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DOMESTIC HOMICIDE REVIEW
REPORT INTO THE DEATH OF 'Martin'/2015

Report compiled by Kath Albiston

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PREFACE

This Domestic Homicide Review (DHR) was carried out following the death of 'Martin' on 1st November 2014. This was the fourth statutory homicide review carried out in Northumberland. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to convey our profound sympathy to the family and friends of Martin and assure them that in undertaking this review we are seeking to learn lessons from this tragedy, and to improve the response of agencies in cases of domestic violence. The Panel would also like to express gratitude to Martin's sister for her contribution to the review process.

Acknowledgements and thanks also go to members of the Safer Northumberland Partnership and all those who have given of their time and co-operation through this review process as Review Panel members, Individual Management Review (IMR) authors, and staff members of participating agencies who were interviewed as part of the preparation of IMRs.

1. INTRODUCTION

1.1 Background to the Review

1.1.1 This review relates to the death of 'Martin', who was murdered in November 2014. Following the discovery of Martin's body, Northumbria Police commenced a murder investigation and Ms L, his partner, was charged with his murder.

1.1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Martin prior to the point of his death, as well as agency contact with Ms L.

1.2 Purpose of the Review

1.2.1 The purpose of a Domestic Homicide Review as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.

1.2.2 DHRs are not inquiries into how the victim died or who is culpable; this is a matter for the criminal courts.

1.2.3 DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action would be initiated, the established agency disciplinary procedures would be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently, but separately to, disciplinary action.

1.2.4 As far as is possible, DHRs should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

1.2.5 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

1.2.6 The review also assesses whether agencies have sufficient and robust procedures and protocols in place, which are understood and adhered to by their staff.

1.3 Terms of Reference

1.3.1 The specific terms of reference agreed for this review were:

a) Was the victim experiencing coercive control on the part of the alleged perpetrator? Was there indication of the victim being isolated by the perpetrator and could this have prevented them from contacting services?

b) Were there any concerns relating to substance use or mental health issues in the case of either the victim or alleged perpetrator? Were these acted upon appropriately and pro-actively? In what way may these have impacted in relation to any domestic abuse or the responses by agencies? *Consider if the interplay between domestic violence or abuse, substance use and/or mental health issues, may have led to any 'narrowing of focus' and the failure to explore other issues.*

c) Did the gender of either the victim or the perpetrator influence or impact on the response of agencies? If so, in what way and what was the result of this? Consider responses to concerns, assessments undertaken and risk management actions.

d) Did full and relevant information sharing take place? Was there evidence of a multi-agency and coordinated approach to assessment and management of risk? If not, why did this not occur and what were the implications of this as regards effective management of the case?

e) Where information came to light or was disclosed, were any decisions taken not to proceed with this further? If so, was this appropriate, and what were the outcomes of any such decisions?

f) If there was a low level of contact with your agency why was this so? Were there any barriers to either the victim or the alleged perpetrator accessing your services and seeking support?

g) Do you hold any information offered by informal networks? The victim or perpetrator may have made a disclosure to a friend, family member or community member.

h) Whether the perpetrator had a history of any violent behaviour and if any referrals were made to services in light of this;

i) Whether any risk assessments had been undertaken previously on the perpetrator and whether these had judged risk appropriately;

1.3.2 The time period covered by the review was from 1st January 2011, when it was believed Martin and Ms L may have commenced a relationship, until 1st November 2014. This was in order to allow for an analysis of issues relevant to the homicide. In addition, any events prior to this period, relating to the risk posed by the alleged perpetrator or the vulnerability of the victim, were considered. This included any relevant history of criminal investigations, convictions, cautions and sentencing outcomes, as well as any known history of relevant mental health problems, treatments and outcomes.

1.4 The Review Panel

1.4.1 The review Panel membership was as follows:

- Max Black – Independent Chair
- Kath Albiston – Independent Overview Report Author
- Allan Brown - Northumberland Community Safety
- Ian Billham - Northumberland Community Safety
- DCI John Douglas - Northumbria Police
- Debbie Reape - Northumbria Healthcare NHS Foundation Trust (NHCFT)
- Leesa Stephenson - Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- Fiona Kane – Northumberland Clinical Commissioning Group (CCG)
- Elaine Blair – Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
- Jane Bowie - Adult Social Care, Northumberland County Council
- Steve Day – Children Social Care, Northumberland County Council
- Christine McManus - North East Ambulance Service NHS Foundation Trust (NEAS)
- Maureen Gavin - National Probation Service (NPS)
- Gary Connor – Northumbria Community Rehabilitation Company
- Dr Mohammed Munawar – Insight Healthcare
- Gillian Thirlwell – Northumberland Victim Support Service (VSS)
- Julie Young - Northumberland County Council Strategic Housing
- Alex Bennett - Northumberland Fire and Rescue Service (NFRS)
- Anna Stabler/Bev Walker - NHS England
- Rob Bailey – Byker Bridge Housing and Support
- Rachel Moore – Northumberland Recovery Partnership

1.4.2 The Chair retired from Northumbria Police after 30 years service during which he was Detective Chief Inspector with strategic responsibility for the investigation of domestic abuse in the local authority areas of North Tyneside, Northumberland and Newcastle, and was child and vulnerable adult safeguarding lead and a member of the the Local Safeguarding Children's Boards and Safeguarding Adults Boards in those areas. He worked closely with local groups and CAADA (now called Safelives) in introducing the

MARAC process to the Northumbria region. Since leaving the police, he works as a care assistant providing personal care for elderly people suffering from mobility issues and dementia, and providing consultancy services to local authorities in the UK and abroad relating to child and vulnerable adult abuse.

1.4.3 The Overview Report Author is a qualified Probation Officer and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer since 2006 she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews and scoping exercises in relation to provision of domestic violence services. Alongside her involvement with a number of Domestic Homicide Reviews, the author also currently acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for public and private law cases.

1.4.4 Neither the Independent Chair nor Overview Report Author has had any previous involvement with Martin or Ms L, or any supervisory responsibility for any of the professionals' work being reviewed.

1.5 The Review Process

1.5.1 The review consisted of the following key meetings:

- 09/12/14: Meeting of the Northumberland Domestic Homicide Review Core Panel – agreement that case met criteria for a formal review to be conducted.
- 10/02/15: Initial Panel Meeting – terms of reference finalised.
- 13/03/15: Initial Individual Management Review (IMR) authors meeting.
- 11/06/15: Agency IMRs submitted.
- 03/07/15: Panel and IMR authors meeting – presentation of IMRs.
- 21/10/15: Panel meeting to review the first draft of the Overview Report.
- 18/12/15: Presentation to the Safer Northumberland Partnership Board

1.5.2 Individual Management Review (IMR) reports were completed by the following agencies:

- Northumbria Police
- Northumbria Healthcare NHS Foundation Trust (NHCFT)
- Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
- North East Ambulance Service Foundation Trust (NEAS)
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- NHS Northumberland Clinical Commissioning Group (CCG)
- Adult Social Care, Northumberland County Council (ASC)

- Northumbria Community Rehabilitation Company (CRC)
- Insight Healthcare
- Byker Bridge Housing and Support

1.5.3 All IMR authors were independent of the case and had no previous contact with Martin or Ms L, either as a practitioner or through the management of staff involved.

1.5.4 In addition to the above, Newcastle Adult Social Care, Changing Lives and Turning Point provided chronologies of involvement. Upon review of these it was felt the nature or extent of their contact did not warrant the completion of an IMR. No other agencies on the Panel, or in other third sector organisations where requests for information were sent, identified any relevant contact with either Martin or Ms L in this case. Those agencies who were contacted and confirmed no relevant information was available were:

- Northumberland County Council Strategic Housing (although it was noted that information is only kept for a period of two years)
- Victim Support Northumbria
- Northumberland Fire and Recovery Service
- Children's Social Care – Northumberland and Newcastle
- National Probation Service
- Northumberland Recovery Partnership
- Escape Family Support, Northumberland

1.5.5 The review process was not completed within six months due to a number of reasons. Firstly, as the review progressed, additional agencies were identified that needed to be involved through the completion of chronologies or IMRs; these were Insight Healthcare, Byker Bridge Housing Changing Lives, and Turning Point. Secondly, there were two parallel reviews being undertaken by the Independent Police Complaints Commission and Northumberland, Tyne and Wear NHS Trust; it was necessary for these to be completed and the findings considered prior to the finalisation of this overview report. Finally, within the Northumbria area there were significant numbers of ongoing DHRs and Serious Case Reviews that meant that many Panel members were involved in multiple concurrent reviews; this placed significant demands upon their time, which had to be considered in relation to the scheduling of meetings and completion of various stages of the review.

1.5.6 Prior to publication of this report all those who had input into the review process were given the opportunity to comment upon the report, and any changes considered necessary were made so accordingly.

1.6 Profiles of Agencies Involved and IMR Methodology

1.6.1 **Northumbria Police** serves a population of 1.5 million people and covers an area from the Scottish border down to County Durham, and from the

Pennines across to the North East Coast.

1.6.2 The IMR for Northumbria Police was undertaken by a Detective Constable within the Protecting Vulnerable People Unit, and was quality assured and approved by the Detective Chief Inspector of the same unit. In order to prepare the report, the author accessed all relevant information stored in Northumbria Police's computerised systems and the Police National Computer. In addition, two Police Constables were interviewed in relation to specific incidents identified in the undertaking of the review.

1.6.3 **Northumbria Healthcare NHS Foundation Trust (NHCFT)** manage hospital, community health and adult social care services in Northumberland, and hospital and community health services in North Tyneside. NHCFT provide care to a population of around half a million and have ten hospitals.

1.6.4 The IMR for NHCFT was undertaken by the Professional Lead Acute Liaison Nurse Learning Disabilities, who was supervised in relation to the process by the Operational Service Manager for Safeguarding. The final report was quality assured and approved by the NHCFT's Deputy Director of Nursing and Lead for Safeguarding. In undertaking the IMR the author reviewed medical records and the patient admission system (PAS). No professionals involved were interviewed, as there was no indication from the records reviewed that this would be beneficial. A discussion did however take place with an Alcohol Specialist Nurse within NHCFT to ascertain information regarding current pathways.

1.6.5 **Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)** is one of the largest NHS Trusts in the UK and delivers healthcare services from six sites within the Newcastle area.

1.6.6 The IMR for NUTH was undertaken by The Head of Occupational Therapy, with supervision, quality assurance and approval by the Head of Nursing for Freeman Hospital and the Patient Services Director for NUTH. In order to complete the IMR medical records and case notes were reviewed, and interviews undertaken with key staff involved in this case.

1.6.7 The **North East Ambulance Service (NEAS) NHS Foundation Trust** provides a number of NHS services, and covers the counties of County Durham, Northumberland and Tyne and Wear, along with the boroughs of Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees. This includes 60 ambulance stations and serves a population of 2.6 million.

1.6.8 The IMR for NEAS was undertaken by the Named Professional for Safeguarding Vulnerable Groups, and approved and quality assured by the Director of Clinical Care and Patient Safety. Call systems and electronic records were reviewed in order to complete the report.

1.6.9 **Northumberland, Tyne and Wear (NTW) NHS Foundation Trust** is one of the largest mental health and disability trusts in England. It works from 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and serves a population of 1.4 million.

1.6.10 The NTW NHS Foundation Trust's IMR was undertaken by the Deputy Head of Safeguarding and Public Protection, and the final report was quality assured and approved by the Director of Specialist Care. In undertaking the review all paper and electronic were examined, and an interview was undertaken with a Community Psychiatric Nurse from Addiction Services.

1.6.11 **Northumberland Clinical Commissioning Group (CCG)** is the statutory body responsible for planning, purchasing and monitoring the delivery and quality of local NHS healthcare and health services for the people of Northumberland. All 44 GP practices within the Northumberland area are members of the Northumberland CCG.

1.6.12 The IMR for Northumberland CCG was completed by the GP Lead for Adult Safeguarding, and the report was approved and quality assured by the Director of Quality and Patient Safety. For the purpose of the IMR, the author reviewed medical records and interviewed four GPs involved in the care of the victim and perpetrator.

1.6.13 The IMR for **Northumberland Adult Social Care (ASC)** was undertaken by the Strategic Safeguarding Adults Manager, and approved and quality assured by the Head of Safeguarding and Strategic Commissioning. For the purpose of the IMR an interrogation of Adult Social Care records was undertaken, as well as telephone discussions with a Social Worker and Enquiry Referral Coordinator involved in this case.

1.6.14 **Northumbria Community Rehabilitation Company (CRC)** manages adult offenders on community orders and release from prison. The IMR was completed by the Safeguarding and Reviewing Manager, overseen by the Director of Offender Management for Sunderland, and approved by the Deputy Chief Executive.

1.6.15 **Insight Healthcare** is commissioned by the NHS to provide primary care psychological therapy services in the Northumberland area. Patients are referred by their GP's or can self-refer. Insight's Northumberland service follows the NHS Improving Access to Psychological Therapies (IAPT) Stepped Care Model; treating patients who are able to make use of the talking therapies approach at the primary care level. Clients presenting with complex or enduring needs may be referred to secondary care services via their GP. The IMR for Insight was completed by the Head of Clinical Governance, and quality assured and authorised by Insight Healthcare's Director of Services.

1.6.16 **Byker Bridge Housing and Support** offers a varied range of supported housing, primarily in the Newcastle area. The Director for Byker Bridge completed the IMR on behalf of the organisation.

1.7 Family Input into the Review

1.7.1 Martin's sister met with the Chair of this DHR in order to assist the review process. Her input was invaluable to the review and has been considered throughout the process.

1.8 Criminal Proceedings

1.8.1 In May 2015 Ms L was convicted of Martin's murder and sentenced to life imprisonment with a minimum tariff of twenty years.

1.9 Coroner's Inquiry

1.9.1 The Coroner's Inquest was finalised following the conclusion of the criminal investigation and the conviction of Ms L. Within this it was found that Martin had been unlawfully killed.

1.10 Contact with the Perpetrator

1.10.1 The Panel also gave consideration as to whether an interview with the Perpetrator, Ms L, should take place. The purpose of such an interview would be to identify whether they felt that there was anything agencies could have done in their interaction with Ms L that may have changed the course of events that led up to the death of Martin. However, information provided by the Probation Service indicated that Ms L continued to deny the homicide and therefore it was not felt that it would be appropriate to speak with her.

1.11 Other Reviews

1.11.1 Parallel to this review process a Serious Untoward Incident (SUI) review was undertaken by Northumberland, Tyne and Wear Trust. In addition, an investigation took place by the Independent Police Complaints Commission (IPCC). Details of these are included where relevant within the body of this report.

1.12 Confidential Information

1.12.1 For the purpose of this review Ms L was contacted, via her solicitor, requesting her permission for disclosure of confidential records. As this was not received agencies involved in the review were asked to consider whether the public interest in maintaining the duty of confidentiality owed to the individuals, was outweighed by the public interest in the use and disclosure of confidential information and records for the purpose of this review. All agencies concluded that there was an overriding public interest in favour of the provision of relevant information in relation to both

Martin and Ms L.

1.12.2 Full consideration was given to the need to anonymise or redact any necessary information prior to publication, in line with Home Office Guidance for the completion of DHRs.

CONCLUDING REPORT

2 THE FACTS

2.1 Family structure and background

2.1.1 Both Martin and Ms L were of White British origin. At the time of his death Martin was residing with Ms L in the Northumberland area.

2.1.2 Martin was adopted at the age of two weeks and grew up with his parents and three adoptive siblings, two brothers and one sister. Martin first married at the age of 19; there were no children from this relationship. He then had a further relationship, within which he had a daughter, who was an adult at the time of his death. Following this he married again, with this relationship ending in around 2005/2006.

2.1.3 Information made available to the review suggests that Martin's relationship with Ms L began in approximately 2011, although the exact date is unclear.

2.2 Narrative Chronology

2.2.1 Both Martin and Ms L had a significant history of involvement with services which, for the purpose of this review, all agencies outlined in a comprehensive chronology. In order to assist in understanding the analysis of agencies involvement, and the recommendations arising from this review, a summary is provided below of key events within this chronology. This is separated into two sections, namely the review period specified within the terms of reference, and the period preceding this.

Agency contact prior to the review period (prior to 2011)

2.2.2 As Martin and Ms L do not appear to have been in a relationship at this time, their contact with agencies prior to the review period are considered separately.

Martin

2.2.3 Martin had been known to a number of agencies for a significant period of time. He first came to the attention of Northumbria Police in 1983 for criminal damage, and was subsequently known to them for offences related mainly to shoplifting and drunkenness. As regards his contact with health agencies, the first reference made in agencies' IMRs was in April 1990, when he attended A&E for a reported overdose, following which he was referred to NTW. Following this, from 1993 to 1995 a number of referrals from his GP were received into NTW's Community Mental Health Team (CMHT), all stating low mood, anxiety and alcohol related issues; appointments were offered following referrals but declined.

2.2.4 From 1990 – 2006 Martin also had 9 relevant attendances at NHCFT's Accident & Emergency department (A&E), 2 of which were overdose related, with 7 other incidents related to injuries of unknown source. Martin's attendance then significantly increased in 2007, and it appears from information within a number of agencies' IMRs that this this was following the ending of his marriage. In 2007 and 2008 he attended NHCFT's A&E service on 23 and 21 respective relevant occasions, 6 of these related to overdoses, 23 to alcohol use, and 17 to injuries of unknown sources. The Mental Health Crisis team saw Martin on a number of occasions in A&E and all mental health reports stated that increasing alcohol use was causing anxiety. No significant mental health issues were identified during these assessments. Martin was advised to seek support from other services in relation to his alcohol use.

2.2.5 In addition during this period, a number of further referrals were also received into the Primary Care Community Mental Health Team (CMHT) from Martin's GP, stating ongoing low mood and increasing alcohol use. It was also cited that Martin had lost his job as a post man, his marriage had ended, and he was experiencing ongoing social stressors. Martin's engagement with the CMHT was reported to be poor.

2.2.6 Martin also came to the attention of Northumbria Police in 2007 due to a numerous reports of drunk and disorderly, and specific incidents involving his ex-wife. On 04/01/07 staff from Wansbeck General Hospital contacted police reporting that Martin had made off from medical admissions after being admitted for taking an overdose of paracetamol. Martin was later found intoxicated in the street and was returned to hospital. Similar to information from other agencies, it was noted in Police records that Martin's marriage of 13 years had recently ended, along with his job, and that because of this he was 'suicidal'. When Martin was spoken to he stated he had had thoughts of killing his ex-wife. As a result of this Martin's ex-wife was spoken to and she informed police that Martin had never been violent and she was not at all concerned for her own safety. She was however assessed as being at high risk of domestic violence. Notes stated that Martin had been diagnosed with bipolar depression and it was reported that he was 'considered a very ill man'.

2.2.7 On 15/06/07 Martin again attended the home address of his ex-wife, where there was a verbal dispute in which he kicked the door. He left the address prior to police arrival. The dispute was believed to have been in regard to their son's upcoming birthday party arrangements. The following day Martin's ex-wife again reported that he had attended her home and 'kicked off'. Upon police attendance it was established that there had been a verbal argument over property and Martin left the address at the request of the police. Later that same day he returned in a drunken state and, after being abusive to officers, was arrested for being Drunk and Disorderly. Domestic Abuse Records were submitted in relation to both these dates.

2.2.8 On 11/07/07 Martin attended the home address of his father, he was reported to have been drunk and asking his father for money. He had not caused any problems and was removed from the address by police. A Domestic Abuse Record was submitted.

2.2.9 From 2008 to 2009 Martin was also known to Northumbria Probation Trust (NPT), with his last period of supervision being a Community Order that was revoked on 18/02/09.

2.2.10 In 2009 and 2010 Martin continued to attend NHCFT's A&E services, with a total of 9 and 6 respective relevant visits. In 2010 further contacts were also made with NTW's Addiction Services and records indicate that Martin's alcohol consumption was at dependent levels, there were periods of homelessness, and a number of hospital attendances/ admissions were alcohol related. Between mid February to end April 2010 Martin was offered 5 appointments with Addiction Services, of which he attended 2. At his last appointment he stated he had stopped drinking and wanted rehabilitation, however it was documented that he showed little motivation to change.

Ms L

2.2.11 From 2000 to 2011 Ms L attended her GP and was also seen and assessed on many occasions by mental health practitioners in NTW's Crisis Team and Mental Health Teams. In 2004 a Locum Psychiatrist made a diagnosis of borderline personality disorder with psychotic episodes. In 2005 a Consultant Psychiatrist also concluded a diagnosis of Borderline Personality Disorder.

2.2.12 During this period, Ms L also had significant contact with Northumbria Police, which is particularly relevant in light of her later perpetration of this domestic homicide.

2.2.13 In 25/01/01 a report was received by police that Ms L had attended the address at which her son was in foster care, and abducted him, also assaulting the foster carer. She was found several hours later and her son was returned to foster carer. Ms L became violent and was arrested for breach of the peace. Three months later she attended Newcastle County Court for the final custody hearing of her two sons and during the hearing made threats towards her ex partner (P1). The police report indicates there were concerns about Ms L's mental health at the time.

2.2.14 GP records also indicated that Ms L had three children who had been taken into care. Following her taking of an overdose, she also reported to NTW's crisis team that this was due to ongoing stressors of her children being taken into care.

2.2.15 On 02/04/02 Ms L and her new partner (P3) were accused of throwing paint at the front door of Ms L's ex-partner (P2). Ms L was arrested but no further action was subsequently taken.

2.2.16 On 06/12/02 Ms L made an allegation of rape against P2, however it was concluded that there was insufficient evidence to prosecute. Ms L made threats towards him and his family, including sending a wreath to his door. Once more there were reported concerns for Ms L's mental health. No Domestic Abuse Record was completed and no warning was issued to Ms L regarding the threats and harassment.

2.2.17 On 25/02/04 Ms L reported that she had been involved in a domestic incident with her then partner (P4) and that he had hit her with a golf club. Upon police attendance, both parties were reported to be drunk. Ms L was arrested on suspicion of Section 18 Assault against P4, and he was arrested on suspicion of Section 47 Assault against Ms L. No further action was taken against either and there is very little information recorded on this incident, making it unclear as to why Ms L was arrested for a Section 18 Assault.

2.2.18 On 17/04/04 Ms L reported to police that she had been involved in a domestic incident with P4, during which he had threatened her with a knife. Upon police attendance it was established that P4 suffered with mental health issues and had failed to take his medication. P4 had been seen by his doctor the night before and the doctor had advised Ms L to contact the police if there were any further problems. No offences were disclosed by Ms L. P4 was arrested to prevent a further breach of the peace, but was later released without action being taken. The incident log was updated with a 10 point DV update.

