Walsall
Safeguarding Partnership

SAFEGUARDING ADULT REVIEW
Gloria

2023

Table of Contents

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1. INTRODUCTION

1.1 Gloria was a 50-year-old white British woman. She had a complex vascular disease and other health problems. Gloria had one leg amputated in January 2020 and the other in February 2021. She had cataracts in both eyes with deteriorating visual impairment. Gloria was involved in a relationship with a partner for approximately seven years until early March 2021. Their relationship was characterised by allegations of domestic abuse and deteriorated following the first amputation, which left Gloria more reliant on her partner. Gloria was found deceased at her home on 1st April 2021. The Coroner's conclusion was suicide.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Walsall Adult Safeguarding Partnership to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Walsall Adult Safeguarding Partnership the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) 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, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. All Walsall Safeguarding Partnership members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4. This case was referred to the SAR Sub-group of the Walsall Adult Safeguarding Partnership on 25th May 2022 and considered for a SAR by the statutory partners on 11th July 2022. Following additional scoping information being gathered, the statutory partners agreed to progress to a SAR on 10th October 2022.

2.5. The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection to the Walsall Adult Safeguarding Partnership Board, or its partner agencies.

2.6. **The review**

2.7. This safeguarding adults review commenced on 7th March 2023.

2.9 Key areas to be addressed by the review were:

- How effective was inter-agency communication and information sharing in providing support for Gloria.

- Explore what opportunities there were to intervene on a single or multiagency basis.

- The process to notify /communicate Gloria's death to agencies involved in her care or support needs to be explored for its efficacy.

- Gloria was subject to 11 episodes of alleged domestic abuse what opportunity was there to escalate concerns.

- What consideration was there to identify increased risk to Gloria in the context of her deteriorating physical and mental health and subsequent increasing vulnerability and what this meant in terms of Gloria's mental capacity to make decisions about her experience of domestic abuse?

- Assess the quality of the multiagency response to incidents of domestic abuse reported by Gloria including at the point that this matter was referred to MARAC - what lessons are there for action that could and should have been taken to protect Gloria from the risk of further domestic abuse.

- Linked to the mental capacity assessment is Gloria's decisions to manage her own care and what is considered as 'self-neglect'. Gloria was a double leg amputee and therefore immobile, risk to her safety and care increased significantly when her partner left the home and stopped providing support. What consideration was given

to test out the reality of Gloria's mental capacity for decisions made relating to her ability to provide self-care and her refusal for referral to key supporting agencies?

- Explore the practice of record keeping regarding change of address, consider whether there is there a system anomaly between health services and what opportunities there are to put this right.

- There were several incidents of Gloria's assertion of suicidal ideation. To develop an understanding of Gloria's vulnerabilities, (her amputations, loneliness, dependency and loss of independence, increasing concern for mental ill health and hallucinations and experience of domestic abuse), her health and care needs, capacity to care for herself and her loss and level of independence and consider:
  - What practitioners knew of Gloria's declining physical and mental health, including Gloria's assertion that she wished to end her life.
  - How practitioners perceived and assessed risks to Gloria and how these were responded to?
  - Any barriers/difficulties agencies encountered when supporting Gloria that may have impacted on the case?
  - To explore how agencies respond when an adult with declining physical and emotional health develops thoughts of self-harm or suicide. What is the practice for the oversight and review of medication and prescription drugs in the adult's care plan and what steps could have been taken to reduce the risk of suicide through the misuse of drugs?
  - To explore what preventative action could have been taken which may have impacted on the outcome for Gloria.

- What opportunity was there to undertake carer needs assessment, what is understood by this by key agencies involved?
- Given the allegations of domestic abuse with regard to Gloria's partner, what consideration was there of his suitability to provide care?
- What consideration was given to developing a coordinated care plan which would best support Gloria and the needs of her carer?

- Were safeguarding procedures followed and how should agencies have responded to protect when an adult with care and support needs alleges abuse by their carer?

- To identify good practice that was in place.

- To identify lessons to be learned to improve future professional practice.

2.10 **Contact with family and friends**

2.11 A letter was sent from the Walsall Safeguarding Partnership to a member of Gloria's family to notify them of the review and to ask if, and in what way they would like to be involved. No reply was received.

3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. The chronology for this safeguarding adults review covered the period from January 2020 – April 2021, one year and four months.

3.2. The following services were involved with Gloria during the time covered by the chronology:

- Russell's Hall Hospital Physical Health Psychology Service (PHP)
- Walsall Healthcare NHS Trust (Walsall Manor Hospital (WMH))
- Royal Wolverhampton Trust New Cross Hospital (RWT)
- Dudley Group NHS Foundation Trust (Russell's Hall Hospital (RHH))
- Black Country Integrated Care Board (Lockstown GP Practice)
- West Midlands Ambulance Service
- West Midlands Police
- Walsall Council (Adult Social Care (ASC))
- Birmingham, Solihull and Black Country Diabetic Eye Screening Department
- Early Access Mental Health Service in Walsall

3.3. A table of acronyms used in this report is given in appendix 4.

3.4. **Gloria**

3.5. Gloria was born in 1970 and was 50 years old when she died in 2021. She was one of five siblings. Her eldest sister had died from cardiac related problems and her mother had passed away in 2017. Gloria had an "on-off" partner for seven years. Gloria said that she had no contact with family and friends.

3.6. Gloria trained and worked as a social worker from 2002 and retired in 2016 due to ill health.

3.7. One of Gloria's legs was amputated in 2020 and the other in 2021. She was described as becoming wheelchair bound. Gloria was blind in her left eye and lost most of her sight in her right eye due to cataracts. Gloria had vascular disease and had suffered at least eight heart attacks, and had a stent fitted. Other health conditions included neuritis, sleep apnoea, diabetes and asthma. Mental health needs included depression, anxiety and post-traumatic stress disorder.

3.8. Gloria lived in accommodation which was no longer suitable for her and in October 2020 she moved to a flat.

3.9. Gloria loved animals. She had a cat and then some kittens, but was unable to keep them when she moved to the new accommodation which did not allow pets. Gloria liked to be active and to get out and about even if just food shopping. She was very independent, drove and had a car, but the amputation of her legs took that part of her life away from her.

3.10. Practitioners described Gloria as easy to get on with, but also frustrating at times. They said that she "knew her own mind". As a qualified social worker Gloria did not want ASC to know of her circumstances. It is possible that embarrassment and shame played a role in Gloria's decision making. She may have been embarrassed that she was in an abusive relationship, and was dependent on her partner. She may have felt she would be judged. Embarrassment and shame are powerful emotions, and are often not credited with the importance they should be as a barrier to people accepting help.

3.11. **Chronology – events between January 2020 and April 2021**

3.12. After the amputation of her right leg on 31st January 2020 Gloria had thoughts of suicide and was referred to the Physical Health Psychology Service (PHP) which is part of Russell's Hall Hospital (RHH).

3.13. A district nursing visit was first attempted on 23rd February 2020 to attend to Gloria's wounds following her amputation, but Gloria appeared not to be at home and nurses were unable to leave a note for her because she lived in a flat.

3.14. On 29th February 2020 district nurses returned and were able to attend to Gloria.

3.15. Gloria was discharged from the PHP on 20th July 2020. Gloria reported no further thoughts of suicide. During this time, she had two hospital admissions due to leg injuries following falls.

3.16. On 25th October 2020 Gloria moved to a ground floor flat, which was more suitable for her needs and which enabled the use of a wheelchair.

3.17. Between 13th and 20th December 2020 Gloria had a heart bypass operation.

3.18. On 1st January 2021 Gloria called West Midlands Police saying that she had argued with her partner after she suspected that he had brought another woman into her home, whom he had sex. WMP suspected that Gloria may have been in mental health crisis and called for an ambulance. Gloria was taken to Royal Wolverhampton Trust New Cross Hospital (RWT), a general hospital and admitted.

3.19. On 4th January 2021 WMP visited Gloria in hospital having been advised by the hospital that Gloria may have suffered domestic abuse by her partner.

3.20. On 5th January 2021 Gloria's partner was arrested and his house key was returned to Gloria. On the same day, at her own request, Gloria was discharged from hospital and she declined any care package or support.

3.21. On 13th January 2021 Gloria's case was considered at the Walsall Locality Multi-Agency Risk Assessment Conference (MARAC), but Gloria did not wish to make a complaint or seek a non-molestation order against her partner. She was referred to ASC for additional social support.

3.22. On 25th January 2021 Gloria attended the emergency department of RHH complaining of pain, redness and swelling in her left foot. She had surgery to the arteries in her left leg and was discharged on 31st January. During her stay in hospital Gloria gave consent to be referred to the PHP. Gloria denied thoughts of suicide and no risk was identified in the risk assessment used by the PHP at the time.

3.23. On 7th February 2021 Gloria was admitted to RHH and on 16th February 2021 Gloria's left leg was amputated below the knee. In the meantime, on 8th February 2021, ASC closed the referral (made following the MARAC on 13th January 2021) due to Gloria's admission to RHH, but had also received on 8th February a safeguarding concern from WMAS about Gloria's ability to care for herself.

3.24. On 25th February 2021 Gloria was discharged from hospital and was placed on the occupational therapy waiting list. Gloria requested post-discharge contact with the PHP counsellor**.**

3.25. On her return home Gloria received district nursing support for her wounds and on 8th March 2021 was discharged from this service because her wounds had healed.

