Executive Summary

Safer Cornwall

Safeguarding Adults Board

Joint SAR/DHRS 4

Year of Death 2020.

Author: Paul Northcott

Date the review report was completed: 03/02/2021

Contents

1.0 Review Process

1.1 This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the death of Maria who was resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;

- Maria - Deceased female. Maria 's ethnicity was a white European. She was aged forty-one when she took her own life.
- Adult B - Maria's' husband. Adult B's ethnicity is white European and he was aged forty-one at the time of Maria's death.
- Adult C - Eldest son (from a previous marriage)
- Child A - Youngest child of Maria and her husband
- Adult D - Male friend of Maria

1.3 The inquest held by HM Coroner recorded her death as suicide by hanging.

1.4 The decision to commission a review was taken by the Chair of the Cornwall Community Safety Partnership in November 2020. All agencies that potentially had contact with Maria and her family prior to the point of her death were contacted and asked to confirm whether they had involvement with them.

1.5 Thirteen of the seventeen agencies contacted confirmed that they had contact with Maria and her family and they were each asked to secure their files.

2.0 Contributors to the Review

2.1 The contributors to the DHR were;

- Devon and Cornwall police- IMR.
- Primary Care Services (five GP's)- IMR
- Royal Cornwall Healthcare Trust (RCHT), Cornwall Foundation Trust (CFT) and Outlook Southwest - IMR
- SWAST - IMR
- Probation – IMR
- Adult Social Care -IMR
- MARAC – IMR
- First Light – IMR
- Together for Families (this included Education and children Services) – IMR
- We Are With You (WAWY) - IMR
- Harbour Housing – IMR
- Cornwall Housing – IMR

2.2 Specialist domestic abuse advice and scrutiny was provided by the members from First Light who are a charity that provides specialist support to those who have been affected by domestic abuse and sexual violence.

2.3 All of the IMR writers were independent. None of the writers' members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

3.0 The Review Panel Members

3.1 The Panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair.
- Lyn Gooding – Chief Executive Officer, First Light
- Lisa Sherwin – Senior Probation Officer, National Probation Service
- Geraldine Taylor – Project Manager, Cornwall Housing
- Detective Sergeant Rob Gordon – Devon and Cornwall Police Criminal Case Review Unit
- Detective Chief Inspector Steve Reid - Devon and Cornwall Police Local Investigation (Cornwall and the Isles of Scilly (CIOS)
- Rebecca Sargent –Together for Families (TFF) Head of Children and Families Services Lead
- Michelle Daly -Harbour Housing Safeguarding and Escalation Lead
- Marion Barton – Cornwall Council Rough Sleeping Lead
- Sid Willett – Cornwall Council Drug and Alcohol Team Drug Related Death Prevention Lead
- Lynda Edward – We Are With You (WAWY) Complex Needs Lead
- Sarah Pulley – NHS Kernow Clinical Commissioning Group (CCG) Lead Nurse for Adult Safeguarding and Prevent
- Anna MacGregor – Cornwall Council Domestic Abuse and Sexual Violence Co-ordinator, MARAC
- Alexandra Morgan-Thompson – Cornwall Housing Quality and information Manager
- Laura Ball – Cornwall Council – Domestic Abuse and Sexual Violence Strategy Manager
- Ben Davies – Cornwall Council – Children and Families Service
- Andrew Carson/James Sawford – Adult Social Care (ASC) Statutory Assurance Manager
- Kerry Whincup – Cornwall Council MARAC Chair
- Martin Bassett – Cornwall Council Safeguarding Adult Reviews and Development Manager
- Clare Martin – NHS Kernow CCG Deputy Director of Nursing
- Zoe Cooper – Royal Cornwall Healthcare Trust (RCHT), Cornwall Foundation Trust (CFT) and Outlook Southwest. Consultant Nurse for Integrated Safeguarding Services for CFT and RCHT

3.2 The Panel met formally on four occasions. All of the Panel members were independent. None of them knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

4.0 Author of the Overview Report.

4.1 The Cornwall Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report in November 2021.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

4.3 Paul retired from the police service in February 2017. Paul has not worked for Safer Cornwall Community Safety Partnership, nor any of the agencies involved in this review in the period specified in the review.

4.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[1] webinars.

5.0 Terms of Reference

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 The methods for conducting DHR's are prescribed by the Home Office guidelines[2]. These guidelines state;

> *'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be*

[1] Advocacy after fatal domestic Abuse.
[2] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'.

In addition to the above and in line with the SAR process Cornwall Community Safety Partnership agreed that the review should;

- Seek to establish whether the events of October 2020 could have been prevented.

- The time period that will be subject to close scrutiny to between **October 2017 and the October 2020.** This time scale will be subject to change if information emerges that prompts a review of any earlier incidents or events that are relevant. Agencies are requested to provide a synopsis of engagement prior to the relevant period

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Conduct and review relevant research and previous SAR's to help ensure that the review process is able to maximise opportunities for learning to help avoid similar suicides/ homicides occurring in future.

In addition, the following areas will be addressed in the Individual Management Reports and the subsequent Overview Report:

Case Specific Terms of reference

- *Term 1:* ***Risk /Vulnerability Identification and Management****: Consider how (and if knowledge of) the risk and vulnerability factors surrounding this matter are fully understood by professionals, and how to maximise opportunities to intervene and signpost to support.*

- *Term 2; Were the appropriate actions taken to identify* ***risk and vulnerability and were risk assessments*** *effectively completed and overseen.*

- *Term 3:* ***MARAC.:*** *Timeliness and efficacy of any involvement in MARAC.*

- *Term 4:* ***Barriers to support****: (a) Determine if there were any barriers Maria faced in both reporting their concerns and accessing services. This should also be explored against the Equality Act 2010's protected characteristics. (b) Consider whether complex needs regarding alcohol misuse and mental health presented a barrier to*

accessing support (c)) Were there any barriers experienced by family, friends and colleagues in reporting the abuse.

