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Cumberland Community Safety Partnership

DOMESTIC HOMICIDE OVERVIEW REVIEW INTO THE DEATH OF KELLY IN JANUARY 2022

PARMINDER SAHOTA: INDEPENDENT CHAIR & AUTHOR

DATE COMPLETED: 31 JULY 2024

Contents

Preface

Pseudonyms, except for the chair and panel members, were utilised throughout the review.

The Independent Chair and Review Panel offer their deepest sympathy to all affected by Kelly's tragic loss and thank them for their contributions and support for this process.

The essential purpose of undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from a person's death where domestic violence and abuse are known to be present within the relationship. Professionals must understand what happened in each case for these lessons to be widely and thoroughly learned and what needs to change to reduce the risk of such tragedy.

The Chair would like to thank the panel and those who supplied chronologies and information for their time, patience, and cooperation.

Glossary of Terms

Accident and Emergency	A&E
Adult Social Care	ASC
Acute Medical Unit	AMU
Domestic Abuse	DA
Domestic Abuse, Stalking and Honour Based Violence and Risk Identification Checklist	DASD RIC
Domestic Homicide Review	DHR
Crime Survey of England and Wales	CSEW
Cumbria Community Safety Partnership	CCSP
Cumbria, Northumberland, Tyne and Wear Foundation NHS Trust	CNTW
Individual Management Review	IMR
Multi-Agency Risk Assessment Conference	MARAC
Multi-Agency Tasking and Coordination	MATAC
North Cumbria Integrated Care	NCIC
North West Ambulance Service	NWAS
Opiate Substitute Treatment	OST
Recovery Steps Cumbria	RSC
Risk Indicator Checklist	RIC
Safeguarding and Public Protection	SAPP
Safeguarding Report	SAF
Terms of Reference	ToR
Vulnerable Adult	VA
Vulnerable Child	VC

1.1 Introduction

1.1.1 The report has been undertaken following the tragic death of Kelly in January 2022. Kelly was referred to the North Cumbria Community Safety Partnership (CCSP). A partnership meeting was held on the 9th of February 2022 to review the case. The partnership panel agreed that the Domestic Homicide Review criteria were achieved.

1.1.2 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime, and Victims Act 2004, enacted in 2011. A DHR means a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse, or neglect by

(a) a person to whom he[1] was related or with whom he was or had been in an intimate personal relationship or
(b) a member of the same household as himself,
Where the definition set out in a or b has been met, then a Domestic Homicide Review should be undertaken. Section 2 of the statutory guidance highlights circumstances which indicate a Domestic Homicide Review:

1.1.3 The review was conducted following the Home Office's guidance for the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (revised December 2016)[2].

1.1.4 The review examines agency responses and support given to Kelly, a resident of North Cumbria, before her death in January 2022. Kelly was in a relationship with Michael at the time of her death.

1.1.5 In addition to agency involvement, the review will also examine the last eight months of her life (May 2021 – January 2022) to identify any relevant background or trail of abuse before her death, whether support was accessed within the community and whether there were any barriers to accessing support. The selected chronology mirrored Kelly's heightened engagement with the police, throughout which she communicated her wish to end her life. Finally, the review recommends improving the support provided to victims who present to services in a circumstance similar to Kelly's.

1.1.6 The review will consider the agency's contact/involvement with Kelly from May 2021 to January 2022.

1.1.7 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process

1.1.8 Kelly died in the hospital following an untreated compound fracture; the cause of death was Sepsis and haemorrhage due to the compound fracture of the clavicle. Kelly informed the ambulance that Michael (partner) had pushed her, causing her clavicle (collarbone) injury.

[1] Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.2 Case Summary

1.2.1 The following occurred two weeks before Kelly died:

1.2.2 Michael called 999; he disclosed that his friend Kelly had sustained a shoulder injury after falling at home. When paramedics arrived, Michael was asleep, and they examined Kelly. An isolated injury with bruising and swelling was observed over her right collarbone. They speculated that Kelly's limited mobility indicated a potential clavicle fracture.

1.2.3 Kelly informed the paramedics that she had argued with Michael, who pushed her and caused her to lose her balance and fall against the wooden bedframe, hitting her shoulder against it. Kelly stated Michael had pushed her as he thought she would punch him.

1.2.4 The paramedics informed Kelly that an X-ray would be necessary at the hospital. Nevertheless, she declined to attend and stated she would do so later that morning. In light of the paramedic's concern, an alternative mode of transportation was extended to Kelly at the cost of the ambulance. However, she declined the offer. When asked by the paramedics, Kelly responded that she felt safe at Michael's home and declined police involvement.

1.2.5 The pharmacist called Recovery Steps Cumbria (RSC). They conveyed concern regarding Kelly's presentation, noting that she appeared on the edge of fainting and was significantly pale and perspiring. The pharmacist provided Kelly with a COVID-19 lateral flow test. Kelly informed the pharmacist that the hospital had tested her. However, North Cumbria Integrated Care (NCIC) reported that Kelly had not attended their hospital until the following day.