3.26. On 13th March 2021 Gloria was taken to RWT by WMAS. The hospital noted that she was "unwell" and had been seeing "strobe lights" and had "social problems". WMAS were concerned about Gloria's ability to cope at home with her disability and that she had suffered domestic abuse from her partner. It is unclear when Gloria's partner had returned to live with her. Gloria refused to stay in hospital despite these concerns and WMAS transported her back home. WMAS raised two safeguarding concerns with ASC.

3.27. The first safeguarding concern was raised at 17.12pm when Gloria claimed that her partner had been verbally and physically abusive to her and that she had "thrown him out" of her accommodation, stating that she did not want him back. Gloria said that she did not wish to involve the police, had sustained no injuries and denied that she had been physically assaulted. Gloria declined any further support from the Safeguarding Team and the safeguarding referral was closed. The second safeguarding referral was raised at 21.10pm by the ambulance crew that transported Gloria home who were concerned about her mental and physical health. There were boxes on the floor creating a trip hazard for Gloria and the ambulance crew were concerned about her mobility and lack of care provision and that she should not have been discharged home.

3.28. An OT (Occupational Therapist) telephoned Gloria on 15th March 2021 and arranged to visit her at home accompanied by a Rehabilitation Officer on 26th March 2021.

3.29. ASC put in place a crisis package of care to run from 16th March to 23rd March 2021 in response to the safeguarding concerns of 13th March. This included one morning care call to support with Gloria's personal care.

3.30. On 16th March 2021 Gloria declined the care package saying that she /had a friend staying with her to support her.

3.31. On 17th March 2021 Gloria attended the ophthalmology department and stated she was very upset due to her sight and limb loss. This had made her feel vulnerable. A nurse from the PHP reported to the OT that the Gloria required support with her accommodation and that the flat was unclean and smelled of "urine or weed".

3.32. On 18th March 2021 Gloria was taken to the emergency department of New Cross Hospital complaining of chest pain and was admitted to the Assessment Medical Unit (AMU) for observation and monitoring as she was considered as at high risk of a heart attack. It was noted that Gloria had eight previous heart attacks. Some 18 hours after arriving at the hospital Gloria self-discharged against medical advice. However, ASC suspended Gloria's care package because they were advised that she had been admitted to hospital.

3.33. The OT arranged for Gloria to receive one personal care call a day, along with one weekly shopping call from 25th March 2021 to 31st March 2021. This was a short-term "crisis" package, and as such was a free service.

3.34. On 25th March 2021 the police telephoned the OT to advise that Gloria said that there were "people in her flat". When the police attended, Gloria was alone in the flat. Gloria informed the OT that she believed that somebody had been hiding in her bedroom. Gloria added that she believed that her partner had brought his friends, including a blonde woman, to the flat and they had been "partying" in the room and having sex. Gloria noted that when she entered the room, "they went quiet". The OT has since confirmed that she believed these to be "paranoid type" ideas due to Gloria's mental health needs.

3.35. On 26th March 2021, the OT and Rehabilitation Officer from the Visual Impairment Team visited Gloria together at home as arranged. Gloria told them that her deteriorating sight loss sometimes "plays tricks on her". Gloria agreed to have a care package, to be provided with kitchen equipment, and for the Rehabilitation Officer to help her with skills training. The OT and Rehabilitation Officer were concerned about Gloria's apparent paranoid ideas and mental health in general.

3.36. On 29th March 2021 Gloria's partner contacted the PHP counsellor expressing concerns about Gloria's "behaviour", although he did not believe Gloria to be at risk and was concerned for his own mental health. Gloria's partner had accessed mental health services over the weekend and confirmed that he had support for himself.

3.37. On 30th March 2021 at 09.49am, Gloria returned a telephone call from the PHP counsellor. Gloria stated that she was struggling with poor and deteriorating eyesight, causing "accidents" around her flat and her seeing images and people whom she was not sure were there. Gloria confirmed that she was receiving support from the Visual Impairment Team. Gloria mentioned her partner's "friends" who she felt were in the flat, which her partner denied. Gloria declined the offer of a safeguarding referral saying that, as a trained Social Worker, it was not necessary. This was explored further by the counsellor who expressed her concerns regarding the possibility of "strangers" in her flat. Gloria reassured the counsellor that she now kept the door locked and the key in a bag around her body. A further call was scheduled for 13th April 2021.

3.38. On 30th March 2021 the OT asked Gloria's GP surgery to refer Gloria to the local mental health service. Later that day at 3pm, the OT telephoned Gloria to complete a financial assessment to allow for the continuation of a care package for her. Gloria was advised that she would need to contribute financially to the cost of the care visits and Gloria stated that she was unable to do this due to being in "a lot of debt and owning property that she could not pay for". Gloria asked for her care visits be cancelled and, following confirmation by the OT's line manager, the care package for Gloria was cancelled with the final visit being 31st March 2021. The PHP counsellor was unaware of this information and Gloria had not disclosed any information regarding her finances during their conversations.

3.39. On 31st March 2021, Gloria's GP referred her to the Early Access Mental Health Service. The GP noted that ASC were concerned about Gloria's "paranoid ideations". The GP, however, felt it was likely that Gloria had Charles Bonnet syndrome, and asked for help from the mental health service, in managing this condition. Charles Bonnet syndrome causes a person whose vision has started to deteriorate to see things that are not real. These are sometimes described as hallucinations but are likely to be of different nature from those experienced in, for example, psychosis. The incorrect address, however, was recorded on the referral letter to the Walsall Early Access Mental Health Service.

3.40. On 1st April 2021 the Community Recovery Mental Health Service sent a letter to the incorrect address advising Gloria of an assessment appointment scheduled for 13th April 2021 (to be undertaken via telephone due to COVID). On 1st April 2021 the Rehabilitation Officer telephoned the OT to advise her that she had ordered the kitchen skills equipment for Gloria and discussed her concerns regarding Gloria's mental health. She was advised that the GP had been requested to refer Gloria to the local mental health service. The Rehabilitation Officer then commenced on two weeks annual leave. The same day, the PHP counsellor contacted the OT to notify her of Gloria's partner's recent telephone contact with her expressing his concern about Gloria's mental health. The PHP counsellor also contacted the GP Surgery and the GP confirmed that he had referred Gloria to mental health services.

3.41. Later that day, at 22.06pm, Gloria was found deceased by WMAS, who had been alerted by a concerned neighbour.

3.42. On 6th April 2021, RWT received notification of Gloria's death by the Coroner's office and the PHP service lead was notified on 7th April 2021.

3.43. Unaware of Gloria's death, on 13th April 2021, a Registered Nurse from the Community Recovery Mental Health Service sent an "ACCURX" text message asking Gloria to make contact. A notification alert was returned advising that Gloria was deceased.

3.44. Both the OT and the Rehabilitation Officer from the Visual Impairment Team were unaware of Gloria's death until 16th April 2021 when the Rehabilitation Officer attended Gloria's property in an attempt to see her and, on arrival, was notified by a person on the premises that Gloria was deceased.

3.45. The Coroner recorded Gloria's cause of death as

1a Cardio Respiratory Depression
1b Central Nervous system depression
1c Excess intake of Morphine, Gabapentin and Paracetamol

3.46. The immediate cause of death was cardio respiratory depression, the underlying cause of which was central nervous system depression. The coroner's conclusion was suicide.

4. THE EVIDENCE BASE FOR THIS SAFEGUARDING ADULTS REVIEW

4.1 The analysis of Safeguarding Adults Reviews by Michael Preston-Shoot (2017) and The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. There is, for example, a considerable amount of practice guidance for how to work with people who self-neglect but few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 **The impact of the coronavirus pandemic.**

4.7 During the last two tears of Gloria's life the Covid-19 pandemic led to changes in the way services were provided.

4.8 Gloria received support from PHP and district nurses in line with guidance throughout the period of restrictions in response to the Coronvirus pandemic.

4.9 The second national lockdown was followed by the reintroduction of an enhanced tier-system. Walsall was placed in tier 3 from 2nd December and moved to the highest tier, tier 4, "Stay at Home" restrictions from 30th December 2020.

4.10 The impact of the coronavirus pandemic, and the restrictions in response to it, on the services working with Gloria, will be considered in this report.

4.11 **Self-neglect, mental capacity and freedom of choice**

4.12 All the contacts with Gloria took place within a policy context that emphasises choice, independence and personal control and which forms part of an overall neo-liberal Government led approach to adult social care and welfare (Ward et al, 2020).

4.13 Safeguarding Adults Reviews (amongst others Andrew, Staffordshire and Stoke, 2022; Harold, Brent 2022; Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998[1], the Care Act 2014[2], the Mental Capacity Act[3] and the Mental Health Act 1983.

4.14 At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising protection from harm (essentially Articles 8 and 2 of the Human Rights Act 1998). The guidance on working with people who self-neglect helpfully challenges the either/ or nature of this question by asking practitioners to consider:

4.15 Is a person who self neglects really autonomous when:

a) They do not see how things could be different.
b) They do not think they are worth anything different.
c) They did not choose to live this way, but adapted gradually to circumstances
d) Their mental ill-health makes self-motivation difficult.
e) They have impairment of executive brain function.