- *Term 5:* ***Timeliness of decision making/action planning****: Was information regarding Maria acted upon in a timely manner.*

- *Term 6:* ***Domestic Abuse and Safeguarding Policies****: In services where there was involvement with the victim or perpetrator were there adequate safeguarding and domestic abuse policies and procedures and were they followed. In this regard, please consider best interests' considerations for Maria.*

- *Term 7:* ***Information Sharing and Partnership Working;*** *Efficacy of information sharing, partnership working and communication between agencies in place to address the level of risk and safeguarding concerns? E.g. Extent to which partners worked together via MDT, professionals meetings.*

- *Term 8:* ***Professional Curiosity and Routine Enquiry****: Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed.*

- *Term 9:* ***Training:*** *Consider knowledge, training need and availability for professionals and whether the circumstances of this case require addressing.*

- *Term 10:* ***Equalities and Intersectionality****: Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.*

6.0 Summary

6.1 Maria had been born, and had grown up, in Cornwall where she lived with both parents and her older brother. Maria had one older sister who lived elsewhere. Maria was profoundly affected by the separation of her parents and began to drink alcohol in her teenage years.

6.2 Maria had been engaged on two occasions. Maria and her first fiancé had separated, and she later described to professionals how he had been violent and abusive. During that relationship the couple had a son (Adult C). Adult C has stated that although his father may have been verbally abusive, he had not witnessed any physical abuse.

6.3 Maria had been employed in a variety of roles and at one stage she had managed a small business. She was described as very independent and had purchased her own house prior to meeting her second husband.

6.4 Maria met her husband (Adult B) when her son was aged around seven years old. Her husband had been previously married and had two children, both of whom lived with their mother. Maria married her husband in 2010 and they lived together in Cornwall.

At that time Maria had, according to her son, suffered from post-natal depression and she had received counselling.

6.5 Maria and her husband lived in private accommodation and had a child in 2011. She had then suffered from post-natal depression on a second occasion, and when her youngest child went to school Maria struggled to find a purpose in life. It was at this time that she began to drink heavily on a more regular basis.

6.6 Maria had experienced poor mental and physical health for the duration of the time period under review. She had been diagnosed with generalised anxiety disorder in 2016. Adult C has stated that his mother had been suffering from mental anxiety for many years due to poor self-image, and he was aware that she had attempted to take her own life in 1998. Maria had suffered from post-natal depression following the birth of Adult C and her youngest child.

6.7 Maria had been supported by a range of agencies during that time including primary and secondary health services, Adult Social Care, Children's Services, Housing, WAWY and the third sector.

6.8 Maria broke her leg in 2016 and this had led to her misusing codeine (Health records and own admission) which had been prescribed to provide pain relief. Maria had continued to drink alcohol and she had attempted to return to work but found this impossible due her dependency on drink and prescription drugs. At that time Maria had become dependent on alcohol and she was using it to help her to cope with what she described as a 'void' in her life.

6.9 Maria had frequently disclosed incidents of domestic abuse involving her husband to professionals but she would always withdraw the statements when sober. Maria had stated that the abuse would escalate when both had been drinking. When speaking to agencies Maria would state that the abuse had continued throughout their relationship and consisted of physical, sexual, psychological and material abuse.

6.10 Adult C has stated that Adult B had wanted to protect his wife and had found her behaviour increasingly difficult to manage. Adult C had witnessed Adult B defending himself on many occasions from Maria as she could become violent due to the alcohol. Adult C had also confronted Adult B on many occasions about the abuse that Maria had reported and had always felt satisfied that there had been no violence.

6.11 Adult C stated that Adult B had tried to support his mother despite her behaviour and felt that his step father had always been reasonable despite the pressures that he had to manage.

6.12 Maria received intensive support from alcohol services, including rehabilitation, detox and recovery support. In 2018 Maria went to a detox centre but only spent twenty-four hours at the premise. She received further support at an alcohol rehabilitation unit between December 2018 and March 2019.

6.13 Maria left the family home in October 2019 after her relationship with her husband had deteriorated. Following this her access to her youngest child was significantly restricted. Her husband progressed formal proceedings through Children's Services and the Family Court so that he could gain custody of their child.

6.14 In December 2019 there was a fire at the house where Maria was living. As a result of the fire the house was uninhabitable resulting in Maria becoming street homeless, and she ended up living in a tent. After a period of a month Maria was provided with a place at a detox centre. Whilst at this premise Maria breached the rules. A further placement was found for her at another rehabilitation centre in February 2020 where she stayed for twenty-six weeks. At that time she made good progress and she transitioned to 'move on' flats.

6.15 In March 2020 Maria made a report of rape against Adult D. After contact with the Police she denied that a rape had occurred and stated that she had been physically assaulted. Maria stated that she didn't want to make a complaint. Adult D was arrested but failed to answer questions when he was interviewed. A police supervisor assessed the case but found that there was insufficient evidence to support a victimless prosecution without further supporting information from Maria. A medium risk refused DASH was appended to the crime.

6.16 In July 2020 Maria was asked to leave the supported accommodation after contravening the rules. At that time Maria was extremely lonely and felt isolated, which according to one of her friends led her to forming a relationship with another resident at the accommodation. Maria was provided with temporary accommodation at a local hotel whilst alternative arrangements were being considered. Whilst at this premise Maria claimed that she had been drugged and sexually assaulted by Adult D. Maria stated that she had been subjected to repeated sexual and physical abuse over a week's period whilst at the hotel. The matter was reported to the Police but Maria later withdrew the allegation as she felt 'too tired'. The male was arrested but denied all allegations and without any additional evidence police took no further action.

