of any unresolved risks can best be shared and communicated to all agencies involved with that adult (and made available to those agencies that go on to work with an adult). This summary should be recorded and be easily accessible to relevant agencies, to reduce the risk of incomplete information sharing.**

Action plan:

i) The summary should identify the adult at risk's perception of the concerns, include risk assessments describing the unresolved risk(s) and describe support offered, whether it was taken up and any reasons identified for refusal of support.

Learning: the DHR and Learning Event noted an apparent absence of safety plans shared between health professionals and carers, in response to the numerous safe harm episodes in this case. This seemed to be true both when the victim was discharged from ED after an incident, but also after admission to psychiatric units for assessment

6. **The DHR recommends that the CCG, RWT and BCHFT should consider refreshing guidance to their professionals concerning safety planning after a self-harm incident, informed by NICE Self Harm Clinical Guidance 133**

Action plan:

i) The Safer Wolverhampton Partnership should seek assurance that the above- named agencies have reviewed their self-harm risk management strategy.

Learning: the DHR discovered there is an absence in Wolverhampton of specialist counselling and support aimed specifically at self-harm and suicidal ideation. These services support families and carers to understand self-harm and suicidal ideation and respond effectively. This kind of service would also improve the Adult Early Help Offer and offer GPs an appropriate pathway for patients presenting with similar vulnerabilities to those of the victim in this case

7. **The DHR would recommend commissioners of mental health services in Wolverhampton should explore the feasibility of funding suicide prevention services for adults of any age who may self-harm or report suicidal ideation**

Action plan:

Safer Wolverhampton Partnership to seek appropriate feedback relating to this recommendation, from mental health service commissioners

Learning: the DHR noted that elder abuse and interfamilial violence were poorly understood and not properly recognised by some professionals in this case, and that this impacted adversely on both criminal and safeguarding decision making that failed to take these factors into account.

8. **The DHR would propose to Wolverhampton Safeguarding Together that the Learning & Improvement subgroup consider how best learning from this DHR, and particularly learning related to elder abuse and interfamilial violence, be communicated broadly to frontline professionals**

Action plan:

i) The learning from this DHR to be submitted to the Learning & Improvement subgroup of Wolverhampton Safeguarding Together for consideration.

ii) SWP to seek assurances from WST concerning how the DHR learning will be shared with professionals