4.16 Is a person who self neglects really protected when:

a) Imposed solutions do not recognise the way they make sense of their behaviour.
b) Their 'sense of self' is removed along with the risks.
c) They have no control and no ownership.
d) Their safety comes at the cost of making them miserable

4.17 **The Domestic Abuse Act 2021**

4.18 The Domestic Abuse Act 2021 defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

4.19 For the definition to apply, both parties must be aged 16 or over and 'personally connected', which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

4.20 Controlling behaviour is defined as, "*A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour*".

4.21 Coercive behaviour is defined as, "*An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

4.22 Domestic abuse is a recognised causal factor in victim mental health problems (Mahase, 2019) and there is also evidence that people with mental health difficulties are more likely to experience domestic abuse than the general population (Rodway, et al, 2014). People with chronic physical health problems are also at increased risk of intimate partner violence compared to partners without chronic physical health problems (Khalifeh et al 2015).

4.23 Gloria had mental health needs (depression, anxiety and post-traumatic stress disorder) and physical health problems (Type 2 diabetes, asthma, chronic obstructive pulmonary disease, at least eight heart attacks and had a stent fitted, as well as the amputation of both legs and deteriorating vision).

4.24 Significantly, mental and physical health conditions can make victims of abuse more vulnerable, and perpetrators can find it easier to gain control by exploiting their victims' vulnerability to make them even more dependent on them.

5. ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Gloria.

5.2 Gloria's background as a social worker and the effect on Gloria's response to services

5.3 One in five adults experience domestic abuse in their lifetime. This equates to one in four women and one in six to seven men (National Centre for Domestic Violence). For many workplaces there will be at least one colleague who is experiencing domestic abuse.

5.4 During the course of this Review practitioners commented that Gloria's experience as a qualified social worker may have influenced her refusal of services. She may have been embarrassed that other social workers and other professionals would know her circumstances.

5.5 On 15th July 2020 a district nurse offered to refer Gloria to ASC for a care and support needs assessment. Gloria declined saying that she had worked as a social worker and would not be happy for the social work team to see her records. Gloria believed the information would be used for gossip. It is not possible to determine if this had been Gloria's experience. Some local authorities take steps to limit access to case records when a colleague becomes a client, or is associated with someone who is a client of children's and /or adult social services. Walsall Social Services should assure the public that their information is protected and only used to support appropriate service delivery to meet their needs.

5.6 Risk of suicide: What was known about Gloria's suicidal thoughts?

5.7 After the amputation of her right leg on 31st January 2020, Gloria expressed suicidal thoughts and received the PHP service until July 2020 when she reported that she no longer thought of suicide. Gloria had also told a district nurse in June 2020 that she had suicidal thoughts. On 13th September 2020, Gloria contacted her GP to request a "Do-Not-Resuscitate" order if her heart or breathing stopped, saying that she would not be able to live with the removal of both legs as she was already struggling with the removal of one. During Gloria's admission to RHH from 25th to 31st January 2021 hospital staff identified that counselling and mental health services were required for Gloria's "low mood, suicidal thoughts and anxieties". Gloria told staff that she wanted "to give up". Gloria was re-referred to the PHP by a physiotherapist at RHH. However, Gloria denied thoughts of suicide and no risk was identified in the risk assessment used by PHP. When Gloria was discharged from hospital on 25th February 2021, following the amputation of her second leg, Gloria requested a further follow up contact from the PHP counsellor. On 30th March 2021 Gloria's GP spoke to Gloria on the telephone and she denied any suicidal ideation. Two days later she was found dead. The coroner determined that Gloria had taken her own life.

5.8 Some practitioners (hospital staff, a physiotherapist, a district nurse, the PHP counsellor, and the GP) knew of Gloria's suicidal ideation at different points in time, but not necessarily all at the same time, however referrals were made to, and information shared with, the PHP counsellor.

5.9 In September 2020 Gloria asked her GP for a Do Not Resusitate Order. By this time Gloria was already fearful that she may lose her left leg and had thought about the problems she may face being a bilateral amputee and whether these were circumstances she could live with.

5.10 It appears that ASC were not aware that Gloria had suicidal thoughts, or had a history of suicidal ideation. ASC recognised and noted a number of physical and sensory changes which were "life changing" that would likely contribute to a further deterioration in Gloria's mental health. During the care and support needs assessment undertaken on 26th March 2021 ASC noted multiple losses in Gloria's life, the ending

of many relationships and the loss of contact with siblings who lived locally. The assessment made no reference to exploring the impact of these losses any further, nor whether Gloria was accessing support for this. There was also no reference Gloria's thoughts of suicide, since ASC were unaware of these. It is not clear, however, whether knowledge of Gloria's suicidal ideation (even past, if not current) would have changed the way in which ASC supported her and, for instance, handled the impact upon Gloria of having to pay for a care package. Gloria cancelled care visits two days before she died saying she could not afford them.

5.11 Suicide Safety Plans

5.12 Gloria's thoughts alternated between suicidal and non-suicidal. Sometimes this happened quite quickly, for example, at the end of January 2021 staff at RHH noted that Gloria had suicidal thoughts, which she subsequently denied when she spoke with the PHP counsellor. On 30th March 2021 Gloria told her GP she did not have any suicidal thoughts, but was found deceased two days later.

5.13 Although in Gloria's case there is no evidence that she had made previous suicide attempts, the move from contemplation of suicide to suicide attempts and then to completed suicide can occur suddenly (Apter and Wasserman, 2006). The Royal College of Psychiatrists (2020) advises that suicidal thoughts (and risk) can vary across a relatively short time period and that the assessment of suicide risk by clinicians needs to be individually focused and carried out regularly.

5.14 Given what is known about the rapidity with which suicidal intention can turn into suicidal acts, it would have been appropriate for a safety plan to have been drawn up as a contingency, but there is no evidence that one was done.

5.15 The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, recommends a (suicide) safety plan for any individual who has suicidal thoughts or who has self-harmed. A safety plan (see Appendix 4) is an agreed set of activities, strategies to use and people and organisations to contact for support if someone becomes suicidal, if their suicidal thoughts get worse or if they might self-harm. The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

5.16 There is emerging evidence of the effectiveness of safety plans (Zonana et al. 2018) and it is important that safety plans are co-created with patients and encourage communication with family and friends.

5.17 No suicide safety plan appears to have been considered and the development of one with Gloria may have provided strategies for her to cope with suicidal thoughts.

5.18 **Medication: restricting access to common means of suicide**

5.19 A suicide safety plan should include restricting access to common means of suicide. According to the Royal College of Psychiatrists this could involve:

- Removing things that could be used for self-harm or suicide
- If stopping self-harm is not an option yet considering ways to make self-harm safer
- If medication is in the home, making it safer or storing less
- Identifying and avoiding distress triggers.

5.20 Had a safety plan been developed, this might have triggered consideration of restricting Gloria's access to common means of suicide. In addition, the involvement of other agencies, for example, Gloria's GP did not lead to a review of medication specifically to consider the risk of suicide and overdose. It appears that Gloria administered the medication herself.

5.21 Gloria's prescribed medication, as at 17th March 2021, were morphine modified release 40mg taken twice daily, Oramorph taken pro re nata (PRN) (as required), baclofen 10mg taken at night, amitriptyline 25mcg taken at night, gabapentin 600 mg TDS taken 3 times a day.

5.22 Both morphine and Oramorph are strong opioid painkillers, Oramorph is in liquid form taken by mouth. Baclofen is used to treat pain and certain types of muscle stiffness and tightness. Amitriptyline may be prescribed for the treatment of neuropathic pain and for the treatment of major depressive disorder. Gabapentin is used in the treatment for partial seizures and nerve pain.

5.23 Depressive and psychotic disorders may be exacerbated by treatment with Baclofen. Suicide and suicide-related events have been reported in patients treated with Baclofen. In most cases the patients have additional risk factors associated with an increased risk of suicide including depression and/ or a history of previous suicide attempts. Baclofen requires close supervision and carers should be alerted about the need to monitor for worsening mental health needs, suicidal behaviour and thoughts or unusual changes in behaviour.
https://www.medicines.org.uk/emc/product/2594/smpc#gref.

5.24 There is no record that Gloria's partner was asked to monitor her behaviour for signs of suicidal ideation, nor that any alternative arrangements were put in place once he was no longer living with her.

5.25 The second most common suicide method reported by the National Confidential Inquiry into Suicide and Safety in Mental Health (2017) was self-poisoning. The most common drugs in fatal overdoses are opiates, both prescription and non-prescription. Internationally, opiate misuse and dependence are rising. The Confidential Enquiry recommended that opiate prescriptions should be reviewed carefully. It suggested that they should be subject to "safer prescribing", including reduced use overall and administration of short-term supplies.

5.26 The Coroner determined that Gloria's death was connected with an excess intake of morphine, gabapentin and paracetamol. Although Gabapentin is widely perceived as safe, drug-induced respiratory depression has been noted when Gabapentin is used alone or a combination with other medications.

5.27 A review of Gloria's medication with suicide risk reduction in mind may have considered the interrelationship and interaction between the prescribed medicines and whether there were any "safer" combinations, reducing the quantity of medication provided for each prescription and increasing the frequency of prescriptions accordingly (although this may have been more costly for Gloria in terms of prescription charges, she may have been entitled to a medical exemption certificate giving her free prescriptions because of her disabilities). If these considerations were impractical, thought may have been given to whether it there was a case for restricting Gloria's access to medication and requiring it to be administered and monitored by carers.

