SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

and

WORCESTERSHIRE SAFEGUARDING ADULTS BOARD

Joint DOMESTIC HOMICIDE REVIEW

and

SAFEGUARDING ADULT REVIEW

Executive summary Report

into the circumstances

of the death of a woman aged 61 years

in August 2019

Case No DHR 18

Mark Dalton
Independent Domestic Homicide Review Chair
and Report Author

September 2021/Revised September 2022/March 2023

Contents

1. Introduction

1.1 This is an Overview Report of a Domestic Homicide Review (DHR) under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004.

1.2 The subject of this Review is a white British female who was 61 years and 8 months old at the time of her death. She will be referred to as SP in this Review. SP died as a result of drowning in a river. It is not thought that SP was deliberately attempting to end her own life. The reports of her actions and behaviour are strongly indicative of an attempt to avoid detention by the Police and subsequent treatment under the Mental Health Act. SP was in a distressed state and had long-standing mental health issues alongside a history of being the victim of domestic abuse.

1.3 At the time of the final fatal incident her ex-husband (with whom she still shared a house) was imprisoned for breaching a Domestic Violence Protection Order (DVPO). The relationship was long-standing and complex, although the couple were legally divorced, they remained living in the same property. Her ex-husband described himself as a carer for SP, although there were obvious signs that the standards of care were poor. There were indications that this relationship was also controlling and abusive.

1.4 This combined Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) has been commissioned by South Worcestershire Community Safety Partnership and Worcestershire Safeguarding Adults Board in response to the untimely death of SP.

1.5 The initial scoping of the circumstances leading up to the death of SP identified a history of concerns about domestic abuse and long-term mental health and care needs. The understanding and response by Agencies to these needs will be the focus of this Review.

1.6 It was agreed to undertake a combined Review to ensure that the learning about Domestic Abuse and Mental Health and Care needs are efficiently and appropriately shared between all Agencies.

1.7 The decision to undertake a Domestic Homicide Review was taken by South Worcestershire Community Safety Partnership following notification by the Senior Investigating Officer, West Mercia Police, regarding a death where domestic abuse had been identified between the victim and partner. The circumstances of the death fall within Section 9 of the Domestic Violence Crime & Victims Act 2004 which required consideration of conducting a Domestic Homicide Review.

2. The Review Process

2.1 Worcestershire Safer Communities Board was notified on 15th August 2019 by the West Mercia Police Statutory and Major Crime Review Unit, regarding a death where domestic abuse had been identified between the victim and partner. The DHR sub-group was convened on the 3rd October 2019 to consider the initial scoping of the DHR. The circumstances of the death fall within Section 9 of the Domestic Violence Crime & Victims Act 2004 which required consideration of conducting a Domestic Homicide Review.

2.2 The DHR Subgroup also felt that the criteria for a SAR were met and that a joint DHR/SAR should be undertaken. The DHR Subgroup recommended to the Community Safety Partnership (CSP) that a joint DHR/SAR would be appropriate in this case.

3. Domestic Homicide Review Panel

3.1 In accordance with the statutory guidance a DHR Panel was established to oversee the process of the Review. Members of the Panel and their professional responsibilities are as follows:

Mark Dalton,	Independent Chair and Overview Report Author.
Tim Rice, Worcestershire County Council Public Health.	Senior Public Health Practitioner.
Suzanne Hardy, Herefordshire and Worcestershire Health and Care NHS Trust.	Safeguarding Services Manager.
Caroline Mann, Worcestershire County Council Adult Services.	DoLS Team Manager.
Lloyd Griffiths, South Worcestershire Community Safety Partnership.	Chair of SWCSP.
Emma Whitworth/ Louise Wall, West Mercia Police.	Detective Chief Inspector.
Deborah Narburgh, Worcestershire Acute Hospitals NHS Trust.	Head of Safeguarding.

Heather Manning, Herefordshire and Worcestershire Clinical Commissioning Group.	Designated Nurse for Safeguarding Adults, Children and Children Looked After (Interim) Mental Capacity Act Lead.
Lisa Peplow, West Mercia Women's Aid.	Regional IDVA Team Manager.
Karen Sheldon Worcestershire County Council Public Health	Administrator

3.2 The South Worcestershire Community Safety Partnership appointed Mark Dalton to chair the Review and to author the Overview Report. He is an independent registered Social Worker and experienced SILP (Significant Incident Learning Process) Reviewer. He has extensive social work experience in the statutory and voluntary sector and has undertaken DHR's for other Community Safety Partnerships. He is independent from all the Agencies involved in this case and the South Worcestershire Community Safeguarding Partnership. He has previously undertaken Adult Safeguarding Reviews for the Worcestershire Safeguarding Adults and is also undertaking a second Domestic Homicide Review for the South Worcestershire Safeguarding Partnership.