6.17 Maria was then moved from temporary accommodation to a High Tolerance supported living facility in August 2020. This supported living accommodation is specifically for those fleeing from domestic abuse and sexual violence. After this Maria's mental health continued to decline and her alcohol dependency increased. In September 2020 a security guard at the supported accommodation found Maria trying to hang herself. Maria was taken to hospital but later discharged. Four days later Maria had attempted to jump from a first-floor window but again was prevented from doing so by another security guard. On that occasion Maria refused to go to hospital.

6.18 In October 2020 Maria made a further report of rape against an unknown male. Multiple attempts were made to support her through the investigative and examination process. The Police on this occasion were unable to find any evidence of the alleged assault. Five days later Maria was found by a member of staff at the supported accommodation premise with a ligature around her neck. Maria was unconscious and not breathing and therefore had to be resuscitated. Maria was transported to hospital and later discharged.

6.19 Between the October 2017 and October 2018 Maria had attempted to take her own life through hanging on eight occasions. On these occasions she was always found to be under the influence of alcohol which was seen to drive her high-risk behaviours. Despite being assessed by the Psychiatric Liaison Service (PLS) following these incidents it was always concluded that she did not have an acute and enduring mental Health condition, and when sober she had no desire to actually take her own life. There was no evidence found when Maria was sober that would have indicated that she lacked capacity[3].

6.20 In October 2020 Maria took her own life by hanging herself at the supported accommodation where she had been residing. At the time of her death Maria had limited contact with her family or friends, although her father had maintained contact with Maria and was attempting to support her.

6.21 Following the post-mortem the cause of death was listed as hanging. Maria had also consumed a large amount of alcohol and there were levels of codeine, diazepam and chlordiazepoxide detected in her blood.

7.0 Key Issues Arising from the Review

7.1 This part of the report seeks to address the terms of reference and the key lines of enquiry within them.

7.2 **The events that shaped Maria's life**

7.2.1 Maria's childhood and adult life experiences had a profound impact on her physical and mental wellbeing. There were a number of events in her life that had led to her decline in mental health and her alcohol dependency. Whilst some professionals working with Maria had listened to her life experiences there was a lack of awareness across all agencies. In some instances this lack of awareness came down to a lack of professional curiosity, information sharing and Maria not feeling able to share those details, whilst on other occasions Maria simply wasn't asked. Often professionals treated Maria on how she presented at times of crisis rather than looking at a more co-ordinated and holistic approach to her needs.

7.2.2 The importance of identifying the effects of past trauma and incorporating this into the support that is provided should not be underestimated. The Commissioners of services in Cornwall have confirmed that the trauma informed approach is not being holistically embedded within all agencies. This learning requires a cultural change as well as an individual practice change across all agencies (**Recommendation 1**).

7.3 **Impact of COVID**

[3] Having mental capacity means being able to make and communicate your own decisions.

7.3.1 The true impact of COVID on Maria has been difficult to determine in terms of her being socially isolated at a time in her life when she needed continuous help and support. Her friend described how the isolation from her family, and the inability to socialise had a huge impact on her mental wellbeing and susceptibility to being a victim of abuse.

7.3.2 What is known is that Maria was desperate to see her youngest child who was seen as a protective factor in preventing the further deterioration in her health. Maria lived for her children and the separation from them was significant in terms of her being able to cope with her daily life.

7.4 Alcohol Dependency

7.4.1 Maria had referred herself to Addaction in 2018 and a co-ordinated response was initiated by WAWY, together with all relevant agencies. There were however, missed opportunities within Health to refer for specialist support - despite four admissions to ED for alcohol abuse and being noted as 'alcohol dependant' Maria was not referred to the Alcohol Liaison Team for approximately five months.

7.4.2 Professionals were clear with Maria about the effects that her dependency was having on her health. and they had also provided advice and guidance in terms of her reliance on over-the-counter medication.

7.4.3 Maria's family felt that agencies should have invested more time with them to fully understand the impact of Maria's behaviour and to assist them in finding solutions to manage the complexity of her needs. The concept of 'Think Family[4]' needs to be broadened from its current use to address the needs of families dealing with members who have complex needs. Health and WAWY should therefore review current support options with a view to improving the outcomes not only for those with complex needs but also those supporting them (**Recommendation 2**).

7.4.4 There were periods where Maria felt able to take back control of her life. On many occasions this desire was driven by the fact that she wanted access to her youngest child and re-establish contact with her family. However, these moments were often short lived, and Maria would continue to turn to alcohol to escape her mental anxiety and the domestic abuse that she was suffering. During the review agencies stated that Maria's dependency on alcohol and her presentations when under the influence of alcohol meant that they struggled to support her, and this limited the treatment options that were available to her.

7.4.5 Professionals tried to work with Maria to develop plans to safely reduce her dependency and had signposted her to other support agencies. This included developing self-coping strategies. Records show that Maria had accessed the Mutual Aid Partnership Groups (MAP) and the Women's Group in the locality. The recovery worker had also encouraged Maria to attend local Narcotics Anonymous (NA) and Alcoholics Anonymous (AA)

[4] Think Family is an approach to help practitioners consider the family as a whole when assessing the needs of and planning care packages with a parent suffering complex issues.

meetings although on many occasions she felt that she was unable to attend the groups or turned up intoxicated. The level of support and signposting that was offered should be seen as good practice.

7.4.6 In addition to the support that Maria had been offered by Health services she had also been offered structured programmes for rehabilitation on three occasions. These programmes had been arranged by WAWY. The success of these programmes was determined by Maria's ability to participate and service ability to engage her in them. When referred on the 9th of May 2018 Maria remained at the facility for approximately twenty-four hours. At that time Maria had left the premise stating that she did not feel safe due to the males who were there, and that she preferred community-based programmes. Records show that staff were cognisant of her concerns and knew that she would have benefitted from being in a woman only facility however there were no such facilities available in either Devon or Cornwall at the time.

7.4.7 Agency records show that professionals had consistently tried to work with Maria and encourage her to remain engaged with the rehabilitation programmes. Unfortunately, two detox placements broke down as Maria had developed friendships with other male residents within those settings. This was against the rules at the accommodation.