5.28 **Gloria may have planned her suicide and concealed suicidal thoughts to avoid any interventions to prevent her suicide**

5.29 A review of 70 major studies of suicidal thoughts (McHugh et al. 2019) showed that about 60% of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or GP. It is possible that there were times when Gloria denied suicidal ideation when she was thinking of suicide. For example, when Gloria spoke to her GP on 30th March 2021, she may have decided to take her own life, and did not want any intervention to prevent her from doing so. Gloria may also have cancelled care calls at the end of March 2021 to avoid people being in her home who might prevent her taking her own life. For a variety of reasons, for example, stigma, shame, fear, or embarrassment) people may conceal or minimise their suicidal thoughts (Royal College of Psychiatrists 2020).

5.30 This highlights the value of a compassionate and therapeutic relationship, so people feel freer to disclose their thoughts. There is also a need to consider further factors, including an assessment of the degree of emotional pain, a thorough mental state examination, as well as identifying risk factors and/or red flag warning signs. Clinicians should not assume that patients experiencing mental distress without reporting suicidal ideas are not at elevated risk of suicide. (Royal College of Psychiatrists 2020).

5.31 **Other factors that may have contributed Gloria's feelings of wanting "to give up"**

5.32 In addition to Gloria's loss of independence, loss of contact with family and loss of relationships, there were other factors which may have had a negative impact on Gloria. These related to the provision of health care and support services to Gloria in 2020 and 2021. Some of these experiences may have been outside practitioners' sphere of influence, or were caused by reactions and responses to the 2020/21 Covid-19 pandemic, but the effects may have been substantial. These included the following:

5.33 There was a backlog of patients waiting for eye surgery. Despite the impact of Gloria's deteriorating eyesight on her, Gloria was still waiting for surgery for cataracts at the time of her death.

5.34 Due to the effects of, and response to, the Covid-19 pandemic the delivery of equipment, recommended by an Occupational Therapist, to Gloria was a delayed.

5.35 Gloria's PHP counselling appointments and physiotherapy appointments were by telephone which Gloria did not feel was an effective way of delivering therapy.

5.36 Gloria was unhappy with the services she received from district nurses. Gloria believed, following an incident with a locum nurse, that the district nursing team had written negative comments about her in their notes; Gloria asked for a telephone call 15 minutes prior to the arrival of a district nurse so that she could take pain relief, but this did not happen; the district nurses missed some visits; Gloria had an infection in her leg after district nurses had not been to visit her between 13th September and 9th October 2020 for wound care; and sutures were not removed after Gloria had heart bypass surgery.

5.37 **Missed opportunities and barriers to assessing Gloria's needs.**

5.38 After Gloria was discharged from hospital on 18th March 2021 following heart problems, she telephoned her GP surgery about another medical matter. The GP surgery did not take this opportunity to check on Gloria's wellbeing. By now Gloria was a bilateral amputee. It would be reasonable to enquire how she was managing and to address any concerns or support issues that may arise from being a bilateral amputee with heart problems, deteriorating vision and a recent history suggesting domestic violence. This was a missed opportunity to assess Gloria's self-care and coping and the emotional impact of her health problems.

5.39 The assessment carried out by Gloria's GP on 30th March 2021, resulting in a referral to "early access psychiatry" was conducted by telephone. This meant that any non-verbal cues to Gloria's emotions and mental health state were not picked up. Whilst Gloria denied any suicidal ideation, given Gloria's recent second amputation and ongoing heart problems, a face-to-face appointment may have been the most appropriate medium for a comprehensive and "accurate" assessment.

5.40 **Domestic abuse**

5.41 Gloria's physical and mental health problems may have made her more vulnerable to domestic abuse and domestic abuse may have increased the intensity of her mental health problems. Gloria reported in January 2021 that she had suffered abuse from her partner for about a year, which dates back to her first amputation. WMP suspected that Gloria's resulting disability may have contributed to her partner's alleged behaviour towards her.

5.42 Gloria was reported to have been with her partner for seven years, and on this basis they would have started their relationship in 2015. At the initial stage of agreeing the terms of reference for this review it was thought that Gloria had been the subject of 11 episodes of domestic abuse. However, during the course of this review, West Midlands Police confirmed that Gloria was the named victim in two cases of alleged domestic abuse, which came to their attention. The first was on 12th February 2020

when Gloria alleged her partner had stolen her car but during the investigation, told police that she had given her partner permission to use the vehicle.

5.43 The second was in early January 2021 when Gloria made an allegation that her partner was having sex with someone else in her flat, and when she confronted him about it, he threatened to rape her, slit her throat and drink her blood if she ever "cheated" on him. He allegedly punched her in the face near her eye and the hospital recorded bruising in this place. However, on 7th January 2021 Gloria withdrew all three parts of the allegation. Gloria said that she no longer wanted to make a complaint, a decision which she had come of her own accord. Gloria said she was unsure if she had been truthful and that she may have hallucinated the events because of the medication she was on.

5.44 As Gloria withdrew her support for a prosecution, and could not confirm whether offences were committed or imagined, the police considered they had no evidence with which to continue with the investigation and insufficient evidence to provide a realistic prospect of conviction. Gloria's partner had been interviewed and denied all allegations.

5.45 Gloria's partner made two allegations in which he was the victim of domestic abuse by Gloria. The first was on 15th July 2019 when he alleged that Gloria had assaulted him, and that she had returned home and he wanted her removed. The second was on 28th March 2021 when he alleged that Gloria was harassing him. Gloria's partner explained that he did not want to get Gloria into trouble but wanted her to stop making accusations and attempts to have him arrested. He also said that in January 2021 Gloria's behaviour had become erratic and that she had hit him on the head, resulting in mild concussion. Gloria's partner did not want to make a statement, and therefore he was given safety advice and referred to the National Centre for Domestic Violence. The Police did not speak to Gloria about this incident. Due to the unwillingness of Gloria's partner to take the matter further and a lack of corroborative evidence the police took no further action.

5.46 Sharing information and the recognition of a pattern of possible abuse

5.47 No agency was aware of all the reports of domestic abuse that Gloria made and therefore there was no coordinated response**.** Apart from the reports of alleged domestic abuse coming to the attention of West Midlands Police, there were other occasions when Gloria alleged that she was being abused by her partner. Gloria made these allegations to agencies other than the police. There were opportunities missed by individual agencies to share information with other agencies, including reporting them to the police, and in consequence no agency built up a comprehensive picture and pattern of the alleged domestic abuse that Gloria experienced through the coercive and controlling behaviour of her partner.

5.48 The pattern of alleged abuse, and reporting and sharing of it, is illustrated below.

(a) On 12th February 2020 Gloria alleged that her partner had stolen her car. On investigation WMP recorded that Gloria had given her partner permission to use her car. It is not clear whether this information was reported to ASC.

(b) On 14th May 2020 Gloria disclosed domestic abuse by her partner to a clinical trials assistant at Royal Wolverhampton Trust (RWT), who contacted the hospital safeguarding team at the RWT and was advised to take several actions including raising a safeguarding concern with ASC. This was not followed through despite RWT policy requiring a safeguarding concern to be raised, where safeguarding concerns were identified for a person with care and support needs (at this time Gloria would appear to have care and support needs as a result of the amputation of her right leg), irrespective of their wishes. The clinical trails team were asked to make a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) risk assessment, but did not. When Gloria did not respond to subsequent attempted contacts by the team, there was no consideration of whether asking WMP to carry out a safe and well check would be appropriate.

(c) On 15th July 2020 Gloria disclosed domestic abuse to a district nurse, who offered her domestic violence leaflets with contact details for support. Gloria refused to take the leaflets. The nurse did not report or refer the matter elsewhere.

(d) On 1st January 2021 a district nurse offered to report the domestic violence Gloria had experienced at the hands of her partner to the police. Gloria refused. The nurse assessed that Gloria had the mental capacity to make this decision. On this basis the nurse did not report the information to the police, nor did she report it to ASC.

(e) In early January 2021 Gloria disclosed domestic abuse to staff at RWT. The case was referred to a MARAC and the police and ASC were involved.

(f) On 25th January 2021 Gloria told staff at RHH that during a disagreement with her partner her left foot was knocked from her wheelchair and that he had pushed her twice in the past. RHH noted the matter as a safeguarding concern but there is no evidence of action taken or onward referral.

(g) Whilst Gloria was in RHH following the amputation of her left leg, on 18th and 19th February 2021, she received messages from her partner refusing to allow her to return to the flat and saying that she must find somewhere else to live. Gloria and her partner held a joint tenancy. Whilst her partner subsequently agreed to facilitate the delivery of additional equipment to the flat to aid Gloria, there is no evidence that the hospital linked the previous reports of her partner pushing her and knocking her foot, to the attempt to stop Gloria from returning to her own home. RHH did not appear to recognise a possible pattern of coercive and controlling behaviour or domestic abuse. RHH did not share the information with other agencies.

(h) On 13th March 2021 WMAS sent two safeguarding concerns to ASC, one of which concerned physical and domestic abuse of Gloria by her partner. This safeguarding concern was closed at Gloria's request.

(i) On 13th March 2021 Gloria disclosed to staff at RWT that her partner locked her in her flat. This does appear to have been explored. This could have been another example of abuse, possibly false imprisonment and coercion and control. The information was not shared with other agencies.