2.2.19 On 24/06/05 Ms L attended the home address of her daughter. Ms L was reported to be drunk and a verbal altercation took place. When Ms L refused to leave her daughter called the police. She was arrested for Breach of the Peace and subsequently released without charge. One month later, on 25/07/05, Ms L's daughter reported that she had been receiving abusive text messages from her mother. Enquiries revealed that both had been sending abusive texts and both parties were warned regarding harassment.

2.2.20 On 30/07/05 Ms L attended the address of her partner (P5), both parties were believed to be drunk and when P5 asked Ms L to leave she had refused, resulting in a verbal altercation. Ms L left at the request of the police and no offences were disclosed.

2.2.21 On 01/08/05 P5 reported a domestic incident at his home to police. Upon police attendance it was established that there had been a drunken verbal dispute during which P5 had asked Ms L to leave, and she had refused. Ms L left the address when requested to do so by the police.

2.2.22 On 05/12/05 Ms L reported to police that she had been involved in domestic incident with her partner (P6). Upon police attendance it was established that there had been a drunken verbal dispute during which she had asked P6 to leave and he had refused. P6 left the address when requested to do so by the police. There is a 10 point DV update on the log.

2.2.23 On 23/05/06 it was reported to police by a third party (friend of Ms L) that P7, the partner of Ms L, had assaulted her. Upon police attendance it was established that P7 had been warned earlier by police not to approach Ms L and despite this he had again approached her and had grabbed hold of her arms. P7 was subsequently arrested for a breach of the peace, and admitted grabbing Ms L. Ms L was also spoken to and stated she did not want to make a complaint. There is a 10 point DV update on the log.

2.2.24 On 25/06/06 a neighbour of Ms L reported that she had been assaulted by her. The neighbour refused to give a statement and Ms L denied any involvement, therefore no further action was taken.

2.2.25 On 14/11/06 it was reported to police by a Housing Officer that Ms L's partner (P7) had been assaulted by her with a metal bar and that he had reported that he was scared of Ms L. Upon police attendance it was established that there had been a violent domestic during which Ms L had assaulted P7, resulting in him suffering two black eyes, a cut to his forehead, and a bite to his arm. P7 claimed that Ms L had hit him with a dumb bell. Ms L was arrested and admitted the assault stating she had 'just lost it'. She admitted to punching P7 to the head, head-butting him, and biting his arm. P7 refused to prosecute and Ms L was given a caution. There was no domestic violence report for this incident.

2.2.26 On 20/03/07 a further incident between Ms L and P7 is reported to police by a concierge who stated that P7 had been locked out of his flat by his now ex-partner Ms L, who had stolen his flat keys. Ms L denied any involvement but when searched was found to have the keys. She was subsequently arrested for being drunk and disorderly.

2.2.27 On 24/06/08 a neighbour of Ms L reported that he had been threatened by her and was afraid to return home. The neighbour reported that Ms L had been running around the area threatening people with a hammer. He refused to make a complaint. When police spoke to Ms L she was accompanied by her then partner (P7) who was noted to have been 'badly beaten up'. He had two black eyes, a broken nose, numerous cuts and extensive bruising to his upper body. He reported that he had fallen in the bath.

2.2.28 On 09/08/08 police attended a report of a domestic in the street and found Ms L involved in a verbal altercation with P7. The parties were separated and no offences were disclosed.

2.2.29 On 22/10/08 police received a call from a neighbour of Ms L's mother stating that there was an ongoing domestic. It was established that Ms L had attended her mother's address and attacked her mother (aged 74), punching and kicking her about the body and head. Ms L was later charged and convicted of Section 47 Assault. A Domestic Abuse Record was submitted.

2.2.30 On 24/10/08 Ms L called the police stating she had thoughts to murder her mother. Police attended and Ms L was detained under Section 136 of the Mental Health Act, later being sectioned under Section 2. During this admission Ms L reported to NTW staff that she had gone to discuss her experience of childhood sexual abuse with her mother. Ms L also described chronic symptoms of dysphoric mood, sleep disturbance, auditory pseudo hallucinations and intermittent paranoia. She stated she had no remorse for the attack on her mother. Eventually Ms L took her own discharge, as the criteria was no longer met to fulfill further detention under the Mental Health Act. At discharge her diagnosis was harmful use of alcohol, post-traumatic stress disorder, and emotionally unstable personality disorder. She was discharged with medication and at this time it was documented that she was still considered to be a significant risk of harm to others. She was referred to the CMHT following discharge and a letter was sent to her GP.

2.2.31 On 23/11/08 a neighbour of Ms L's reported that she had been assaulted by her. Ms L was charged with the assault, but no further action was taken following advice from the Crown Prosecution Service. On release from police custody on 24/11/08 Ms L attended the home of P7 and attacked him. She was reported to have punched and scratched him and pushed him into the bath, as well as threatening to slit his throat. P7 reported that he was afraid of Ms L and feared she would kill him or others due to her mental health issues. He also stated that he had needed hospital treatment in the past due to being assaulted by her. Ms L was arrested and charged with Common Assault. She was later arrested for breach of bail by attending P7's home on 06/12/08.

2.2.32 On 06/01/09 Ms L further breached her bail conditions by attending P7's home. On this occasion he reported that she assaulted him by punching and scratching his face, and stabbing him with a kitchen knife in the arm. His injuries were consistent with this report and he was taken to hospital for treatment. Ms L was arrested for Section 47 Assault. During interview she made a counter allegation against P7, resulting in his arrest for Common Assault. No further action was taken against either for this, or the earlier assault on 24/11/08, due to lack of evidence. Ms L further breached bail conditions by attending P7's home on 09/01/09.

2.2.33 As a result of the incident on 06/01/09, Northumbria police referred the case to MARAC. On 22/01/09 Ms L was discussed at MARAC in relation to the risk she posed to P7.

2.2.34 On 26/01/09 Ms L was made subject to a twelve month Suspended Sentence Order made for the earlier offence (22/10/08) of Section 47 Assault on her mother. Early on in this Order an entry was made on Ms L's records on 11/02/09, stating that she was reported to have a Section 18 wounding offence against her ex-partner, P7, outstanding. It reported that she was living with him at the time of the alleged offence. It is also recorded that both were perpetrators of domestic abuse within the relationship, and they were

interdependent on each other due to their alcohol misuse. Contact with Ms L's solicitor on 11/03/09 confirmed that the Section 18 offence, as well as another offence of Section 39, had been discontinued with 'no further action'. On the whole Ms L generally complied with this Order, although appointments were often re-arranged at Ms L's request. This sentence expired on 25/01/10, and at the point of termination her Offender Manager, who was responsible for supervising her on the Order, recorded that Ms L was not in a relationship.

2.2.35 On 15/02/10 police received a report of an ongoing domestic on-going at the caller's neighbour's address. Police attended and found Ms L staying at the address of her new partner, P8. It was established that there had been a verbal altercation, Ms L was removed and no offences were disclosed. The following day P8 called police to report Ms L kicking at his door. On police attendance she was arrested for breach of bail conditions. Records were not clear as to the circumstances for the bail or the conditions.

2.2.36 During 2009 – 2010 further referrals from Ms L's GP expressed concern regarding a decline in her mental health. Within a GP letter it was stated Ms L had been offered follow up appointments following her previous discharge from hospital, but had not engaged, she had also reported to have stopped medication and to be complaining of feeling depressed and paranoid. The GP suggested that this may be a psychotic episode. The referrals were accepted and appointments were offered. No psychosis was found and her presentation was reported to differ depending on social stressors at the time of each presentation.

2.2.37 On 03/06/10 Ms L was sentenced to a twelve month Community Order with one requirement of Supervision for an offence of Assaulting a Police Officer. During this Order she reported that she was living with her partner, P9. It is recorded in July 2010 that Ms L described her partner P9 as having bipolar depression, and she stated that he was a heroin user. A case record entry made on 27/01/11 refers to P9 attending her probation appointment with her, but no further comment was made about him or the nature of the relationship. Ms L advised the Probation Officer that P9 had a gambling habit, was depressed, and was using heroin. The recording went on to say that Ms L admits that 'she loses her temper with him and can lash out at him'. There are no actions documented in response to the behaviour reported by Ms L.

2.2.38 Following the above office appointment, Ms L's attendance deteriorated and enforcement action was considered. However, as her Order was due to end on 02/06/11, the team Manager at that time agreed that Ms L should be further encouraged to comply with the Order for the remaining 4 months, rather than instigate breach action. Ms L next attended an arranged appointment on 18/03/11, and her attendance improved to a sufficient standard to avoid any necessary enforcement action being taken. At the appointment on 18/03/11 it is recorded that Ms L seemed 'very down', but she denied she was depressed instead claiming that she was menopausal. She went on to say that P9 was no longer gambling and was working with NECA

(North East Council on Addictions), so she no longer needed to get angry with him. However, at her next appointment on 14/04/11 she reported that she was stressed due to an argument with her boyfriend in the street and that he was mentally abusive towards her. During this Order the Offender Manager attempted to do some work with Ms L around her emotional well-being and self-control, via individual supervision sessions and worksheets from the Citizenship Programme. Just prior to the end of her Order, Ms L telephoned her Offender Manager and stated that she and P9 has split up due to his heroin use and she had moved out. At her final appointment on 20/05/11 Ms L she reported that she was still living with the friends in Newcastle, but was hoping to secure her own tenancy once she had raised money for the bond. This Order then expired on 02/06/11.

2.2.39 From 06/08/10 to 27/08/11 (overlapping the time period of review) police were called to six incidents relating to Ms L and P9. It is of note that three of these occurred after Ms L had reported to her Offender Manager that she had separated from P9. Five of the incidents were reported to be verbal altercations, and on two of these no offences were disclosed. On one occasion Ms L was arrested and later charged with Breach of the Peace, on another P9 was arrested for Breach of the Peace and later released without action being taken. On the former incident, P9 was reported to have been found hiding in the bathroom. The two later incidents in July and August 2010 involved Ms L slashing or slitting her wrists. Paramedics attended on both occasions. On the latter occasion (27/08/11) P9 was outside and reported that Ms L was smashing up the flat and had self harmed. On entry Ms L was found surrounded by broken glass. She could give no explanation as to what had happened and then became violent, resulting in her being detained under Section 136 of the Mental Health Act and taken to hospital (NUTH). Ms L was found to have a broken arm and claimed P8 had assaulted her, as a result of which he was arrested for Section 20 Assault. Further investigation indicated Ms L had attacked P9 with a small table following a drunken verbal altercation and he had then restrained her, likely resulting in injury to her arm. Charges were not pursued. At this time Ms L was seen by NTW staff and records indicated there were no signs of mental illness. It was not apparent what actions mental health practitioners took on discharge.

The Review Period: 1/01/11 – 1/11/14

2011

2.2.40 In 2011, Martin attended NHCFT's Wansbeck General Hospital (WGH) A&E on 27 occasions, 15 of his attendances were alcohol related and 8 related to injuries of unknown sources, often believed to be the result of falls related to his alcohol use. He also had 5 seizure related attendances, which were believed to be related to alcohol withdrawal. He had 17 recorded overnight stays, and also left on 6 occasions before treatment. Throughout much of this period Martin was recorded as either homeless, of no fixed abode, 'sleeping rough', or staying with friends. In addition to his contact with WGH, Martin

was also seen in excess of twenty occasions at NUTH's Royal Victoria Infirmary (RVI) A&E.

2.2.41 Northumbria Police also had numerous contacts with Martin in 2011 resulting in him either being conveyed to hospital, or charged with minor offences such as Drunk and Disorderly, Shoplifting or Public Order Offences.

2.2.42 During this period, Martin also presented on a number of occasions to use services, such as laundry, food or showers, at Ron Eager House, a day centre managed by Changing Lives. He was reported to be either 'rough sleeping' or living in hostels during this period. Staff recollected Martin being intoxicated on attendances; he was never violent or verbally abusive to staff or other service users while in the centre.

2.2.43 Until August 2011, Ms L appeared to have remained in a relationship with P9 and a number of police incidents were noted, as outlined previously. In November 2011 Ms L also began to present at Ron Eager House; her accommodation status at this time was not known. She was reported as presenting 'protectively' towards Martin, and as being verbally abusive, but not physically violent, towards staff.

Summary of Key Events in 2011:

2.2.44 On 29/03/11 Police attend to report of an assault at the home address of Ms L's mother. Ms L was reported to have caused a disturbance and damaged property but there was no complaint made. Ms L continued to be abusive and violent and was arrested and charged with Breach of the Peace. There was no Domestic Abuse Record submitted.

2.2.45 On 13/05/11 Martin attended WGH A&E via ambulance. Martin was said to have looked intoxicated and was recorded as slurring that he is 'pissed' after drinking three litres of cider the evening before. He was recorded as having chronic alcohol excess and claimed he drank up to seven litres a day. During this contact Martin stated that he was currently staying with 'friends' on their sofa but would not go into more details. Martin clinical notes recorded that he was of no fixed abode. Later that day Martin was more alert and able to converse fully with the doctor, stating that he had been sleeping in a park for the previous four nights. On observation his clothes were soiled beyond redemption and the hospital had none to offer. Martin stated that he had no next of kin that he spoke to or wished for the hospital to contact. He stated that his plan was to go back to Newcastle to try and stay with a friend but he was unsure of the house number or a contact phone number to verify this, or aim for discharge.

2.2.46 It was identified from the information above that Martin was in social crisis and a call regarding a Safeguarding concern was made to Social Services, who then referred this to the Housing department at Northumberland County Council. It was recorded that they were very helpful, but reported at this time

that there was no accommodation available for a man with these alcohol problems. It was agreed that they would pass his details on to the Out of Hours team and continue to look for accommodation for discharge. It was recorded that they would contact the Medical Admissions Unit with details if they found suitable accommodation. Martin was then admitted to hospital due to social reasons.

2.2.47 On 16/05/11 Martin was reviewed on the ward and stated that he lived in private rented accommodation, which contradicted information from 13/05 that he was of no fixed abode. Martin was then seen by Care Facilitation regarding home circumstances, and it was recorded that he had arrangements in place to stay with friends on discharge, until he could arrange something more permanent. He didn't feel he needed any support from social services on discharge, and described 'functional independence'. He was advised to speak to Care Facilitation should his housing situation change.

2.2.48 On 17/05/11 Martin was recorded as being up and mobile and constantly on and off the ward. He maintained that he had accommodation to be discharged to. His alcohol intake was also discussed and he stated that he was planning to abstain/ consume in moderation; he was informed regarding risks of continued alcohol excess. Martin was then discharged home and instructed to follow up with his GP if required.

2.2.49 Martin was brought in by ambulance two days after discharge, on 19/05/11, as he had been found on the pavement and a passer-by had phoned for an ambulance. Martin stated that he was unable to stand as he had a painful left ankle, left knee and right hip and right shoulder after a fall. Martin stated that he had drank a 'couple of cans' that night although is unable to elaborate any further. On examination Martin was stated to be smelling strongly of urine, alcohol and faeces and also has soiled clothing. On this occasion he was found to have fractured his left ankle, for which he was given a cast, and was later discharged.

2.2.50 On 21/05/11 Martin's daughter contacted North East Ambulance Service (NEAS) asking for her father to be removed from outside her address. NEAS contacted police who declined to attend and Martin was taken to WGH. On 25/05/11, following discharge, Martin was lying on the grass outside the hospital, resulting in police being called.

2.2.51 On 04/06/11 Martin was found unable to stand and admitted once more to WGH. Following this, on 05/06/11, Northumbria Police sent an Adult Concern Notification to Northumberland Adult Social Care due to numerous contacts with Martin and concerns relating to his 'alcoholism and homelessness'. Adult Social Care notes recorded this as a concern relating to alcohol misuse and injuries sustained in falls. There was nothing to suggest concerns about relationships at that time. The response from Adult Social Care was to try to ascertain Martin's whereabouts via police, GP records and the Community

Mental Health team. When it was established that contact could not be made due to Martin being of no fixed abode, the case was closed. On 20/06/11 Police were contacted to advise them that no contact could be established, and discussion also took place around the fact that Martin had not consented to the referral. Police were advised that Martin could be signposted to, and supported by, homeless services or the Mental Health Crisis Team.

2.2.52 On 25/11/11 Ms L was arrested and charged with Breach of the Peace after becoming violent towards ambulance staff.

2.2.53 On 07/12/11 a referral was received from NUTH's Freeman Hospital (Ward 16) to NTW's Newcastle Addictions Services (Plummer Court) following Martin's recent admission for collapse and falls due to levels of intoxication. Ward 16 had an agreement with Plummer Court that any patients who were admitted out with the normal procedure, i.e. assessment and elective admission, will be referred and assessed by a medic from Plummer Court for ongoing support and treatment. A holistic assessment took place and a letter was sent to Martin's GP. During this assessment Martin stated he was living in supported accommodation in Newcastle and reported no other social problems apart from housing. No partner was identified in the assessment and the outcome was that he was offered a CPN from Plummer Court.

2.2.54 Following the above Martin was picked up by NEAS on a further 8 occasions in December 2011 (2 of these occurring in the same day) and taken to NUTH's Royal Victoria Infirmary (RVI) Hospital. On all but the last of these occasion Martin was found lying in public places, often intoxicated. On the latter occasion NEAS were called as Martin was reported to have taken an overdose.

2012

2.2.55 During 2012 Martin engaged intermittently with Plummer Court and from 07/02/12 was living in Byker Bridge House, a direct access hostel in Newcastle. He continued to attend Ron Eager House to use services regularly until April 2012, with a further periods of contact in July. During this time he had no attendances at Wansbeck General Hospital, likely as a result of the fact that he was residing in the Newcastle area, however he was taken 14 times to NUTH's RVI by ambulance, and conveyed home by ambulance staff on one further occasion. As in 2011, many of the calls to NEAS related to Martin being found lying in public places, often intoxicated.

2.2.56 Ms L stopped attending Ron Eager House in January 2012, but then attended again on five occasions in May. She was not thought to be rough sleeping but accessed the day centre for food and information on benefits. She was often verbally abusive to staff, but was never physically violent in the service. She then became resident at Byker Bridge House on 05/06/12, and remained there until 07/08/12 when she moved to another of their properties, a three person shared accommodation. She remained there until 23/11/12 when she

was asked to leave following numerous warnings regarding the conduct of her visitors, and disruption towards other residents of the property and neighbours.

2.2.57 Following Ms L's departure from Byker Bridge House, Martin also disengaged resulting in him also being asked to leave on 25/09/12. He was thought to be present at Ms L's property throughout most of her stay, despite numerous warnings that this was in breach of her licence agreement. He was also reported by other residents as being present during the disruptive incidents that occurred out of hours.

2.2.58 In October 2012 Martin and Ms L presented at Ron Eager House together on 3 occasions, with Martin attending a further time on his own. There were no concerns by staff about the relationship between them.

Summary of Key Events in 2012:

2.2.59 On 09/01/12 it was reported to police by a third party (passer-by) that there was an on-going domestic incident, when police attended they found Martin and the female occupant of the address asleep. The occupant requested Martin be removed from the address and he left without incident. A Domestic Abuse record was submitted.

2.2.60 On 07/02/12 Martin attended his planned appointment with Plummer Court. He stated he was drinking a minimum of two litres of cider and a maximum of six, with unknown amounts of vodka. He described seizures most weeks, poor memory and tingling in his hands and feet. He was advised to see his GP for a physical health check. Martin attended two further appointments on 14/02/12 and 22/02/12, where he stated he had moved into Byker Bridge House and had slightly reduced his alcohol intake. The plan was for the CPN to see him weekly and review after 6 weeks. Martin then failed to attend the subsequent 4 appointments offered.

2.2.61 On 17/04/12 Ms L called NTW's Crisis Team requesting advice and stating that she needed some support from Mental Health services as she currently had lots of stressors. She reported that she was living in a hostel, had family and personal difficulties, and was requesting a medication review. Ms L was advised to contact her GP, which she agreed to do, and to make contact with the CPN within the hostel.

2.2.62 A further appointment for Martin with Plummer Court was offered in May, and he attended with his Turning Point worker. His alcohol intake had increased. Martin informed the CPN that his mother had died and his father had not told him, making him angry and upset. Over the next couple of months the CPN made attempts to engage Martin, this included visiting Martin at Byker Bridge Hostel on 13/06/15 when they contacted the CPN to say Martin could not attend his appointment due to a fall. At this appointment Martin was reported to look 'unkempt' and intoxicated, he stated he was drinking 4 litres of cider,

however staff believed he was drinking more. Martin had bruising to his face from the fall and had attended hospital initially, but then repeatedly refused to go for check up at fracture clinic. Martin was reported to have no GP at this point. He was also struggling to walk up the stairs and could only manage short distances. It was felt that he had capacity to make decisions. The CPN plan was to maintain contact with Byker Bridge Housing and also discuss Martin's case at a complex case meeting. The key worker then discussed Martin's case with the Consultant Psychiatrist on 14/06/12 and the plan was to consider inpatient detox and referral to a Recovery Centre for support afterwards.

2.2.63 On 26/06/12, staff of Byker Bridge House made a Safeguarding referral due to concerns around Martin being financially abused by other service users. A Social Worker attended the hostel to see Martin. The outcome of the visit was that the Social Worker was to check any other past or present service involvement, enquire why Martin had not been picked up by Social Services Drug and Alcohol Team, and arrange a Safeguarding strategy meeting.

2.2.64 On 06/07/12 Martin was reported missing to Police by staff at Byker Bridge House. Staff reported that he was vulnerable due to his alcoholism and his ill health, and was believed to be at risk of financial abuse at the hands of other residents. He later returned of his own accord.

2.2.65 On 14/07/12 Martin had an admitted to the RVI following a seizure during which he fell and hit his head. Information supplied to NTW indicated that Martin sustained a fractured skull and intracranial bleed. Whilst he was in hospital he was visited by his keyworker from Plummer Court. Martin was discharged on 18/07/12 to Byker Bridge.

2.2.66 A Safeguarding Strategy meeting took place on 18/07/12 and an action plan was put in place. The action plan was for the Social Worker to explore the possibility of detox and rehabilitation with Martin, discuss appointeeship, and look at possible longer term accommodation for him in the event that he deteriorated. No further action was taken within Safeguarding, as the individual who had taken financial advantage of Martin was no longer resident at the hostel; the risk was felt to be longer term general concerns around Martin's management of money particularly when he was intoxicated.