7.4.8 This case clearly demonstrates that women only facilities are required to ensure that individuals like Maria can seek rehabilitation in an environment that they consider to be safe. Such accommodation would also help to minimise the risks associated with mixed sex facilities where individuals can be further victimised due to their vulnerability. Funding has now become available in Cornwall to make adaptations for women only units but this is currently in its early stages. The commissioning arrangements and the delivery of the project needs to be monitored by the Drug and Alcohol and DASV Commissioners to ensure that suitable accommodation is consistently available to vulnerable groups (**Recommendation: 3**).

7.4.9 Maria had told her IDVA and her friend that she felt let down by the supported accommodation that had asked her to leave and that she had no option but to rely on the male, as she had no funds to support herself. Whilst staff were unable to prohibit and control the relationships that Maria formed whilst she was in the community, the DHR panel believe that the process and practice of dealing with relational issues in residential services does need to be reviewed (**Recommendation 4**).

7.4.10 Cornwall Foundation Trust and Adult Social Care recognise that whilst there are pathways offered to individuals to manage alcohol dependency the options to deliver long term support can be difficult to sustain. The review identified that a more sustainable and flexible way of commissioning and delivering services needs to be implemented.

7.4.11 In Maria's case consideration should have been given to a person centred care and treatment plan, which could have detailed how she wanted to be treated when she was under the influence of alcohol. Such a plan might have given her control over her treatment and a greater focus and clarity for professionals when engaging with her. (**Recommendation 5**).

7.4.12 In terms of improved practice, CFT has introduced an alcohol withdrawal detection guideline. Had this been in place at the time of Maria's admissions the CFT IMR concluded that she may have been referred to alcohol liaison sooner, although in Maria's case it is unlikely to have made a significant difference as alcohol support services had already been involved in her treatment for a number of years (**Recommendation 6**).

7.5 Maria's Mental Health

7.5.1 In the latter years of her life her mental health had deteriorated and that this had led to an increased risk of self-harm. Adult C felt that his mother's mental health had declined following the birth of her youngest child. It was at this time that he felt that she was struggling with her self-image and that she had post-natal depression. He also believed that she had struggled to manage the weight loss from her gastric surgery, and that this had caused her pain and discomfort leading to her dependency on prescription medication and alcohol.

7.5.2 On reflection some of the IMR writers felt that many of the initial contacts with Maria had not led to timely referrals to both primary and secondary adult mental health services. There was also a feeling that whilst primary care interventions were in place to support Maria, the pathways that she required were not appropriate in terms of supporting her specific mental health needs. Agencies have reflected that whilst processes and systems are in place, current commissioning arrangements often prevent services being delivered effectively particularly when there is no underlying acute or enduring mental health disorder.

7.5.3 Agencies (GP, WAWY, TFF) had referred Maria to mental health services and she had often presented at times in crisis to ED. The CFT IMR writer has confirmed that on each of these occasions she was appropriately assessed in terms of her immediate needs and that appropriate follow up was put into place.

7.5.4 Overall the assessments which were completed were consistent in terms of their outcomes and Health professionals concluded that in Maria's case she did not reach the thresholds laid down by the Mental Health Act 1983 for detention and the least restrictive option was to discharge her to a place of safety with supervision by WAWY.

7.5.5 CFT's internal serious Incident (SI) review observed that the decisions reached were in line with policy and practice and that in this case it was apparent that external services did not have a full appreciation of the role, scope and operating practices of mental health services. They concluded that whilst CFT teams and staff acted in accordance with operational policy this had not been clear to those outside of the organisation and that "the communication management between the CMHT and other services could be improved upon to ensure stakeholder services understand respective remits, commissioning criteria, and roles and responsibilities" (**Recommendation 7**).

7.5.6 Although there has been nothing identified through the review process that would contradict the conclusions that were reached by the PLS there is evidence in the chronology (and at MDT) that there was significant frustration (GP, WAWY, Children's Services) about the lack of Integrated Community Health Teams (iCMHT) involvement

in Maria's case. Some professionals had felt that there was an over emphasis on Maria's dependency on alcohol to the detriment of her mental health.

7.5.7 The report writer has met with other DHR Chairs working in the County and there is recognition that this issue has failed to be addressed following previous DHR's and is a common theme in present reports. This is a system wide issue and further work is required by Commissioners to address the issues presented in this and other cases (**Recommendation 8**).

7.5.8 Towards the end of Maria's life there was evidence of attempts to address Maria's mental anxiety. There were however opportunities where additional support was considered but it was not followed up.

7.5.9 At present work is currently taking place to implement a dual diagnosis strategy **(Recommendation 9/10**). This strategy seeks to strengthen the pathway between treatment and mental health services to better support clients. This strategy has recently been reinvigorated and needs to be driven by the partnership to improve the outcomes for those with complex needs and their families.

7.5.10 In this case Maria would not have triggered the threshold for such a strategy as she did not have an enduring mental health condition. Any development of the strategy must therefore include recognition of those suffering from mental anxiety and distress who may not reach the threshold for the diagnosis of an enduring mental illness **(Recommendation 11**).

7.6 Capacity

7.6.1 Maria met the definition of vulnerability used by statutory agencies[5] and Adult Social Care had considered this as part of their assessment process under the Care Act 2014.

7.6.2 Records show that the GP's who were supporting Maria had considered her mental capacity as had the Psychiatric Liaison team, the CMHT, SWAST and Housing. When Maria was sober, professionals believed that she was able to make informed decisions. Conversely some professionals (GP, Children's Social Care, WAWY) did question whether Maria had full capacity,[6] and concerns had been raised in relation to her having impaired executive functioning[7] when under the influence of alcohol and prescribed medication.

7.6.3 From[8] the records held it would appear that no one had formally considered whether 'best interest' intervention was required in this case, particularly in view of the risks that were identified and the level of self-neglect that was taking place.