5.49 In summary there were six occasions where alleged domestic abuse was reported to an individual agency, but not shared with other agencies, such as the West Midlands Police, ASC or Black Country Women's Aid (BCWA, which supports victims of domestic abuse in the community and provides the independent domestic violence advocacy (IDVA) service for the area). These organisations might then have recognised a pattern of suspected abuse, sought to engage with Gloria and coordinated a multi-agency response, with the aim of reducing the risks of repeated domestic abuse.

5.50 Serial domestic abuse perpetrator identification, and approach to handling cases, sharing information and data protection.

5.51 In addition to concerns about the domestic abuse of Gloria, her partner had a history of domestic abuse, including common assault on his previous partner in 2014. The matter was dropped with no further action taken. In 2013 there had also been a domestic incident with the same previous partner, which did not amount to criminality. Gloria's partner also had two domestic incidents reported about him in 2010.

5.52 The Association of Chief Police Officers (ACPO, 2009) define "a serial domestic abuse perpetrator" as an individual who has used or threatened violence or abuse against two or more victims who are unconnected to each other. Gloria's partner fits this definition but WMP did not identify Gloria's partner as a serial perpetrator. As part of this Review, WMP commented that either officers did not go back far enough in their records to pick up the 2014 incident, or did not identify him on the basis that the allegations had been retracted and had not resulted in a conviction or caution.

5.53 If Gloria's partner had been identified as a serial perpetrator of domestic abuse, then further options might have been available. Even though may not have been relevant in Gloria's case, they may be appropriate in similar cases. Identification as a serial perpetrator may lead to disclosure of previous offending history to a new partner using Clare's Law (the Domestic Violence Disclosure Scheme, the "Right to Know") so that a potential victim is aware of the heightened risk of domestic abuse.The decision about disclosure is made at a MARAC meeting. Serial perpetrators of domestic abuse may also have an Offender Manager. As Gloria's partner was not convicted of an offence, none of this would not have applied in Gloria's case.

5.54 If a serial perpetrator is identified, WMP may also consider evidence-led prosecutions in "the correct circumstances". Evidence-led prosecutions mean that domestic abusers can be prosecuted without the direct support or direct involvement of victims. Agencies and support services may hold information that can provide relevant evidence to assist in building a case. This may include case notes from physical and mental health services and adult social care. However, in accordance with the Controlling and Coercive behaviour: Statutory Framework Guidance April 2023 "any use of a victim's case notes, or any other personal data to

build a case, should be approached sensitively and with the victim's consent". This is because "engaging with support services can be a vital step towards recovery and victims should feel confident in doing so". Consequently appropriate identification of serial perpetrators offers a wider range of options for intervention.

5.55 Balance is required between respecting an adult's wishes, protecting their personal data, and protecting them from domestic abuse. RWT has a policy of raising safeguarding concerns (including those of domestic abuse) to ASC irrespective of the adult's wishes, if the adult has care and support needs. It is not clear whether other services had a similar policy.

5.56 Neither the Care Act 2014 nor the Care and Support Statutory Guidance state that the three criteria set out in s42 of the Care Act 2014 must be met for a safeguarding concern to be raised. On this basis it may have been appropriate for agencies to have sent all of the domestic abuse concerns they had about Gloria to ASC as safeguarding concerns irrespective of whether they judged her to have care and support needs. At least one agency then would then have recognised a pattern of domestic abuse, and have sought other interventions, for example involving BCWA. Alternatively, all the domestic abuse concerns could have been sent directly to BCWA.

5.57 The MARAC did not appear to consider all of the concerns associated with Gloria and her safety, and actions from the MARAC were not followed through.

5.58 Gloria telephoned WMP on 1st January 2021. WMP believed that Gloria was having a mental ill-health episode and asked WMAS to attend. WMAS found that Gloria had an eye injury and took her to RWT. Gloria reported to hospital staff that she had been subjected to domestic abuse by her partner. Gloria was admitted due to concerns about her returning home in light of her disclosures of abuse. RWT informed WMP of the domestic abuse and police officers visited Gloria in hospital on 4th January 2021 to interview her. Gloria said that her partner had hit her and threatened to kill her

5.59 Gloria also told hospital staff that due to her medical conditions she had to leave her job and had applied for her pension. When she received her pension, her partner spent £45,000 of it within three months. Gloria claimed her partner engaged in controlling tactics within the home to limit her ability to navigate her environment, for example, by removing light bulbs so she could not see and leaving clothes on the floor which made it difficult for Gloria to move around the flat in her wheelchair. It appears that WMP did not question Gloria's partner specifically about this when they took his statement, but he said he was taking care of Gloria's finances as her carer. He denied controlling her and assaulting her.

5.60 Both the hospital, who completed a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH,) and WMP, who completed a Domestic Abuse Risk Assessment (DARA), assessed Gloria to be at high risk of harm.

5.61 On 5th January 2021 Gloria was discharged from hospital, at her request. Gloria's partner had been arrested and was in police custody. His key to the flat had been

returned to Gloria. It appears, however, that Gloria's partner returned on an unspecified date.

5.62 On the 7th of January 2021, Gloria told WMP that she no longer wished to make a complaint. Although Gloria said she had come to the decision to withdraw her complaint of her own accord, the police notes do not state if they explored the reasons for this. For example, Gloria may have been fearful of retribution, or actual threats of further abuse. Gloria alleged that her partner was physically and emotionally abusive towards and had threatened to kill her. Gloria had become increasingly dependent on her partner, and said she was not able to pay for a carer, and thus she was in a 'lose-lose' situation. If Gloria reported her partner then she may lose any form of support from him, and if she did not agree to police prosecution she was at risk of continuing domestic abuse.

5.63 Gloria told police officers that her tenancy was in her name only, however, when officers attended her home to arrest her partner the caretaker showed police officers a tenancy record which had both her and her partner's names on it. Gloria had also told officers that her landlord was a friend of her partner.

5.64 A MARAC meeting was held on 13th January 2021, which discussed Gloria's case. The minutes of the MARAC were brief, and the representative from ASC took very few notes from the meeting, so in hindsight it is not possible to identify whether the minutes were a comprehensive reflection of what was discussed. It appears, however, that the issue of Gloria's housing was raised because the MARAC chair noted concerns that, even though Gloria's disclosures of domestic abuse were very detailed, and so likely to be true, they had not been recognised as examples of coercive and controlling behaviours and options such as supported accommodation or a needs assessment had not been offered.

5.65 No actions, however, were recorded in the MARAC minutes about possible enquiries that could be made to explore with Gloria the nature of the tenancy agreement and if the link between the landlord and Gloria's partner impinged on Gloria's ability to end what appeared to be a co-dependant relationship and housing arrangement.

5.66 The actions from the MARAC meeting were for Gloria's GP and district nurses to encourage her to consent to a care and support needs assessment from ASC with a view to rehousing Gloria and to provide her with support. However, there is nothing in the information provided by the GP and the district nurses to indicate that these conversations took place. Nor is there any evidence following the MARAC meeting that the issue of rehousing Gloria was considered again either at single or multi-agency level.

5.67 In general, there appeared to be no follow up or monitoring of the actions agreed at the MARAC. As Gloria did not support charges being brought against her partner, the domestic abuse concern appears to have been left with no particular action agreed.

5.68 As well as Gloria's housing situation, the MARAC may not have sufficiently considered the suitability of Gloria's partner as her carer, and how this and other factors, including Gloria's amputations and her worsening vision, increased the risk of abuse.

5.69 No consideration was given to whether Gloria, in a coercive and controlling relationship, with mental health needs, had the mental capacity to make decisions about domestic abuse.

5.70 A safeguarding referral of physical and domestic abuse made on 13th March 2021 was closed down.

5.71 On 13th March 2021 ASC received two safeguarding referrals from WMAS, one for the physical and domestic abuse of Gloria by her partner and the other concerned the state of Gloria's home and her ability to care for herself. WMAS reported that Gloria's partner had deliberately placed items in the property in an attempt to harm Gloria. ASC contacted Gloria who confirmed a referral had been made to BCWA. ASC contacted Gloria who told ASC that she was "not coping" and that her priority was to receive care and support. Gloria did not want to take any action against her partner and did not give consent for the safeguarding referral to progress any further. There is no evidence documented to suggest that Gloria was provided with information, advice and guidance should she wish to progress the matter at a later date. It was felt by ASC that the threshold for opening a section 42 adult safeguarding enquiry had not been met as Gloria was deemed to be able to protect herself. On this basis the safeguarding concern for domestic abuse was closed.

5.72 Given Gloria's significant physical disability, visual impairment and mental health problems, the conclusion that Gloria was able to protect herself was questionable. ASC could have done more to explore Gloria's rationale for wanting the safeguarding referral to be closed down, and could have undertaken a formal mental capacity assessment to determine if Gloria had the capacity to make decisions about her own protection.

5.73 Section 42(1) of the Care Act 2014 states, "The local authority must make enquiries (or cause enquiries to be made) where it has reasonable cause to suspect that an adult:

(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect,
(c) and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

5.74 Making a judgement on s42(1c), about whether or not the adult is unable to protect themselves because of their care and support needs, can be difficult and may require gathering additional information and a discussion with the person about whom the concern has been raised.

5.75 Consequently, the conclusion from national guidance is that if sections 42(1a) and (1b) have been met, the concern should be recorded as requiring a safeguarding enquiry, even if there is uncertainty about whether s42(1c) has been met. If during information gathering there is reasonable belief that s42(1c) does not apply then the local authority can decide not to pursue the matter as a safeguarding concern (see

https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-faqs).