2.2.67 Between July and November regular communication continued between Byker Bridge and Plummer Court to help engage Martin and increase motivation to cease alcohol use.

2.2.68 On 27/07/12 Ms L was seen at her GP practice. It was recorded that she was not taking her prescribed medication as it made her feel drowsy. She reported that he had been separated from her partner for 1 year, and that she had been living in Byker Bridge Hostel for 8 weeks. She reported having been sexually and physically abused whilst in hostel. A history of self harm, cutting and a previous mental health section was noted, along with none specific

suicidal thoughts. It was noted that the Crisis Assessment Team were supporting her. The outcome of this appointment was a referral to the Community Mental Health Team.

2.2.69 On 12/09/12 NTW received a referral from Ms L's GP, he expressed concerns and wanted her medication reviewed due to her diagnosis of 'paranoid schizophrenia'. The CPN advised the GP that Ms L's diagnosis at her last consultation with a Psychiatrist was of Borderline Personality disorder, harmful use of alcohol and PTSD. A clinic appointment was offered to Ms L on 03/12/12. When she failed to attend she was offered a further appointment for early 2013, which she did attend.

2.2.70 On 19/11/12 NEAS received an alert from police that Martin had been assaulted. On arrival the crew were informed Martin had been experiencing a continuous nosebleed for 40 minutes and was confused. They were also informed that he was a known alcoholic and consumed less than his normal amount of alcohol that day. Martin claimed to have been punched and reported no loss of consciousness. However, injuries sustained were not consistent with this explanation. Martin had self-mobilised from the scene of the assault to a friend's address and was able to mobilise without assistance. On route to the A&E Martin experienced two seizures and suction was required to clear airway due to significant nosebleed. He was admitted to hospital before being discharged on 20/11/12. He was then readmitted with seizures five hours later.

2.2.71 On 01/12/12 Martin discharged himself from hospital, and his partner, who it would appear in retrospect to be Ms L, informed staff he would be staying at her mother's address. Communication was received by NTW from RVI Liaison nurse to say Martin did not want any further support from Plummer Court after discharge. The CPN discussed Martin's case with the Multi Disciplinary Team and, given Martin's lack of motivation and engagement, it was decided to discharge him from Addiction Services.

2.2.72 On 02/12/12 police received a report of a suspicious male ringing the doorbell of a local resident. Martin was found drunk in the street. He stated that he had just been discharged from hospital and was looking for his friend's address as he was currently homeless. He was extremely cold and was taken to the police station to warm up. An Adult Concern was submitted but there is no record of this with Newcastle Adult Social Care.

2013

2.2.73 Throughout 2013 Martin again had multiple attendances at A&Es in both Newcastle and Northumberland, with 19 attendances noted for WGH, 11 of which were alcohol related attendances, 8 others relating to injuries of unknown sources, and 5 seizure related. He had 3 overnight stays and left once before treatment. He also continued to come to the attention of police officers and on 5 occasions was charged with minor offences of Drunk and

Disorderly and Failing to Obey a Constable.

2.2.74 Both Martin and Ms L continued to intermittently attend Ron Eager House throughout 2013. Staff recollected that Ms L would text staff on the work mobile to ask them to do tasks for Martin, but that Martin would then come into the day centre alone. Martin's last attendance was on 29/07/13 and Ms L's on 06/09/13.

Summary of Key Events in 2013:

2.2.75 On 12/01/13 Ms L reported to Police that Martin was missing from home. She stated that he had just been released from hospital after suffering from fits and was on medication for depression. Martin was later found later at hospital and returned home.

2.2.76 At Ms L's appointment with NTW on 14/01/13 a full review of her mental state, history and medication was undertaken. Her diagnosis was reviewed and she was given a diagnosis of bipolar affective disorder & borderline personality disorder. The psychiatrist referred Ms L for psychological therapy. At the time Ms L stated she was single and living with her ex foster carer. Ms L continued to be seen and supported by CMHT while waiting for appointment with the psychologist; the waiting time was approximately six months. Medication was reviewed at appointments with a Psychiatrist, approximately every three to four weeks. During this time her mental health was monitored and she displayed no symptoms of psychosis or expressed suicidal ideation or harm to others. Ms L was reported to have good insight into her mental health, and attended most appointments.

2.2.77 On 14/01/13 Martin was admitted to the RVI Hospital for detox. On 16/01/13 Police were called to the RVI by staff reporting trouble with Ms L, who was visiting Martin, and was drunk and refusing to leave. Upon police attendance Ms L left the hospital.

2.2.78 On 25/01/13 Police spoke to Martin. He stated that he would rather sleep rough than go back to his girlfriend's address. He stated that Ms L made his life hell. No further exploration or action appears to have been taken as a result of this.

2.2.79 On 14/02/13 NTW received a referral letter from Martin's GP stating he was a new patient to the surgery, and was currently living with his partner and her mother. He was reported to have an alcohol dependency issue. Martin stated both he and his partner required support from Plummer Court. On 27/02/13 a letter was sent to Martin inviting him to attend an assessment appointment for 04/04/13.

2.2.80 On 21/02/13 a neighbour (N1) of Ms L reported being assaulted by her. It is alleged that Ms L carried out an unprovoked attack on N1, throwing her against a washing machine and punching her to the head. Ms L was

subsequently charged and convicted of assault.

2.2.81 On 13/03/13 Police attended reports of problems with a couple. Upon attendance Ms L was found on the porch roof of a block of flats attempting to gain entry. She was reported to be drunk and abusive, and was arrested and charged with being Drunk and Disorderly.

2.2.82 On 21/03/13, during an attendance at the RVI, Martin reported that Ms L was throwing away his pain killer medication that he had been given following his diagnosis of a hernia. He stated he had had no medication for two days and medication was given. It appears that no attempts were made to explore this further.

2.2.83 On 04/04/13 Police attended a report of drunken male. Upon attendance Martin found asleep in local restaurant, and was taken to a local hostel and provided with a room. He was reported to be drunk and unable to stand. As a result, an Adult Concern Notification was submitted to Northumberland Adult Social Care. This was not however progressed beyond the Central Referral Unit, as it was not felt to meet the criteria for Safeguarding. This was also the date of Martin's appointment with Plummer Court, which he did not attend. Information was received that he had presented to Wansbeck A&E in an intoxicated state with a shoulder injury. He was reported to have left before treatment after sobering up. However, a few hours later he was re admitted after being found by a member of the public in a very intoxicated state, having either fallen or had a seizure.

2.2.84 On 07/04/13 Martin was brought in by ambulance to WGH. He had rung the ambulance himself and stated that he felt as though he was having 'fits, he (was) also frightened that he might fall and sustain a head injury and die'. Martin reported that he was of no fixed abode. He was transferred to the Medical Admissions Unit and went on to say that all of his belongings were at flats in Newcastle. He stated that it was his ex-partner's friend's house, and that he had a big argument with them so left Newcastle on Tuesday 02/04/13. Later in the evening Martin left the ward and Police were then contacted to see if they could trace him. He was later found in the street by children.

2.2.85 On 08/04/13, Ms L reported Martin missing to the police, but was informed that he had been located at the hospital. On the same day, it was documented within Martin's medical notes by a doctor that 'this man does not want to stop drinking. There is no point 'detoxing' him.' It was also recorded that the Alcohol Specialist Nurse had spoken to Martin's partner Ms L, that Martin had community support with Plummer Court and had requested contact on discharge. Martin was discharged from hospital on 09/04/13.

2.2.86 On 24/04/13 Police attended a report of concern for male. Upon attendance Martin was found sitting in the street. Martin had earlier been reported missing by Ms L. Martin smelt of alcohol and was unable to walk. He was taken back home into the care of Ms L. An Adult Concern Notification was

submitted to Newcastle Adult Social Care. This is recorded on 26/04/13 (on Newcastle's Care 1st electronic social care record system) as an Initial Safeguarding Adults Concern. The concern stated 'Ms L, Martin's partner called stating he had not felt well and had gone missing from (address), he was found by myself to be extremely unsteady on his feet, smelling strongly of alcohol, although he blamed medication for his condition. I attempted to return him to the address, however he was incapable of walking a few steps even aided by myself without falling over, therefore transport was provided to prevent further risk of danger or incident to Martin and he was returned to the care of Ms L.' The case was closed as no significant harm had occurred and police had escorted Martin home.

2.2.87 On 25/04/13 Martin attended RVI A&E with Ms L, who stated she was struggling to cope with Martin at home, as he was intermittently confused. She requested a psychology referral. Martin was referred to Plummer Court.

2.2.88 On 16/05/13 Martin attended NTW's Addiction Services for assessment, accompanied by Ms L. During assessment they both stated they wanted to be free of alcohol as it was causing issues within their relationship. They were living together in the Newcastle area but he had been referred to Housing Advice Centre in an attempt to secure accommodation, no further details were documented. Within the core assessment document the IMR author could see that the CPN had documented 'no abuse stated' in response to the question about abuse experienced at any time in your life. Martin did not attend any subsequent appointments and was going to be discharged.

2.2.89 On 06/06/13 Ms L's neighbour, N1, reported to police that some plants belonging to her had been damaged and left outside her front door. Upon attendance by police it was established that N1 had recently been having trouble with Ms L and she suspected her of the damage. N1 believed Ms L was targeting her and there had been numerous incidents, some of which had not been reported to the police. N1 stated that because of Ms L's behaviour she was frightened of returning to her flat and was staying with her father. N1 was noted to suffer from poor health and an Adult Concern was sent to Newcastle Adult Social Services as a notification.

2.2.90 In June 2013 Ms L reported to NTW that she had moved house and changed GP. As a result, her care was transferred to a different psychiatrist in a different area team in Newcastle. Ms L missed her first appointment but then attended subsequently. It was recorded that she was alone at this appointment, described feeling low following physical health issues, but that her partner Martin tried to cheer her up and attempted to engage her in various activities. No problems or relationship difficulties were documented. She reported having missed psychology appointments as letters were sent to her previous address, however she was still keen to attend. Despite attempts to engage her, Ms L missed her next 4 appointments with CMHT.

2.2.91 At an attendance at WGH on 23/06/13 Martin reported that he had split up

from his girlfriend and was of no fixed abode.

2.2.92 On 27/07/13 Ms L reported Martin missing. There was concern for him as he had just been recently discharged from hospital having been treated for alcoholism and depression. He returned of his own accord 2 days later, stating he had been staying at his friend's house.

2.2.93 On 31/07/13 Martin attended an appointment at Plummer Court (having contacted them himself on 19/07). He was seen by a CPN, and it is reported that his alcohol had reduced and his mood was good. There was no mention of Ms L and no evidence that relationships were explored. The plan was for brief intervention on relapse prevention and referral to the recovery centre. An appointment was given for two weeks hence, which he also attended.

2.2.94 On 11/08/13 Ms L's neighbour, N1, reported being further assaulted by her. It was alleged that Ms L attempted to push N1 down a flight of stairs. Ms L was arrested but no further action was taken as there were no independent witnesses

2.2.95 On 20/08/13 Martin presented at the RVI A&E, accompanied by Ms L, stating he had slammed his body against the wall, as he needed to 'beat the evil out'. NTW's crisis team were contacted who conducted an assessment over the phone. An attempt was made to speak to Martin but he instructed staff to speak to his partner, who identified that he had expressed no further thoughts of self harm. She also reported that he had been to his GP that day, who was going to refer him for counselling, and this had caused him some distress. The assessor then later spoke to Martin's worker from Plummer Court, who had no concerns regarding Martin's well being, citing his commitment to stopping drinking as his main problem, with no previous evidence of psychosis. It was felt that his presentation on this day did not appear in keeping with a psychotic presentation or withdrawal.

2.2.96 On 29/08/13 Martin attended a further appointment at Plummer Court. He stated he had been abstinent for nine days after tripping and re-opening the fracture to his shoulder, he strongly denied any intentional self injury. He reported experiencing withdrawals for approximately three days after stopping drinking. He admitted to taking more than the prescribed Trazadone. Martin stated he 'could not be bothered to make contact with the Recovery Centre and might try AA'. A telephone call was made to the GP to inform of the overuse of prescribed medication. Martin failed to attend his next appointment in September.

2.2.97 At an attendance at RVI A&E on 06/09/13, Martin stated he hadn't drunk in sixteen days, but had drank that day and felt he may have a fit as a result. He said he had attended A&E as he 'wanted to be set right'. During this it was noted that he reported that his home life was 'stressful', but no further information was recorded.

2.2.98 On 19/09/13 Ms L was sentenced to a twelve month Community Order with the requirement of Supervision, following her conviction of Section 39 Assault against her neighbour. This sentence was supervised by Northumbria Community Rehabilitation Company. Details of the offence involved the neighbour being grabbed, thrown against a washing machine, and hit on the back of the head. Ms L had asserted that she had been acting in self-defence and as a result had pleaded not guilty. She was later found guilty after trial. This Order was initially allocated to be managed by Offender Manager 1 (OM1).

2.2.99 On 04/10/13 a telephone call was received by a CPN within NTW's Addictions Service from Martin's sister. She expressed concerned about his current relationship, stating she thought there may be domestic violence perpetrated by Ms L. She stated she was receiving 'nasty' texts from Ms L. She also expressed concern about Martin's physical health, stating he had had to have a further period in hospital to control seizures. She was advised that the CPN would speak to Safeguarding and the hospital regarding his physical health. The CPN did speak to NTW's Safeguarding and Public Protection Team and was advised to complete an IR3 (internal safeguarding recording system), obtain details of the partner, and consider completing a Risk Indicator Checklist in relation to a possible MARAC referral. Following completion of these actions, a further discussion was to take place with the Safeguarding and Public Protection Team practitioner for Domestic Abuse.

2.2.100 On 10/10/13 Martin attended an appointment at Plummer Court with Ms L. He was seen on his own and domestic violence was discussed. Martin stated that he was fine and there were no concerns as suggested by his sister. He described a 'fairly good relationship' with his family. When Ms L returned to the session the CPN had the same conversation with both her and Martin. Ms L stated there was some conflict with Martin's family but did not expand further. There was felt to be no evidence to suggest Martin was a victim of domestic violence, therefore there was no further action was taken regarding referral to MARAC. There was also an ongoing plan and treatment options for Martin in respect of his alcohol misuse over the remainder of 2013. However, due to many failed attendances he was discharged at the end of December 2013. Prior to this, three home visits were made to try and engage Martin.

2.2.101 Martin's sister made a further telephone call to NTW on 25/10/13 expressing concerns requesting to speak to Martin's key worker who was unavailable. There is no evidence that this call was returned.

2.2.102 On 31/10/13 Martin was admitted to the RVI for a hernia repair, and following his discharge on 05/11/13 he had no further contact with Newcastle upon Tyne Hospitals.

2.2.103 On 29/10/13 Ms L's neighbour (N1) reported that Ms L was harassing her. Following the assault in February, N1 has subsequently obtained an

injunction against Ms L but despite this she had continued to harass her. Ms L was arrested and charged with harassment.

2.2.104 On 15/11/13 in response to Ms L notifying her Offender Manager with the CRC that she had moved to Northumberland, OM1 undertook a home visit to the new address. Ms L initially reported that Martin was residing with her at the same address, and he is described as her partner. On a subsequent home visit conducted on 18/12/13, Ms L informed OM1 that he did not reside in the house but lived in a caravan nearby. Ms L described the relationship as positive and supportive.

2.2.105 On 20/11/13 Ms L contacted the crisis team in an attempt to obtain medication (no mental health crisis was detailed), the crisis worker offered to contact the GP on Ms L's behalf, as he was aware that without medication her mental health was likely to deteriorate. He also made a referral to Northumberland CMHT services. Northumberland CMHT also received contact from Ms L requesting medication and she was advised the same, that she should contact her GP. In addition, the CPN made contact with the GP practice and asked them to contact Ms L directly; Ms L was advised of this.

2.2.106 On 06/12/13 Martin's adult daughter reported to police that her father had been to her home address causing trouble. Upon police attendance it was established that Martin had attended whilst drunk wanting to see his grandson, he was refused entry and there was a brief verbal only dispute before he left the area. He was spoken to later and warned regarding his conduct. A Domestic Abuse Record was submitted. Police received a further call the next day that Martin had attended the home again. He was spoken to and issued with a Police Information Notice for Harassment (PIN).

2.2.107 On 31/12/13 Martin sent in a completed self-referral questionnaire (printed from the website) to Insight Healthcare to request an appointment. On the self-completed questionnaire Martin stated 'My partner is very supportive however she finds it very difficult to cope'. In answer to a question 'Is there anyone you fear may harm you, or harm others who are close to you?' he had marked 'no'. The self-referral request was triaged by the clinical lead and it was agreed that a face to face assessment appointment was to be offered to Martin. Martin did not respond to attempts to follow up his request by telephone, or by a letter dated 03/01/14 requesting him to contact the service if he still required treatment. As there was no further contact the file was closed on 11/01/14, as per Insight processes, and a letter was sent to Martin's GP.

2.2.108 Between December 2013 and March 2014 attempts were made to engage Ms L by NTW's Community Mental Health Team, but she failed to attend and was discharged in March 2014 following discussion within a multi-disciplinary team meeting.

2014

2.2.109 As in previous years Martin's regular attendance at A&E in Northumberland continued in 2014. He attended on 10 occasions, with 4 alcohol related attendances and 9 other relating to injuries of unknown sources. He had a total of 5 overnight stays.

2.2.110 On 08/01/14 Ms L reported to the police that her partner, Martin, had returned home to their shared address in a drunken and argumentative state. Police attended and Martin was found to very intoxicated and was subsequently arrested for a breach of the peace before later being common law released. There was no reported violence.

2.2.111 On 10/1/14 Martin attended a GP appointment accompanied by Ms L; this was unusual as he usually attended alone. Ms L was very concerned about Martin's staggering, slurred speech, headaches and aggression. She reported that he was not drinking, but at the time of the consultation it was noted that he smelt of alcohol and the symptoms described were considered most likely to be due to his alcohol problem. The GP (Dr B) arranged some blood tests, which were consistent with heavy alcohol consumption. When Martin attended again two weeks later he appeared sober and reported that he was no longer drinking. His mood was low so his antidepressant medication was changed. He did not continue taking this after the initial prescription.

2.2.112 On 06/02/14 the GP practice received a letter from Ms L expressing concern about Martin's mental health, this included his consent to the sharing of information with her. Dr B responded to this letter acknowledging her concerns, advising that Martin's medication had been changed recently, that counselling was a possibility, and that a review appointment would be needed.

2.2.113 During her supervision by Northumbria CRC Ms L was seen at the Ashington Office on 06/02/14 for a three way appointment with OM1 and OM2. The purpose of this appointment was to transfer her case from Newcastle to Northumberland.

2.2.114 On 13/03/14 Martin attended Blyth Community Hospital via self-referral. The presenting complaint was a limb injury. Martin stated that he had a big fall out with his partner and felt he could not return, and also that he spent night with a friend. Martin was not keen to accept Patient Transport Service (PTS) for a lift home and stated that he would go to a friend's house in Ashington but did not know the address. Martin was recorded as not known to social services. Discussion took place with a duty officer from Adult Social Care and an email referral was made and subsequently processed on 19/03/14, with the Intake Team contacting Blyth Social Care Team to follow it up.

2.2.115 On the same day the duty Social Worker made a telephone call to Martin's mobile number and left a voicemail message asking him to contact them to

discuss needs. Further messages were also left on 21st and 24th March, and a call made to the Homefinder team to see if Martin known to them. On 24/03/14 a letter was then sent to Martin saying that social services had tried several times to contact him to discuss undertaking an assessment of his health and social care needs, and asking that he make contact via a direct line to the allocated social worker.

2.2.116 On 2nd and 7th April calls were made by Adult Social Care to the referrer at Blyth Minor Injuries Unit. Contact was finally made on 10/04/14 when the referrer informed the Social Worker that she had not had any further contact with Martin since the referral. The Social Worker explained that he had made several attempts to contact him, as well as sending a letter attempting to arrange visits but that there had been no response. The referrer confirmed that Martin would have the ability to seek formal help if he needed it.

2.2.117 As a result of all the above, on 14/04/15 a Letter was sent to Martin saying that the Social Worker had tried to contact him several times to arrange an assessment of his care needs, but that as he has not responded, involvement was to cease. A number for Foundry House was offered to facilitate self-referral should he wish to do so.

2.2.118 Ms L was made subject to a concurrent six month Community Order on 19/03/14, with one requirement of an Exclusion Zone. This requirement did not necessitate oversight by Probation Services. The Order was made following Ms L's conviction for breach of a Restraining Order. It was reported that on 30/10/13 Ms L followed home the victim of her index offence and 'harassed' her. She denied this, and stated that she had only seen the victim and taken a photograph of her. She initially entered a not guilty plea, but on the day of trial she changed her plea to guilty and was sentenced to the Community Order. The requirement of an exclusion zone prohibited Ms L from entering a designated area where the victim resided.

2.2.119 On 08/04/14 Martin once again self referred to Insight Healthcare. Then on 01/05/14 he attended his 1st meeting, which was an assessment appointment. Within this it was recorded that his issues were complex and long-standing, and that he presented with signs of depression and anxiety; as result he was placed on the waiting list for a high intensity face to face treatment. Martin described Ms L as supportive, and did not report any negative aspects about the relationship nor give the practitioner any concerns about risk to his wellbeing.

2.2.120 06/05/14 Martin was brought in by ambulance to WGH intoxicated. It was queried whether he had fallen as he had a 'bump to his head'. Martin claimed that his partner had punched him in the shoulder. No further exploration or action appears to have been taken as a result of this.

2.2.121 Following a number of attempts to contact him, Insight Healthcare sent Martin a letter with an appointment for 10/06/14. He subsequently failed to attend

and a discharge letter was sent to his GP. Martin subsequently contacted Insight saying that he had not attended due to a hospital appointment. He was once more placed on the waiting list for an appointment with a therapist.

2.2.122 On 08/06/14 Martin was brought in by police to WGH with the presenting complaint of vomiting. On his Patient and Carer information Ms L was recorded as his partner and next of kin. On examination Martin was intoxicated, sleepy, felt nauseous and denied any pain. Martin informed the staff nurse that he had taken 12 co-codamol two days before. On the morning of 09/06 Martin stated that he felt better, but that evening informed the nurse that he felt he was a threat to himself and others. Martin was asked how and in what way and he stated that he feels "like walking in front of a bus".

