SUNDERLAND SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

CONCERNING: '***TRACY'***

FINAL REPORT 12th December 2016:

EXECUTIVE SUMMARY

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Introduction

1. This is the Executive Summary Report of a Safeguarding Adults Review (SAR) commissioned by Sunderland Safeguarding Adults Board (SSAB). It provides a summary of the key learning points and recommendations arising from the SAR. The full Overview Report offers more detailed analysis of the events which impacted on Tracy[1], including the evidence bases behind the learning points and recommendations.

2. The 2014 Care Act placed a new statutory duty for Safeguarding Adults Boards (SABs) to carry out SARs[2] in cases where a vulnerable adult dies or comes to serious harm as a result of abuse or neglect and there is reasonable cause for concern about how the SAB, members of it, or other persons with relevant functions worked together to safeguard the adult.

3. The Act is clear that the purpose of SARs is to identify lessons that can be learned and to ensure that these lessons are applied in the future. This SAR has not set out to apportion blame on organisations, or individuals working for those organisations. Rather, the focus has been on understanding as fully as possible what took place; how organisations worked individually and collectively; and most importantly the actions needed to prevent (or at least reduce the risks of) other vulnerable adults coming to serious harm as a result of abuse or neglect.

[1] For reasons of confidentiality, pseudonyms of Tracy and Jack are used throughout the report in place of the real names of the married couple who are the subjects of the SAR. For similar reasons, references to precise ages and locations are also avoided, where possible.

[2] SARs were previously referred to as Serious Case Reviews / SCRs, but were not a statutory duty prior to the 2014 Care Act.

Summary of events leading to the decision to hold a Safeguarding Adults Review

4. Tracy is between 60 and 70 years old and has been married to Jack (of similar age) since she was 17 years old. Until the incident which triggered this SAR, the couple lived together in Sunderland. They have a grown up son and daughter and grandchildren, residing in the Wearside area.

5. Tracy has long history of mental health problems and is well known to local mental health services. She had been diagnosed some years earlier with a bi-polar disorder and had received treatment from community based mental health services, with intermittent admissions for in-patient treatment at times of mental health crisis.

6. Police and ambulance services were called by Jack to an incident at the couple's address[3]. Tracy had been repeatedly stabbed in the chest area by Jack, using 2 kitchen knives. When emergency services arrived she was bleeding profusely and was close to losing her life. Jack had self-inflicted cuts to his wrists. Following the paramedic response and a period of intensive hospital inpatient treatment, Tracy has made a good recovery from her physical injuries.

7. Jack was initially charged with attempted murder, but this was subsequently changed to Section 18 assault with intent, to which he entered a guilty plea. He was granted bail by the Court, prior to sentencing. The sentence imposed was 7 years imprisonment.

8. An initial scoping exercise arranged by the SSAB Learning and Improvement in Practice Sub-Committee highlighted a number of concerns, resulting in the conclusion that there was statutory duty under the 2014 Care Act for an SAR to

[3] Specific dates have been removed from the Executive Summary report, to help maintain confidentiality.

be arranged. Key concerns arising from the scoping exercise and review of a chronology of multi-agency contacts included: [4]

- Prior to the stabbing incident, Tracy had repeatedly reported (to services including the police, mental health services and a specialist domestic violence service) that she was a victim of domestic violence and other forms of abuse perpetrated by Jack.
- On occasions when the police were called to incidents where Tracy reported that Jack had subjected her to violent assault and other forms of abuse, no police action was taken against Jack, on the basis that the presenting evidence supported Jack's accounts - that Tracy's mental health problems and consequent behaviours were the primary causes of these incidents.
- There was evidence to suggest that Jack may have used Tracy's mental health diagnosis as a tool of coercive control, whilst agencies in contact with the couple failed to recognise this behaviour.
- Tracy spent periods in a women's refuge after domestic violence incidents had occurred. She was assessed as being at high risk of suffering domestic abuse and was referred into the Multi Agency Risk Assessment (MARAC) process, however, it was not clear that this resulted in any effective actions to address or reduce risks of future domestic abuse.
- There was evidence of mis-communication and ineffective joint planning processes between some of the services in contact with Tracy. It was felt that this may have contributed to missed opportunities, where risks to Tracy could have been better recognised and more effectively dealt with.