3.3 The Agencies contributing to this Review were:

Worcestershire County Council (Adult Services).
West Mercia Women's Aid.
West Mercia Police.
Herefordshire and Worcestershire Clinical Commissioning Group on behalf of the GP Surgery.
Worcestershire Acute Hospitals NHS Trust.
Worcestershire Health and Care NHS Trust.

3.4 They provided an Independent Management Review and an Agency chronology in accordance with the Terms of Reference.

Scope of The Review

4.1 The scoping period of this Review is between 1st January 2017 (or from the date of first contact in 2017 between Agencies and SP) until August 2019. Where there is historic identification of domestic abuse or the recognition of health or care needs for SP, these will be summarised and included where relevant.

5. Chronology

5.1 September 2017 - SP's mother spoke to her GP (SP and her extended family were registered at the same GP Practice) to share her concerns about SP's mental health and self-neglect. The GP attempted to see SP at both her mother's address and her own home, but was unsuccessful in meeting with her.

5.2 20th November 2017 – Police were called to an incident at a family member's home because SP was clearly distressed and appeared mentally unwell. A DASH[1] assessment was completed and originally assessed as high risk due to the potential risk SP posed to her mother.

5.3 21st December 2018 - SP let herself into her mother's home and refused to leave. She was mentally unwell at the time and the family called for Police assistance.

5.4 February 2019 - SP's family contacted the Adult Safeguarding Team regarding SP's presentation out of concern she was being abused by her ex-husband. Family members had noticed that she was losing weight and had healing burn marks on her hand.

5.5 Following the referral from the family the plan was to contact the GP with a request to review SP's mental health. The GP made attempts directly and via family members to arrange an appointment for SP, but she was unable to meet with them. The Safeguarding Referral was closed at this point with the concerns unaddressed and unresolved.

5.6 16th July 2019 – Police investigated a serious physical assault on SP by her ex-husband. The incident was reported by a neighbour. SP also disclosed controlling behaviour, including who she was allowed to see, being confined to the house and not allowed to use the telephone unless her ex-husband was present. The Police completed a DASH risk assessment and assessed the risk as high.

5.7 17th July - The Police established a Risk Management Plan (RMP) as an attempt to manage the risk of further domestic abuse. The plan noted SP's isolation as

[1] The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist is a tool used to assess the immediate risk, threat and danger a survivor is subject to.

a barrier to seeking help, together with the incident reported by the neighbour the previous day.

5.8 19th July 2019 – A Domestic Violence Prevention Order (DVPO) was issued by the Magistrates Court preventing SP's ex-husband from visiting the home or contacting SP.

5.9 The same afternoon SP's ex-husband was arrested at the home address for breaching the order. A DASH risk assessment was completed, and the risk assessed as medium because the assessment was based on the fact that SP's ex-husband had been arrested, rather than an assessment of the potential of future risk to SP – which would have remained high.

5.10 20th July 2019 – SP's ex-husband was fined for breaching his DVPO and released under the same conditions. He stated he was SP's carer and advised he would go back to the address to ensure SP had food, even though he was informed if he returned at any point he would be further arrested.

5.11 22nd July 2019 – Police Officers undertook a welfare visit to SP who disclosed that her ex-husband had stayed there the previous night in breach of his DVPO.

5.12 23rd July 2019 – SP's ex-husband was again seen visiting the home. SP did not wish to make a formal complaint. This further breach underlined for the Police the necessity of making regular visits to SP in an effort to build a relationship with her.

5.13 24th July 2019 – SP's ex-husband was arrested for again breaching his DVPO and received a 4-week custodial sentence.

5.14 A DASH was recorded as medium risk based on the Officer's knowledge of the situation rather than asking SP. The assessment could also have considered the potential for future risk once SP's ex-husband was released.