---

[5] Care Act 2014

[6] Capacity means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time (NHS 2022).

[7] Executive functioning is an umbrella term used to identify a wide range of cognitive functions commonly thought to be situated in the frontal lobes of the brain. This includes, for example: insight, attention, planning, organisation, initiation, generating ideas, inhibition, control of behaviours and emotions, problem-solving, evaluation, judgment and decision-making skills.

7.6.4 In some records there was a lack of analysis and reference to legislation (Mental Capacity Act and Care Act). There were some occasions where capacity would appear to have been assessed but the rationale for the outcome was not fully documented.

7.6.5 There were also missed opportunities to fully assess Maria's capacity whilst she was in the community. Mental Capacity Assessments were not completed by ASC despite the referrals that they had received. Three mental capacity assessments were started prior to Maria's death but not completed (**Recommendation 12**).

7.6.6 Under the Care Act 2014, Local Authorities must: carry out an assessment of anyone who appears to require care and support. Within ASC three needs assessment episodes were raised, but none were successfully completed. In this case Adult Social Care had not proactively followed up on the information that had been provided to them by agencies and were relying on information being presented to them.

7.6.7 The ASC IMR identified that further training, advice and guidance is required around the complex issue of fluctuating capacity and the need to find different approaches to work with people with multiple complexities. Many key workers do not receive any training in relation to capacity and the issue of consent (**Recommendation 13**).

7.7 Risk Management

7.7.1 All of the agencies who had contact with Maria had risk management processes in place. Whilst each agency was looking at risks factors that were pertinent to their own organisation there was also a collective understanding of the issues that Maria was facing due to the multi-agency information sharing that had taken place.

7.7.2 There was however an over reliance on WAWY being able to manage those risks and agencies have since identified that it would have been helpful to have had a specific and recorded discussion about the risk and protective factors with all of the key professionals earlier. The need for such a co-ordinated multi agency risk management plan was recognised in April 2018. Professionals felt that an earlier collective approach may have identified patterns in her behaviour, including areas of vulnerability and would have ensured that there was a holistic approach when working with Maria. Such an approach was not fully instigated until the October 2020.

7.7.3 Maria reached a point of crisis when she felt that she was unable to see her youngest child, and it is unclear whether all agencies truly understood the impact of this in terms of her taking her own life.

7.7.4 Many professionals felt at a loss as to what they could do to support Maria and they believed that they had exhausted all available pathways of care and support or were frustrated by the responses by other agencies. There was considerable agency involvement at this time but much of it had occurred in silos and some agencies would have been unaware of all of the risks.

7.7.5 The review has highlighted that in those cases where there are complex needs and where the individual is attempting to take their own life often there is a lack of clarity as

to who owns such a case in terms of case management. In order to overcome some of these issues Cornwall are looking at proposals for a rapid response unit for dealing with individuals who are reaching out for help and threatening to take their own lives. Any such proposal must link in with the work being undertaken on the Dual Diagnosis Strategy and the Community Mental Health Transformation Framework. Services must be integrated to achieve positive outcomes and referral pathways need to be clear for all professionals working in the County **(Recommendation 14).**

7.8 Domestic Abuse

7.8.1 Maria had been the victim of domestic abuse whilst living with her first fiancée. She had also disclosed that she was being abused by her current husband. Agency records document physical and sexual assault. There were also disclosures of economic, psychological and emotional abuse some of which was witnessed by her youngest child. Maria had also made disclosures to her family.

7.8.2 Despite the disclosures that Maria had initially made to professionals she would later retract her allegations or minimise the abuse that she had disclosed. Research has shown that many victims of abuse will retract statements and disclosures due to emotional (fear, embarrassment, shame, and self-blame), physical (partners physical presence, abuse, controlling and coercive behaviour) and organisational pressures (appropriateness of setting and time for disclosures)[9].

7.8.3 The frequency of the abuse that occurred in the relationship was difficult to determine due to Maria feeling unable formally report the incidents that were occurring. Professionals working in all the agencies were alive to the fact that many cases of domestic abuse can go unreported[10] and had tried to actively engage with Maria to obtain the true facts.

7.8.4 Although Maria would disclose some of the details of abuse that she was suffering there were other occasions where she was very protective of her husband. She stated that her husband was struggling to manage her behaviour and was trying to help her but often this left her feeling 'suffocated'. She would also appear to justify his actions by stating that it was her fault. Such a response is not an uncommon response by victims[11] due to the abuse that they are suffering, and the level of coercion and control inflicted on them by those committing domestic abuse.

7.8.5 What was apparent in agency records was that Maria felt that there was a consistent level of coercion and control in the relationship, and this would have undoubtedly affected the way in which she presented to professionals and impacted on her levels of anxiety and alcohol consumption.

7.8.6 There were occasions where Maria was seen by Health and other agencies together with her husband despite concerns being known about coercive and controlling behaviour. There was evidence in records of some professionals had discouraged this

[9] Heron L, (2021).
[10] On average victim's experience fifty incidents of abuse before getting effective help (Safe Lives ;2018)
[11] Lahav (2017)

(WAWY) but that it still happened. It is important that those individuals who may be the victim of domestic abuse have the opportunity to speak freely and with confidence with professionals. Agencies need to reinforce this message through existing training and supervision **(Recommendation 15)**.

7.8.7 Overall, the professionals that Maria came into contact with and that were aware of the allegations were responsive to the fact that she was suffering abuse and they did actively try to illicit the information from her and encourage her to report the matter to the Police. Whilst joint work was undertaken together with First Light, Maria's case would have benefited from a more co-ordinated approach by domestic abuse services.

7.8.8 Agency records show that they were proactive in working with the couple to address the concerns that had been raised. The couple were referred to Relate[12] and Maria's husband was referred for emotional support by his GP and accessed support from Outlook Southwest[13], who engaged in "Silver Cloud" [14]online support and which he completed.