Terms of Reference

9. The above points summarise the main 'headline' concerns which resulted in the decision to carry out an SAR. Based on these concerns the following Terms of Reference questions were established, to cover a timeline of 30 months leading up to the stabbing incident.

[4] This is not a comprehensive list of concerns. Section 7 of the full overview report provides more detailed accounts of the full range of concerns arising from events and agency responses prior to the stabbing incident.

1. What is your organisation's involvement in the MARAC process?

2. Did consideration of TRACY within the MARAC process result in a robust and comprehensive action plan?

3. Was TRACY's voice heard by your organisation?

4. a. Was TRACY's mental capacity to make informed decisions regarding her care considered by your organisation?

b. Was consideration given to whether TRACY's decision making was affected by coercion or control from her husband?

5. a. Within your organisation what is the expected practice regarding victims of domestic abuse receiving contact from potential perpetrators?

b. Does your organisation have a domestic abuse policy, if so, how does this support the victim and staff members working with them?

6. Was TRACY's husband identified by your organisation as TRACY's carer in light of her mental and physical health problems?

7. Were appropriate safeguarding measures taken in relation to any children that may have been subject/witness to abuse?

8. Was TRACY offered support by your organisation in relation to alcohol abuse?

9. With specific regard to domestic abuse:

a. Was domestic abuse regarded as a safeguarding issue by your agency?

b. Was TRACY considered by your agency to be a victim or perpetrator?

c. Did the portrayal of TRACY's mental health by her husband affect the decisions made by your organisation with regard to her risk of domestic abuse?

10. What is your organisation's policy with regard to the updating of customer details, such as Next Of Kin/person to contact in an emergency?

11. Were decisions made by your Agency influenced by TRACY's husband, such as discharge arrangements and follow-up care?

12. Did your agency inform others involved in TRACY's care regarding changes in her situation, such as discharge plans and living arrangements?

It was agreed that additional terms of reference may be included following the appointment of the Independent Overview Author.

Individual Management Reviews

10. Based on the initial scoping exercise, it was ascertained that the following agencies had had significant involvement with Tracy and her husband during the relevant period. Chronologies and IMRs were provided by each of these services:

Organisation	**Primary role**
Northumbria Police	Call outs to domestic incidents
GP Practice (IMR produced by Sunderland NHS Clinical Commissioning Group (SCCG)	Primary healthcare services to Tracy
Wearside Women in Need (WWIN)	Accommodation in a women's refuge and domestic violence outreach support
Salvation Army (SA)	Supported accommodation
City Hospitals Sunderland NHS Foundation Trust (CHS)	Medical care for Tracy at CHS including: • Emergency Department • Out-patient • In-patient
Northumberland Tyne & Wear NHS Foundation Trust (NTW)	Mental health treatment and support: • Community Mental Health Services • In-patient Mental Health Services
Sunderland City Council Adult Social Care[5] (ASC)	Hospital Social Work Team input in relation to discharges from CHS

[5] The Adult Social Care IMR was requested and provided later in the SAR process, after it became apparent that the Hospital Social Work Team had had some brief but significant involvements relating to hospital discharge processes.

Tracy's involvement with the SAR

11. Tracy met with the SAR Panel Chair and the Overview Report Author. She spoke of her experiences, feelings and views about the services she was in contact with during the period under review. Tracy's contributions have directly informed all of the key learning gained from the SAR process.