5.15 Later the same day SP was detained by the Police under section 136 Mental Health Act.[2] The Police had visited to complete a welfare check and they became concerned about SP's presentation; her physical condition; she had visible injuries on her arms that looked like bite marks. It was believed they were self-harm marks, possibly due to anxiety.

5.16 Paramedics eventually took SP to hospital accompanied by her brother. SP needed to be restrained to prevent her from leaving hospital and she was eventually assessed by an Approved Mental Health Professional over 12 hours

[2] Officers incorrectly detained SP using S136 of Mental Health Act. S5 Mental Capacity Act would have provided the appropriate legislation for SP to be seen with regards to the injuries on her arms.

after the ambulance had first been called. The conclusion of the assessment was that SP did not meet the criteria for detention in hospital at that time. A plan was made for a period of further assessment by the Home Treatment Team with the proviso that if SP did not engage then a further Mental Health Act assessment should be considered.

5.17 25th July 2019 – the Home Treatment Team commenced support of SP, this comprised daily visits for the next 8 days. However, despite some improvements, concerns remained about SP's self-neglect, poor eating habits and the self-inflicted wounds and bite marks on her arms.

5.18 Subsequently Police welfare visits took place on 25th, 26th 28th, 29th, 30th, 31st July and 1st, 2nd August.

5.19 Early August 2019 – a Mental Health Assessment was arranged at SP's home with her sister present. Prior to the assessment, the Approved Mental Health Professional spoke with SP's brother who had expressed concerns that she would run away once she was aware of the purpose of their visit. SP's brother did not believe that she would be violent or aggressive but did not appreciate that this meant the criteria for having Police present was not fulfilled and thus Police support was not requested.

5.20 During this assessment SP quietly left her property without any of those in attendance aware that she had gone. Once it was realised that she had left the building the Police were alerted, and a search commenced.

5.21 It was some hours before SP was spotted on the banks of the river, although this particular spot was a likely destination and was actively being searched by family members and Police Officers. The Police Officers believed that SP had seen them and decided to approach her. At this point she entered the river and swam away. The Police Officers did not follow, but her brother swam after her but was unfortunately unable to reach her before she disappeared under the water. SP's body was later recovered from the river.

6. Analysis.

6.1 Domestic Violence Prevention Order

6.2 Domestic Violence Prevention Orders became available to the Police in 2014. The purpose of the DVPO is to protect victims of domestic violence where there is insufficient evidence to charge a perpetrator and provide protection to victims via bail conditions.

6.3 The Police practice shows a good use of the available legislation. There were 2 strands to the Police strategy to safeguard SP. Firstly, Police Community

Support Officers (PCSO's) made regular calls to SP to try to build a relationship and instil in her confidence and trust that the Police were there to protect her. Secondly, they decisively used the DVPO to disrupt her ex-husband's continued contact with SP. The Police were aware that he may continue to try to visit SP and were keeping a sharp lookout for him in the vicinity of the house.

6.6 There were missed opportunities to ensure SP's welfare through a combination of factors. Firstly, incorrectly grading the domestic incident on 19th July as being of medium risk combined with the process of managing the backlog of referrals. Secondly, the failure to request for assessment after court, potentially represented a failure to adequately ensure safeguarding was in place for SP.

6.7 Mental Health Act Assessment

6.8 Within the scoping period of this Review SP was assessed twice under the Mental Health Act. The first occasion occurred on 24th July 2019 following her attendance at hospital as a result of the Police calling paramedics during one of their welfare visits. This assessment took place at 1:30 am after SP, who was accompanied throughout this episode by her brother, had been in the care of paramedics and hospital for approximately 12 hours, including 3 hours in an ambulance.

6.10 In accordance with the plan the Home Treatment Team began a week of further assessment to assess SP's willingness to engage with services in the community and ascertain how mentally ill she was. This decision was opposed by SP's brother who was present during the assessment and had direct experience of SP's illness over several years. He believed SP remained at risk and vulnerable whilst living at home and needed hospital care.

6.6. The conclusion of the Home Treatment Team was that a further Mental Health Act assessment was necessary given the risks of SP disengaging from their service once her ex-husband was released from custody and ongoing concerns about self-neglect and physical health.

6.12 The arrangements for the Mental Health Act assessment on the 3rd August inadvertently provoked the crisis which led to SP entering the river and subsequently drowning.