2.2.123 On 10/06/14 it was recorded that Martin had been left for the Deliberate Self-Harm Team to review. However, Martin was then recorded as being missing from the ward. Security and staff were unable to locate Martin in the hospital grounds, as a result Police were informed. Ms L attended the ward and was also looking for him and was asked to inform ward if she located him. Martin later returned to the ward and stated that he went to the park and fell asleep there.

2.2.124 On 11/06/14 Martin was seen by the Alcohol Specialist Nurse. He disclosed a long history of heavy alcohol abuse and denied any illicit drug use. Martin stated that his last reported seizure was in January 2014. He denied any current thoughts of self-harm or suicidal ideation and reported that he lived with his partner. No housing issues were reported. A discussion took place with Martin in regards to the health risks of continuance and risks of sudden cessation. Martin is recorded to have stated that he intends to abstain from alcohol and engage with community support. Martin gave consent for referral to the Northumberland Recovery Partnership (NRP). The Alcohol Specialist Nurse also recorded in medical notes that she had spoken to Ms L, who was concerned about Martin's mental health and felt it was not drink related.

2.2.125 Martin was also seen the same day by the self-harm team; Ms L was also present. Martin was reported to have smelt strongly of alcohol and it was recorded that he had had half a bottle of vodka that morning (went off the ward and bought it). Martin recognised that he had an alcohol problem and experienced cravings. No self-harm issues, or thoughts of suicide were identified. He was subsequently discharged home.

2.2.126 On 13/05/14 Ms L saw a GP complaining of being tired all the time and having hot flushes. Blood tests were taken. She reported that she was supporting her partner on an alcohol recovery programme. There is no specific documentation of exploration of carer issues. She was re-referred to Mental Health services and a letter received later by the GP indicated that her carer stress levels were reduced due to her partner receiving counselling.

2.2.127 On 23/06/14 Martin was seen by NTW specialist alcohol service and

described years of alcohol abuse, stating he had been dry for a week prior to the appointment and that he wished to remain alcohol free. Martin was allocated a key worker for support and three further attempts were then made to contact Martin by letter and phone in July. As no response was received he was discharged from the service.

2.2.128 On 22/07/14 Ms L had an assessment by NTW Community Mental Health Team following referral from her GP in May. A review of her mental health and current situation was documented and she stated she was drug and alcohol free, her mental health was stable and that her main issues are her caring role for her partner (name not documented). Her partner was reported to be undergoing an alcohol detoxification, however Ms L felt things were improving as he was receiving support from Talking Therapies. There is no evidence that Ms L was offered a carers' assessment. Within the core assessment, the section looking at the service user's experiences of physical, sexual, emotional abuse was addressed at this appointment. Ms L reported that she had experienced sexual abuse as a child from her maternal grandparents and that she had informed her mother, who had not believed her. Ms L also stated that her mother was physically and emotionally abusive towards her. No evidence of current domestic abuse was documented.

2.2.129 It was also acknowledged that Ms L had been offered psychological therapies in the past but she had not engaged. On this occasion follow up arrangements were put in place for Ms L to be offered details of a local service 'GRACE' who offer counselling, support and information to women who have experienced childhood sexual abuse. Ms L was offered telephone numbers for support groups and discharged back to her GP at her request. The assessing doctor wrote to the GP outlining her extensive psychiatric history and giving a formulation of the assessment, stating the following:

'At assessment today Ms L reported that overall she feels mentally stable, and her carer stress levels have reduced, due to her partner receiving counselling. Ms L reported only occasional and fleeting thoughts to self harm over the past year, and she feels she has developed good coping strategies to distract herself from negative thoughts. Ms L is abstinent from alcohol, and has been for over a year, and does not use recreational drugs, which she has done in the past.

After discussion in our MDT, we did not feel Ms L's current presentation indicated CMHT involvement, a discussion took place with the Consultant Psychiatrist who advised that if Ms L experiences a deterioration in her mood in the future her medication can be increased.'

2.2.130 NTW had no further contact with Ms L until after her arrest.

2.2.131 Martin attended his first two therapy appointments with Insight on 5/08/14 and 12/08/14. There was no risk to him identified within these meetings.

2.2.132 On 29/08/14 Ms L missed her last appointment with CRC, although no action was taken.

2.2.133 Martin attended his 3rd therapy session with Insight on 09/09/14. Within this he disclosed abuse as a child, although did not give details of the abuser, reporting that he had no ongoing contact.

2.2.134 On 10/09/14 Police attended the home address of Ms L and Martin in order to deal with an allegation of threatening text messages being sent by Ms L to Martin's sister. It was noted that Martin appeared frightened of Ms L and it was believed he was not receiving the required help and that Ms L was the controlling and dominant partner in the relationship. Martin was reported to be a 'known alcoholic', in ill health and requiring support. As a result of these concerns an Adult Concern was submitted to Northumbria Adult Services.

2.2.135 On 11/09/14 the Adult Concern Notification (ACN) was received by Adult Social Care. The ACN described Ms L as becoming more and more irate during the police visit, refusing to listen, and as having contacted her solicitor on the phone. Martin was described as having a broken shoulder and awaiting surgery. When Ms L left the room Martin was apologetic for her behaviour, but was extremely quiet when Ms L was present and stopped talking altogether when she returned to the room. Ms L was described as appearing very dominant in the relationship and Martin appeared vulnerable and timid in Ms L's presence, but also due to his injuries and alcohol problems. The ACN also describes the house as sparsely furnished, and that the couple would not allow the attending officer to access beyond the very bare front room. The officer states there was no overpowering smell of alcohol, but both Martin and Ms L's speech was slurred. The officer states that he was concerned that Martin was not receiving the help he needed and that he had recently disclosed to his sister that he was abused by a neighbour as a young boy. Ms L was described as appearing to the officer to be the dominant party in the relationship and as controlling of Martin even in the short time the officer was present.

2.2.136 Following a call to Martin on 11/09/14, a home visit was undertaken on 12/09/14 by two duty Social Workers. The purpose of this was to follow up the ACN, to check Martin's health and wellbeing, and offer referral for a Community Care Assessment. The door was answered by Ms L, who advised that Martin was not in and that he would be back in about twenty minutes. Ms L did not open the door sufficiently to allow Social Workers to see inside. Ms L was advised that the Social Workers would call back, which she accepted. On the second visit, Ms L again answered door and said that Martin was on his way back from Newcastle but still on the bus. Ms L advised social workers that she had contacted Martin following their earlier visit and that he was "chewed about it". It was reported by Ms L that Martin had been trying to trace his birth mother and he initially thought the Social Workers were visiting about this. It is recorded that Ms L was very firm and persistent that if the Social Workers had been sent by Martin's sister, then neither she nor Martin would

allow them access. She stated that the only contact and help that Martin wanted was from Family Support Services to help find his birth mother. The Social Worker reassured Ms L regarding the purpose of the visit, to which Ms L responded that the police should never have visited and had been called by Martin's sister. The Social Worker recorded that Ms L maintained her stance that this was not a visit that Martin had consented to and that he did not need support. Ms L offered for the Social Workers to return when Martin got back, but said that he would say the same as she had. The Social Worker recorded that at no time during the visit was Ms L hostile or expressing any action to prevent Social Workers from meeting Martin.

2.2.137 Following the above a discussion took place between the Social Worker and Team Manager, and the Team Manager requested that the Social Worker emailed the Emergency Duty Team to request a welfare check over the weekend, as well as to offer referral for Community Care Assessment of needs if Martin required, and consented to, this. An email was then sent to the Emergency Duty Team detailing the background and requesting a welfare check. The Social Worker advised that she had made two unsuccessful attempts at face to face contact as duty worker, and that on both occasions she has been told by Ms L that Martin was not there. The referral requested a face to face visit to check Martin's welfare and offer Community Care Assessment if this was indicated. Receipt of this was acknowledged and it was agreed the case would be allocated as soon as possible.

2.2.138 On 13/09/14 a home visit took place by the Emergency Duty Team Officer. He recorded that an unidentified female answered the door. The Emergency Duty Team Officer identified himself and asked to speak to Martin. The female stated "I know you" and closed the door. The Emergency Duty Team Officer knocked on the door again and the female answered the door and stated 'Martin has told me to tell you to piss off'. She then closed the front door again. A telephone call was then made from the Duty Officer to Northumbria Police to request a welfare check to the property in order to verify Martin's safety in view of failed entry.

2.2.139 A welfare check was undertaken on 13/09/14 by Police, in which Martin was seen by Officers and was described as fit and well. He stated he did not want any Social Services help and made no disclosures regarding his relationship with Ms L. Ms L was found to be 'very unpleasant' and was not happy with the police coming to her door. Adult Social Care were updated that a visit was carried out by police and both Ms L and Martin spoken to. Ms L was described as somewhat abrasive and Martin as indicating quite firmly that he did not want a Social Worker and requested that none visit. He was reported to have acknowledged that he had 'one or two issues' but insisted that he did not require a Social Worker. Otherwise, he was described as appearing okay to the officers who visited and they left without further concerns.

2.2.140 On 14/09/14 Martin's sister received further texts from Ms L and alerted police of her concerns. No action was taken by police as no offences were

identified. Martin's sister was advised to change her phone.

2.2.141 On 16/09/14 Martin's sister attended a police station regarding the text messages sent to her by Ms L. She informed police that she wanted no contact from Ms L but was happy to have contact from her brother Martin, as she was concerned for him. No action was taken.

2.2.142 Ms L's Community Order terminated on 18/09/14.

2.2.143 Martin attended therapy sessions with Insight on 23/09/14 and 07/10/14.

2.2.144 Martin's last attendance at WGH was on 15/10/14.

2.2.145 On 28/10/14 Martin attended his 7th Insight appointment and reported further anxiety and panic, which he linked to seizures and fears for his health. In addition he referred to relationship difficulties due to his partner's unpredictable behaviour, which he linked to her mental health. He did not disclose any violence or abuse. In this session the therapist explored Martin's 'personal resources and own resilience' and developed coping strategies.

2.2.146 Martin is believed to have been murdered on 01/11/14, his body having been found on 07/11/14.

3 FAMILY PERSPECTIVE

3.1 In meeting with the Chair of this review, Martin's sister raised a number of areas of concern that were considered within the review process and the recommendations arising from it.

3.2 One concern raised was the role of Adult Social Care in general, and why no support interventions were put in place over the years for someone who was in her brother's position. More specifically, Martin's sister also queried whether, when she had expressed concerns to staff at NTW in 2013 about Ms L's abusive and controlling behaviour towards Martin, these were taken seriously and addressed appropriately. In addition, she expressed concerns on two occasions to police in 2014 about Ms L's abusive behaviour towards her. On the first occasion she felt the Officer understood her concerns and took the appropriate action, but on the second occasion she feels that her concerns were ignored and not taken seriously. Such concerns resulted in her making a complaint that was being dealt with by the IPCC concurrent to this review.

3.3 Martin's sister also felt that Ms L was successful in misleading practitioners by describing herself as Martin's 'carer', and that she may have accompanied Martin under the 'carer' soubriquet whenever he was spoken to by professionals, thereby denying him the opportunity to speak freely about the abuse he was suffering.

3.4 All of these factors are considered below in the analysis of agencies' involvement with Martin and Ms L.

4 ANALYSIS OF AGENCY INVOLVEMENT

4.1 Detailed below is the analysis of agencies' involvement with Martin and Ms L. This is taken both from individual agency IMRs, as well as consideration by the author of this report of each agency's involvement within the broader context identified by this review.

4.2 Northumbria Police

4.2.1 Martin and Ms L individually had extensive contact with Northumbria Police, both during and prior to the review period.

4.2.2 In relation to Martin, his contact was mainly in relation to minor offences or concerns around his welfare. There were also a small number of domestic abuse incidents involving Martin attending the home of his ex-wife, father or daughter, as well as one incident involving a partner asking for him to be removed from her address in 2012. Those relating to his ex-wife dated back to 2007, following the breakdown of his marriage. On one of these occasions Martin told police officers he had thoughts of killing his ex-wife. As a result of this she was spoken to and reported that he had never been violent and she was not concerned for her own safety. She was however assessed as being at high risk, although how this assessment was arrived at is unclear. It appears to have been based on the threats of Martin and general concerns around his presentation and mental health. Later in the year police were called to his ex-wife's home on three occasions within two days when Martin was reported to have attended the home and 'kicked off'. These incidents were recorded as verbal disputes, and on the final occasion Martin had become abusive to police officers, resulting in him being arrested for being drunk and disorderly. The incident relating to Martin's father occurred shortly after this when he attended the address intoxicated and was removed by police. The final incident involved Martin's adult daughter and occurred on 06/12/13, when she reported to police that her father had been to her home address causing trouble. On all these occasions a Domestic Abuse Record was submitted, and in the case of his daughter Martin was issued with a Police Information Notice for Harassment (PIN) when he returned to her home the following day.

4.2.3 Outside of these incidents Martin's primary contact with Northumbria Police involved him being stop checked on 124 occasions. Numerous stops were as a result of him being found intoxicated in the street, and on many of these occasions it was deemed necessary to call an ambulance or take him directly to the local hospital. The IMR author identified that based on police records 'Martin had an extensive history of alcoholism and mental health issues', as well as often presenting as homeless, yet despite this there were only five

occasions during the review period (05/6/11, 02/12/12, 04/04/13, 24/04/13 and 10/09/14) on which Adult Concern Notifications[1] (ACN) were submitted. The IMR author noted that until March 2015 there was no requirement to submit an ACN when 'attending to a report of a drunk', as the definition used within the policy document did not allow for this situation. The decision therefore to submit a concern was one taken by the attending police officer. The definition has since been amended and the IMR author felt that the circumstances of numerous incidents involving Martin would now result in the submission of an ACN. However, it was not clear on what basis this could be asserted, the IMR author identified no one reason for this increase but felt it was due to a number of factors including training, re-organisation of the Protecting Vulnerable People (PVP) Unit, and closer working relationship with Adult Social Services. However, there has been no specific training since changes occurred in March 2015.

4.2.4 Whilst the previous police definition may not have automatically resulted in submission of an ACN, the Panel representative for Adult Services identified that the issues around self-neglect, now clearly identified as a Safeguarding issues within the Care Act 2014, had always been considered within Northumberland's Safeguarding Adults Multi Agency Policy and Procedures, and therefore could have resulted in referral; as was demonstrated at the discretion of certain Officers on the few occasion in which concerns were submitted.

4.2.5 As regards Ms L, her involvement with Northumbria Police clearly shows a pattern of violent and threatening behaviour. Outside of her relationship with Martin, this included verbal altercations, threats, and violent assaults, involving seven of nine known partners, in which Ms L was seen as either the primary or joint perpetrator. In addition, there were incidents of police call outs in relation to verbal disputes, alleged threats, harassment and assaults of her adult daughter, her mother, four different neighbours, police officers, and ambulance staff. This included conviction for a Section 47 Assault of her mother in 2008, and Section 39 Assault and Harassment of a neighbour in 2013, both of which resulted in her being made subject to Community Orders.

4.2.6 In examining the response given to incidents involving Ms L as a perpetrator, there is one incident, on 06/01/09, following which the victim was referred to MARAC. The referral related to Ms L's partner, P7, against whom a number of incidents/concerns were reported to police from November 2006 to January 2009. There are however a number of reports of severe violence and/or visible injury including allegations that Ms L had hit P7 with a metal bar/dumb bell (14/11/06); that he had been seen with two black eyes, a broken nose, numerous cuts and extensive bruising to his upper body, and reported that he had fallen in the bath (24/06/08); that Ms L had punched, scratched him, pushed him into the bath and threatened to slit his throat (24/11/08); and, in the incident resulting in a MARAC referral, that she had

[1] An Adult Concern Notification is the mechanism within Northumbria Police by which Safeguarding referrals are made.

punched and scratched his face, as well as stabbing him in the arm with a kitchen knife. In all but one of these incidents, no charges were pursued. While this often appeared due to the alleged victim not wishing to proceed, the IMR author identified that where the victim does not support a prosecution, but it is clear that a criminal offence has taken place, police in all cases should prepare a file of evidence for the CPS to consider a victimless prosecution. This does not appear to have occurred in relation to many of these incidents.

4.2.7 The IMR author identified that there does appear 'to be a difference in the way police officers dealt with a number of incidents involving Ms L and her partners. Positive action was not always taken against Ms L when dealing with domestic abuse incidents and the history of her offending does not seem to have been considered'. This prompts consideration of one particular question identified within the terms of reference for this review, namely to what extent gender may have played a role within this. The IMR author indicated that in the incident on 24/06/08, in which P7 presented with significant injuries, the decision not to speak to him alone and complete a DASH risk assessment, despite Ms L's known history, 'could have been influenced by the gender of the suspected victim'. In addition, the author concluded that 'there were incidents of domestic violence involving Ms L where the actions taken by police officers could have been influenced by gender bias'.

4.2.8 In addition to her presentation as a perpetrator of abuse Ms L was also identified as a victim in a number of incidents. In 2002 she reported having been the victim of rape by her ex-partner P2, and a decision not to charge was made by the police on the basis of insufficient evidence. The IMR author noted that CPS advice would now be sought regarding such a charging decision in a case of rape. At the time however this did not occur and there is also no evidence of any further follow up or support being offered to Ms L in light of the allegation. The author felt that this would now prompt the use of a DASH risk assessment and the outcome of this may prompt further support. Following this allegation Ms L then made threats towards P2, to 'rip his eyes out and rip his genitals off'. She was also suspected of making threatening telephone calls, throwing paint over his property, and sending a wreath to his door. There was no domestic violence record completed and no warning issued to Ms L regarding the threats/harassment. Concerns were expressed regarding Ms L's mental health although it is not clear what these were. As a result, little evidence of any proactive response to Ms L as either a victim or a perpetrator within these related incidents can be demonstrated.

4.2.9 At a later date on 25/02/04 an incident occurred involving Ms L in which she reported that her then partner, P4, had hit her with a golf club. Both parties were reported to be drunk and both were subsequently arrested on suspicion of assault, Ms L for Section 18 Assault and P4 for Section 47 assault. Following CPS advice, no further action was taken against P4 due to insufficient evidence, and the police made the decision to take no further

action against Ms L. There was no domestic violence record completed for this incident and very little detail is recorded as to the circumstances behind it or the Section 18, for which Ms L was arrested. While the Section 47 Assault was recorded as a crime, the Section 18 Assault was not, despite Ms L's arrest for the offence.

4.2.10 Ms L was also often reported to be under the influence of alcohol and concerns were also noted regarding her mental health, including occasions in which she was said to have self harmed (05/07/11, 27/08/11). At the latter incident, on 27/08/11, North East Ambulance Service requested police assistance to the report of a female slitting her wrists. Police attended together with paramedics and found Ms L's partner P9 outside in the street; he stated that Ms L was inside the address smashing the flat up and expressed concerns that she had self-harmed. Police and paramedics entered the flat and found her lying on the sitting room floor surrounded by broken glass. Ms L could give no explanation as to what had happened, became violent, and was subsequently detained under S136 of the Mental Health Act and taken to hospital. Ms L was found to have a broken arm and claimed her partner had assaulted her. Her partner was arrested for S20 assault and no further action was later taken against him. It was reported that Ms L had attacked P9 with a small table following a drunken verbal altercation. He had then restrained her, which was when it was likely that she suffered the injury to her arm. In relation to this incident, while action was taken to address the presenting mental health concerns there is no evidence of any follow up action being taken regarding the issues of domestic abuse and the associated risk, either to Ms L or her partner P9, despite evidence of significant injury and the alleged use of a table leg as a weapon. Police did not record a crime in relation to this incident.

4.2.11 In specific relation to Martin and Ms L, on 08/01/14 Ms L reported to the police that Martin had returned home to their shared address in a drunken and argumentative state. Police attended and Martin was found to very intoxicated, and he was subsequently arrested for a breach of the peace and later released without further action. A DASH risk assessment was completed and submitted; Ms L was assessed as "Standard" with just three risk indicators identified, these were 'separation', 'suspect mental/alcohol/drugs' and 'abuser previous criminal history'. Ms L did not wish to make any complaint against Martin and it was reported that it was a verbal argument only. While this was the only domestic abuse incident recorded in relation to Martin and Ms L, prior to this, in January 2013, Martin had reported to officers that he would rather sleep rough than return home as Ms L made his life hell. There is no evidence of any further exploration or action having taken place in relation to this.

4.2.12 On 10/09/14 Martin's sister reported to police that she had been receiving threatening text messages from Ms L. She stated that she believed Ms L was 'unstable' and 'causing havoc'. The text messages were viewed by police and deemed not to be threatening but more 'unwanted'. Martin's sister was

advised that Ms L would be spoken to and told not to make any further contact with her. Ms L was subsequently spoken to at her home address, where Martin was also present. Ms L stated that the messages had only been sent on behalf of Martin. She was issued with a Police Information Notice for Harassment[2] and during this became irate and abusive. While issuing the PIN it was noted that Martin was very quiet in the presence of Ms L; he was reported to have appeared timid and vulnerable and Ms L to have appeared controlling. At this time Martin had a broken shoulder and was awaiting surgery. As a result of the observations made, an ACN was submitted for Martin.

4.2.13 There was no DASH risk assessment completed or submitted, as this was not reported as a domestic incident. However, following the observations made of the interaction between Ms L and Martin, i.e. signs of coercive control, the IMR author concluded that a DASH could have been completed and submitted.

4.2.14 On 14/09/14 and 16/09/14 Martin's sister reported that she had received further threatening text messages from Ms L. She also stated that she believed Ms L was schizophrenic, and that she was concerned for her brother. The text messages were written as if they were from her Martin, stating he was safe. The messages were viewed by police officers and deemed not to be threatening or harassing. Martin's sister was advised to change her telephone number. In addition, a PIN had been issued to Ms L after the first report of threats having been received, and despite further reports of threats/harassment no follow up action was taken. If a course of conduct amounting to harassment has already taken place the offence is complete and a crime should be recorded. As a result, positive action could then have been taken against Ms L.

4.2.15 Martin's sister has expressed that she was not happy with the course of action taken by police in this latter incident. As outlined above, it was recognised by the IMR author and by this review, that further action could have been taken and the concerns of Martin's sister dealt with more proactively. In summary this might have included, speaking to Martin alone to discuss concerns around domestic abuse and completing a DASH risk assessment with him, as well as pursuing action against Ms L under the Protection from Harassment Act 1997. Outside of this review, this matter is also being addressed by the IPCC, following a complaint made by Martin's sister.