12. **The SAR Chair, report author and panel members have been highly impressed by the courage that Tracy has shown, in sharing her experience and insights as a survivor of domestic abuse and a user of local services. All of the agencies involved in the SAR wish to record their gratitude for Tracy's contributions which have been highly valuable in helping to ensure that key lessons are learned for the future.**

SAR Panel

Independent Chair:

Julie Lister, Operations Manager Gentoo

Independent overview Author:

Richard Corkhill, Independent Consultant

Agency membership:

- Sunderland City Council
- The Salvation Army
- Sunderland NHS Clinical Commissioning Group
- Northumbria Police
- North East Ambulance Service
- Northumberland Tyne & Wear NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- South Tyneside NHS Foundation Trust
- Wearside Women in Need

Summary of key learning points

Key learning point 1:

13. Where risk assessments carried out within a very short period of time have reached widely differing conclusions about risk levels, it is important to carefully consider why this may be and the quality and depth of the evidence bases which informed the assessments.

Key learning point 2

14. All agencies with adult safeguarding responsibilities should promote and maintain an awareness that people with a diagnosis of mental health problems may have particular vulnerability to coercive control. A skilled coercive abuser may mislead family members and professionals alike, into an acceptance that domestic incidents stem from the victim's mental illness and behaviours. Where this is what is reported by an alleged perpetrator, the possibility that indicators of mental illness are potentially responses to repeated episodes of abuse should not be ruled out. When applied skillfully this type of victim blaming by the perpetrator can be very difficult to detect, particularly because the abuse victim can present as being angry and "irrational" (and might be under the influence of alcohol) whilst the abuser appears calm and reasonable.

Key learning point 3

15. When working with situations of domestic violence, it is essential that inter-agency referrals about high risk victims should be clearly recorded. There should also be a reliable feedback system, so that when a referral is made, the referring agency should request and receive confirmation of receipt. With few exceptions, this should be achievable using electronic communications.

Key learning point 4

16. The current multi-agency MARAC protocol states that a high risk assessment for domestic abuse should always result in a MARAC referral and it should be the assessing agency's responsibility to make sure that this takes place. There is an urgent need to review the protocol and how it works in practice, particularly

following placement in a refuge and (most critically) at the point where a woman may decide (often without any advance notice to refuge staff) to leave a refuge and return to a high risk relationship.

17. Whatever the outcomes of a review of the MARAC protocol, it is essential that the protocol (including any revisions made as a result of the review) is properly understood and consistently applied by all of the MARAC partners.

Key learning point 5:

18. NTW and CHS staff could have consulted with their safeguarding leads who in turn could have established that no MARAC referral had been made. That this did not take place was a further missed opportunity.

Key learning point 6:

19. There is no reference in GP records that Tracy's disclosure to the practice nurse was subject to any further discussion within the practice or that any actions followed. This was a missed opportunity for staff at the practice to seek advice from the CCG Safeguarding Team and to initiate actions to offer Tracy support. The IMR for the GP practice confirms that this was an ongoing theme throughout the review period, highlighting that out of 58 contacts between Tracy and the practice, there were only 2 documented occasions when domestic violence concerns were discussed.

Key learning point 7

20. Although the CPN had recorded that a MARAC referral had been made, they appear not to have questioned why there was no evidence of any MARAC related activity. This was poor practice. The situation was compounded further when the CPN passed on the misinformation (that a MARAC referral *had* been made) to the GP practice, meaning that the primary healthcare service was working under the misapprehension that domestic violence issues were being actively addressed. This would make it unlikely that primary healthcare clinicians

would see any need for them to refer to MARAC or to a specialist domestic violence service.

Key learning point 8

21. It is of fundamental importance that women's refuge residents should have immediate and barrier-free access to the local primary healthcare services in the local GP catchment area. If significant refuge staff time is taken up with negotiating individual residents' access to local primary healthcare services, this inevitably reduces capacity to work directly with residents. This issue requires urgent resolution between all parties, with leadership from Sunderland CCG.