6.13 Adult Safeguarding Response.

6.14 The Adult Safeguarding Team play a crucial role in coordinating the multi-agency response to domestic abuse. Assessing the risk to SP and protecting her was dependent on receiving and analysing information from Agencies who were aware of her difficulties and family members who were concerned.

6.15 The initial contact from SP's mother and sister in 2017 did not result in any proactive action. Poor record-keeping has unfortunately meant there is no record of the letters sent by SP's family members outlining their concerns.

6.16 In February 2019 family members again referred SP to Adult Safeguarding due to their concerns that she was being abused. Adult Safeguarding then requested that the GP visit SP at home to assess her mental health. The GP made two attempts to undertake the requested home visit (against normal GP practice guidelines, which stipulate that a GP would not normally undertake a home visit at the request of a third party without the patient's consent) but was unable to see SP. The GP advised the Social Worker from the Adult Safeguarding Team that without SP's consent he could not offer support. However, given the nature of the concerns, the lack of consent should not have prevented the Social Worker from contacting the Police because of the concerns about domestic abuse. At this point, the concerns should have been escalated rather than closed down. A referral to the MASH would have potentially raised concerns about the need to offer further support.

6.17 SP's lack of engagement with Agencies meant that awareness of her circumstances hovered around the threshold for intervention and it would seem that her case never quite reached the trigger point for further intervention prior to the Domestic Violence Prevention Order imposed on her ex-husband in mid-July 2019.

6.18 Engagement with Multi-Agency Risk Assessment Conference (MARAC)

6.19 A referral to MARAC was not considered following the Domestic Abuse incident recorded on 16th July. The Harm Assessment Unit (HAU)[3] standard operating procedure states that in all high-risk domestic abuse cases, the DARO should refer the case to a MARAC coordinator. At the time due to a lack of capacity, not all high-risk cases were referred or discussed at MARAC. This was against the standard operating procedure and appears to be a local 'work around' due to the volume of cases. The decision whether to refer or not remained at the DARO's discretion with no formal agreed considerations or policy in place.

6.20 The incident on 19th July when SP's ex-husband breached the DVPO, represented the second incident within a week and consideration should have been afforded to assessing the risk as 'high' due to the escalating incidents within a short space of time. Had this been assessed as high risk it would have

[3] The Harm Assessment Unit is a department within the Police that specialises in evaluating and assessing risk to vulnerable people.

been reviewed by a DARO the following day, potentially allowing for support to be put in place for SP.

6.21 The usual route for any Agency which has a safeguarding concern is to request a Section 42 assessment under the Care Act 2014. The Police felt this was an appropriate response following the breach of the DVPO by SP's ex-husband on the 23rd July 2019. Unfortunately, an administrative error within the Police meant this request was not made to the Adult Safeguarding Team.

6.22 As SP's condition deteriorated and with the impending release from custody of her ex-husband, the Police again requested an urgent Section 42 assessment on the 31st July. A referral to the Multi-Agency Risk Assessment Conference (MARAC[4]) was also submitted based on the professional judgement of the PCSO's who were regularly visiting SP. Sadly SP had died before the meeting had taken place.

6.23 All referrals from the Police to other Agencies are made through a centralised process to ensure quality and consistency across the Force area. In the case of the safeguarding referrals for SP, these were not progressed due to an inaccurate assumption being made that other Agencies were already aware and would share information.

6.24 The need for clarity and precision in interagency communication is also underlined by the erroneous description of the process for detention under the Mental Health Act recorded by the Police on 2nd August. The Police log has recorded that they were informed by the Adult Safeguarding Team about the mental health assessment and that the opinion of the mental health worker was that SP needed to be admitted under section 2 MHA, but this was dependent on which doctor saw her and whether any beds were available. As described above (see 6.13) this is not the actual process and it would have helped the Police understand their potential role if this had been accurately described.

6.25 The usual mechanisms for safeguarding adults include the DASH risk assessment tool, referral to MARAC, and use of Risk Management Plans (RMP). The volume of referrals for cases of domestic abuse means that all Agencies become familiar with the use of these. However, in the case of SP, they were not effective in protecting and coordinating the Agency responses to her.