4.2.16 One action that was taken by officers who attended on 10/09/13 was the submission of an ACN. As a result of this Adult Social Care contacted police after they had attended the home address of Martin and Ms L and been

[2] The Protection from Harassment Act 1997 which prohibits harassment, was brought into force on 16 June 1997. The legislation was always intended to tackle stalking, but the offences were drafted to tackle any form of persistent conduct that causes another person alarm or distress, including neighbour disputes. It is recognised that most incidents of stalking will be linked to domestic abuse and the procedure for Investigation of Domestic Abuse must be followed. One of the options when dealing with incidents of harassment is the use of a Police Information Notice (PIN). A PIN was introduced in order to provide officers with a consistent approach to notifying a person when their behaviour is alarming or distressing and may constitute an offence under the Protection from Harassment Act 1997.

refused entry. It was requested that a welfare check was made and a visit took place on 13/09/14 where Martin was seen by officers and reported to be fit and well. It was recorded that he stated he did not want any Social Services help and he made no disclosures regarding his relationship with Ms L. Within this visit however there was no evidence of any attempts by officers to see Martin alone, which would appear warranted given Ms L's history of abusive behaviour, Martin's vulnerability, and the recent concerns of both Martin's sister and the police officer who submitted the original ACN. The check that took place would appear to have been extremely superficial given the nature of the concerns.

4.2.17 The IMR author offered no conclusions as to why DASH risk assessments were not completed with Martin in these instances, why officers apparently failed to adequately follow up Martin's sister's reports of harassment, or why more extensive enquiries were not made within the welfare visit. Given the previous issues identified it brings into question whether issues around Ms L's gender may have impacted upon the extent to which she was viewed as a perpetrator, and whether Martin's own vulnerabilities and issues around alcohol use, resulted in a less proactive approach being taken towards addressing him as a potential victim.

Conclusions regarding Northumbria Police's involvement

- Both Martin and Ms L had an extensive history of alcohol misuse, mental health concerns, and periods of homelessness, despite this only five Adult Concern Notifications (ACN) were submitted for Martin and none for Ms L. The IMR author noted a general lack of recognition of Martin's vulnerability despite strong evidence of this. The submission of ACNs would have assisted in building a more extensive picture and possibly led to multi agency consideration and management.
- There is clear evidence of Ms L as a perpetrator of abuse involving a number of previous partners, as well as concerns around coercive control demonstrated in relation to Martin. Despite this her history of behaviour was rarely identified and acted upon in accordance with domestic abuse procedures, and there are a number of reported incidents involving Ms L where no positive action was taken due to decision by police. The reasons behind these decisions was unclear.
- The response to Martin's sister's expressed concerns was limited and should have involved a more pro-active response to potential risk of domestic abuse to Martin, as well as pursuing of the crime of harassment in relation to Ms L.
- While the reasons behind lack of action taken in relation to both Ms L's history of abusive behaviour, and concerns and harassment reported by Martin's sister, were unclear, it has been identified that the gender may have played a part. In addition the IMR author identified that the extensive histories of Martin and Ms L in terms of their alcohol misuse and mental health difficulties, may have influenced the actions of officers in failing to fully consider issues of risk and vulnerability.

4.2.18 In relation to addressing the above Northumbria Police identified that a review of the stalking and harassment policies and procedures was currently being undertaken and that as part of this review the use of PIN's was being addressed. In addition, a trial of the Multi Agency Tasking and Coordination Process (MATAC) was currently underway. The MATAC allows perpetrators of domestic violence to be identified using recency, frequency and gravity of offences (RFG methodology). Perpetrators highlighted by RFG methodology would be brought for discussion at the MATAC. The MATAC would decide how each perpetrator would be targeted and who should do it. Consideration would be given to victims in each case and to potential victims. In theory, individuals such as Ms L should be considered within the MATAC process, with the focus upon her as a perpetrator. However, this would rely upon her being correctly identified as such and appropriate course of action taken.

Further recommendations for Northumbria Police as a result of this review:

- **To review submission of Adult Concern Notifications in relation to issues of self-neglect related to alcohol use, mental health and housing issues, in order to ensure that vulnerability is being correctly identified and alerted.**
- **To review training received by Officers in relation to domestic violence and abuse and ensure that it includes explicit consideration of female perpetrators and male victims and the dynamics within this, included those who present as both a victim and perpetrator.**
- **To ensure that officers undertaking welfare checks in cases where there are concerns around Safeguarding and/or Domestic Abuse are aware of the need to see victims alone and to make direct enquiries regarding potential abuse.**
- **To review practice in DV cases where there is serious injury, to ensure that policy is being adhered to and that consultation with CPS is occurring.**

4.3 **Northumbria Healthcare NHS Foundation Trust (NHCFT)**

4.3.1 The NHCFT IMR highlighted that Martin was a regular user of the departments and wards within NHCFT. Prior to the time period specified in the terms of reference the IMR author identified 68 attendances from 1990 to the end of 2010 which were thought to be relevant to the review, i.e. indicative of a risk of harm to Martin. Subsequently, within the four years covered by the review there were a total of 56 attendances. There was noted to be a rise in attendances in 2007/2008, 2011 and again from 2013 to 2014. In considering the issues presenting at these attendances the IMR author identified four areas of vulnerability, namely, alcohol abuse, housing issues, mental health/self harm issues, and other evidential factors.

4.3.2 As regards Martin's alcohol use it was identified that he attended NHCFT on a significant number of occasions in relation to alcohol abuse. As a

consequence, on the majority of attendances Martin was supported with overnight stays and withdrawal regimes, as well as provision being given to his personal hygiene. The appropriate protocol and procedures with regards to alcohol withdrawal were managed and supported by the Clinical Institute Withdrawal Assessment scale revised version (CIWA) [3]. In addition, associated symptom control, medication, vitamin replacement and hydration were provided.

4.3.3 Repeat admissions made note of the on-going contact with alcohol services and Martin was encouraged and signposted to seek further support from these services, and to seek referral from his GP to an appropriate detoxification programme. It had been referenced however, that at times he was not registered formally with a GP and therefore would not have been able to pursue this. On a number of attendances Martin was either referred to the Specialist Alcohol and Addiction Services, or declined such support, on a number of occasions stating that he already accessed, or was to access, the services (23/08/09, 27/12/09, 04/01/10, 01/05/11 and 07/04/13). He was also seen by a specialist Alcohol Service within NHCFT whilst an inpatient in June 2014.

4.3.4 In addition to his alcohol use, Martin had on sixteen occasions reported that he was either homeless, sleeping rough, staying with friends or of no fixed abode. The IMR author identified two key incidents within the review period (13/05/11, 13/03/14) where Safeguarding Adult referrals were made; although in the former case this does not appear to have been recorded as a referral by Adult Social Care but was seen as advice given by telephone. The IMR author identified no further evidence, apart from the occasions summarised above, that there was any information or support given to Martin around seeking help to find accommodation. It was identified that the actions taken in the cases where this did occur were indicative of good practice.

4.3.5 As regards Martin's mental health, he had accessed NHCFT on thirteen recorded known attendances in relation to incidents referencing Mental Health and/or Self Harm. Two of these occurred as early as 1990 and 1992. Following this in 2007 there were four recorded attendances to NHCFT in relation to overdose. In 2011 a code was added to Martin record on the Patient Administration System (PAS) - Alert Code 32 – Self Harm. NHCFT Staff that accessed PAS would be able to see this code when using the system. The IMR identified this as an example of good practice.

4.3.6 On 08/06/14 Martin was brought in to A&E at by Police. Whilst Martin was an inpatient at NHCFT he admitted to have taken an overdose of non-prescription drugs. Martin stated that he felt 'a threat to himself and others' and that he felt 'like walking in front of a bus'. Martin also made reference to having anxiety and depression. An account was recorded which made reference to Martin's girlfriend (likely to be Ms L) stating that she wanted

[3] The CIWA is a validated assessment tool used for alcohol withdrawal and is also recognised within the current NICE guidelines for Diagnosis and Clinical management of alcohol related physical complications.

more mental health support/ inpatient assessment for Martin. Martin was seen by the Self –harm Team (NTW) and it was recorded that his partner Ms L was also in attendance at this meeting. Martin had been recorded as stating that he had no self-harm issues or thoughts of suicide and that he was 'feeling brighter' and no suicidal ideation. Martin was discharged home with no further involvement from the self-harm team, although he was recorded as having engagement with Insight Healthcare and there was an assurance that a follow up appointment had been made.

4.3.7 In addition to the issues around alcohol use, housing issues and mental health, Martin's contact with NHCFT provided some information regarding his relationship with Ms L, and potential concerns of abuse and violence. Within nine of Martin's attendances in 2013 and 2014 there is reference to contact with Ms L (not necessarily named). In addition, throughout this period he often presented with different trauma injuries or symptoms. An example of this is that from 08/03/14 to 13/03/14, over five concurrent day accounts, he attended A&E six times with different trauma injuries or symptoms. He gave different explanations for each injury and it was documented that Martin was not deemed to be a good historian, as he was changing information constantly. The IMR author stated that it was inconclusive as to whether Martin had been subject to domestic abuse or whether the injuries had been caused through self-inflicted behaviour linked to alcohol use and self-neglect. There is no evidence however that the injuries were queried. The causes and reasons that Martin had given previously may have been plausible accounts given that on almost all of the occasions he attended hospital he was under the influence of alcohol, or he had been found in various locations where it had been clear that he had fallen or caused himself injury. This may have led to an assumption being made about his injuries and a consideration of risk or potential domestic abuse was therefore not undertaken.

4.3.8 Specific incidents in relation to Ms L were also identified. Firstly, on 12/03/14 when arrangements were discussed for the Patient Transport System to take him to his home despite him saying that 'he does not want to go there'. Martin had also stated that he had a 'big fall out' with his partner and felt he could not return home. On this occasion Martin then left the A&E department, and it remained unclear as to why he had felt he could not return home.

4.3.9 On 6/05/14 Martin attended A&E stating that he had a fall and been injured, noting it as 'bump to his head'. It was also however documented that Martin claimed that his 'partner punched him in the shoulder today'. There was no record of any further exploration of this or assessment around domestic abuse. At this stage the IMR author felt that the Multi Agency Risk Assessment Conference DASH risk assessment checklist would have been appropriate to use. The Safeguarding Adults process could also have been considered and discussed with the patient.

4.3.10 Within the above incidents the IMR author deemed that the gender of the victim may have had an overall influence on the response from NHCFT staff

in not considering Martin as a potential domestic abuse victim. However, the author noted that based on Martin's history, with reference to his presentation to A&E and his dependency on alcohol, it was difficult at times to ascertain the cause of injuries or to take a detailed history.

4.3.11 It is following the above disclosures that on 08/06/14, as already discussed, Martin was seen following an overdose and his girlfriend, in hindsight believed to be Ms L, was reported to be present throughout discussions around support. It was recorded that there was some discrepancy between what Martin had told the staff and the information from Ms L. Mediating protective factors that were compiled as an outcome of the assessment stated that both Martin and Ms L were very positive about the discharge plan. The presence of Ms L throughout this contact can be seen as concerning in light of the proximity to the previous incidents in which Martin had expressed concerns and disclosed domestic violence.

Conclusions regarding NHCFT's involvement

- The IMR author for NHCFT concluded that the information reviewed gave a 'depiction of a man that was potentially vulnerable and possibly isolated from the wider community'. There were an extensive number of emergency hospital admissions for problems associated with alcohol dependency, and for injuries where he had presented with seizures or where he had been under the influence of alcohol. From an organisational perspective, the IMR author did not deem that any of these aspects prevented Mr Martin having the same access to healthcare services afforded to any member of the public. Protocols and procedures in relation to his alcohol abuse were followed and there were some examples of good caring practice, communication, collaborative working and appropriate engagement of specialist and external services from NHCFT.
- Despite the good level of response identified in relation to presenting health needs, it was identified that there were only two referrals within the time period of the review to Safeguarding Adults despite Martin's high level of vulnerability. Had the Safeguarding process been enacted this may have resulted in a multi-agency approach that could have utilised agencies outside of the Accident and Emergency arena. The IMR author also identified that this may have also resulted in a reduction in attendance at A&E department.
- The IMR author also identified that evidence that was available for this DHR did not offer a reliable basis for any retrospective judgment on whether or not Martin had possessed or lacked capacity and whether his ability to make informed decisions about his accommodation status or leaving the department was considered under the MCA (2005).
- Two incidents were identified when Martin should have been identified as a potential victim of abuse and further exploration or assessment should have taken place.

4.3.12 In relation to the above NHCFT recommended that it be ensured that their staff are aware that when a male or female presents with injuries, or alleges they have been a victim of domestic abuse, the DASH risk assessment should be completed; that an alert will identify those people who have complex needs relating to alcohol and who are frequent attenders to NHCFT, facilitating access to specialist NHCFT support services; and that regular awareness raising take places around Safeguarding Adult procedures.

Further recommendations for NHCFT as a result of this review:

- **To incorporate into the recommended alert system a prompt for Safeguarding referrals, where necessary, in relation to frequent attenders.**
- **To ensure that NHCFT's Safeguarding awareness raising and training includes and highlights issues around self-neglect related to alcohol use, mental health concerns, and housing issues; as well as the need, in cases where concerns around domestic abuse or violence have been identified, to try and see patients alone at subsequent attendances.**

4.4 Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)

4.4.1 Martin attended the Newcastle Upon Tyne Hospitals NHS Foundation Trust A&E department 76 times during the review period. Alongside these attendances there were 11 outpatient appointments and 14 episodes of inpatient stays.

4.4.2 On approximately fifty percent of the occasions when Martin attended A&E he was brought in by ambulance after being found collapsed on the street. During 2011 and 2012, records indicated he was homeless and 'sleeping rough'. During 2013, Martin's medical records with NUTH cite different addresses for him, however the records do not indicate the alleged perpetrator Ms L as his next of kin. Often he would be brought into A&E for a place of safety. On a number of occasions he left the department shortly after being brought in, and prior to being reviewed by the medical team.

4.4.3 In relation to Martin's attendance at A&E the IMR author noted approximately 90% of these were alcohol related. Martin sustained a number of injuries that appeared to relate to excess alcohol consumption. As with NHCFT, there is nothing to suggest these injuries were queried further.

4.4.4 During Martin's attendance at A&E on the 20/8/13, he was reported to be slamming his body against the wall stating that he "needs to bleed the evil out". On this occasion a referral was made to the Crisis Team who conducted a telephone assessment. This was one of the few occasions the Trust had to explore issues around his mental state. This resulted in a number of referrals to other agencies. He was again referred to the alcohol liaison service, the

fracture clinic and was also referred to his GP who agreed to arrange for him to access the counselling service. Ms L attended with Martin on this occasion, although she was only referred to in records by her first name. The IMR author noted that a review of the medical notes for both Martin and Ms L failed to highlight the nature of their relationship. Martin was not listed as the next of kin on Ms L's medical records, neither was she listed as his.

4.4.5 The author also identified 3 episodes when the victim alluded to issues with his partner. The first was on the 21/3/13 where he self-presented at A&E and advised that he had not taken his pain killers in two days as his partner had thrown away his medication. The notes around this report are vague, although it appears no attempt was made to explore the circumstances around this. This could have potentially provided insight into his vulnerability within the relationship and was a missed opportunity. There was also no documentation of a risk assessment being undertaken. On this occasion he was referred back to his GP for a review of his medication.

4.4.6 On 25/4/13 Martin again attended the A&E following a fall where he had sustained a fractured humerus. The medical notes indicated that his partner Ms L was also in attendance and reported to staff that she was struggling to cope at home as Martin was intermittently confused. He difficulties coping do not appear to have been explored further with her. Following an examination by the medical team, it was felt that Martin was not confused and therefore did not warrant a psychology referral. The team did refer to Plummer court and Martin was advised to re-engage with their services. Again, the IMR author noted that this was another lost opportunity for staff to explore issues at home, which could potentially have highlighted areas of risk. The third episode occurred on the 6/9/13 following another self-presentation at A&E when Martin reported home was stressful at present but no attempts were made to explore the reasons for such stress.

4.4.7 In considering the above, the IMR author identified that as staff were understandably focused on the physical needs of the patient this may have impacted on the cues above being missed. The author also felt there was no indication from the information held that gender issues had an impact, although this cannot be conclusively identified.

4.4.8 The IMR author identified that between March 2012 and December 2014 a pilot project was in place in which an IDVA (Independent Domestic Violence Advocate)[4] was located within the hospital. This was put in place to follow up identified victims of domestic violence and offer them specialist support. This service could also be extended to victims who disclosed domestic violence elsewhere in the Trust's hospitals, and where consent was obtained from patients to meet with or be contacted by the IDVA. The IDVA was in post when both Martin and Ms L attended the A&E, and Martin made the above

[4] The IDVA was employed by victim support and seconded to the Trust.

disclosures, which could be seen as potential indicators to trigger further enquiry around domestic abuse. An interview with the senior charge nurse in the A&E suggested that knowledge of MARAC within the A&E was limited during the period of review and that while some staff in the A&E received domestic violence training, awareness was not as embedded as it is now. The IDVA appointment led to further training around the use of the domestic violence assessment tool, which is now felt to be embedded in practice in the A&E.

4.4.9 The IMR author noted that the Trust does have a policy in place with regards to domestic violence/abuse, as well as readily available information for staff with regards to Domestic Violence. These are located within the dedicated Safeguarding Adults and Children's intranet pages and are easily found. This page also contains the referral forms (IDVA, Cause for concern, MARAC) as well as training programmes for domestic violence. The contact details for key personnel within the Safeguarding Team are also included here, as well as links to interagency policies.

4.4.10 The Adult and Children Safeguarding Teams are also available to provide advice and support for staff. Once staff undertake the relevant safeguarding training they are given a credit card sized information leaflet which also lists key contacts for the team. Staff are encouraged to carry this alongside their staff ID badges so the information is easily accessible at all times. The Safeguarding Service is accessed frequently by staff, and this is evidenced by the year on year increase in referrals documented within the Safeguarding activity dashboard. In addition, the organisation facilitates comprehensive training for Safeguarding Adults and Children at induction and afterwards at mandatory training updates. It was also identified that the existing Adult Safeguarding Policy contains a cause for concern form, which staff can use to raise issues of abuse/suspected abuse with the Safeguarding Team. It is not clear however whether this would also prompt consideration of self-neglect as a Safeguarding issue.

Conclusions regarding NUTH's involvement

- Similar to issues identified in relation to both Northumbria Police and NHCFT, Martin's multiple attendances at A&E and the issues of alcohol misuse, mental health concerns and housing, do not appear to have been considered in relation to his vulnerability as a whole. Thus no Safeguarding referrals were made during the period of his contact. The focus of most interventions centred on his excessive use of alcohol and associated injuries. While attempts were made to support Martin to reduce/eliminate his alcohol consumption, this may have lead to a narrowing of focus, impacting on a lack of consideration of the broader Safeguarding issues.
- There were three occasions on which further exploration could have taken place regarding the situation at home. On one of these, Martin disclosed a potential incident of abuse, in which his partner had thrown away his pain

medication. This was not picked up on or explored further, and domestic violence or abuse was never considered as potential issue.

4.4.11 The recommendations outlined within the IMR for NUTH included maintaining levels of awareness and training of domestic abuse/violence for staff within the organisation; considering the reinstatement of the IDVA within the hospital; working with the Local Authority to develop a business case for the provision of an IDVA within the hospital; maintaining and further developing the high level of awareness of the Safeguarding team who are available to offer support and advice to staff; and continuing to embed the development and understanding of partnership working with internal and external agencies which will enable the Trust to achieve best practice and outcomes for patients at risk of domestic violence/abuse.

Further recommendation for NUTH as a result of this review:

- **To ensure that NHCFT's Safeguarding training and documentation includes issues around self-neglect related to alcohol use, mental health concerns, and housing issues.**
- **To review training in relation to domestic violence and abuse and ensure that it includes explicit consideration of female perpetrators and male victims and the dynamics within this; as well as the need, in cases where concerns around domestic abuse or violence have been identified, to try and see patients alone at subsequent attendances.**
- **To consider use of an 'alert' system, as recommended in NHCFT's IMR, to identify patients with complex needs who are frequent attenders to A&E. This is in order to facilitate access to specialist support services and prompt, where necessary, Safeguarding referrals.**

4.5 **North East Ambulance Service (NEAS)**

4.5.1 NEAS located recordings of 49 contacts with Martin between September 2011 and October 2014. Crews attended from a variety of stations within the area where Martin was residing at the time, and a total of 94 staff had attended to Martin within the review period. 7 members of staff had attended on 2 occasions (some within the same shift) and 2 members of staff had attended to Martin on 3 occasions. On these occasions the IMR author noted that crews recorded 43 occasions where Martin was intoxicated or alcohol had been consumed; 38 occasions when he was found in a public place; 9 occasions when he was found to be living at a Hostel; and 29 occasions when he was of no fixed abode. The author noted that at each episode of contact by the crews with Martin an assessment was undertaken, and on the majority of these contacts Martin was transferred to either the Royal Victoria Hospital (33 times) or Wansbeck General Hospital (11 times). On two occasions the crews did take Martin home, when there was a known address for him. However, as the data above shows Martin was, on the majority of contacts, living 'on the street'.

4.5.2 Crews document on patient report forms that Martin was a 'known alcoholic' and 'regular caller', was found on many occasions in public places, and due to a history of epilepsy would be found either fitting or post fit when the crews attended. There are two incidents where Martin claimed he was assaulted. The first of these occurred in September 2011 when Martin reported that he had been forcibly ejected from a shopping centre by security staff, although this was found not to be the case on review of CCTV. The second incident, relates to 19/11/12 when crew were informed on arrival that Martin had been experiencing a continuous nosebleed for forty minutes and was confused. Martin claimed to have been punched, however the injuries sustained were not consistent with this explanation.

4.5.3 The IMR author noted that call handlers and the attending crews had not identified Martin as a vulnerable person as no Safeguarding referrals were located. The author identified that on 09/06/12 Martin advised that his mobility issue was due to self-neglect but this does not appear to have been explored further by the crew. In addition, a number of other incidences were identified where indicators of vulnerability were apparent. These include when he was noted to be 'doubly incontinent, generally weak, off legs, jaundiced and not eaten properly for approx. 6 days' (15/06/2012); 'sleeping rough and temperature recorded to be 33.4ºc' (11/01/13); 'on examination confused and very cold' (13/01/13); 'Martin soaked through due to weather conditions, cold to touch' (24/01/13); 'he is homeless, does not want to be on his own in case he has a fit/falls, bangs his head and dies' (07/04/13); and 'advises he is feeling confused and disorientated and not taken his medications for 3 days' (29/06/13).