7.8.9 There were three episodes in Maria's life where she experienced physical and sexual abuse by other males two of which involved Adult D. In terms of agency response to domestic abuse the police officers who engaged with Maria followed policy (D034[15]) and guidance in relation to evidence led prosecutions and adhered to the single safeguarding process.

7.8.10 The investigative actions surrounding her incidents were largely hampered by Maria's inability to engage, her changing accounts, the lack of corroborating evidence, and on some occasions evidence that directly undermined her initial account. It would appear that much of this reluctance to engage was attributable to her mental anxiety and the abuse that she was suffering.

7.8.11 IDVA's had built up a good rapport with Maria and had continued to support her even at times when she felt unable to engage or was under the influence of alcohol. The IDVA's had considered risks and there is evidence that they were actively working with and escalating risks to other agencies. There was also evidence of effective case management at those times in Maria's life when she was in crisis.

7.8.12 Professionals involved in the review felt that Maria's case should have been referred to MARAC earlier, but it has been highlighted that on many occasions she was unable to take part in the process due to her alcohol dependency and mental anxiety, and therefore this meant that her case didn't reach the threshold for referral on the information that was available at the time. All agencies have agreed that the process needs to be holistic and look at all of the available information when reviewing a case. Such oversight would enable all suitable cases to be referred to MARAC even where a victim feels unable to take part in the process.

[12] Relate provide professional help and support to strengthen peoples relationships.
[13] Outlook South West offers mental health therapy for people suffering with stress, low mood and worry.
[14] Silver Cloud provide evidenced based wellbeing and behavioural health interventions through digital platforms.
[15] Devon and Cornwall Police's Domestic Abuse Policy.

7.8.13 In relation to Secondary Health Services there was evidence of Routine Enquiry (RE) although its use was not consistent. There were some instances of RE and DA questions being asked but further actions not followed up by asking whether Maria wanted any support. Whilst there have been improvements in the use of RE this has yet to be fully embedded (**Recommendation 16/17**).

7.8.14 The Probation Service (NPS) only came into contact with Maria as a consequence of her drink driving conviction and there was no opportunity to meet with her to explore her circumstances. As a consequence of this case Probation have identified that domestic abuse practice could be improved by having the MARAC discussions recorded on their National Database for those individuals known to the service (**Recommendation 18**).

7.8.15 The Service also identified that at present child safeguarding checks are made as a matter of routine by Courts Administrators when individuals are sentenced. The Probation Service has made a further recommendation that this practice should be expanded to include Vulnerable Adult safeguarding checks. This would be particularly important in cases of violence, or where abuse is known or suspected (**Recommendation 19**).

7.8.16 During the review process a further area for learning was identified by the Courts Team. In order to prevent offenders being sentenced without the Probation Service being made aware, daily meetings between CPS prosecutors and Court officers should be held. (**Recommendation 20**).

7.8.17 The Housing providers that were involved in Maria's case were acutely aware of her vulnerability and she was supported to access temporary accommodation. At present no assessment will take place when a person is under the influence of alcohol. This policy directly led to Maria rough sleeping. This issue has been reviewed and Cornwall Housing Ltd and Cornwall Council are currently working on a long-term project to reduce the use of Bed and Breakfast accommodation for emergency and temporary accommodation which is encouraging. (**Recommendation: 21**).

7.9 Operational Practice, Policy and Procedure

7.9.1 Although there were opportunities to improve information sharing in this case there were examples of good practice. There have also been further changes in practice to improve information sharing opportunities since this case, including at MARAC meetings.

7.9.2 In terms of supervision it was apparent that some of the staff in RCHT were not aware of its significance. In particular, Acute staff within ED were unable to discuss who they might seek supervisory support from. The RCHT IMR report writer identified that staff, across all disciplines and designations, need to understand the significance of supervision in respect of safeguarding (**Recommendation 22**).

7.9.3 The Health IMR writer identified that during the Pandemic domestic abuse information leaflets and notices that had previously been placed in hospital settings had been taken down. This was in response to infection control measures. RCHT/CFT, and all other

agencies, need to ensure that relevant literature and support material is available in prominent locations throughout their sites (**Recommendation 23**).

7.9.4 First Light is currently running the Primary Care DASV identification and referral pathway pilot. This pilot offers three named workers who are a direct point of contact for each surgery. A simple referral process has been developed, and advice and support are provided to those patients the surgeries have identified as being victims of abuse. The pilot is currently in its second year and is delivering improved outcomes but at present it only has funding to deliver the project until 2023 (**Recommendation 24**).

7.9.5 In Maria's case there were significant delays in getting an OPA[16] for her. On review the apparent lengthy delay between requesting an urgent OPA and the process being carried out, was actually within the expected standard of twelve weeks. The Health IMR writer has however questioned whether there should be a mechanism for seeking and gaining more timely input from the consultant. Such a referral would have been beneficial in assisting Maria to manage her condition whilst in the community (**Recommendation 25**).

7.10 **Training**

7.10.1 Representatives of the agencies involved in this review have confirmed that training and awareness in relation to domestic abuse, MSP and adult safeguarding continues to be delivered to all staff in order to promote greater knowledge and understanding.

7.10.2 The GP IMR writer has identified that GP practices would benefit from additional domestic abuse training which includes details of the MARAC and DASH. At present First Light deliver this training but attendance by some GP's and surgery staff has been inconsistent (**Recommendation: 26**).

7.10.3 The review has also identified that frontline practitioners working with those with complex needs require access to additional training in Mental Capacity and dependency behaviours (**Recommendation: 27**).

8.0 Conclusions

8.1 Historically individuals like Maria have fallen through the gaps between services, and they become disconnected from the help and support that would make a difference to them. This problem has been made worse by a lack of available services, inflexibility in their approach, or services not working in a co-ordinated way. This results in many people with multiple, complex needs circulating through different services and systems without improvement in their lives but at a cost to them, their families, and the community. This can be seen in this particular case.