6.26 There seem to be two main factors which militated against this; firstly, SP's lack of consent and not accepting that she needed help. It is axiomatic in safeguarding practice that it is done "with" the person and not "to" them. Secondly, her very obvious mental health needs took priority, and it was a

[4] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. Professional judgement is one of the criteria for referral and is used where the level of risk is difficult to assess and where there has been no direct disclosure of abuse.

reasonable professional belief that if her mental health stabilised and improved then she was more likely to engage with safeguarding services.

6.27 Identifying Domestic Abuse Alongside Mental Illness.

6.28 On several occasions when SP did come to the attention of the Police a DASH assessment was completed (although never with SP's consent, and on one occasion where SP was assessed as the perpetrator of abuse against her mother). None of these assessments led to further action or referral for ongoing support. SP was never willing to make a complaint about her ex-husband, and this fact also militated against further action being taken.

6.29 The fundamental principles of Adult Safeguarding are a set of values known as Making Safeguarding Personal.[5] At the practice level this is a set of common standards for all Agencies to engage with people with respect for their wishes, to include them in decisions about actions taken to safeguard them and prevent further abuse and to take the time to build relationships to support people in making difficult decisions.

6.30 The Police were well aware that SP would not support a prosecution of her ex-husband (also the Crown Prosecution Service would not authorise charges without a written statement from SP), the decision to invest time in building trust with SP through daily visits by the Police Community Support Officers was a good example of Making Safeguarding Personal in action.

6.31 Plans were in place for SP to be discussed at a MARAC at the time of her death. She remained reluctant to complain about her ex-husband and this case highlights the challenges of responding to domestic abuse where there are also serious mental health concerns, and the victim finds it difficult to engage with services trying to support them.

6.32 It would be unwise to speculate whether the discussion at MARAC would have materially changed SP's circumstances. However, it would have achieved more effective information sharing between Agencies and potentially introduced additional services through the involvement of Women's Aid, which would also have attempted to support SP.

6.33 SP's mental health challenges did not prevent the recognition and investigation of the incidents of domestic abuse. Her reluctance to engage with professionals and her dependency on her ex-husband were the significant barriers in providing future safeguarding.

[5] The Making Safeguarding Personal toolkit is a good introduction into how this approach should work in practice.

6.34 Evidence of Coercive Control

6.35 Since the death of SP in 2018 there have been a number of significant changes in the way Domestic Abuse is understood by professionals and in the wider community. The passing of the Domestic Abuse Act into law in 2021 raised awareness of the concept of controlling or coercive behaviour[6] and it is likely that this would have been investigated as an important element in the abusive relationship between SP and her ex-husband. this is not to say that there was unequivocal evidence of this, but there were sufficient grounds to investigate this further.

6.36 SP's ex-husband described himself as her carer when it was quite clear that the standard of care was inadequate. It was also known that SP did not have control of her own finances and her vulnerability was apparent to everyone she came into contact with.

6.37 SP's ex-husband's behaviour kept her vulnerable, isolated and dependent. She was afraid of coping without him, and he took no action to improve the quality of her life by engaging with mental health services or adult social care on her behalf.

6.38 The proactive use of the Domestic Violence Prevention Order had the unintended consequence of focusing the Police intervention as a single agency operation and concentrating on addressing her ex-husband's breach of the Order rather than inquiring further into the antecedents of his behaviour and the welfare of SP.

6.39 Engaging People Who Are Isolated.

6.40 SP presented a challenge to the network of professionals who would usually intervene in cases of mental illness or domestic abuse. All non-mandated services are dependent on the service user consenting to referral. SP was never assessed as having the capacity to give consent until the events immediately leading to her death, when the prospect of being Sectioned against her will prompted her to run away from professionals trying to help.

6.41 The capability of a person who may lack mental capacity, to give consent is governed by The Mental Capacity Act 2005 [7]. The initial assumption is that a person has the capacity unless there is proof that they do not. A further assumption is that people have the right to make decisions that others may think are unwise. Given SP's previous traumatic experience of being Sectioned and her dependency on her ex-husband for aspects of her care, her decisions

[6] The Domestic Abuse act includes controlling or coercive behaviour and economic abuse in the statutory definition of Domestic Abuse.

[7] Mental Capacity Act 2005. Code of Practice.

may seem to have been unwise, but they are not in themselves evidence of a lack of capacity.

7 Conclusion.

7.1 The set of circumstances which led to the death of SP is unusual for a Domestic Homicide Review because the perpetrator of the domestic abuse was in prison at the time of her death and the Agencies which have the responsibility of protecting SP inadvertently contributed to the confusion which resulted in her eventual death.

