Adult O
Date of Death: February 2020

Safeguarding Adults Review
Domestic Homicide Review

Executive Summary

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Date: December 2024

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1. Introduction

In August 2020, the Newcastle Safeguarding Adults Board (NSAB) agreed to undertake a Safeguarding Adults Review (SAR) following the death of Adult O, a 39 year old white British woman with care and support needs. At the time of her death Adult O was in a relationship with a man, JC. In 2022, Adult O's family requested that her death be considered for a Domestic Homicide Review (DHR). This request was accepted by Safe Newcastle in June 2022. Therefore, this report summarises a joint SAR / DHR process.

Adult O was not formally a victim of a domestic homicide. Her exact cause of death is unknown but appears from the records to be an unsurvivable brain injury. However, the Home Office Pathologist undertook a post-mortem and concluded that there was no third-party involvement. Adult O's family are not in agreement with this view.

What is unarguable, however, is that she had experienced a long and repeating history of domestic abuse from a number of partners, in conjunction with a pattern of chronic and chaotic substance misuse. These were both significant contributory factors to the physical decline that led to her death. As a result it was agreed to review this tragedy as a joint SAR/DHR.

The SAB has a statutory duty to undertake SARs under section 44 of the Care Act 2014. The Community Safety Partnership (Safe Newcastle) has a statutory duty to undertake Domestic Homicide Reviews under section 9 of the Domestic Violence, Crime and Victims Act 2004[1]

2. Methodology

A joint multi-agency panel of the SAB and Safe Newcastle was set up to commission the independent author and oversee the review. It was agreed that this review would concentrate on an approximately two year period prior to her death.

Initial information was sought from agencies involved with Adult O and her final partner JC. This supported the development of Terms of Reference which are included as an appendix. More detailed Information was sought from the involved agencies in the form of Individual Management Review (IMR) reports addressing the themes in the Terms of Reference. Agencies were also invited to include any other information they considered relevant. This included information from outside the time period identified.

The following agencies were involved in the process:

- Newcastle upon Tyne Hospitals NHS Foundation Trust. Lesley Sinclair
- Department for Work and Pensions. Jackie Butson
- Your Home Newcastle City Council Housing Provider (contact with JC). Caron Storey

[1] Although the circumstances of Adult O's death were not considered a homicide, a DHR is appropriate in this case because it does meet the Section 9 criteria and can take place even if a suspect is not charged with an offence or they are tried and acquitted. Overall responsibility for establishing this DHR lies with Safe Newcastle and the Chair has agreed to initiate this review.

- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Jo Sharpe
- Newcastle City Council (Adult Social Care) Jonathan Jamison and Sam Keith
- Newcastle Safeguarding Adults Board. Claire Nixon
- Newcastle City Council, (Community Safety Team) Joan Flood
- Newcastle Integrated Domestic Abuse Service (NIDAS). Laura McIntyre
- Northumbria Police. Ian Callaghan
- North East Ambulance Service. Jane Stubbings
- North East and North Cumbria Integrated Care Board. Dr Karen Hutchinson
- The Probation Service (contact with JC) Paul Weatherstone

An initial SAR/DHR Panel meeting was held in November 2022 to discuss the process, terms of reference and timeline of the review. IMRs were drafted and submitted. A Practitioner Reflection Day was held in April 2023 and contributed a range of thoughts and views on Adult O, JC and the individual and joint response to their needs. The Panel met three times.

All this information was analysed by the report writer and an initial draft of this report was produced and went to the Review Panel in June 2023. Further changes were made over the next two months, and a final draft was completed for the Panel in August 2023.

3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of fifteen SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers and drug users. He has undertaken research and led training with Against Violence and Abuse on the role of alcohol as a contributor to domestic violence and abuse. He has undertaken the Home Office's online learning on conducting Domestic Homicide Reviews.

4. Adult O

Adult O was a 39 year old White British woman who died in February 2020. She repeatedly experienced violence and domestic abuse from her male partners from at least 2007 onwards. This may have included financial abuse.

Adult O also had alcohol and drug use disorders. At the time of her death she was drinking approximately 3.5 litres of cider a day (26 units). She had had a long history of heroin use for which she had received opiate substitution therapy (methadone). By her death, she was reported to have stopped using heroin but was known to occasionally use cocaine.