4.5.4 As well as Safeguarding issues, the IMR author noted there was no record of a mental capacity assessment being undertaken on any of the contacts, or that the crews deemed him to have capacity. The author was therefore unable to clarify if an Assessment of Capacity had been considered or undertaken or to see any documenting of whether Martin was deemed to have the capacity for the decisions he was making around his own welfare. This is despite the crews noting on a number of occasions that Martin refused to be examined or to have hospital treatment.

4.5.5 As regards any indicators or disclosures of domestic violence or abuse, the author noted that there was only one reference to Ms L in the chronology and this was in relation to her seeking help for Martin after an alleged fall. No concerns were noted.

4.5.6 The IMR author identified that NEAS have an Adults at Risk Policy, first ratified in 2009 and reviewed annually. They also offer Essential Annual Training (EAT) programme for Safeguarding and this is being constantly reviewed and updated in line with local and national guidance and Legislation. Operational staff now receive Safeguarding training for both children and adults on an annual basis. Since the introduction of the Safeguarding Policy

and Procedures, the on-going EAT programme, and changes to the referral process, there has been an increase in the number of referrals being placed by the 999/111 contact centre staff and Operational crews. Crews will place referrals for General Welfare concerns linked to self-neglect, environmental or care assessment requirements. NEAS also have a Capacity to Consent to Examination or Treatment Policy. However, the lack of referrals in the case of Martin occurred despite such things being in place.

Conclusions regarding NEAS's involvement

- As with other agencies, Martin's contact with NEAS indicates him to have been highly vulnerable, yet there is no evidence of any Safeguarding referrals having been made. The IMR author concluded from the analysis of records that crews may have made assumptions regarding how Martin presented himself to them, often labelling him as being 'intoxicated' and a 'frequent caller'. This appears to have impacted upon the way his vulnerability was perceived and subsequently addressed.

4.5.7 The IMR recommended that action be taken to ensure staff recognise and consider the different types and patterns of abuse and neglect, especially self-neglect.

4.6 **Northumberland, Tyne and Wear NHS Foundation Trust (NTW)**

4.6.1 Martin and Ms L both had intermittent contact with NTW throughout the review period, with their last contact being 08/06/14 and 22/07/14 respectively. The IMR author concluded that referrals were received appropriately and acted upon in a timely fashion, although in both cases there was poor engagement and missed appointments. Ms L was given various diagnoses over her involvement, which may have been due to her presentation at the time. It appeared that Mental Health practitioners proactively encouraged both Martin and Ms L to engage in treatment and offered appointments as and when they were requested, even if a number of previous appointments had been missed. It was also evident that substance misuse had a major impact on their wellbeing, and practitioners recognised this in considering future care and treatment.

4.6.2 It only became evident that Martin and Ms L were in a relationship when Martin made a very brief statement in session in October 2012, and it was some nine months later before Ms L mentioned the relationship. Martin attended health appointments mainly on his own and on the two occasions Ms L did accompany him she was reported to have appeared supportive. No information was disclosed regarding domestic violence or abuse from the couple or from other agencies. However, there were concerns from Martin's sister, and it was also known that Ms L had a violent history.

4.6.3 A number of assessments were undertaken of Ms L during her contact with NTW and two of these occurred during the review period on 14/01/13 and 28/07/14. Both of these identify a history of historical violence, with information received from correspondence from probation services. The IMR identified it is usual practice to work collaboratively with other agencies and share proportionate and relevant information, which appears to have occurred by obtaining details of Ms L's criminal background from Probation service. However, the author felt that further information could also have been obtained by submitting a police disclosure form.

4.6.4 As regards the contact from Martin's sister, on 04/10/13 a call was received in which she expressed concerns that she thought her brother was a victim of domestic abuse from his current partner. Given this information the practitioner appropriately contacted NTW's Safeguarding Team who advised them to speak to Martin and consider completing the DASH risk assessment and if necessary making a referral to MARAC (Multi Agency Risk Assessment Conference). Martin did not attend his appointment that day so at the next appointment, on 10/10/13, the practitioner spoke to Martin alone; he denied any domestic abuse and stated he was happy and his relationship was fine. Following this the CPN discussed the concerns with both Martin and Ms L, and Ms L indicated 'family contact was not great and there was some conflict' but did not expand. As a result of these conversations Martin's CPN did not feel the completion of the risk assessment or referral to MARAC was necessary, as there were no indicators or disclosures from Martin.

4.6.5 The IMR author identified that as the primary role of these sessions was to address Martin's substance use, the practitioner appropriately sought and followed advice from the Safeguarding Team regarding the domestic abuse concerns raised by Martin's sister and did appropriately see Martin alone. However, due to the concerns raised by Martin's sister, the issue of domestic abuse could have been explored further and revisited with Martin at next appointment. This was particularly important given that, while Martin was spoken to alone, Ms L was waiting to enter the appointment and in such circumstances, where a perpetrator is in close proximity, this is likely to inhibit disclosure. Additionally, in the context of domestic violence and abuse, raising the concerns directly with Ms L could have resulted in increased risk to Martin or his sister.

4.6.6 The author identified that within the above response they did not feel that gender influenced action taken, and highlighted that training delivered to NTW staff shares the learning from other DHRs, which includes a previous review where the victim was male.

4.6.7 Finally in relation to this contact, the author highlighted that they could not see any communication to GP following the information received by Martin's sister, which would have been expected given the nature of the concerns.

4.6.8 As regards the call from Martin's sister on 25/10/13 the IMR author could see from the health records that Martin's sister requested to speak to the addictions worker, and upon being informed that the worker was not available said she was happy to leave a message on the answer machine. During interview the author discussed this with the addictions worker and he was unable to recall this message, and as nothing was documented he does not think he returned her call. There was no evidence to suggest Martin's sister rang again. The author has been unable to speak to the administration person who took this call to seek any further clarity on the nature of the call.

4.6.9 In relation to the above concerns expressed by Martin's sister it was evident throughout the health records, risk assessments and letters to GP, that historical assessments documented that Ms L posed a risk of violence or harm to others. This risk was assessed as greatly increased when she was intoxicated or emotionally aroused. In 2009 following a MARAC meeting it was suggested that Ms L be seen by two clinicians and this was documented in NTW's alert page on the electronic system; this has been usual practice since 2009 when a patient has been subject to MARAC, and the alert also states that a clinician can contact the Safeguarding and Public Protection Team for further information. This historical risk does not however appear to have been explicitly considered in relation to the risk posed to Martin. In addition, as already discussed, no police disclosure form was submitted, that could have obtained any more up to date information around risk. The IMR author felt this should be usual practice when information is available from other sources, or self-disclosed, regarding violence, aggression or criminal activity.

4.6.10 The IMR author confirmed that NTW have a Domestic Abuse Policy, last updated in 2013, that outlines the course of action if employees have concerns regarding domestic abuse. DASH Risk Indicator Checklists (RIC) are completed by staff across the organisation and are quality checked by the Safeguarding Children and Domestic Abuse Practitioners, to ensure the information is robust, and a decision is then made regarding next steps. If a MARAC referral is identified as needed, these are also quality assured prior to submission. Domestic abuse awareness is part of induction for all new staff into the organisation, in addition to ongoing training within NTW's training strategy. Bespoke training has also been provided to all Crisis Teams and Self Harm Teams within the organisation on domestic abuse, including how to complete a DASH Risk Indicator Checklist and making a referral to MARAC. At the time of writing this report the NTW was also delivering level 3 training in domestic abuse. It is therefore reasonable to expect staff, given their level of training and knowledge, to fulfil expectations in relation to identification and disclosure of domestic violence. In this case Martin did not make any disclosure of domestic abuse to NTW staff, and exploration of concerns expressed did not appear to warrant a referral to MARAC.

Conclusions regarding NTW's involvement

- While the information submitted by the victim's sister within her first call was responded to in a serious manner and acted on appropriately, this information should have been shared with the GP stating the actions and considerations of the CPN which could have prompted selective enquiry at Martin's next appointment with his GP. In addition, further exploration could have taken place with Martin at the next appointment with his CPN.
- There was limited evidence identified of historical information relating to Ms L being considered in relation to the potential risk posed to Martin. Furthermore, broader information to inform the risk could have been obtained by submission of a police disclosure form.
- While Martin was appropriately seen alone, the concerns of Martin's sister were subsequently also shared with Ms L, which could have placed Martin or his sister at increased risk.
- There was no evidence that the second call by Martin's sister was followed up on, which is of particular concern given the initial concerns she expressed.

4.6.11 The recommendations from the IMR include that 'police disclosure forms' should be submitted, when information is received from other agencies or self-disclosed regarding violence, aggression or criminal activity, to then contribute to the risk assessment; and that information regarding domestic abuse, and actions taken should be shared with the GP / primary care.

Further recommendations for NTW as a result of this review:

- **To ensure concerns of third parties are appropriately followed up on and that this information is not shared directly with those considered to pose the risk, unless this has been explicitly considered and discussed with the third party referrer.**
- **To ensure that historic risk information is explicitly considered and documented in relation to any current concerns and the decision making and actions that follow.**
- **To review procedures for risk assessment to ensure they include the need to identify and request information from all appropriate sources when completing/updating risk assessments. To sample completed assessments to clarify that this is taking place.**

4.6.12 In addition to their involvement with this DHR, NTW also undertook a Serious Untoward Incident Review. Within the actions arising from this it was noted that: 'This was a complex situation of a service user who had been transferred to Newcastle East CMHT, did not attend for a number of appointments and then moved area again to Northumberland'. It was concluded that this led to her not being managed as a transfer of care as she should have been, but treated as a new referral. In addition, it was recognised that as a result of the patient's disengagement with mental health

services there was a lack of continuity in service transfer arrangements between East Newcastle and Northumberland, and that advice offered by the team administrator, direct to the patient, was without reference to the clinical context of the patient. In order to address these issues, two actions were identified:

- When patients undergo a transfer of care, teams should ensure they follow the Trust Care Co-ordination policy. All Service Managers should ensure that their Community Clinical Managers discuss this in their team meetings and send copies of meeting minutes confirming this to Incident and Claims.
- The Trust should ensure that administrative staff have agreed protocols in place regarding pathway management, which should be agreed at the Safe group.

4.6.13 The SUI also addressed the fact that Martin's sister had raised concerns about Ms L potentially abusing him. The actions arising from the SUI review in relation to this were for the Addictions Governance Manager to clarify action taken by addictions following advice from Safeguarding and feedback to Incident and Claims; and for the Clinical Risk Manager to clarify with the Safeguarding team lead what would happen now and how risk information would be shared.

4.7 **Northumberland Clinical Commissioning Group**

4.7.1 As with other agencies, Northumberland CCG identified that both Martin and Ms L had longstanding mental health and alcohol issues. In relation to this, when issues presented to GPs both Martin and Ms L were referred promptly and appropriately to mental health services, although in both cases there were failures to attend appointments. The IMR author highlighted that the response of GPs to patients failing to attend appointments is complex and needs to take into account the vulnerability of the patient, the nature of the problem leading to referral, and any potential communication difficulties. In the case of both Martin and Ms L it was felt that the response of the GP was proportionate and appropriate. The IMR author for the CCG concluded that the management of both victim and perpetrator reflected good GP practice with frequent appointments, appropriate referrals and prescribing.

4.7.2 The IMR author also identified that mental health and substance misuse problems are promoted to GPs as issues that should prompt selective enquiry about domestic violence and abuse. This was not done in either case, but it was felt this was understandable in the context of very longstanding problems and referrals being made to mental health services, which would have had more time available to make comprehensive assessments. In addition, there were no additional indicators to GPs of domestic violence or abuse.

4.7.3 Martin consulted frequently and on all but one occasion he was alone. When Martin and Ms L were seen together on 10/01/14, Ms L appeared very concerned, and subsequently wrote a letter to the GP (06/02/14); this included a signed consent from Martin regarding the sharing of information with Ms L. In the context of the prior joint consultation this was taken at face value as an indication of concern, and it is only with the benefit of hindsight that this can be seen as potentially indicative of coercive control and an attempt to exert undue influence within the relationship. The IMR author felt that in in the absence of other indicators, to have viewed it in this way would have required a degree of suspicion that is not typical of GP patient/family interactions. However, it was recognised that it may have been wise to discuss the letter with Martin when he was next seen alone, in order to confirm that he was indeed happy with it.

4.7.4 Ms L's history of violent behaviour was documented on her medical records summary but had not been picked up on by the GPs. Given the historical nature of these incidents, the fact that they did not involve Martin, and the confidentiality issues the IMR author felt that it was reasonable that they were not also noted on Martin's medical records. While it is good practice to document that someone is a victim of domestic violence, it is not normally recommended in the case of adults that records should indicate when their partner has a past history of violence. As partners may have different GP practices this would often be impractical. However, had this history been available to the GP working with Martin this may have resulted in Ms L's attendance with Martin and the signed consent letter for the sharing of information to be viewed differently, perhaps prompting further exploration with Martin.

4.7.5 As regards the issue of gender, the IMR author noted that among GPs there is a greater awareness of female victims, but training for GPs does include the fact that men can be victims too. The IMR author felt that there was no evidence that gender influenced the response of the GPs in this case.

4.7.6 Within the IMR it was also noted that Ms L clearly regarded herself as Martin's carer. Issues regarding this were mentioned briefly when she consulted on 13/05/14 but were not fully explored. However, this was understandable within the context of a single appointment that also included assessment of Ms L's physical problems. In addition a referral was made to mental health services, who would be expected to have more time to make a full psychosocial assessment including carer issues.

Conclusions regarding Northumberland CCG's involvement

- While mental health and substance misuse problems are promoted to GPs as issues that should prompt selective enquiry about domestic violence and abuse, this was not done in the case of either Martin or Ms L. While this can

be seen as understandable in the context of very longstanding problems and referrals being made to mental health services, the fact that a problem has existed for a long time should not preclude enquiry about domestic violence as it may be a new problem or at the root of longstanding difficulties.

- Carer issues were not fully explored with Ms L on 13/05/14. However, this was also seen as understandable within the context of a single appointment. The Care Act introduces new rights to carer assessments and it is important that primary care teams are aware of this and the referral route for an assessment by the Local Authority. Carer stress is a frequent problem, and although it is not known whether this was an issue in this case, it is important that it is looked for as it can on occasions lead to deterioration in relationships with various types of abuse occurring, as well as increasing risk in cases where abuse already exists.
- Ms L's history of violence was not known by the GP working with Martin, and therefore not considered in relation to Ms L's attendance at Martin's appointment or her subsequent supplying of Martin's signed consent to share his information.

4.7.7 The IMR recommended that the CCG recirculate to practices the exemplar policy and to promote its adoption; and remind practices of the importance of exploring carer issues and the role of carer assessments.

Further recommendation for Northumberland CCG as a result of this review:

- **To encourage practices to implement systems whereby when a partner or family member is requesting access to information, GPs cross reference with the individual's records where possible to ensure there are no concerns in relation to domestic abuse.**

4.8 **Adult Social Care (ASC), Northumberland County Council**

4.8.1 During the period of this review Adult Social Care for Northumberland received three Safeguarding alerts, two from Northumbria Police (05/06/11 and 11/09/14) and one from NHCFT (13/03/14).

4.8.2 The first Adult Concern Notification received from Northumbria Police centred on Martin's vulnerability due to alcohol misuse and injuries apparently sustained in falls. There was no mention of concerns about his relationship at that time. The response from Adult Social Care was to try to ascertain his whereabouts via police and GP records, but then to accept quickly that it would not be possible to make contact with him as he was no fixed abode. The issue of consent was also raised, as this had not been granted, and the case was closed.

4.8.3 Following this, an urgent alert was received from a Nurse Practitioner at the minor injuries unit on 13/03/14. It was recorded on SWIFT that '*On discussion (the victim) informed her that he could (sic) return to the home that she (sic) shares with his partner but he did not divulge the reason for this*'. The note was recorded on a contact note for a telephone call and went through the care management referral pathway, and not Safeguarding. The IMR writer spoke to the referral co-ordinator who made this recording and confirmed that this was a typographical error and should read that '*he could NOT (author's amendment) return to his home address but he did not divulge the reason for this'.* It was also recorded that the Nurse Practitioner had the benefit of knowing the victim '*for some time*' and is described as being '*concerned about him on this occasion as he appears vulnerable*.'

4.8.4 Martin had also given his mobile number and expected Adult Social Care to make contact, which infers he gave consent for the referral on this occasion. However, despite a number of attempts to telephone him on the mobile number provided, and letters being sent to various addresses no contact was made. There does not appear to be any follow up with the fracture clinic or GP to check that Martin attended appointments. The Social Care team did check for an update with the Nurse Practitioner who made the referral. The Nurse confirmed that in her opinion, Martin would be able to access support if he needed to, and the case was again closed without an assessment of capacity, care and support needs, or collation of multi-agency information.

4.8.5 It was not clear how much of Martin's failure to engage was due to his choice not to access social services, his chaotic and at times itinerant lifestyle, or the control and coercion exerted by his partner. The case was however closed when Martin failed to engage directly. His mental capacity to determine this choice was not formally assessed at this point and there is no recorded evidence that Safeguarding procedures or MARAC were considered. The IMR author felt that it would have been reasonable to expect these to have been considered given the knowledge and training available to practitioners.

4.8.6 Finally, the Adult Concern Notification submitted by Northumbria Police on 11/09/14 related directly to perceived relationship problems and risks associated with Ms L's behaviour, following police officers' attendance to concerns raised by Martin's sister. Within the notification it was clearly stated that there were concerns that Martin could be subject to duress from Ms L. He is described as being: '...*apologetic for her behaviour, but extremely quiet when (Ms L) was present and stopped talking altogether when she returned to the room. (Ms L) seems very dominant in the relationship and (Martin) appeared vulnerable and timid in (Ms L's) presence…. (Ms L) seems a dominant party in the relationship and was controlling of his behaviour even in the short time I was at the address'.*

4.8.7 There was no evidence from the Adult Social Care notes that Safeguarding measures were considered at this stage, nor corroborating information sought

from family. A call was made to Martin's mobile number and Ms L answered. It was not then clear from the notes who made the decision to conduct a home visit the following day. Given the concerns for Martin's safety, and the fact that Ms L had access to his phone, this was not unreasonable, as it would hopefully allow for an independent discussion with him.

4.8.8 On this occasion, more strenuous efforts were made to see Martin. The Social Workers involved visited twice, and were told by Ms L that Martin was not at home. They handed the situation over to the Emergency Duty Team (EDT) and requested that a further visit be conducted to ensure Martin was safe and well and to offer an assessment. When EDT also did not gain entry, they requested that the police visit to conduct a welfare check for Martin. This was duly undertaken (according to the notes this was after a delay of several hours due to operational pressures for Northumbria Police) and the feed-back provided was that Martin did not want to see a Social Worker.

4.8.9 The IMR author spoke to the EDT worker involved to confirm that it is normal practice for police to be asked to attend an address to check a person's welfare where there are concerns and Adult Social Care cannot gain entry. Once the person's immediate safety has been confirmed, the situation would ordinarily be passed back to day time staff who would be responsible for any follow up action the next day.

4.8.10 There appears to be no record of the rationale for the Team Manager's subsequent decision to accept the police's assessment of the situation, and Ms L's assertion that he did not want to see anyone. At no time was Martin seen on his own, to afford the opportunity to disclose any immediate concerns for his safety or to discuss possible alternative accommodation/refuge. The case was again closed.

4.8.11 The IMR author highlighted that records indicate that the risk assessment for Martin was conducted without considering the dynamic risks and interplay associated with Ms L's mental health and previously violent history. The information held on mental health records was not sought/shared to facilitate a comprehensive assessment of the situation. There was no compilation of a risk assessment in relation to Ms L, which may have led to recognition that a multi-agency framework was needed either through the MARAC or Safeguarding Adult procedures to help protect the victim.

4.8.12 At the point of the final case closure in September 2014, a multi-agency Safeguarding assessment/meeting might have been convened to consider all of those factors, but this did not happen. At this point, information would potentially have been available from a range of different sources, e.g. GP records, NHS hospital records, Police, Social Care records, Mental Health records and family members, but there is no evidence to suggest that there was an attempt to collect this information or to bring this information together. Had the information been pooled, it would have potentially identified that the

victim was at increasing risk and led to consideration of other measures that could be put in place to help safeguard him.

4.8.13 It is of note that in relation to all the above contacts, Martin was at no point seen by Adult Social Care staff, to allow the opportunity to express any concerns or obtain his wishes and feelings. While there was evidence that several efforts were made to engage the victim in a community care assessment of his needs, it is not clear whether these letters included signposting information, helpline numbers, details of voluntary organisations, or other support services available for people experiencing problems as a result of alcohol misuse. In addition, in the latter incident, strenuous efforts were originally made to see Martin, however there was then an overreliance on the results of the police welfare visit. The issue of limited capacity due to alcohol dependence, or the undue influence and psychological abuse he could be vulnerable to as a result of his addiction, does not appear to have been thoroughly considered at any point.

4.8.14 The IMR author felt that there was a possibility that there was less professional curiosity into the potential for domestic violence at the point of referral because the victim was male. The victim was not seen alone at any point to assess the undue influence he was under or the risks he faced, and yet it was identified that this would normally be a priority in domestic violence cases involving women.

Conclusions regarding Adult Social Care's involvement

- There is no evidence that further Safeguarding procedures or MARAC were considered in relation to any of the three alerts received by Adult Social Care. Such consideration could have been given following referrals in March 2013 and September 2014
- The case was closed without Martin being seen by Adult Social Care staff on any of the three occasions, and this further resulted in no assessment of his capacity to make this choice, having been undertaken. On the latter occasion in September 2014 there appears to have been an overreliance on the welfare check completed by police, despite Martin not having been seen alone during this. In addition, despite the concerns, there is little documentation around the decision to close the case and no evidence of any broader information collection or the undertaking of a robust risk assessment to consider the needs of Martin and the risks relating to Ms L.

4.8.15 In addressing the above, the IMR for Adult Social Care recommended that improved documentation should be developed to support decision making, particularly in relation to case closure where risks are potentially high and the person's capacity to make decisions is unclear. In addition, it was recommended that the supervision and training framework for adult social

care staff should include clear guidance in relation to management of complex cases, domestic violence and case closure.