Key learning point 9

22. Better communications between WWIN, CHS ward staff and the Hospital Social Work Team should have clearly established that Tracy would be welcome to return to the refuge, subject to her being medically fit for discharge and there being a multi-disciplinary discharge plan to which WWIN had signed up. WWIN records show that that they requested a pre-discharge meeting with CHS. CHS have no record of this request being made.

Key learning point 10

23. Whether or not CHS had a record of a request for a discharge meeting, the facts were that CHS nursing staff and the Hospital Social Work Team were aware that Tracy had been admitted from the refuge. This would have clearly identified that she had been fleeing domestic violence at the point of admission to hospital. In these circumstances, best practice would have been to convene a pre-discharge meeting and to include an invitation to WWIN. Such a meeting would have at least have given clarity on the potential option of Tracy to returning to the refuge.

Key learning point 11

24. The circumstances surrounding the 'red escalation' status at CHS appears to have been a significant factor in the decision to discharge Tracy, despite her

being homeless. This is understandable, given that she was deemed medically fit for discharge and there was a need to free up beds for other patients with urgent medical needs. However, there was a period of 6 days during which she had been fit for discharge and this period should have allowed for pro-active work to ensure that the discharge would be to an environment best able to meet her needs as a person at risk of domestic violence.

Key learning point 12

25. That the Salvation Army service was a much less appropriate placement compared to the refuge should have been abundantly clear. Yet none of the agencies involved at this time (in particular WWIN Outreach Team, Access to Housing, the CPN and the Salvation Army) appear to have considered a need to urgently review the situation, with a view to Tracy's return to the refuge. This was a major missed opportunity.

Key learning point 13

26. Whilst it was positive that Tracy's longer term housing needs were being actively pursued, it was inappropriate for her to be nominated for a property in close proximity to the domestic abuse perpetrator. This highlights that agencies supporting domestic violence victims with social housing applications need to ensure that social housing providers have relevant information about ongoing risks and any implications of these risks for the location of accommodation offers. Apart from the delay this would cause in finding suitable housing, it added to Tracy's sense that her needs were not being listened to. If Tracy had received a suitable housing offer at this point, this would have given her a positive option, making it less likely that she would decide to return to her husband. This was another missed opportunity.

Key learning point 14

27. There is a need for CHS to audit their internal flagging systems to ensure that where the hospital hold records of past domestic violence concerns, this is made known to staff involved in subsequent hospital admissions / A&E attendances.

Key learning point 15:

28. At the time of this admission, Salvation Army staff should have informed ward staff of the potential domestic violence risks posed by Jack. They may have assumed that CHS staff would be aware from her recent admission, but the evidence of this case confirms that no such assumptions should be made.

Key learning point 16:

29. Feeling socially isolated whilst in hospital was a key factor in Tracy deciding to return to her husband after the last hospital admission. This highlights the importance of preventative outreach services which can help people in such vulnerable circumstances to build self-confidence and work towards social and emotional independence from an abusive partner.

Key learning point 17:

30. As acknowledged in the ASC IMR, there were missed opportunities for Hospital Social Work staff to engage sensitively with Tracy about her situation and ongoing domestic violence risks and there is also concern about weaknesses in case recording practices and evidence of confusion about her discharge address. This indicates a need for regularly updated and refreshed domestic violence training and awareness raising for members of the Hospital Social Work Team.

Individual Agency Recommendations

The following recommendations are reproduced from agency IMRs:

Northumbria Police

1) Where other agencies are involved the Police should not rely on other agencies and submit an Adult Concern Notification (ACN) where the criteria are met.