At the start of the review period, her health was already very poor. As a result, she was a regular user of health services. In addition, there was a high probability that Adult O was experiencing cognitive impairment due to a road traffic collision in 2011, violent assault by a female associate in 2019, the long pattern of domestic abuse from her partners, a stroke in 2018 and as a result of her alcohol use. This is likely to have impacted on her ability to care for herself, to protect herself and to engage with

services.

A subsidiary problem was that services found her very difficult to engage into any package of treatment or care. At times, this is likely to be because she was under the influence of alcohol or drugs. She could also be very abusive or aggressive to staff, and at times this led to the termination of services, particularly health services.

Adult O had some involvement with the Criminal Justice System. Between 2006 and 2020 she was recorded as the victim in 23 crimes and as a witness in relation to two of them. She was also subject to 10 arrests between 2006 and 2015.

5. Description of JC

JC was Adult O's partner in the last six months of her life. He is a White British man who was 41 when Adult O died. He was diagnosed with anxiety and depression in 2001 and post-traumatic stress disorder and alcohol use disorders in 2007. In 2019 he was having alcohol induced seizures and hallucinations which suggest dependent drinking. He also used cannabis and had taken multiple drug overdoses in the past. JC also had mental health problems and, at times, would ring the Police with suicidal thoughts.

JC had a long involvement with the criminal justice system. JC was both aggressive to others generally and a high risk perpetrator of domestic violence specifically. He had alerts on record that he should not receive a home visit due to being "aggressive, usually intoxicated" and he was barred from one pharmacy due to abusive behaviour.

The Probation Service identified records of 30 domestic violence incidents of which 19 were in 2019: some of the recent incidents concerned Adult O. However, during that period he had been in a relationship with another woman, YV, and again there appears to have been violence and abuse.

6. The relationship between Adult O and JC and her earlier relationships

The relationship between Adult O and JC lasted for no more than the six months immediately prior to Adult O's death. They had separate properties and the extent to which they cohabited is unclear. At one point JC said the relationship was over because of the stress that dealing with her health crises had on his drinking. However, the relationship appears to have continued and with a pattern of violence and abuse from JC towards Adult O until just before her death when her health was deteriorating significantly.

Adult O was the victim of violence and abuse in previous relationships. She first came to the attention of Adult Social Care in October 2007 when she was the victim of assault from her then partner. Adult O was discussed in MARAC nine times between 2011-2014. (She was also discussed once in 2017 and once in 2020). She was the victim of violence in at least three other relationships prior to meeting JC.

7. Key Learning Points

Many agencies made efforts to help Adult O. There is no sense that she experienced professional neglect or specific prejudicial attitudes. Practitioners who encountered her appear to have tried to help her within the framework of their particular discipline. However, a different approach was required to keep Adult O safe.

Adult O experienced a number of factors that were impacting on her ability to care for herself and keep herself safe – possible problems with cognition, the compulsion associated with dependency, the wider health impacts of alcohol and the impact of domestic abuse. As a result, services found it very difficult to engage her in a constructive programme of care. Therefore, she required a more assertive and collaborative approach from services, including a more confident use of legal powers such as the Mental Capacity Act.

None of these more assertive approaches could or would have been used unless she was identified as someone who needed more intensive work to engage her. At one level, identification is simple, Adult O's needs are visible in plain sight. But the needs tend to be visible to one agency at a time, the Hospital, Primary Care, Police, or Alcohol and Drug Services. What is required is a mechanism whereby an individual agency can flag her as someone requiring more intensive, multi-agency intervention.

This can have two elements:

- A policy or procedure guiding the management and escalation clients that agencies find difficult to engage like Adult O (and possibly JC)
- A clear multi-agency framework for the management of these individuals supported by care coordination.

This review suggests that the response to clients that services find difficult to engage will be strengthened by the development of a local policy or procedure which guides professionals on how to work with such clients. This should build on Newcastle SAB's existing Eight Principles of Engagement. It should include comment on the level of risk that requires a more assertive approach and identify the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management.

Multi-agency structures do exist in Newcastle. A safeguarding process itself could fit that requirement if there are concerns about abuse, neglect or self-neglect. As in any other area, there is a MARAC as well as other multi-agency risk management groups. However, lessons from SARs and DHRS as well as practice in other parts of the country suggest that these structures do not work particularly well for people with substance use disorders who actively push back at help. For example, her family are concerned that, given Adult O's frailty, her long history of being a victim of violence and abuse and above all the evident challenges of trying to engage her, no further action is identified from the MARAC meeting in January other than repeated attempts to contact her by phone.