7.2 SP had suffered with mental health issues for most of her adult life. She was isolated and her mental health problems made it difficult for her to have positive relationships with anyone and she became more reclusive. It seems that she had an unhealthy dependency on her abusive ex-husband, and this relationship served to place another barrier between SP and her family.

7.3 In the months preceding her death an assault by her ex-husband had drawn attention to the reality of the domestic abuse which she had endured for a considerable period of time. Proactive steps had been taken to protect her by the use of the DVPO, however this was a short-term solution and other safeguards would need to be in place following her ex-husband's release from prison.

7.4 Following the decision not to Section SP on the 24th July a period of home assessment commenced which to some extent broke down barriers between SP and various professionals and may have eventually built trust which would enable her to accept support. There were some indications that this approach was beginning to work. Unfortunately, the attempt to assess SP did not capitalise on the relationship that was beginning to develop with the PCSO's and Home Treatment Team.

7.5 The confusion and miscommunication that occurred on 3rd August between the Mental Health Crisis Team, the Approved Mental Health Professional (AMPH), the Home Treatment Team, the Police and members of the family were contributory factors which lead to SP entering the river.

7.6 SP's death was a tragic accident and not a deliberate attempt to end her own life. Although SP had a history of suicide attempts and deliberate self-harm. Her family have discounted the idea that she entered the river to take her own life. SP was known to be afraid of being Sectioned and sometimes fearful of the Police. It would seem most likely that she entered the river in an agitated and frightened state after being approached by the Police to avoid being detained under the Mental Health Act.

7.7 The NICE (National Institute for Health and Care Excellence) study highlights that the odds of being a victim of domestic violence were threefold higher for those with a mental illness or a related disability and also there is a higher risk of abuse

around the time of separation when a woman separates from her partner. We now know that both were factors in SP's life. It is difficult to know how many other individuals are in the same circumstance as SP. Agencies would not routinely be aware of these individuals unless a specific incident brought them to their attention. This is a situation worthy of further exploration and analysis; and a review of how vulnerable people are identified and supported in the community should be considered.

13 Lessons Learned.

8.1 In circumstances where mental illness and domestic abuse are present at the same time, there is the potential for one or other of the issues to predominate and exclude proper consideration of the range of safeguarding and health risks to be skewed based on the focus of the lead agency. In SP's case for example, it is perhaps unsurprising that the Police focus was on issues of domestic abuse and the prosecution of the perpetrator rather than fully recognising SP's chronic mental health crises and taking steps to refer her to Adult Social Care or Mental Health services.

8.2 A significant lesson in this case is that there is a clear difference between sharing concerns and making a referral. The Police knew that some of the concerns about SP were known to other agencies, (they had been discussed at a multi-agency triage meeting held on 19th July, which had shared information but crucially did not allocate decisive actions to be taken) but a specific referral for a S42 enquiry was not made until 31st July.

8.3 The mechanisms to intervene and support a person with SP's level of mental illness are dependent on either the individual recognising a need and consenting to receiving help or having a family member or friend with their best interests at heart, who can support their engagement with mental health services. Although it must be said that only in exceptional circumstances can a person with the mental capacity to make their own decisions be compelled to accept treatment against their will, and this would require detention under the Mental Health Act.

8.4 SP had a number of illnesses which prevented her from seeking support, at times her needs were both chronic and acute. SP's wariness of Psychiatric Services meant that she was discharged to the care of her GP. Although given the nature of her mental health it was extremely unlikely that she would be able to access help of her own accord. This situation is an inevitable result of the way services are currently arranged; where the onus is on the patient to recognise they need help and seek appropriate support.

8.5 However, there is also the issue of the Domestic Abuse of a vulnerable person which continued for many years after Agencies were first made aware of its

probable existence. Here there is more scope for a mandatory intervention, and while there was some proactive intervention through the use of the DVPO this did not lead to any multi-agency support for SP.

8.6 in the light of the misunderstanding between the Approved Mental Health Professional, SP's brother and the Police at the crucial point where the attempt was made to assess SP in August, there is clearly scope to improve interagency communication and raise the awareness of adult safeguarding in all Agencies.