Sunderland CCG

1) Training to be delivered to GPs and Practice Nurses on Domestic Abuse including coercive control, raising and responding to a MARAC alert, physical symptoms that could be an indicator of domestic abuse, importance of 'hidden harm' with regard to children in the household.
2) Domestic Abuse Referral Pathway to be developed and disseminated to be used by Primary Care staff.
3) Primary Care Guidance will be reviewed to ensure that there is specific information to ensure that all Primary Care staff are using the same 'flags' and coding systems to records Domestic Abuse situations.
4) Ensure that where Domestic Violence is coded or identified this is subject to on-going routine enquiry by staff in Primary Care.
5) The GP practice in question to receive feedback on the case. The clinicians in the practice also need to receive Adult Safeguarding training which is appropriate to their role, this training should include specific reference to Domestic Violence.
6) GP Practices to be given guidance to review their procedures to ensure that where there are known risks in relation to a patient or household, which include a history of serious assaults; this should trigger a routine risk assessment in relation to lone working.

Wearside Women in Need

1) Staff training re: advocating for service users where there is discomfort about a decision or action around a service user. Remind staff about their individual responsibility. Staff reflect on practice in weekly meetings.
2) Where possible staff visit service users when they are in hospital. Revisit and update WWIN hospital visiting policy.
3) Encourage greater reflection in staff team on impact of trauma and PTSD on service users' behaviour. Identify training resources to enable learning
4) Overhaul of all outreach team systems. Introduction of new software to save time & improve information sharing.

5) Review how WWIN works with women with complex needs and attempt to identify funding to enable more intensive & focused work with them.
6) Continue to attempt to advocate for service users in multi-agency settings where other agency staff may not have had training, or have an understanding of domestic violence, particularly in relation to older women and mental health

Salvation Army

1) Details of Domestic Abuse Training to be circulated
2) Information from MARAC – To work within a protocol with MARAC Co-ordinator
3) Update the procedure for staff supporting residents who are in hospital – to particularly include the key learning from this SAR in relation to domestic violence issues

City Hospitals Sunderland NHS Foundation Trust

1) Domestic Abuse Awareness training including selective enquiry and how to raise concerns, will be included in mandatory training for all staff.

2) The following processes will be audited to ensure there is a robust system in place to identify patients where domestic abuse risks are known to staff and to ensure that Next of Kin details are appropriately updated on patient's electronic records:

- The process for flagging patients where domestic abuse risks are known to staff will be audited and the outcome acted upon accordingly.

- The process to review and update Next of Kin details on patient's electronic record at every inpatient/outpatient admission and attendance will be audited.

3) The Discharge Policy will be updated to ensure that there is a clear procedure on the need for multiagency pre - discharge meetings where there is significant

Safeguarding (including domestic abuse) risk, especially if the patient is likely to be homeless on discharge.

Northumberland Tyne & Wear NHS Foundation Trust

1) Staff to be reminded of their responsibilities to report a domestic abuse incident to the police when disclosed.
2) MARAC referrals are submitted by trust staff and monitored by SAPP team.

Sunderland City Council Adult Social Care

1) Adherence to the retention policy relating to the retention of records in the HSWT.
2) Regular auditing of Case Files to ensure quality of Case Recording.
3) Awareness Raising / Training for Hospital SW staff (and other SW teams) in relation to DV.
4) To work with partner agencies, (in particular Health / Hospital) to agree a coordinated policy and strategy to support victims of DV.

Overview recommendations:

Overview recommendation 1

SSAB must ensure that key learning highlighted in the Overview Report is shared across the partnership.

Overview recommendation 2

Sunderland CCG must develop a protocol to ensure robust arrangements for women in the refuge to access primary health care services.

Overview recommendation 3

The Sunderland MARAC Steering Group must consider the learning from this SAR and use it to inform the current wider review of the MARAC process.

Overview recommendation 4

WWIN to produce a policy and procedure in relation to hospital discharge arrangements.

Overview recommendation 5

In the light of learning from this SAR, City Hospitals Trust and the Hospital Social Work Team to jointly review hospital discharge arrangements for people at risk from domestic abuse.

Overview recommendation 6

Current multi-agency domestic abuse training to be amended to reflect the findings and learning from this SAR.

Overview recommendation 7

Local Commissioners to ensure that all of the key learning points arising from this SAR are utilised, to inform future commissioning in relation to domestic abuse services.