Therefore, local commissioners and strategic leads may wish to consider setting up a multi-agency group to manage chronic dependent substance users like Adult O and

JC. The Northumberland Blue Light operational group, of which the local Mental Health Trust is already a part, offers one model. This group brings together key agencies such as Police, Housing, ASB Teams, Mental Health, Hospital and others together with the Specialist Alcohol Services. This will enable the identification of the most challenging clients and the development of consistent, jointly owned interventions. This initiative was developed in partnership with the former Public Health England and won a Royal Society for Public Health Healthier Lifestyles Award and A Guardian Public Health & Wellbeing Award.

Adult O could and should have been protected via legal frameworks such as the Care Act or the Mental Capacity Act.

Adult O was subject to six safeguarding referrals during the period of the review. All but the last of these enquiries was reported to be completed and closed appropriately. Nonetheless, Adult O died. The addition of the escalation policy and structure highlighted above may well enhance this pathway. It was also noted, at points, that agencies failed to submit safeguarding concerns when this would clearly have been appropriate.

More importantly, Adult O's care highlights that practitioners continue to struggle to use the Mental Capacity Act in ways that will better protect people with repetitive and compulsive behaviours. The focus on "decision specific" assessments means that practitioners did not follow the advice in paragraph 4.30 of the 2007 Code of Practice that suggest that in taking a capacity decision: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.* In other words, past decisions, for example to protect oneself, which have not then been executed, can form part of a current assessment. The Code of Practice acknowledges that practitioners need to look up from the immediate context and take a longer term view when assessing capacity.

National concern about such situations has led to an increasing emphasis on considering executive capacity. In assessing capacity with vulnerable and self-neglecting individuals like Adult O it is important to consider executive function. The Teeswide Carol SAR talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both take a decision and *put it into effect* (i.e. use the information)? This will again necessitate a longer-term view when assessing capacity. Repeated refusals of care should have raised questions about Adult O's ability to execute decisions. The new draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

Ultimately, the challenges of using existing legal frameworks with people like Adult O do raise questions about the adequacy of the legislation for this client group. Those who commission and plan the development of Alcohol Treatment Services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group; or new legislation to better meet their needs.

All of the above provide a framework within which a more assertive response could have been delivered to Adult O. However, the question remains as to what services are practically going to do differently with her. The two central themes in Adult O's life are domestic abuse and her substance use disorder. This review has considered responses to both of these elements.

Adult O used both alcohol and opiates; it was acknowledged by both family and practitioners that her most consistent problem was her dependency on alcohol. There was strong agreement that the best package of care for her would have been a detoxification followed by a period in residential rehabilitation. This would have provided time to stabilise her health, assess her cognition and help her to reconsider her current situation. This was offered to her on at least two occasions. She did not take up this offer and it is acknowledged that at most times during the review period she would have rejected this offer. However, it is important that efforts are made to "sell" the benefits of this option to her and, if she agrees, that the opportunity is there for her to move swiftly into rehabilitation.

In the absence of residential care, the next best approach is one built on assertive outreach. With individuals like Adult O, it is unrealistic to wait for her to be "ready to change". She needs a practitioner who has a specific focus on relationship building and working with her intensively to reduce harm and motivate change. Frontline alcohol services should have the commissioned capacity to undertake assertive outreach with the most challenging chronic dependent drinkers. The Mental Health Trust's existing service in Northumberland may offer a model.

This report has not provided the same depth of analysis of JC's care needs but it is likely that many of the above comments apply to his needs e.g. having a focus on clients that services find difficult to engage, the need for residential care and the benefits of an assertive outreach approach. The key area of difference is obviously the response to the domestic abuse.

Adult O's relationship with JC was relatively short-lived. It may have lasted no more than six months and was really only obvious to professionals from about three to four months before her death. Nonetheless, steps were taken to address the abuse she suffered. She was referred to MARAC at the end of December 2019 and was discussed at the group in January 2020. Even before the MARAC, an IDVA was trying to make contact with her. At the MARAC, it was agreed that efforts should continue to be made by the IDVA.

However, there are also questions about the efforts made to address the domestic abuse. The repeated failure of the IDVA to be able to make contact with Adult O, does suggest that alternative strategies were required. This review has already addressed the need for policies and procedures to develop work with people with substance use disorders that services find difficult to engage and these principles also apply to addressing the domestic abuse.