Further recommendation for Northumberland Adult Social Care as a result of this review:

- **To ensure that the guidance recommended also stresses the need to identify and collate relevant information from a broad range of sources to inform risk assessments of both victims and potential perpetrators.**
- **A protocol should be developed by Adult Social Care for joint visits to be undertaken with Police in cases where an adult is or may be at risk of abuse and/or neglect and Adult Social Care staff have been unable to gain entry.**

4.9 **Northumbria Community Rehabilitation Company**

4.9.1 The majority of Ms L's contact was with the Northumberland Probation Trust, prior to it becoming two organisations on 01/06/14, after which time she was supervised by Northumbria Community Rehabilitation Company (CRC).

4.9.2 Ms L was subject to four periods of supervision. The first of these was from 24/09/97 to 23/03/99, when she was made subject to an eighteen month Community Rehabilitation Order for Theft. She was then further supervised between 26/01/09 and 26/01/10, following her sentence to a twelve month Suspended Sentence Order for Section 47 Assault against her mother. Subsequently from 03/06/10 to 02/06/11 Ms L was supervised under a twelve month Community Order with one requirement of Supervision, for an offence of Assault PC. Finally, from 19/09/13 to 18/09/14 she was sentenced to a twelve month Community Order with the requirement of Supervision, following her conviction of Section 39 Assault against her neighbour. It is during this latter sentence that the first reference to her relationship with Martin is found in case records.

4.9.3 As regards the overall management of Ms L's Community Orders the IMR author noted that she was seen on a regular basis and that the frequency of contact was generally in line with National Standards. In relation to her last period of supervision, which commenced in September 2013, the frequency and consistency of contact with Ms L reduced in the last four months of her Order. She attended as instructed on 26/06/14, and was not then seen during the remainder of her Order. Her Offender Manager (OM3) had to cancel an appointment that had been arranged for 31/07/14 and instead spoke with Ms L by telephone, agreeing it would count as a contact. This can be viewed as acceptable practice when cases are stable and nearing the end of their supervision. Ms L next appointment was arranged for 29/08/14, which she failed to attend. OM3 tried to contact her by telephone without success. She was not offered any further appointments and the Order then terminated on

18/09/14. The expectation at this stage of a twelve-month Order, where there are four months remaining, would be a minimum frequency of monthly appointments. This is usually based on evidence of progress on the Order, the offender demonstrating stability, and no particular areas of concern to address. Given Ms L's mental health problems, alongside concerns at that time as to whether she was engaging fully with mental health services, and the support she required with her tenancy, more frequent appointments should have been considered.

4.9.4 The IMR author met with OM3, who had been managing the case during this latter part of the Order, due to the split in the organisation and OM2's move to a different office. OM3 expressed some concern that as a Probation Service Officer (PSO), and not a qualified Probation Officer, she had been allocated the case. This concern was due to Ms L's mental health problems, and the previous allegations of domestic abuse. However, OM3 went on to explain that she would have raised any significant issues with her Team Manager or a colleague.

4.9.5 Due to her long standing mental health problems, Ms L's case should have been managed by a Probation Officer as per the organisation's guidance on role boundaries. However, the allocation to a PSO was undertaken within the context of the split and a significant number or case and staff moves. There is existing guidance on the allocation of cases, which Team Managers adhere to.

4.9.6 In addition, to the above issue around supervision, records do not document a handover when the case was transferred from OM2 to OM3, which took place within the same office. However, OM3 described how she met with Ms L prior to taking over the management so had an over view of the case. What is missing is evidence of a clear and consistent plan of how the case would be managed once transferred to OM3, other than to keep things 'ticking over'. It is unfortunate that Ms L had to have a second change of officer so soon after the case being transferred to Ashington. This was as a consequence of the split into two organisations, and staff being moved to different offices. At the time there were many cases being transferred between officers and staff moves. Notwithstanding, Ms L's case management and transfer should have involved a structured three way meeting with the two OMs in order to share information about the case, ensure continuity of case management, agree plans for the remainder of the sentence, and enable Ms L to be part of the process.

4.9.7 In relation to the frequency of contact with Ms L, OM3 asserted that the minimum frequency of appointments she arranges for her cases is monthly, with occasional phone contact permitted in appropriate cases. She describes how when she was allocated Ms L's case she had also 'inherited' 40 new cases and was having to split her time between two offices. By her own admission, she allowed this case to 'slip' and acknowledged that she should

have offered further appointments towards the end of her Order. Notwithstanding, OM3 stated that during her time supervising Ms L no concerns were raised about the relationship with Martin, or any deterioration in her behaviour noted. She did not present with any problems and there appeared to be no changes in circumstances. OM3 also described Ms L as quiet and consistent during contacts.

4.9.8 Throughout her supervision Ms L's mental health appeared to be a significant focus. There was evidence of liaison with GPs and mental health services throughout. A flexible approach was taken with her in terms of re-arranging appointments and accepting absences due to Ms L not feeling well enough to attend. Enforcement action was also taken due to non-compliance on Orders. During the most recent Order OM1 was pro-active in trying to obtain information from Mental Health professionals, and arrange the relevant appointments on behalf of Ms L.

4.9.9 Throughout her time on community sentences, recording refers to Ms L attending some supervision sessions with her own agenda, which reduced the focus on offending related factors. However, during her last period of supervision there were no current concerns known about domestic abuse or her relationship with Martin and, given the amount of time that had lapsed since the allegations of assault of P7, the need to explore domestic violence specifically with Ms L during supervision was not assessed as necessary. However, exploring her behaviour within relationships was considered and the focus of her sentence plan was firstly, to increase skills in dealing with others/difficult situations, and adopt strategies to manage these; and secondly, increase awareness of de-stabilising/self-harm triggers, by monitoring of her mental health and by Ms L accessing support from the CMHT, co-operating with assessments, keeping appointments with them, and requesting that her medication be reviewed by a Psychiatrist. This sentence plan was felt by the IMR author to be appropriate to her risks and needs as known at the time. A review of the sentence plan was carried out by OM1 in February 2014, and refers to work being undertaken on victim empathy. The objective of increasing skills in dealing with others/difficult situations was removed from the review plan. The explanation offered for this was "undertaking work in examining her offending behaviour has been difficult given that Ms L does not accept responsibility for her actions and blames the victim." The review goes on to describe how Ms L was of the opinion that she handled the situation (index offence) appropriately and did not see any point in doing any work on "dealing with difficult situations". The IMR author highlighted that addressing offending behaviour where the offender has been found guilty after trial, and is continuing to deny the offence, can be very difficult.

4.9.10 As regards Ms L's history of violence and assessment of her risk in relationships, an assessment completed in February 2009 for the start of her first Community Order identifies Ms L's mother, P7, future partners and close

friends, staff in the criminal justice or mental health system, and the public, as at medium risk of harm. The nature of the risk is described as verbal abuse, intimidation and threats, physical abuse and aggression. The assessor felt that alcohol, non-compliance with medication, dwelling on issues, becoming angry, and reacting negatively to people, were factors that increased the risk of harm. This assessment acknowledged that Ms L was charged with Section 39 assault against her partner, P7, in November 2008 but the case was dropped. At the time she was also subject to police bail for an offence of Section 18 assault against the same partner. The non-disclosed section records feedback from a MARAC meeting held on 22/01/09. This stated that there had been five reported incidents of domestic abuse against P7 by Ms L in the previous six months, including the incident where she was alleged to have stabbed P7 in the arm with a kitchen knife. There were also counter-allegations of violence towards Ms L by P7, and they were described as inter-dependent on one another. Her mother, the victim of the index offence, also described being terrified of Ms L.

4.9.11 Following the above, Ms L was due to appear in Court in May 2010 and had a pre-sentence report prepared. This associated assessment refers to the two alleged assaults against P7 and identifies him and future partners as potential victims. It goes on to state that she has reconciled with her current partner and they are living together again. The assessment does not specify who this partner is, but case records refer to her partner at the time as being P9.

4.9.12 When she was sentenced to the Community Order in June 2010, the same information in relation to alleged assaults against P7, and that she had returned to live with her partner, is carried forward. An OASys review assessment completed in October 2010 then details accommodation problems she was having in relation to neighbours. She reported being assaulted, having her door kicked in and her car tyres slashed. The relationship section stated that her current relationship appeared to be stable. The emotional well-being section offered a comprehensive view of Ms L's mental health and associated difficulties. It describes a long history of psychiatric problems, a mental health admission in 2008, auditory and visual hallucinations, feelings of paranoia, and struggling to work out what is real and what is imagined, which could leave her feeling panicky and aggressive. Ms L described herself as having schizophrenia, but the assessment states that there is no verification of this on probation records, and the last contact with a psychiatrist indicated that she had borderline personality disorder and her poor engagement with treatment had exacerbated her problems. The risk assessment concluded that she was a medium risk of harm to staff and known adults. P7 and possible future partners are identified as potentially at risk, but her partner at the time (P9) was not. He was described as providing a 'positive support'. It is of note however that in January 2011, Ms L is recorded as having admitted within a supervision session that she loses her temper with him and can 'lash out at him'. There are no actions documented in response to this reported behaviour. It also appears that the CRC and the

Offender Manager completing the assessment were unaware of the significant number of call outs relating to P9 from 06/08/10 to 27/08/11. Even without this information however it is unclear as to why, given Ms L's history, and the assessment of her being a risk to future partner, she would not be considered an ongoing risk to P9. At the point of termination of this Order, Ms L reported that the relationship with her partner was over and she was no longer living with him.

4.9.13 For the Community Order made on 19/09/13 an assessment was completed by OM1, and indicated that her partner Martin lived in a caravan parked outside her home. Ms L reported that she hoped to save enough money for a deposit so that she and Martin could move in to a new property together. Overall, she was assessed as presenting a medium risk of harm to the public, staff and known adult (her neighbour). The circumstances identified as likely to increase the risk of harm were if Ms L's mental health were to deteriorate, during conflict situations where she perceived provocation, when under the influence of alcohol, if she had contact with her mother, disengagement with mental health services or non-compliance with medication. OM1 asserted that Ms L should be seen on a weekly basis, and once an assessment has been completed by the CMHT, liaison was to take place with the allocated CPN to discuss and agree contact.

4.9.14 OM1 then completed a review assessment on 06/02/14, which reflected Ms L's move to Bedlington. The move to a new area was viewed as positive as it was away from her neighbour, who was the victim of the index offence, and the relationship with Martin was described as supportive.

4.9.15 The final assessment was completed on 18/09/14 by OM3 to mark the end of her Community Order. It confirmed that Martin was still living nearby in a caravan, the relationship remained supportive and he was not assessed as at any potential risk of harm by Ms L. It should be noted however, that she had last attended an appointment on 26/06/14, was spoken to on the telephone on 31/07/14, and then had no further contact with the CRC. Therefore, there was a lack of evidence of any active review of the assessment having been considered. OM3 explained that as no new information had come to light, she did not have anything to update or review. This is out of line with polices and guidance on reviewing assessments, as the completion of any assessment requires a full review of existing information, with updates applied and analysed where necessary. The fact that Ms L was seen only twice by OM3 prior to this termination assessment being completed, raises concern around the certainty and accuracy of the information. Based on what was known, Ms L remained assessed as a medium risk to the public, staff and the victim of the index offence. Her alcohol use, one of the factors contributing to her risk, did not appear to be problematic. Her mental health remained an issue for her and a focus of supervision, but it had not deteriorated to any significant degree. Prior to the Order being made in September 2013, she had not been subject to any probation services intervention since June 2011. Antecedents

show Ms L had one conviction during this period in February 2012 for Drunk and Disorderly, for which she received a financial penalty. This gap in her offending indicated that the risk of harm was not immediate, and that Ms L could remain offence free for a period of time.

4.9.16 Within this assessment there is no evidence of any risk being identified to Martin, this was based on no indicators or evidence at the time of any violence or aggression against Martin, and that the previous allegations of domestic abuse dated to 2008/2009. However, as already highlighted it does not appear that information relating to the domestic call outs in 2010/2011 relating to P9 were known. This information may have changed consideration of the potential risk posed to Martin.

4.9.17 The IMR author identified that there was nothing on case records or in interviews with staff that would confirm that the gender of Ms L had an influence on the response of the organisation or practitioners during her most recent Order. Although, in relation to Ms L's report in January 2011 that she had 'lashed out' at her partner P9, the IMR author concluded that as it was not possible to speak to the OM from that time it was 'impossible to state this was due to Ms L's gender, or what (if any) action may have been appropriate'.

4.9.18 Finally, the IMR author also identified areas of effective practice in the management of Ms L while subject to community supervision. OM1 conducted a home visit the day after she learnt that she had moved to a new address, and met with Martin during the two home visits she undertook. While these actions are not specified in national standards which govern levels of contact with cases, it is considered good practice to home visit when an offender moves to a new address, and to meet with any new partner who becomes part of their life. Following the home visits and the agreed transfer to Ashington, OM1 arranged a handover meeting with Ms L and OM2. OM1 attempted to focus some supervision sessions on Ms L's offending and related risk factors. This was despite her being found guilty of the offence after trial and maintaining her innocence throughout the duration of the Order, as well as expressing the view that "probation was a waste of time". There were numerous attempts made to liaise with mental health services with the purpose of sharing information, and encouraging attendance and compliance with services by Ms L.

Conclusions regarding Northumbria CRC's involvement

- The frequency of appointments offered and level of contact with Ms L was inadequate during the last four months of her Order, which culminated in her not being seen for the last 3 months. During this time Ms L's her mental health continued to be problematic and there were issues with accessing services, and it had also been identified that she required support with her

tenancy. Alongside this was the fact OM3 did not have previous experience of supervising Ms L, and had not established a working relationship with her. Given these factors, she should have been seen more frequently in order to manage the case more effectively.

- Ms L's case should have been managed by a Probation Officer as per the organisation's guidance on role boundaries. The allocation to a Probation Service Officer took place within the context of an organisational split and resulting staff moves.
- Knowledge of Martin's existence only came to light at commencement of the Order made in September 2013. At no point during this Order were there any indicators of specific risk to him from Ms L. There was nothing legally in terms of her sentence that could have been done to prevent them being in a relationship. However, in relation to assessments completed it has been identified that the full extent of concerns regarding police call outs relating to Ms L's abuse towards partners was not known. In addition, it is unclear as to how assessments concluded no potential risk to current partners, including Martin and P9, despite the history of domestic abuse and a more history of violent offending, ongoing concerns regarding mental health, and the assessment that she may prove a risk to future partners. While no specific evidence was identified that gender impacted upon such risk assessments, this cannot be ruled out in terms of what appears to be a potential minimisation of Ms L's risk in relation to domestic abuse.

4.9.19 The IMR for Northumbria CRC recommended in light of the above that there were issues around the frequency and nature of contact with Ms L following the internal transfer of the management of her case. The recommendation is that the guidance for transfer of cases internally within the Northumbria CRC be reviewed, revised as necessary, and embedded in to practice. This will ensure consistency of service for offenders, and offender managers and team managers will be fully aware of the expectations when a case is transferred internally.

Further recommendation for Northumbria CRC as a result of this review:

- **To review procedures for risk assessment to ensure they include the need to identify and request information from all appropriate sources when completing/updating risk assessments. To sample completed assessments to clarify that this is taking place.**
- **To ensure training in relation to domestic violence and abuse covers gender related issues and female perpetrators.**

4.10 **Insight Healthcare**

4.10.1 Between 01/05/14 and 28/10/14 Martin attended an assessment appointment and a further six sessions with a mental health CBT trained therapist at

Insight Healthcare. His initial contact suggested that he was not going to engage with the service, nevertheless exceptions were made to promote and achieve engagement. On various occasions Martin had cancelled sessions on the same day that he was due to attend and this would usually have led to discharge from the service after two instances. However in the case of Martin his ill-health was taken into account. Overall the IMR author concluded that staff 'went the extra mile' in facilitating access to the service and as a result, Martin evidently benefitted from treatment for his anxiety.

4.10.2 Martin acknowledged a long standing abuse of alcohol and he was actively seeking psychological therapy in order to support his maintaining abstinence. He reported that he had not used for more than three months (a requirement of engaging in psychological therapy treatment with Insight's service) and the practitioner involved had no reason to suspect that this was not the case. The practitioner was given to understand that Ms L was also abstaining from alcohol use during this period of Martin's treatment.

4.10.3 Martin had described to the practitioner how he had met Ms L in a hostel and she had been instrumental in supporting him to deal with his addiction to alcohol, reporting that she had stood by him in spite of having seen him at his lowest. No disclosures, or indicators, of abuse or coercive control were identified by the practitioner with whom Martin was working. While Martin did present with injuries, including broken limbs and bruises, these were openly discussed. While it may be possible that Martin's injuries were sustained at the hands of Ms L, there was nothing known to staff at the time to give rise to this suspicion. It was believed these were consistent with Martin's report of having 'brittle bones' and other heath difficulties.

4.10.4 On two occasions during his contact with Insight, Ms L cancelled appointments on Martin's behalf. This appeared as a supportive action, and was consistent with Martin's statements that he had been in receipt of hospital treatment. It is Insight's policy to accept cancellations by a third party for the client's convenience in such circumstances, however, the client is always requested to contact the service to confirm that they wish to attend a further appointment. This also occurred with Martin and there was never any indication of his being prevented in accessing the service.

4.10.5 On occasions Ms L also met Martin at the end of a session and assisted him with mobility issues. On one occasion she was introduced to the practitioner working with Martin and thanked him for the work he was doing. The practitioner also reported that at the end of one session, since it had finished later than Martin anticipated, he telephoned Ms L to inform her that he would be late and indicated that she would be concerned about him.

4.10.6 On 12/08/14 Ms L also contacted the service seeking to talk to the practitioner working with Martin, and stated to the administrator that this was about their relationship difficulties. The practitioner made several attempts to

contact Ms L but his calls were not answered. The IMR author outlined that had the practitioner been able to talk with her he would have communicated the strict confidentiality policy and would not have discussed information unless there was a clear risk of harm to Martin or others. There was no reason to believe this was the case and Ms L did not seek any further direct contact. The session proceeded as planned and Martin did not raise any concerns.

4.10.7 Whilst the above incidents standing alone, could in no way be expected to prompt suspicion by the practitioner, in light of the information made available by this review, they can be seen as potential indicators of coercive control on the part of Ms L.

4.10.8 In Martin's final session, on 28/10/14, there was a discussion of how Martin would sustain the benefits that he had experienced through his treatment, including managing his anxiety. He had an understandable ongoing anxiety about his health, and also reported difficulties in his relationship due to Ms L's 'unpredictable behaviour'. However, Martin did not report this as violent or coercive, rather he spoke of Ms L's mental health. Martin sometimes referred to her condition as 'schizophrenia' and sometimes as 'psychosis'. Whilst being unclear of the diagnosis he discussed the impact. He reported that Ms L had been helping him to be more active but that her behaviour could be 'difficult' and unpredictable, in so far as she had not been consistently positive in helping him to maintain positive behaviours; he described her own motivation as variable. Martin found this difficult because he felt that could not rely Ms L's support. The focus of the session was around helping Martin to reinforce his learned coping strategies and to prevent a relapse of his anxiety. He stated that Ms L was in receipt of treatment by professionals and did not disclose any concerns around risk to himself. In light of this the IMR author felt that there had been no reason for Insight staff to take further action

4.10.9 In relation to gender, the IMR highlights that this was a considered factor in providing Martin with a male practitioner in the assessment. A member of staff believed there was a possibility that Martin's family had been known to her in a previous service, and she reported that there may have been a history of violence towards women. An appropriate check was made with the GP, who stated that there was no history of violence to his knowledge, although he did confirm Martin's long-standing abuse of alcohol and complex childhood history. While no violent history was confirmed, the precaution was taken to arrange for a male practitioner in the first instance, until the risk could be further assessed. This was a reasonable precaution and is a standard risk management measure adopted within Insight, where there may be informal knowledge that has not been corroborated.

4.10.10 Martin also stated during the assessment that he would prefer to see a male therapist as he described himself as a 'man's man'. He stated that he would be able to talk about himself and his emotions freely with a man, rather than

having to be careful with his choice of language in front of a female. This was a reasonable request and gender is an appropriate consideration in the provision of such psychological therapy which requires trust and openness in order for a client to engage fully with treatment. It was also appropriate that a male therapist arranged to conduct a face to face assessment to ensure that Insight was the appropriate service to address his needs. It was reported by Martin that he had been violent on occasions when he was arrested whilst being drunk and disorderly and he reported this was directed at the police. As his alcohol use was under control, this was not considered to be an active risk.

4.10.11 The IMR author identified that Insight has clear policies in relation to both adults and children at risk. Whilst the full DASH risk assessment is not used with clients, the indicators included within the assessment would trigger necessary processes for dealing with concerns being raised. In the nature of the treatment being provided by Insight it is not appropriate that the full DASH assessment would be conducted, rather staff would seek advice from the police and/or social services when concerns are raised.

Conclusions regarding Insight Healthcare's involvement

- The risk assessment and management processes used by Insight were effective and adequate, based on Martin's presentation and known history. Staff also took appropriate actions to establish the suitability of treatment by discussion with the GP and alcohol services.
- While in hindsight, a pattern of behaviour demonstrated by Ms L during Martin's contact with Insight is suggestive of possible coercive control, viewed in isolation and without the knowledge of Ms L's history or other indicators, it is not unreasonable that such behaviours were not considered to be indicators of coercive control or abuse.

4.10.12 The IMR identified that in light of this review, it would be useful to continue to provide awareness and training in relation to adults at risk of domestic abuse and violence for all staff. It was also recommended that it would be beneficial for responsible clinical staff in each service to be trained in the DASH risk assessment model with a view to assisting in seeking advice and triggering alerts.

Further recommendation for Insight Healthcare as a result of this review:

- **To ensure that the ongoing awareness raising and training delivered to staff explicitly covers issues of coercive control, particularly in a context in which partners and/or family members may present as providing support.**

4.11 Byker Bridge

4.11.1 Martin was resident at Byker Bridge House from 07/02/12 until 29/09/12. During this period Ms L also became a resident, on 05/06/12, staying until 07/08/12, when she was moved to a three person shared property managed by the organisation. She remained in this property until 23/11/12, having been asked to leave.

4.11.2 Due to the nature of the services provided, i.e. supported accommodation for single people, Ms L and Martin were always treated as two separate individuals rather than a couple, and the IMR author identified that they would have continued to be worked with as such even where a relationship was known to have been formed.

4.11.3 With regard to Martin, during his stay at Byker Bridge House the records show that staff made appropriate referrals to other agencies in relation to Martin's alcohol use, issues of self-neglect, and injuries sustained as a result of alcohol consumption. This included an appropriate Safeguarding alert being made as soon as staff suspected that Martin was vulnerable to financial abuse from another resident. At no point during Martin's stay at Byker Bridge House was any concern raised regarding him being at risk from Ms L.