8.7 In particular Agencies should pay attention to the precise use of language; for example, under the Mental Health Act an assessment is made of the individual's mental health, the decision whether that individual needs to be detained is based on that assessment and is not a foregone conclusion. It is important that this process is accurately described and referred to in conversations with family members and other professionals, to avoid anxiety, unrealistic expectations and potential disappointment if the outcome is different from the one expected.

8.8 While this may seem a relatively straightforward issue, it is important to remain aware of the five guiding principles of the Mental Capacity Act[8], and Agencies must ensure that greater cooperation does not detract from an individual's rights.

8.9 The view of SP's family (the family members include 2 brothers, a sister and SP's mother) is that she was ultimately failed by services which should have safeguarded her and treated her mental illness. They believe she was initially failed by services which did not attempt to engage and support her following her initial discharge from community mental health services in 2006. It is also the family's opinion that despite their contacting and writing to the GP, no useful help or professional interest was forthcoming.

8.10 Secondly in failing to arrange support from the Police for the Mental Health Assessment Agencies potentially enabled SP to put herself at risk which would prove fatal. Their criticism is measured and balanced; they are aware that assessments should be carried out in the least restrictive way. However, their strong belief is that the information they had given based on the knowledge of their sister and recent experience clearly made the case for Police involvement. Their hope for the future is that in similar cases advice from family members is sought and listened to and that they are fully informed of the eventual decision.

8.11 The completion of this Review: coincides with a second DHR being undertaken by the same Overview Report author which raises similar issues about the

[8] These five principles are: Presumption of capacity, Support to make a decision, Ability to make unwise decisions, best interest and the Least restrictive. The 4th and 5th principles apply only when a person has been assessed to not have mental capacity for the decision in question.

interface of the recognition of Domestic Abuse where there are ongoing mental health concerns. In most details and circumstances the cases are markedly different and there are few useful comparisons to be drawn from how the cases were managed. However, it is clear that in both cases the reality of the Domestic Abuse being experienced was overtaken by a focus on mental health issues.

8.12 This is not to say that mental health concerns were insignificant or did not warrant professional attention, but they seem to have led to a lack of attention to the ongoing issues of Domestic Abuse. The lessons to be learned from both cases in this regard are:

- The presentation, particularly the traumatic presentation of mental health issues can mask ongoing Domestic Abuse.
- Victims of Domestic Abuse who have mental health problems may be more socially isolated or lack support to report Domestic Abuse.
- Practitioners need to be particularly alert to indicators of coercive control.
- There is a continuum of vulnerability, where mental health problems and the experience of being a victim of Domestic Abuse combine to increase the impact on the victim. Therefore, front-line professionals who specialise in mental health and those who specialise in Domestic Abuse need to be aware of the potential impact when these factors coalesce.

9. Recommendations.

1. The existing Mental Health Act Transportation Policy[9] should be reviewed, to ensure effective communication between Agencies when a Mental Health Act assessment date and time has been arranged. It is suggested that the review should consider whether in circumstances such as these (where there has been limited contact with Mental Health professionals) that more weight is given to the opinion and experience of carers or close relatives.

2. Where a safeguarding assessment is undertaken on an adult who is the victim of Domestic Abuse and is also seen as having care and support needs, a MASH (Multi-Agency Safeguarding Hub) referral should be made and information from all Agencies considered to inform assessment and planning. A multi-agency meeting should be convened when necessary to consider a multi-

[9] The Mental Health Act Transportation Policy is the responsibility of the West Midlands Ambulance Service. The policy is based on the Mental Health Act 1983: Code of Practice.

agency plan of support from the wider Partnership. Particularly where the person remains 'vulnerable' due to Domestic Abuse and other issues.[10]

3. All frontline practitioners and supervisors should be reminded of the need to accept responsibility for making referrals to other services, and not to assume that other Agencies/professionals will make necessary referrals. An effective referral should also contain sufficient case history for the Agency receiving the referral to understand the service users' needs to enable them to make a fully informed decision about the provision of service.

4. H&WNHSH&CT Should consider the findings from this review and how vulnerable people with a mental illness related disability, are identified and supported in our communities (and whether domestic abuse is routinely considered in care and treatment plans, particularly when people are discharged from services due to difficulties with engaging them).

[10] In this context "other issues may include mental health problems or Adverse Childhood Experiences (ACEs) for example.

Appendix 1.

Domestic Homicide Review Case 18 ToR