It is also noted that no consideration was given to either a disclosure under "Claire's Law", or a Domestic Violence Protection Notice / Order. Both practitioners and the

family were agreed that a disclosure about JC's past history was unlikely to have impacted on Adult O. Nonetheless this should have been a consideration. A DVPN /

DVPO was felt by the family to be more relevant and could also have been considered. Again, it is uncertain whether this would have had an impact on the relationship.

A very specific problem in Adult O's relationship with JC is that at points she attended medical appointments with him and he refused to leave the consultation room, thereby closing down the opportunities to talk about abuse. Agencies need to have an agreed procedure for handling this situation without putting staff and clients at risk.

More generally, both Adult O and JC highlight the importance of professional curiosity. It is impossible to say what the impact of earlier identification of Adult O's new relationship with JC would have been but it was clearly desirable that efforts to intervene began as swiftly as possible.

The review has also explored the response to JC as a perpetrator of violence and abuse. The key agency in this context was the Probation Service. Probation's IMR provides a very through and honest analysis of the general need to improve the response to domestic abuse and the specific need to improve the response to JC. This summary will not repeat that detail but it does highlight the need for ongoing work to ensure the Probation Service's response to domestic abuse is being improved.

The review has also highlighted the lack of other means for addressing JC's ongoing and repeated pattern of perpetrating domestic abuse against female partners. The only structured approach was a referral to MATAC; however, he did not meet the criteria until the very end of Adult O's life. This may raise the question of whether new or alternative interventions are required with perpetrators.

Structured responses to perpetrators of domestic violence remain at an early stage of development. The Government only published its Standards for Domestic Abuse Perpetrator Interventions in January 2023, so this is an emerging field of work.

A strategic review of response to perpetrators across the Northumbria Police force area has been carried out by the Violence Reduction Unit in the Office of the Police and Crime Commissioner during 2022. This work had identified gaps in provision in Newcastle which is currently being addressed through commissioning.

8. Recommendations

Working with individuals that services find hard to engage

Recommendation 1 – Newcastle SAB should lead the development of local procedures that build on the SAB's existing Eight Principles and which guide professionals on how to respond to individuals requiring safeguarding but who they find difficult to engage. (These protocols could equally apply to vulnerable clients outside of the safeguarding context). These procedures should include:

- a structure for determining the level of vulnerability associated with a client, which will then guide the level of persistence that is used to follow-up these clients;
- escalation pathways.

Recommendation 2 – Newcastle SAB should ensure that the procedures include the need to escalate vulnerable clients that services find difficult, to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable clients to multi-agency agency management frameworks is cascaded as widely as possible through their own and partner agencies' communication systems.

Recommendation 3 – Newcastle SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals with substance use disorders.

Working with substance use disorders

Recommendation 4 – Public Health Commissioners who commission and plan the development of Alcohol Treatment Services need to ensure that frontline staff consider residential rehabilitation as an option for clients and that it can be accessed without undue barriers. In particular, a smooth pathway from inpatient detoxification to residential rehabilitation should be possible for complex clients.

Recommendation 5 – Public Health Commissioners should ensure that frontline alcohol services have the commissioned capacity to undertake assertive outreach with the most challenging chronic dependent drinkers and drug users.

Recommendation 6 – Local commissioners and strategic leads should ensure that people with complex substance use disorders can be escalated to a multi-agency framework for joint management. This might be a separate group or could be part of the structure set out in Recommendation 2.

Tackling domestic abuse

Recommendation 7 – Safe Newcastle should work with the Police to ensure that the Police are considering the 'Right To Know' part of the Domestic Violence Disclosure Scheme, also known as "Clare's Law", and that DVPOs/DVPNs are being regularly considered and used when appropriate.

Recommendation 8 - Safe Newcastle should work with health services and other partners to ensure that relevant agencies have an agreed procedure in place, without putting staff and clients at risk, for handling situations where partners or family members of a patient/client refuse to leave the patient/client alone in a consultation room with a professional, thereby closing down the opportunities to ask about abuse.