5.76 **Professional curiosity**

5.77 Practitioners noted the links between mental health problems and domestic abuse. They suggested, however, that where mental health problems are a factor, some professionals may have an unconscious bias towards believing that domestic abuse allegations are fictitious and are attributable to mental illness. Perpetrators of domestic abuse may also try to undermine their victims' credibility as witnesses by claiming that they have mental health problems.

5.78 In order to counter this, it is important to form trusting relationships with clients which might both prompt disclosure and also provide insights into context, circumstances and the presence of coercive control. Relationships like this are based on several interpersonal factors including honesty, truthfulness, consistency, respect, supportive and concerned challenge and the completion of agreed actions. Doing this requires presence and engagement with the person who may be experiencing domestic abuse as well as time, consistency and continuity. It does not require the possession of professional qualifications and trust relationships can be formed with the person by anyone the come into contact with.

5.79 It is also important for professionals to consider the different accounts and perspectives of other colleagues and family members involved with the person. These can be used to form a better understanding of warning signs or patterns that might indicate domestic abuse. Asking about domestic abuse should be a routine enquiry when working with new clients.

5.80 This required professional curiosity to engage with Gloria and to involve others to gain a better picture of her life and relationships. Many professionals were involved with Gloria from different organisations but there was little information sharing between them. This reduced the opportunity to triangulate between perspectives on Gloria's disclosures and professional assessments and observations.

5.81 Care needs and carer support: "Think Family", carer support and suitability to provide care

5.82 The "Think Family" approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016). This approach recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs.

5.83 The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family.
- Work jointly with family members as well as with different agencies to meet needs.
- Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

5.84 Such an approach may have led to greater consideration of how all the needs presented by Gloria and her partner could have been approached. Think Family could have helped to give attention to how Gloria and her partner's individual needs interacted with, and impacted on, each other's and to how Gloria and her partner functioned as unit.

5.85 During the MARAC meeting on 13th January 2021 there was possibly some recognition of Gloria's partner as her carer, and that if Gloria withdrew permission for the police to take her allegations of domestic abuse any further (which she had), her partner still remained a potential source of risk to Gloria. Consequently it would have seemed appropriate that when services found they could not remove her partner through the criminal justice system, nor move Gloria away from him, that support should have been planned for her partner to reduce the risks to her. There did not appear to be a recognition of the role of caring within households and the challenges this can pose. The challenges of caring may have been a contributing factor to domestic abuse but this does not appear to have been considered by ASC.

5.86 Even when Gloria's partner did tell agencies that he was struggling to care for Gloria there was no offer of support. For example, during Gloria's stay at RHH between 7th and 25th February 2021, Gloria's partner told the hospital therapy team that he was Gloria's main carer and that he was struggling to provide the care because the flat was not suitable. This was a missed opportunity for the hospital to have referred Gloria's partner to ASC for support or to have signposted him to support.

5.87 WMAS, however, did make a referral to ASC following Gloria's admission to RHH. The referral detailed that Gloria had an "extensive cardiac history" and was an amputee being cared for by her partner. Gloria's partner was noted as a source of risk. This was a missed opportunity for ASC to have engaged with Gloria's partner as a carer in his "own right", to establish his wishes and feelings and determine the current position.

5.88 On 15th March 2021 Gloria's partner telephoned ASC saying he was ending the relationship with Gloria as he could not cope as her carer. This was another opportunity missed to offer Gloria's partner a carer's assessment or information, advice and guidance. It seems none was offered.

5.89 Consequently, there is little evidence of thinking flexibly about how family members and community resources can contribute to interventions, building on relationships and networks.

5.90 **Opportunities to conduct a care and support needs assessment, and the provision of care and support**

5.91 There appears to have been insufficient attention to ensure that Gloria's care and support needs were assessed and met in a timely manner (Table 1).

Table 1: Assessing and meeting Gloria's care and support needs

In January 2021 RWT referred Gloria for a care package on discharge from hospital.	ASC were unclear whether Gloria had declined care, but did not contact Gloria directly. By 13th January 2021, when the MARAC was held, ASC would have been aware of the alleged abuse, and so had a duty to, but did not, conduct an assessment of care and support needs under S11(2)(b) Care Act 2014, despite Gloria's refusal.
In January 2021 the MARAC referred Gloria for a care and support needs assessment	The referral was closed by ASC when Gloria was admitted to RHH on 7th February. On 8th February ASC received a safeguarding concern from WMAS about Gloria's ability to care for herself. ASC did not progress the concern, for example, by talking to Gloria directly or by contacting RHH. When Gloria was discharged from RHH on 26th February having had her second leg amputated, she returned home without a care package. It is not clear why this was not arranged.
On 13th March 2021 WMAS raised a safeguarding concern about Gloria's ability to care for herself	On 15th March ASC arranged an emergency package of care. On 18th March Gloria went into hospital but self-discharged the same day. Her care calls were suspended and no note to restart them was made until 24th March. A crisis care package was put in place from 25th March.
On 26th March 2021 a care and support needs assessment was undertaken.	Care needs were identified and Gloria agreed to have an ongoing care package.
On 30th March 2021 ASC advised Gloria that she would need to contribute financially to her care package.	Gloria cancelled her care visits on the basis that she could not afford to contribute. It is not clear what support or signposting was given to Gloria to help with debt management. It is not known if this was a further contributing factor towards her death in addition to many life changing events and deterioration of her physical and mental health.

5.92 There appears to have been insufficient understanding of the Care Act 2014 and the duty in section 11(2) (b) to undertake assessments when an individual is at risk of abuse or neglect, even when the person declines. Discharges from hospital were made without a care package in place and there was a lack of assertive follow up and monitoring of Gloria's situation.

5.93 A local authority has a legal duty to meet an adult's eligible care needs. If an adult refuses to pay for homecare, the local authority cannot withdraw the service if the person is deemed not to have the mental capacity to make this decision. The local authority would therefore be expected to continue to meet the adult's needs, while attempting to resolve any dispute. However, if the adult has the mental capacity to make this decision, and understand its consequences, the local authority is not required to continue to meet the adult's needs if they refuse to pay. https://www.alzheimers.org.uk/sites/default/files/2019-05/532lp-paying-for-care-and-support-in-england-190521.pdf. It is not clear whether ASC were aware of their duty in this respect, or if they considered a mental capacity assessment they completed on 26th March 2021, a few days earlier, as confirmation that Gloria had the capacity to make the decision to cancel her care visits.

5.94 Focus on physical limitations

5.95 The care and support needs assessment on 26th March 2021 appears to have focussed primarily upon Gloria's physical care and support needs. There appears to have been little work by ASC with Gloria to discuss in depth her mental health and life changing events and how this impacted upon her.

5.96 There was an absence of multi-disciplinary working and information exchange leading to support that was not sufficiently joined up given Gloria's complex physical and mental health needs.

5.97 Mental capacity and self-neglect

5.98 Gloria's mental capacity to make decisions was sometimes assumed, but otherwise any assessments were generally linked to a specific event (table 2).

Table 2: Situations when Gloria's mental capacity might have been assessed

15th July 2020 Gloria refused the offer made by a district nurse to refer her for a care and support needs assessment	No mental capacity assessment was undertaken
December 2020 Gloria refused to have her wounds redressed	Mental capacity assessment determined Gloria had capacity
1st January 2021 Gloria refused to allow a district nurse to report domestic violence	Mental capacity assessment determined Gloria had capacity
5th January 2021 Gloria decided to be discharged from hospital	RWT noted that Gloria "had capacity"
5th January 2021 Gloria decided she did not need a care package	No mental capacity assessment was undertaken
7th January 2021 Gloria declined to take domestic violence allegations any further	No mental capacity assessment was undertaken
13th March 2021 Gloria declined to take domestic violence allegations any further	No mental capacity assessment was undertaken
13th March 2021 Gloria refused to stay in hospital despite concerns it was not safe for her to go home	The hospital noted "Patient states she has capacity"
18th March 2021 Gloria self-discharged from hospital against medical advice despite having had a cardiac event (pains in chest).	Mental capacity assessment determined Gloria had capacity
26th March 2021	A mental capacity assessment was completed during Gloria's care and support needs assessment, but it did not state which decisions Gloria had the capacity to make
30th March 2021 Gloria cancelled her care package	No mental capacity assessment was undertaken

5.99 In addition, RWT commented as part of this Review that at times Gloria was confused and disoriented, yet an assessment of mental capacity was not undertaken on these occasions.

5.100 it is unclear on the occasions when a mental capacity assessment was made, if sufficient consideration was given to whether Gloria's mental health needs constituted an impairment of, or disturbance to the functioning of her mind or brain (see Appendix 3).

5.101 Gloria's history of consistently taking seemingly unwise decisions over a period of time was not considered. In some cases, it is necessary to consider and assess capacity to make a decision over an extended period of time, to regard mental capacity as a "video" rather than as a "snapshot".

5.102 Mental capacity is decision and time specific, and assessments should be made on the individual's capacity to make a specific decision at a specific time. However, the proposed revised Code of Practice on the Mental Capacity Act makes a clear distinction between considering and assessing capacity, and aims to guard against failing to assess capacity when there is reason to do so. Causes of concern that may prompt consideration of mental capacity include repeatedly making decisions that appear unwise and present a significant risk of harm or exploitation or making a particular unwise decision that is obviously irrational or out of character.