4.11.4 Had Ms L presented as a management risk whilst resident at the hostel, she would not have been put forward for a transfer to another property. However following this move, visitors to Ms L's property began to cause disruption, and Ms L then became abusive towards staff and other residents. Although Martin was known to frequently visit Ms L's property, and was alleged, by other residents, to have been staying there during the disruptive incidents that took place, there is no record of him being harmed, or threatened with harm, by Ms L. Any recorded threats were between Ms L and other residents of the property and the police were called where appropriate, either by on-call staff or by other residents.

4.11.5 The IMR also noted that since the introduction of the Care Act from 1st April 2015, there is now a Safeguarding category covering self-neglect. Should a service user present with issues similar to Martin with regard to non-engagement, frequent hospital visits due to injuries sustained as a result of alcohol abuse, and the associated lack of self care, the IMR author felt that staff would now utilise the Safeguarding process in order to document their concerns and arrange a wider strategy meeting with the appropriate agencies.

Conclusions regarding Byker Bridge Housing's involvement

- An appropriate Safeguarding referral was made when there were direct concerns regarding financial abuse of Martin by other residents.
- There were no indicators of direct risk to Martin by Ms L. Steps to manage Ms L's risk to others were taken appropriately through involvement of the police.

4.11.6 The IMR for Byker Bridge recommended that should someone present with similar issues to Martin in the future they would utilise the current option to make a Safeguarding referral for self-neglect; and in future cases where they are providing support to individuals with a known history of being a victim or perpetrator of domestic violence, or where new concerns are raised, they would refer into the MATAC process. They have also already started to refer support staff to domestic abuse awareness training provided by Community Safety Partnerships.

4.12 Equality and diversity issues

4.12.1 As part of the review process consideration was also given throughout to issues of equality and diversity. In the cases of both Martin and Ms L, there were no specific issues identified in relation to race, religion, age, sexual orientation, or gender reassignment that were seen to be relevant to the review process. As regards the impact of gender, Martin as a male victim of domestic abuse, and indeed Ms L as a female perpetrator of abuse, have been considered throughout this report.

5 LESSONS LEARNED AND CONCLUSIONS

5.1 In undertaking this review a picture has emerged of Martin as an extremely vulnerable individual with extensive issues relating to his alcohol use, mental health concerns, and significant periods of homelessness. He presented frequently to a number of agencies and there has been evidence of good practice in addressing Martin's presenting needs and attempting to engage him in longer term support. However, despite the involvement of a variety of agencies, both statutory and third sector, there is limited evidence of a coordinated multi-agency response, appropriate to the high level of Martin's vulnerability.

5.2 Alongside the above, evidence has emerged of Ms L as someone who herself had issues related to alcohol use and mental health, previous victimisation, and an extensive history of violence, threats and aggression towards partners, family members, professionals and the public. As with Martin, there is limited evidence of any coordinated multi-agency approach to addressing her vulnerability or the risk she posed.

5.3 Martin and Ms L appeared to form a relationship in late 2011, and following this there are a number of points at which responses to presenting concerns did not fully consider issues in the context of the risk and vulnerability outlined above. While there has been no evidence to suggest that the tragic death of Martin could necessarily have been predicted, there was sufficient information available across all agencies, that had it been considered together would have indicated a potential risk of harm to Martin from Ms L. Therefore, while no definitive action was omitted that would have necessarily prevented his death, there are a number of areas where further exploration, intervention or response may have provided a greater awareness of Ms L's risk and Martin's vulnerability, and the interplay between the two. This may in turn have prompted a multi agency approach that would have allowed for more robust management of the risk.

5.4 Complex needs and a lack of identification of, and response to, Safeguarding concerns

5.4.1 Throughout Martin's contact with agencies it has been identified that he was an extremely vulnerable individual with complex needs relating to his alcohol use, mental health, and lack of stable accommodation. He also often presented with injuries, the source of which was not always clear. This presentation was particularly prevalent in his contact with Northumbria Police, NEAS and hospital services in both Northumberland and Newcastle. Despite multiple concerning presentations, extremely limited Safeguarding referrals were made within the time period of this review; five by police, one by hospital staff (and an additional call to Adult Social Care for advice), and one by Byker Bridge Housing.

5.4.2 No agency was able to categorically state why these concerns were not identified as requiring referral to Adult Social Care. However, it has been acknowledged that when dealing with complex presenting needs in often busy and demanding environments, this can sometimes result in a narrowing of focus through addressing the immediate presentation, thus resulting in missed opportunities to explore issues further, or view the wider context. This is an issue that has been highlighted in a national review of the common lessons learned within DHRs.

5.4.3 A number of agencies also raised that prior to the introduction of the Care Act 2014, issues which could be considered 'self-neglect' were not necessarily recognised by staff as appropriate for referral within the Safeguarding or Social Care arena. However, these had always been covered within Northumberland's Safeguarding Adults Multi Agency procedures. The importance of recognising and responding to self neglect is however further required since the introduction of the Care Act, and would apply across all Local Authorities.

5.4.4 In addition to the lack of referrals, Northumberland Adult Social Care also identified a less than robust response to the processing of the three referrals received by them, with limited information gathering, no evidence of risk assessment around Ms L, unclear documentation of decision making processes, and Martin not having been spoken to directly. Such a response resulted in Martin's case never having been considered in a Multi-agency Safeguarding meeting.[5]

5.4.5 In considering the above within Panel meetings the representative of Adult Social Care raised the concept of 'malignant alienation'. In expanding upon this the following information was supplied:

'This concept was first introduced by Morgan and Priest (1984) and was based upon their analysis of 26 unexpected deaths among psychiatric inpatients. They discovered that a significant number of patients who committed suicide lost support from others in the last few weeks of their lives. Staff became critical of these patients' behaviour, which was perceived to be provocative, unreasonable, and over-dependent. They named this process malignant alienation.

In the case of Martin, it could be interpreted that a general attitude of professional weariness had developed. He was presenting on numerous occasions, but proving challenging to manage and mainly dismissive of support offered by agencies. There was an apparent tendency for organisations to respond to immediate issues without investigating further or

[5] It is acknowledged that a one off Safeguarding meeting was held within the Newcastle area in response to specific concerns regarding financial exploitation from residents in the accommodation where Martin was staying. However, the case was then removed from Safeguarding due to the alleged perpetrators no longer living in the accommodation.

considering causal or underlying difficulties, and a sense of hopelessness developed in his case and a sense that his presenting problems were an inevitable consequence of his alcohol use and of his own choosing.

The fact that Martin had notable ongoing health conditions and a history of being the victim of a number assaults did not (generally) lead to professionals deeming it appropriate to refer him to Adult Social Care. When referrals were made, they were seen in isolation with limited attempts made to properly gather any wider information or assess risk through multi-agency collaboration. This may have been a further extension of the professional attitudes adopted by other agencies - that 'the person has capacity and is choosing to make unwise decisions, so there is nothing we can do'. That Martin appears to have been someone who was often difficult and unreceptive to help when he appeared, the cumulative impact of his presentations and behaviour could have resulted in a degree of malignant alienation as described above.'

5.4.6 The above explanation was mirrored in a number of agencies' IMRs where it was identified that Martin's repeated presentation may have impacted, not in terms of the immediate care he was offered, but in terms of staff having fully recognised the level of his vulnerability.

5.4.7 As a result of the above, recommendations for a number of agencies have arisen, both from within IMRs and within this report, for agencies to ensure that staff are aware of the need to recognise and appropriately respond to vulnerabilities relating to self-neglect, alcohol use, mental health concerns, and housing issues. While increasing awareness and enabling staff to know where to report concerns can be achieved, addressing the underlying and embedded issue of malignant alienation presents a greater challenge. It is recommended that following implementation of recommendations around training and awareness, agencies undertake random case sampling to ensure that increased awareness and changes in practice can be identified.

5.4.8 In order to assist agencies in understanding when to refer issues of self-neglect it was also identified with Panel discussions that Adult Social Care in Northumberland, Newcastle, and North Tyneside, are currently developing joint guidance for agencies in relation to thresholds of self-neglect.

5.5 Lack of information sharing and a multi-agency response

5.5.1 Despite a high number of agencies having contact with Martin and Ms L, most agencies were unaware of the breadth of agency involvement until the undertaking of this review. While there has been evidence of good liaison between certain agencies, it does not appear that any agency was aware of all the others with whom Martin and Ms L were working.

5.5.2 The result of the lack of recognition, referral and progression to a Safeguarding multi agency meeting, resulted in the closing of one avenue through which the broader picture may have been revealed. While it cannot be conclusively stated that this would have changed the tragic outcome, it may have resulted in a more coordinated and robust response to addressing Martin's vulnerability, and managing the risk posed by Ms L.

5.5.3 In addition, this highlights the importance of identifying other agencies involved and actively, seeking and sharing information to inform assessments, an area that is considered further in relation to risk assessments.

5.6 Recognition and exploration of indicators of abuse

5.6.1 It has been identified through this review that there were a number of incidents when practitioners either did not respond to, or explore further, disclosures of potential abuse, or indicators of such abuse. These included Martin's disclosure to NUTH staff that his partner had thrown away his medication (21/03/13), and that he was experiencing stress at home (06/09/13); reports to police by Martin that he would rather 'sleep rough' than return home as Ms L 'made his life hell' (25/01/13); disclosures to NHCFT that he did not want to return home (12/03/14) and that his partner had punched him he the shoulder (06/05/14). In addition were Martin's sisters concerns to police regarding Ms L's continued harassment of her and the resulting risk to Martin. In relation to these disclosures there can be seen to be a lack of professional curiosity to seek more information from Martin, and in the case of both the direct disclosure of an assault by Martin, and harassment by his sister, a lack of recognition and follow up to these as domestic abuse.

5.6.2 The response of staff must take into account the context in which they are working, and it is understandable, as already discussed that focus will be upon presenting needs and the primary role of the practitioner, especially in environment such as a busy A&E department. Despite this however this review has highlighted the importance, particularly in the case of individuals presenting with a high level of vulnerability, to be aware of potential indicators and to explore these further in order to try and gain a greater understanding of possible underlying issues. While Martin's response may not have resulted in any disclosure, the use of such selective further enquiry and assessment when indicators are present creates the opportunity to do so.

5.7 Issues of coercive control

5.7.1 There have been a number of occasions identified, particularly in the last eighteen months of Martin's life, when Ms L's presence at appointments, or involvement in Martin's contact with agencies, can be seen as potentially

indicative of coercive control. These include an incident when Martin was in hospital and Ms L attended drunk and refusing to leave (16/01/13); Ms L's request for a psychological assessment of Martin during his contact with NUTH (25/04/13); the telephone assessment undertaken by NTW on 20/08/13 when Ms L is reported to have spoken for Martin; her attendance at his GP appointment and subsequent presentation of a signed letter of consent granting her access to his medical information (10/01/14 and 06/02/14); her presence during Martin's inpatient treatment with NHCFT following an overdose, in which it was noted that she requested he have mental health support or inpatient assessment, and there was a discrepancy between what Martin had told the staff and the information from Ms L; Ms L's increasing attendances with Mr H during his contact with NHCFT (9 times throughout 2013/14); her attempts to discourage Social Workers' contact in September 2014 and presence during the subsequent welfare visit by the police; and the reports of her involvement during Martin's contact with Escape.

5.7.2 It should be stressed that with the exception of the contact with Northumbria Police and Adult Social Care in September 2014, the practitioners involved in the above did not have sufficient information available that they could have been expected to recognise the above incidents as potentially controlling. It is only in retrospect that Ms L's behaviour questionably becomes more than just the behaviour of a supportive or concerned partner. However, what can retrospectively be learnt from this is the importance of creating opportunities where it is possible to see people alone and being alert to individuals being 'spoken for' by others. Indeed, Martin's sister expressed this as a concern at the outset of the review, that Ms L had been presented herself as a carer for Martin and in doing so denying him to speak freely about the abuse he was suffering. Within the above there are a number of incidents when Ms L was seen to speak for Martin, either through cancelling appointments, requesting information or requesting further assessment. While it is of course important to ensure that the voice of genuine carers is heard, this must of course be balanced with the need to hear the voice of individuals themselves. Whilst in his contact with his GP and Insight Healthcare, Martin was also seen alone on most occasions, it can be seen that in the hospital appointments outlined above and in the contact with Adult Social Care and Northumbria Police in September 2014, this opportunity did not occur.

5.7.3 The specific learning that emerges from this for individual agencies has been outlined and recommendations made, but it also highlights an overall need for all agencies to be aware of issues of coercive control and the need to ensure that in situations where a carer may be present it is important to ensure that people are still seen alone to create opportunities for disclosure. This learning has also been identified within a number of other reviews that have taken place regionally.

5.8 **Recognition and assessment of risk posed by Ms L**

5.8.1 In addition to the issues relating to Martin's vulnerability, a further emerging theme is a failure to fully recognise or assess the potential risk posed by Ms L. While there were no specific incidents of abuse towards Martin by Ms L that would have indicated him to be at direct risk, her history of previous violence and abuse towards partners and family members was indicative of the potential for serious harm. This risk was also increased by Martin's level of vulnerability. Within the review it has been identified that there were a number of instances in which this risk was not explicitly considered, or where full information from all available sources was not sought.

5.8.2 This can be seen as particularly prevalent in relation to Ms L's contact with Northumbria Police, where a failure to record several incidents as domestic abuse or to take appropriate steps as a result of this has been seen. In addition, it has been recognised that during her supervision with the CRC, despite a history of abuse, she was often considered not to pose a risk to current partners. There is little information as to why this was thought to be the case, or evidence of full up to date information having being sought from the police. Furthermore, in NTW's response to concerns by Martin's sister, while appropriate action was taken to speak to Martin directly, little consideration seems to have been given to Ms L's history of abuse, or attempts made to gain fully up to date information. Finally, the actions of both the Police and Adult Social Care to the concerns in September 2014 showed little evidence of the risk posed by Ms L having been fully considered and assessed.

5.8.3 This area of learning is one that has also been highlighted within the national review of lessons learned from DHRs around the completion of risk assessments. Within this it was identified that there were a number of cases where risk assessments did not take into account prior known incidents of abuse.

5.9 The impact of gender

5.9.1 Throughout this report consideration has been given to the issue of gender. While no agency could conclusively state that actions taken, or not taken, were as a result of the genders of Martin or Ms L, many recognised that this may have played a part. Indeed, what has emerged is a situation in which full recognition of Martin as a potential victim of abuse, or Ms L as a perpetrator, has not always occurred. While it may be difficult to fully understand the role gender may have played in this, should this review be read as if the genders were reversed, there are a number of situations where it would seem unlikely that concerns would not have been recognised or proactively pursued. Within this it is also necessary to consider Martin's lack of disclosure, or response to direct questioning around his relationship, and the perceived stigma that may be attached to identifying as a male victim of abuse by a female perpetrator. The issue of gender is therefore an important point for all agencies to

consider in relation to staff training and awareness raising arising from this review.

6 SUMMARY OF RECOMMENDATIONS

6.1 A number of specific agency recommendation have arisen either through completion of IMRs or as a result of the overall review process; these are summarised below. In addition however, the key learning points that have arisen are relevant for all agencies working with potential victims and perpetrators. In light of this it is recommended that all agencies consider existing procedures and staff training to ensure that the key lessons learned from this review are fully incorporated and embedded in practice.

6.2 **Summary of recommendations arising from this review**

Northumbria Police

- To review submission of Adult Concern Notifications in relation to issues of self-neglect related to alcohol use, mental health and housing issues, in order to ensure that vulnerability is being correctly identified and alerted.
- To review training received by Officers in relation to domestic violence and abuse and ensure that it includes explicit consideration of female perpetrators and male victims and the dynamics within this, included those who present as both a victim and
- To ensure that officers undertaking welfare checks in cases where there are concerns around Safeguarding and/or Domestic Abuse are aware of the need to see victims alone and to make direct enquiries regarding potential abuse.
- To review practice in DV cases where there is serious injury, to ensure that policy is being adhered to and that consultation with CPS is occurring.

NHCFT

- To incorporate into the recommended alert system a prompt for Safeguarding referrals, where necessary, in relation to frequent attenders.
- To ensure that NHCFT's Safeguarding awareness raising and training includes and highlights issues around self-neglect related to alcohol use, mental health concerns, and housing issues; as well as the need, in cases where concerns around domestic abuse or violence have been identified, to try and see patients alone at subsequent attendances.

NUTH

- To ensure that NUTH's Safeguarding training and documentation includes issues around self-neglect related to alcohol use, mental health concerns, and housing issues.
- To review training in relation to domestic violence and abuse and ensure that it includes explicit consideration of female perpetrators and male victims and the dynamics within this; as well as the need, in cases where concerns around domestic abuse or violence have been identified, to try and see

patients alone at subsequent attendances.

- To consider use of an 'alert' system, as recommended in NHCFT's IMR, to identify patients with complex needs who are frequent attenders to A&E. This is in order to facilitate access to specialist support services and prompt, where necessary, Safeguarding referrals.

NTW

- To ensure concerns of third parties are appropriately followed up on and that this information is not shared directly with those considered to pose the risk, unless this has been explicitly considered and discussed with the third party referrer.
- To ensure that historic risk information is explicitly considered and documented in relation to any current concerns and the decision making and actions that follow.
- To review procedures for risk assessment to ensure they include the need to identify and request information from all appropriate sources when completing/updating risk assessments. To sample completed assessments to clarify that this is taking place.

Northumberland CCG

- To encourage practices to implement systems whereby when a partner or family member is requesting access to information, GPs cross reference with the individual's records where possible to ensure there are no concerns in relation to domestic abuse.

Northumberland Adult Social Care

- To ensure that the guidance recommended also stresses the need to identify and collate relevant information from a broad range of sources to inform risk assessments of both victims and potential perpetrators.
- A protocol should be developed by Adult Social Care for joint visits to be undertaken with Police in cases where an adult is or may be at risk of abuse and/or neglect and Adult Social Care staff have been unable to gain entry.

Northumbria CRC

- To review procedures for risk assessment to ensure they include the need to identify and request information from all appropriate sources when completing/updating risk assessments. To sample completed assessments to clarify that this is taking place.
- To ensure training in relation to domestic violence and abuse covers gender related issues and female perpetrators.

Insight Healthcare

- To ensure that the ongoing awareness raising and training delivered to staff explicitly covers issues of coercive control, particularly in a context in which partners and/or family members may present as providing support.

6.3 **Individual agency recommendation identified within IMRs**

Northumbria Police

- A review of the stalking and harassment policies and procedures is currently being undertaken. As part of this review the use of PIN's is also being looked at.

- A trial by Northumbria Police of the use of Multi Agency Tasking and Coordination Process (MATAC) is currently underway. The MATAC allows perpetrators of domestic violence to be identified using recency, frequency and gravity of offences (RFG methodology). Perpetrators highlighted by the RFG methodology would be brought for discussion at the MATAC. The MATAC would decide how each perpetrator would be targeted and who should do it. Consideration would be given to victims in each case and to potential victims.

NHCFT

- When a male or female presents with injuries or alleges they have been a victim of domestic abuse, the MARAC risk assessment should be completed.
- An alert will identify those people who have complex needs relating to alcohol and who are frequent attenders to NHCFT, facilitating access to specialist NHCFT support services in ECC.
- NHCFT to regularly raise awareness of safeguarding adult procedures.

NUTH

- The Trust to maintain levels of awareness and training of domestic abuse/violence for staff within the organisation.
- Consideration to be given to the reinstatement of the IDVA within the hospital. The Trust to work with the Local Authority to develop a business case for the provision of an IDVA within the hospital.
- To maintain and further develop the high level of awareness of the Safeguarding team who are available to offer support and advice to staff.

- To continue to embed the development and understanding of partnership working with internal and external agencies which will enable the Trust to achieve best practice and outcomes for patients at risk of domestic violence/abuse.
- To share the learning of the impact that distractions can have in a busy department across the wider organisation.

NEAS

- Staff recognising and consider the different types and patterns of abuse and neglect, especially self-neglect.

NTW

- A 'police disclosure form' to be submitted, when information is received from other agencies or self-disclosed regarding violence, aggression or criminal activity, to then contribute to the risk assessment.
- Information regarding domestic abuse, and actions taken to be shared with the GP / primary care.

NHS Northumberland CCG

- To recirculate to practices the exemplar policy and to promote its adoption.
- To remind practices of the importance of exploring carer issues and the role of carer assessments.

Northumberland Adult Social Care

- Improved documentation should be developed to support decision making, particularly in relation to case closure where risks are potentially high and the person's capacity to make decisions is unclear.
- Supervision and training framework for adult social care staff should include clear guidance in relation to management of complex cases, domestic violence and case closure.

Northumbria CRC

- **Internal transfers:** There were issues around the frequency and nature of contact with Ms L following the internal transfer of the management of her case. The recommendation is for the guidance for transfer of cases internally within the Northumbria CRC to be reviewed, revised as necessary and embedded in to practice. This will ensure consistency of service for offenders,

and offender managers and team managers will be fully aware of the expectations when a case is transferred internally.

Insight Healthcare

- Insight should continue to provide awareness and training in relation to adults at risk, domestic abuse and violence for all staff. It would be beneficial for responsible clinical staff in each service to be trained in the DASH model with a view to assisting in seeking advice and triggering alerts.
- Insight should share learning from this DHR across its services and disseminate any additional suggestions

Byker Bridge

- Should someone present with similar issues to Martin we would in future utilise the current option to make a Safeguarding referral for self-neglect. Although, a multi-agency meeting to discuss the issues presented would not necessarily bring to light any concerns over abuse within a relationship.
- In future cases where we are providing support to individuals with a known history of being a victim or perpetrator of domestic violence, or where new concerns are raised, we will refer into the MATAC process. We have also begun referring support staff to domestic abuse awareness training provided by community safety partnerships.

Abbreviations Key

A&E	Accident and Emergency
ACN	Adult Concern Notification
CAADA	Coordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Group
DASH	Domestic Abuse, Honour Based Violence and Stalking risk assessment
DHR	Domestic Homicide Review
GP	General Practitioner
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Coordinating Group
NEAS	North East Ambulance Service (NHS Foundation Trust)
NFRS	Northumberland Fire and Rescue Service
NHCFT	Northumbria Healthcare NHS Foundation Trust
NTW	Northumberland, Tyne and Wear (NHS Foundation Trust)