8.2 Health and Adult Social care professionals acknowledge that services often struggle to engage and work with individuals like Maria who experience ill health (both mental and

[16] OPA is a form of a cognitive behavioural tool that has been developed, to reduce stress quickly and effectively for those who live with mental illness.

physical) in connection with substance dependency and domestic abuse. Despite these challenges all agencies in Cornwall worked within current pathways to deliver care and support.

8.3 Maria had received considerable support during the review period from a variety of statutory and non-statutory organisations. This case does however highlight that, despite that level of intervention, there are still gaps in current service provision and often opportunities for co-ordinated early intervention and care plans were missed.

8.4 In Maria's case there was no clear complex disorder diagnosis, and this meant that her treatment options in terms of her mental anxiety under existing arrangements were limited. This had led to considerable frustration amongst the professionals across numerous agencies who felt at a loss as to what they could offer her. Non-mental health practitioners felt that they did not have the skills or the tools to help either Maria or her family. There is currently a lack of consistency in terms of the existing support pathways for those suffering from mental anxiety and distress and the commissioning of services for those experiencing such challenges needs to be reconsidered. The current lack of services is unsustainable.

8.5 Learning from this review has highlighted the importance of all agencies adopting a trauma informed approach and giving equal consideration to each aspect of the presenting issues for those individuals like Maria who may have complex issues such as alcohol dependency domestic abuse and her mental health.

8.6 Whilst existing partnership arrangements are strong, more robust, enduring, and collaborative working arrangements are needed between alcohol/drug services and Health. Current attempts to improve these arrangements are positive but need strategic support and current commissioning arrangements need to be reviewed.

8.7 On occasions policy and procedures were not adhered to and where this has been identified agencies have demonstrated a commitment to address the learning in these areas. Additional training needs were also identified and have been actioned.

8.8 From the documents that have been reviewed there was no single factor that could be attributed to Maria taking her own life. A combination of mental anxiety, domestic and sexual abuse, childhood trauma, and alcohol dependency had led Maria to a low point in her life where she felt alone and unable to turn to anybody for help. Many of the protective factors that had helped her in terms of crisis had diminished and she had at that time been left feeling that she would not be unable to see her youngest child again on any meaningful basis.

8.9 What is clear is that Maria left a lasting impression on many of the professionals that she came into contact with and her loss was felt across a number of different services.

9.0 Learning and Recommendations

9.1 The learning opportunities identified in this case that have resulted in recommendations listed below;

Learning: In order to improve the outcomes for those with complex needs all agencies should adopt a trauma informed approach and work together to undertake assessments and develop co-ordinated and person centred treatment and welfare support plans.

Recommendation 1: Safer Cornwall Partnership, OSCP and SAB (or/and the SSCOG) to work with all agencies to develop and commission a co-ordinated response to the delivery of trauma informed services for individuals with complex needs.

Learning: In cases involving individuals with complex needs professionals should use the 'Think Family Approach' to increase support options and improve resilience. This will ensure that families can work effectively with agencies to maximise the outcomes of treatment and care plans.

Recommendation 2: RCHT, CFT, GP's and WAWY should review and promote the support options (including the tertiary and voluntary sector) that are available for the family members of those identified with drugs/alcohol dependency and mental anxiety.

Learning: There is a recognised need for the development of 'women only' accommodation in Cornwall to maximise opportunities for rehabilitation and minimise the risk of further exploitation.

Recommendation 3: As part of its domestic violence strategy Safer Cornwall Partnership to monitor the implementation of the programme of work relating to women only spaces in rehab and detox units.

Learning: When Maria was asked to leave supported accommodation due to contravening the rules she was exposed to an increased risk of exploitation and abuse. Whilst staff followed current policy and there was a need to protect other residents a more considered approach is needed in relation to relational issues.

Recommendation 4: Harbour Housing, Cornwall Council and WAWY to review of process and practice of dealing with relational issues in residential services.

Learning: In Maria's case consideration should have been given to a person centred plan (in line with the principles of Making Safeguarding Personal) which could have detailed how she wanted to be treated when she was under the influence of alcohol. Such a plan might have given her control over her treatment and a greater focus and clarity for professionals when engaging with her.

Recommendation 5: WAWY and ASC to work together to improve current working practices and policy in respect of person centred plans.

Learning: The introduction of the screening and identification of alcohol misuse and the alcohol withdrawal guideline provides additional support for staff when dealing with complex cases.

Recommendation 6: RCHT and GP's and WAWY to ensure all health practitioners are educated in the screening and identification of alcohol misuse and the alcohol withdrawal guideline.

Learning: The internal review conducted by RCHT/CFT identified that whilst CFT teams and staff acted in accordance with operational policy this had not been clear to those outside of the organisation and that "the communication management between the CMHT and other services could be improved upon to ensure stakeholder services understand respective remits, commissioning criteria, and roles and responsibilities".

Recommendation 7: The revised and ratified CFT CMHT Policy, once published, to be disseminated to all stakeholders to improve understanding of roles, remits and responsibilities and aid collaborative working. To provide clarity re the interface and working arrangements between community, primary and secondary mental health provision.

Learning: The current MH provision for those individuals who do not have an acute and enduring mental health illness is poor. This is a recognised National issue. There is a need for the Commissioners of current services to come together to implement improved systems and structures in Cornwall.

Recommendation 8: JCSOG to develop an integrated approach to mental health support including integrated teams and pathways for those with mental anxiety and distress that don't meet current thresholds.

Learning: There is a current need to update and implement the Dual Diagnosis Strategy in Cornwall and the Isles of Scilly to ensure that current pathways between drug and alcohol services and mental health services are strengthened in order to support clients.

Recommendation 9: JCSOG to ensure that the Dual Diagnosis Strategy is implemented in line with timeline of the dual diagnosis implementation project plan.