5.103 The presence of these do not necessarily mean that somebody lacks capacity, since people have a right to make decisions that others may feel are unwise, but they might present a need for further investigation, taking into account the person's past decisions and choices, in, for example, the following situations:

- Has the person developed a medical condition or disorder that is affecting their capacity to make particular decisions?
- Are they easily influenced by undue pressure?
- Might someone be influencing or coercing and controlling them?
- Does the person need more information or support to help them understand the consequences of the decision they are facing?

5.104 If there is a proper reason to doubt that the person has capacity to make the decision, it will be necessary to assess their capacity by applying the test in the Act.

5.105 Gloria may have been under the influence and control of her partner, and those party to the MARAC would have been aware of this. Gloria had experienced mental ill health such as suicidal, depression, anxiety and post-traumatic stress disorder.

5.106 In summary, Gloria made a number of seemingly unwise decisions. On some occasions a mental capacity assessment was made and on others one was not. The approach to mental capacity was to view each decision Gloria made as an individual, unconnected

"snapshot", rather than to view Gloria's history of decisions as a "video" or a pattern. This, together with knowledge that Gloria may have been coerced and controlled, should have triggered consideration of a mental capacity assessment. When mental capacity assessments were undertaken it is possible that insufficient consideration was given to whether Gloria's mental ill health, or experiences of coercion and control constituted an impairment in the functioning of her mind or brain.

5.107 Self-neglect

5.108 In February 2021 WMAS made a referral to ASC who felt that Gloria would benefit from support and also mentioned that the property was "cluttered", which may have been an indication that Gloria was self-neglecting. During the care and support needs assessment on 26th March 2021 ASC noted that Gloria's home was cluttered, but there was no indication that ASC connected this with the possibility that Gloria might be self-neglecting. ASC were also aware of other factors such as non-compliance with medication and missed medical appointments. These were also potential indicators of self-neglect. The care and support needs assessment would have been an opportunity to have discussed self-neglect with Gloria. When Gloria cancelled her care package on 30th March 2021 this did not appear to have been considered as self-neglect, nor escalated further, despite having been raised with a manager. This would have been an appropriate time to have brought professionals together to generate new approaches to Gloria's complex needs and circumstances.

5.109 Mental health, hallucinations, Charles Bonnet Syndrome, psychological abuse

5.110 There were differences of opinion about whether Gloria's partner was inviting other people back to the flat and having sex with them, or whether these were hallucinations either caused by Charles Bonnet Syndrome (as suggested by RWT) or psychotic episodes. People whose sight begins to deteriorate can be affected by Charles Bonnet Syndrome, a condition where they see things that are not real. There did not appear to be any exploratory follow up to make a diagnosis of Charles Bonnet Syndrome. Instead RWT sought and obtained Gloria's consent to write to her GP for a mental health review. Charles Bonnet hallucinations are not caused by a mental health problems.

5.111 Gloria's own reports of what happened changed over time. In January 2021 Gloria reported her partner was having sex with others in the flat, and subsequently she reported that she had hallucinated this. On 13th March 2021, however, Gloria told RWT that she was not having hallucinations, and that the people she saw were real. Gloria said that she felt the bed shaking. Charles Bonnet Syndrome hallucinations can only be seen, not heard, smelt or felt https://www.nhs.uk/conditions/charles-bonnet-syndrome/.

5.112 According to the NHS website most people with Charles Bonnet Syndrome know the hallucinations are not real. https://www.nhs.uk/conditions/charles-bonnet-syndrome/

5.113 If Gloria's partner was having sex with other people in her flat, this may have been part of a wider pattern of abuse, possibly psychological abuse as well as physical

abuse. As part of this Review information has come to light which suggests that it was likely that Gloria's partner was having sex with other people.

5.114 **Inter-agency communication and single and multi-agency interventions**

5.115 There were some examples of good inter-agency communication, for example WMAS and RWT kept in contact to ensure that Gloria was not discharged from hospital before her partner was arrested. However, in the main, agencies were working singularly with Gloria. ASC had reflected that it seemed more concerned with physical care and support needs rather than mental health needs, and no attempts were made by ASC to ensure that Gloria received appropriate mental health support, or to coordinate the support she required. The one example of multi-agency working, the MARAC, did not lead to a multi-agency intervention, or at least one was not executed, and made no difference to Gloria's life. Patchy cross-agency information sharing led to a situation where no one was aware of the full picture of Gloria's complex circumstances and needs and where no one took ownership for case leadership and for instigating joined-up multi-agency inventions.

5.116 Record keeping

5.117 Gloria moved home in October 2020 to accommodation more suitable for wheelchair use. For this Review, Gloria's accommodation prior to the move in October 2020 will be referred to as her "old" address and that following the move as her "new" address.

5.118 Following her move some services continued to use Gloria's old postal address for correspondence with her.

5.119 This appears to have emanated from an administrative error at Gloria's GP practice. Gloria's old address was added to the NHS spine (an IT system enabling health and social providers access to patient information). The PHP Counsellor was aware of Gloria's correct address and this oversight did not impact on the PHP service for Gloria.

5.120 It appears that opportunities to spot the error, or at least question which address was correct, were missed. Two addresses were seen on correspondence from other agencies coming into Gloria' GP practice. Gloria's old address was some distance from the surgery and was in fact outside the GP's catchment area. Gloria's new address was close to the surgery. It appears that no one queried the two addresses listed in correspondence arriving at the surgery, no one queried how Gloria would be able to attend the practice given the considerable distance from her home (had her old address been the correct one), and no one queried that the address listed was outside of the GP catchment area.

5.121 Whilst it is the responsibility of patients to provide the correct address and notify of any change of address, it is likely in this instance that Gloria was unaware that her GP had her old address on the system.

5.122 Since GP practices are the prime referrer to secondary care, the consequences of holding the incorrect address for a patient are potentially significant. For example, a patient may not receive details of medical appointments booked for them, resulting in missed appointments, and delays in treatment.

5.123 Both clinical and non-clinical practice staff need to be more aware of spotting anomalies, of the need to check and correct them, and the consequences of not doing so.

5.124 Gloria moved home on 25th October 2020. She received nine visits from district nurses, but on the tenth visit the allocated district nurse for that day went to Gloria's old address, not knowing Gloria had moved. The reasons for this are unknown.

5.125 Notification of Gloria's death

5.126 Where a person has a care and support package, the care provider will inform ASC if the person dies. A person's family may also notify ASC. However, Gloria was not in receipt of a care package at the time of her death, and therefore ASC was not informed.

5.127 ASC found out about Gloria's death on 16th April 2021 when the Rehabilitation Officer attempted to visit Gloria following two weeks' annual leave. This will continue to pose a challenge for ASC where someone lives alone and has no family involvement. ASC provides their staff with guidance on what to do in the event of someone's death but relies on information shared by other agencies in such instances, but this is ad hoc and not part of agreed written guidance.

5.128 Partner agencies may wish to consider a formal multi-agency policy for death notification.

5.129 **Good practice**

5.130 ASC arranged for a joint visit to Gloria by the occupational therapist and the Rehabilitation Officer for visual impairment. This was good practice providing for a collaborative use of combined skills, knowledge and experience.

5.131 Under Section 19(3) of the Care Act 2014 a local authority may meet an adult's needs for care and support, which appear to be urgent, without having conducted a care and support needs assessment. Good practice was demonstrated by ASC by providing a crisis package of care to run from 16th March to 23rd March 2021 in response to the safeguarding concerns of 13th March.

5.132 ASC identified that there may be fire risk factors within Gloria's home and made a referral to the fire service for assessment and advice.

5.133 ASC recognised "through assessment for the need to adjust (Gloria's) environment to promote independence via application for Disabled Facilities Grant (DFG)".

5.134 Gloria had frequent contact with her GP Practice throughout the 2020/2021 Covid-19 pandemic. The Practice continued to make face to face appointments available to Gloria and she had telephone consultations when it was not necessary to physically attend.

6. CONCLUSIONS

6.1 Gloria refused services, such as adult social care. As an ex-social worker herself, Gloria believed that the social work team would use her information for gossip, and therefore she declined help. It is likely that she felt embarrassment, even shame, about her circumstances, including self-neglect and finding herself in a relationship where she was abused. The power of feelings of embarrassment and shame and of being judged should not be underestimated when working with people who self-neglect and refuse services. (**See recommendation 1**).