Recommendation 9 - Safe Newcastle working with the Newcastle Domestic Abuse Local Partnership Board) should (i) benchmark itself against the recommendations set out in the VRU strategic review of responses to domestic abuse perpetrators across Northumbria, and (ii) consider the findings of the VRU commissioned work that has mapped perpetrator interventions and pathways, with specific regard to the findings for Newcastle. This work should be done with a view to identifying actions needed to address gaps and enhance the strategic and operational response to perpetrators.

Recommendation 10 - Safe Newcastle working with the Newcastle Domestic Abuse Local Partnership Board should ensure that any new primary, secondary or tertiary interventions commissioned should be developed in-line with the new Northumbria Outcomes Framework commissioned by the VRU, which should have clear referral pathways and a clear set of outcomes and measures that can demonstrate impact on reducing perpetration and underlying causes of domestic abuse.

Recommendation 11 – Safe Newcastle should work with the Probation Service to review their ongoing work to improve responses to perpetrators of domestic abuse engaged with Probation.

Recommendation 12 – Safe Newcastle should review responses to clients like Adult O who are known to not engage with services or support, to ensure that MARAC actions reflect challenges to engagement, and that MARAC partners have a practice of working together to identify actions that will support opportunities for engagement.

National

Recommendation 13 – Those who commission and plan the development of alcohol and drug treatment services may wish to consider lobbying national government directly, or via the SAB Chairs Network, for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group; or new legislation to better meet their needs.

Appendix 1

Terms of Reference

At a panel meeting in November 2022, the following key issues were agreed as being important and which should be considered within the Domestic Homicide Review - Safeguarding Adults Review:

Identifying abuse

- What indicators of abuse, including coercive and controlling behaviour, did your agency have that could have identified Adult O as a victim and what was your response?
- Were there opportunities for professionals to routinely enquire regarding domestic abuse with Adult O? Did those enquiries take place, if not, why?

Risk Assessment and risk management

- What were the relevant points or opportunities for risk assessment and decision making in this case in relation to Adult O and or her partner/ex-partner? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?
- Do the assessments and decisions appear to have been reached in an informed and professional way?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with? Were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?
- Was the case viewed as complex or challenging by those involved at the time? Were escalation processes followed, including the involvement of senior managers and other agencies?
- Did agencies work together sufficiently to protect Adult O?

Mental Capacity and decision-making

- Was the Mental Capacity Act used sufficiently and appropriately with Adult O?
- What consideration was given to the impact of the cognitive impairment Adult O may have received as a result of the road traffic accident and other assaults?
- What consideration was given to the impact that control and coercion might be having an impact on Adult O's decision-making?

Risks from others

- What knowledge did your agency have that indicated that Adult O's partners/ex-partners might be a perpetrators of domestic abuse and what was the response?
- Were her partner/ ex-partners subject to MAPPA[2], MATAC[3] or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

[2] MAPPA is the Multi-Agency Public Protec□on Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Proba□on Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

[3] MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domes□c abuse

Making Safeguarding Personal, family and community involvement

- When, and in what way, were Adult O's (or where appropriate, her family's) wishes, feelings and views ascertained, considered and acted upon?
- What knowledge or concerns did family and friends and community have about the abuse of Adult O and did they know how to act on them?

Policy and procedures

- Were single and multi-agency policies and procedures, including safeguarding adults, the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?
- Did the agency have policies and procedures in place relating to domestic abuse?

Mental health and addiction

- What knowledge did your agency have of any alcohol, drug, gambling, addictions or mental health issues in respect of Adult O or her partner/ ex- partners?
- What services did your agency provide in response to these issues?

Barriers to accessing support

- Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Adult O (and her partner/ ex-partners) or on your agency's ability to work effectively with other agencies?
- What was your agency's knowledge of any barriers faced by Adult O that might have prevented her reporting domestic abuse and what did it do to overcome them?
- How did your agency take account of any ethnic, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Adult O?
- Is there indication that Adult O was disadvantaged because of her drug and alcohol use – was she prevented from accessing services, care, treatment or justice?
- To what extent did assertive outreach feature in the support and care offered to Adult O? Would Adult O have benefitted from more assertive interventions?

Learning and good practice

- What are the lessons from this case for the way in which your agency works to protect adults at risk and victims/survivors of domestic abuse?
- Please comment on any aspects of the case or the agency involvement that are examples of outstanding or innovative practice.
- Does the learning from this review appear in other Safeguarding Adult Reviews or Domestic Homicide Reviews undertaken by the Newcastle Safeguarding Adults Board or Safe Newcastle?
- Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?