Recommendation 10: Multi-agency Dual Diagnosis Steering Group to continue work regarding agency interface to ensure WAWY attendance at CFT MDT's and interface meetings, multi-agency attendance at GP Hub and local interface meetings become business as usual.

Learning: In order to improve the care and treatment options for individuals suffering from mental anxiety and distress (those not diagnosed as having an acute and enduring mental illness) there is a need for the Dual Diagnosis Strategy to provide optional pathways for professionals working with those with complex needs.

Recommendation 11: The Dual Diagnosis Strategy should include pathways for treatment for those individuals with mental anxiety and distress.

Learning: ASC identified that frontline staff and decision makers find it difficult to understand issues around capacity and consent and that additional work needs to take place in relation to legal literacy.

Recommendation 12: ASC to instigate quality assurance and audit measures to ensure that the current completion of mental capacity, risk and needs assessments are being completed in line with current policy and national best practice.

Recommendation 13: ASC to undertake a training needs analysis to ascertain if training, advice and guidance is required around the complex issue of fluctuating capacity (especially where there is alcohol dependency).

Learning: Cornwall are looking at proposals for a rapid response unit for dealing with cases such as this where individuals are reaching out for help and threatening to take their own lives. To be effective any such proposal must link in with the work being undertaken on the dual diagnosis strategy and the Community Mental Health transformation framework.

Recommendation 14: Complex Needs Team and the Mental Health Commissioner to ensure that the development of the rapid response team is integrated into the dual diagnosis and the Community Mental Health transformation framework.

Learning: There were occasions where Maria was seen by Health and other agencies together with her husband despite concerns being known about coercive and controlling behaviour. It is important that those individuals who may be the victim of domestic abuse have the opportunity to speak freely and with confidence with professionals.

Recommendation 15: CFT, RCHT and WAWY to ensure that DA training reinforces the importance of seeing DA victims on their own for consultations and meetings.

Learning: Whilst there have been improvements in Health staff using Routine Enquiry the review identified that current systems and policies are providing barriers to it being fully embedded into practice.

Recommendation 16: MIU audit of RE practice amongst staff and clinical records to ensure RE is embedded in practice by Area Directors.

Recommendation 17: A Task and Finish group should be set up to look at how ED staff can be helped and supported to embed routine enquiry into their practise, acknowledging what they have told us through this investigation in terms of the perceived pressures and constraints.

Learning: There is a need to identify victims and perpetrators who are known to, but not currently supervised by the Probation Service, and who are subject to MARAC oversight in order to improve current partnership arrangements, reduce risks and oversight of vulnerability.

Recommendation 18: Probation to implement a process to record MARAC discussions on the ND if individuals are known but not current.

Learning: Current processes within the Court system means that there is a disparity in the application of safeguarding checks for vulnerable adults known to Social Care when compared with safeguarding checks for children linked to the individual. Relevant safeguarding checks (MARU/ASC) should be carried out before sentencing any adult.

Recommendation 19: Probation to ensure that adults safeguarding checks are undertaken by Courts Administrators as a matter of course, as they are for child safeguarding.

Learning: There is a need for Probation to identify both victims and perpetrators of domestic abuse, and other complex behavioural issues, when individuals are in the Court process. This will allow Probation to recommend sentencing activity informed by a pre-sentence report for those identified individuals in order to improve outcomes for them.

Recommendation 20: Probation to reinstate daily meetings between CPS prosecutors and Court officers (and where appropriate the court IDVA).

Learning: Current Housing policy and practice acts as a barrier to managing those with complex needs and this gap in service provision has been recognised by Cornwall Housing Ltd. Cornwall Housing Ltd and Cornwall Council are currently working on a long-term project to reduce the use of Bed and Breakfast accommodation for emergency and temporary accommodation.

Recommendation 21: Cornwall Housing Ltd and Cornwall Council to provide an update on progress on the project to reduce the use of Bed and Breakfast accommodation for emergency and temporary accommodation and timescales to the Adult Safeguarding Board.

Learning: The current supervisory structures in RCHT were not known to all staff.

Recommendation 22: RCHT to undertake a review of Supervisory provision available to all acute staff and identify all opportunities and barriers to accessing Supervision. To focus on the perceived hierarchal culture and to understand if this is significantly impacting on our ability to better safeguard patients presenting with and experiencing Domestic Abuse and their families.

Learning: The RCHT /CFT IMR writer identified that during the pandemic leaflets and notices regarding domestic abuse were removed and have not been replaced. The Panel reflected that whilst this learning was identified by the RCHT/CFT other agencies would have also taken the same action during the pandemic.

Recommendation 23: All agencies to undertake a review of public areas within their buildings to ensure that where appropriate DA signposting material is available for staff and service users.

Learning: The GP IMR writer identified that the current approach by GP's could be further strengthened by bringing services such as the IDVA's into the surgery to take part in assessments and consultations.

Recommendation 24: First light to initiate a focus group to work with primary services to establish how IDVA's can actively take part in GP assessments and consultations for appropriate clients.

Learning: In Maria's case there were significant delays in getting Outpatient appointments (OPA's) for her. Such a referral would have been beneficial in assisting Maria to manage her condition whilst in the community.

Recommendation 25: Review of CMHT psychiatrist OPA timeframes, level of urgency and options for more responsive OPA review.

Learning: The Health IMR writer has identified that GP practices would benefit from additional domestic abuse training which includes details of the MARAC and DASH. In addition to this further training is required in terms of Mental Capacity which should be bespoke for practices and trauma informed approaches and dependency behaviours

Recommendation 26: Cornwall and Isle of Scilly Integrated Care Board and Firstlight to develop a training delivery strategy for GP services in relation to MARAC and DASH.

Learning: The review has also identified that frontline practitioners working with those with complex needs require access to additional training in Mental Capacity and dependency behaviours.

Recommendation: 27 – Cornwall SAB to implement training for frontline practitioners relating to Mental Capacity and dependency behaviours.