6.2 Gloria made a number of seemingly unwise decisions. On some occasions a mental capacity assessment was made and on others one was not. The approach to mental capacity was to view each decision Gloria made as a "snapshot", rather than to view Gloria's history of decisions as a "video" or a pattern. This, together with knowledge that Gloria may have been coerced and controlled, may have triggered consideration of the need to assess Gloria's mental capacity. When mental capacity assessments were undertaken it is possible that insufficient consideration was given to whether Gloria's mental ill health constituted an impairment in the functioning of the mind or brain. (**See recommendation 2**)

6.3 Given that suicidal thoughts and risk can change across a relatively short period of time it would have been appropriate for a suicide safety plan to have been drawn up in consultation with Gloria, as recommended by the Royal College of Psychiatrists, which may have provided strategies for her to cope with suicidal thoughts. (**See recommendation 3**)

6.4 ASC, unlike other agencies, was unaware of Gloria's suicidal ideation, which fluctuated over time. Knowledge of this may have informed ASC's approach to Gloria's support needs. ASC were aware of multiple losses in Gloria's life but did not explore these further or check that she was receiving appropriate support. (**See recommendation 3**)

6.5 No consideration was given to restricting Gloria's access to common means of suicide. Her medication was not reviewed specifically to include risk of suicide and overdose. A review should have considered the interaction of the combination of drugs and how they were prescribed and administrated. (**See recommendation 3**)

6.6 It is possible that insufficient caution was exercised when Gloria denied suicidal thoughts, including the occasion two days before her death. For reasons of stigma, shame, fear or embarrassment, people may conceal or minimise their suicidal thoughts. On this occasion Gloria's GP conducted an assessment for a referral to psychiatry services by telephone. A home visit might have been the most appropriate medium in the circumstances and may have picked up on any non-verbal cues which suggested Gloria was concealing her true feelings and intentions. A home visit may

also have spotted any other factors or indicators of self-neglect and/ or suicidal intention, for example, hoarding of tablets. (**See recommendation 4**)

6.7 ASC does not appear to have considered that the challenges of caring faced by Gloria's partner may have been a contributing factor to domestic abuse. No consideration was made of supporting Gloria's carer with the difficulties of the role, such as a carer's assessment, or the development of a joint plan (between Gloria and her partner) to support Gloria's care needs. Consequently, there is little evidence of thinking flexibly about how family members and community resources can contribute to interventions, building on relationships and networks. (**See recommendation 5**)

6.8 There were six occasions where alleged domestic abuse was reported by Gloria to an individual agency, but each individual agency did not share the information with other agencies, such as ASC, who might then have recognised a pattern of suspected abuse and co-ordinated a multi-agency response. (**See recommendation 6**)

6.9 On one occasion a MARAC was held and information was shared at a multi-agency level. However, actions arising from the meeting were insufficient or not carried forward and monitored. For example, insufficient consideration was given to Gloria's tenancy agreement and the relationship between her partner and her landlord and implications for her tenancy rights and her ability to end the relationship with her partner. Actions for the GP and district nurses to encourage Gloria to consent to a care and support needs assessment were not followed through. Gloria refused to support a prosecution and so the domestic abuse concern appears to have been left with no particular action agreed. ASC recorded so few details of the MARAC meeting that it is not clear what actions they were to progress. ASC does not appear to have sufficiently considered the suitability of Gloria's partner as her carer, and how this and other factors may have had an impact on the risk to Gloria of further abuse. (**See recommendation 6**)

6.10 There were some examples of good inter-agency communication, for example WMAS and RWT kept in contact to ensure that Gloria was not discharged from hospital before her partner was arrested. However, agencies tended to work autonomously with Gloria. ASC has reflected that it seemed more concerned with Gloria's physical care and support needs, rather than mental health needs (as evidenced by the care and support needs assessment). There appears to have been little work by ASC with Gloria to discuss in depth her mental health and life changing events and how this impacted upon her. No attempts were made by ASC to ensure that Gloria received appropriate mental health support, or to coordinate the support she required. The one example of multi-agency working, the MARAC, did not lead to a multi-agency intervention. (**See recommendation 6**)

6.11 Patchy cross-agency information sharing led to a situation where no one was aware of the full picture of Gloria's complex circumstances and needs and where no one took ownership for case leadership and for instigating joined-up multi-agency inventions. The MARAC in January 2021 was a missed opportunity to appoint a lead agency. (**See recommendation 6**)

6.12 Domestic abuse can be experienced by both current and ex-employees of public services, including those that provide services to the victims of domestic abuse. Awareness raising of, and policy and procedure development for, the domestic abuse of staff might be useful to create an environment which encourages disclosure and equips staff with the skills and resources top respond effectively. Walsall Health Care has a domestic abuse policy for its employees and the wider development of formalised approaches to supporting, what might be described as, Persons in Positions of Trust who are themselves being abused might be helpful. This could include systems for protecting the confidentiality of, and providing a safe environment for, victims of domestic abuse. This could, include, for example, assurance that records will be locked down, that their case will be handled by an independent person or the use of enforceable confidentiality clauses (**See recommendation 7)**.

6.13 The reasons for Gloria's reticence to involve the police when she alleged domestic violence, and her changing accounts of what happened, were not explored to understand whether fear of retribution or actual threats of further abuse were involved.

6.14 Given Gloria's significant physical disability, visual impairment and mental health problems, the conclusion by ASC that Gloria was able to protect herself from domestic abuse, following the safeguarding concern of 13th March 2021, was questionable. (**See recommendation 8**)

6.15 There were opportunities for individual agencies to have intervened more than they did, but Gloria's refusal of care and support and of referrals to other agencies were decisions that agencies believed Gloria had the capacity to make. Gloria's decisions to decline care and support were not considered within the context of self-neglect. There was insufficient attention to ensure that Gloria's care and support needs were assessed and met in a timely manner. There appears to have been little understanding of Section 11(2)(b) of the Care Act which requires a local authority to undertake and assessment for care and support needs, even when the individual is refusing, where they are at risk of abuse or neglect. (**See recommendation 8**)

6.16 An administrative error at Gloria's GP practice resulted in some agencies using Gloria's old address for correspondence. Opportunities to spot the error and correct it were missed. (**See recommendation 9**)

7. RECOMMENDATIONS

7.1 **Recommendation 1**.

The Walsall Safeguarding Adults Board, should receive assurance, via its self neglect and hoarding sub-group, that people who self-neglect are assured that they are not being judged and that their information is protected and only used to support appropriate service delivery to meet their needs.

7.2 **Recommendation 2**.
The Walsall Safeguarding Adults Board, should via its self neglect and hoarding subgroup, continue to raise awareness, and assess the effectiveness, of the self-neglect toolkit and panel.

7.3 **Recommendation 3**.
The Walsall Safeguarding Adults Board should seek assurance that the review of the Walsall Multi-Agency Suicide Prevention Strategy currently in progress will consider the development of suicide safety plans and risk of suicide in the presence of domestic abuse.

7.4 **Recommendation 4**.
The Walsall Safeguarding Adults Board should receive the criteria used by mental health services for conducting face to face assessments, with the necessary consent, to pick up on non-verbal cues or risks when there are concerns of domestic abuse or self-neglect.

7.5 **Recommendation 5**.
The Walsall Safeguarding Adults Board should seek assurance from the Walsall Domestic Abuse Forum of its work on raising awareness of domestic abuse in family caring situations. This should also include that physical disabilities may reduce a person's ability to protect themselves.

7.6 **Recommendation 6**.

The Walsall Safeguarding Adults Board should seek assurance that the MARAC Terms of Reference about minute keeping and action recording are reviewed so that each partner is clear about its responsibilities in these areas.

7.7 **Recommendation 7**.

The Walsall Safeguarding Adults Board should receive assurance from partner agencies that that all people are given information that their data will be protected if they become the subject of, or a party in, a safeguarding or domestic abuse concern.

7.8 **Recommendation 8**.

The Walsall Safeguarding Adults Board should promote awareness amongst staff of section 11(2)(b) of the Care Act which requires a local authority to conduct a care and support needs assessment, even when the individual is refusing, where that individual is experiencing or at risk of abuse and neglect.

7.8 **Recommendation 9.**

The Walsall Safeguarding Adults Board should promote awareness of the need to be vigilant in recording personal information, how to spot errors and anomalies in addresses and the need to investigate and correct them.

APPENDIX 1: Wellbeing

Section 1(2) of the Care Act (2014) states that:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);
b) physical and mental health and emotional well-being;
c) protection from abuse and neglect;
d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
h) suitability of living accommodation;
i) the individual's contribution to society.

APPENDIX 2: HUMAN RIGHTS ACT

All public sector bodies, whether or they are directly or indirectly funded by the UK Government have a duty under the Human Rights Act to discharge the State's positive obligations under the European Convention on Human Rights:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interferences with liberty, including by private individuals
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons

APPENDIX 3: MENTAL CAPACITY ACT

The Mental Capacity Act requires a three-stage test of capacity to make decisions:

1. Is the person unable to make the decision? i.e. are they unable to do at least one of the following things:
   - Understand information about the decision to be made, or
   - Retain that information in their mind, or
   - Use or weigh that information as part of the decision-making process, or
   - Communicate their decision (by talking, using sign language or any other means)

2. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

3. Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but

have capacity to make others, so it is vital to consider whether the individual lacks capacity to make a specific decision at a specific time.

APPENDIX 4 : Royal College of Psychiatrists Patient Safety Report

The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs".

These risk factors and red flags were specifically formulated for use in primary care settings. The report cautions that risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period".*

The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

A Safety Plan is an agreed set of activities, strategies to use and people and organisations to contact for support if someone becomes suicidal, if their suicidal thoughts get worse or if they might self-harm. The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

There is emerging evidence of the effectiveness of safety plans (Zonana et al. 2018) and it is important that Safety Plans are co-created with patients and encourage communication with family and friends.

Appendix 5: Acronyms used in this report

Acronym	Meaning
ASC	Adult Social Care, Walsall Council
ACCURX	Software to enable communication between patients and clinicians
BCWA	Black Country Women's Aid
DARA	Domestic Abuse Risk Assessment
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment
IDVA	Independent Domestic Violence Advocate
MARAC	Multi-Agency Risk Assessment Conference
OT	Occupational Therapist
PHP	Physical Health Psychology Service at Russell's Hall Hospital
RHH	Russell's Hall Hospital
RWT	Royal Wolverhampton Trust New Cross Hospital
WMAS	West Midlands Ambulance Service
WMP	West Midlands Police