1.2.6 Kelly attended NCIC the following day; the report from NCIC stated her husband accompanied her; she received an X-ray confirming a closed fracture of the clavicle and was prescribed Codeine. She was discharged home to take analgesia and attend the virtual fracture clinic the next day.

1.2.7 Twelve days before Kelly died, the pharmacist raised safeguarding concerns to RSC about Kelly's relationship with Michael. Both Kelly and Michael had attended the pharmacy to collect Kelly's methadone. The pharmacist described Michael behaving erratically while Kelly was hunched over in the chair with her back to Michael.

1.2.8 The pharmacist saw Kelly alone in the supervision room, and she was noted to be shaking. The pharmacist asked her if she was okay, but Kelly did not want to talk.

1.2.9 Eleven days before her death, Kelly attended her planned appointment at RSC with Michael. The administrator observed Michael walking ahead of Kelly and Kelly holding her arm/shoulder and looking in pain. Kelly was heard telling Michael he did not need to bother her today. However, he tried to stop Kelly from entering the consultation room alone. He eventually left the building.

1.2.10 RSC saw Kelly; she reported a fall and had been to the hospital; she advised RSC she would require corrective surgery once the swelling went down. The NCIC report did not state this and recommended that Kelly be followed up at the virtual fracture clinic. The staff member observed swelling of a hematoma to the right clavicle and across the front and back of her chest; she appeared slightly jaundiced and described feeling sick and unwell. In addition, Kelly reported having been prescribed Codeine from Accident and Emergency (A&E), which made her feel worse.

1.2.11 Kelly was described as tearful, stressed and in physical pain. She had been staying with Michael as the heating was out of order and the windows of her home were broken.

1.2.12 Kelly reported the injury was due to a fall and denied any abuse from Michael, stating, “Michael’s bark is worse than his bite.” She did not believe he would hurt her.

1.2.13 RSC contacted the police and Adult Social Care (ASC) to share their concerns about Kelly, her injury and potential domestic abuse from Michael. Kelly had informed North West Ambulance Service (NWAS) that Michael had pushed her, which caused the shoulder injury.

1.2.14 Three days before her death, Kelly was admitted to NCIC. A&E reported that Kelly was accompanied by her ‘husband,’ who advised them that she had fallen at home the week before.

1.2.15 Kelly had an open fracture and bruising over her body; she had a central line in situ, chest drain and a catheter, commenced a cirrhosis care plan, and received an infusion. Kelly was on 30-minute observation, and her condition had escalated to critical care.

1.2.16 RSC informed the hospital of the concerns regarding Kelly’s relationship with Michael.

1.2.17 Kelly received end-of-life care the following day, and her family was informed.

1.2.18 Kelly sadly died in the hospital in January 2022.

1.3 Timescales

1.3.1 CCSP, following the 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, commissioned this DHR after deciding to proceed with a review on February 9, 2022.

1.3.2 Advocacy After Fatal Domestic Abuse circulated expressions of interest for an Independent Chair and Author in March 2022.

1.3.3 Sections 36 to 39 of the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews sets the requirements for review chairs and authors. In this review, the chair and author roles were combined.

1.3.4 The independent chair/author was commissioned for this DHR on 20 April 2022. North CCSP approved the completed report on 2 December 2022.

1.3.3 The first panel meeting took place on 12 May 2022. A second meeting was held on 7 September 2022 to review agencies' Individual Management Reviews (IMRs) and reflective summaries. Additional information was required, and a further meeting was arranged for 21 September 2022.

1.3.5 The IMRs and reflective summaries were reviewed at a third panel meeting on 21 September 2022. This provided an opportunity for all to present challenges and request clarifications.

1.3.6 A fourth meeting was held on 7 October 2022 to review the overview report.

1.3.7 On 18 November 2022, a practitioner event was facilitated to review the themes and insights extracted from the review. The practitioners concurred with the themes and reflected on how these translated to practice.

1.3.5 The Home Office guidance states that reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. However, due to the delay in contacting relatives, the review was finished one month later than the six-month term.

1.4 Confidentiality

1.4.1 Each review's findings are confidential until the Home Office Quality Assurance Panel approves the Overview Report for publication. Information is available only to contributing officers/professionals and their line managers.

1.4.2 The review has been appropriately anonymised following the 2016 Home Office Domestic Statutory Guidance. The panel agreed that pseudonyms would be used throughout to protect the identity of the individual concerned, as the family did not participate. The names of the review panel and independent chair are specified.

1.4.3 To protect the identity of the adult and the partner, the following pseudonyms have been used throughout this review:

1.4.4 The adult: Kelly
1.4.5 The partner: Michael

1.5 Equality and Diversity

1.5.1 During the review process, the review chair and the panel considered all the protected characteristics under the Equality Act 2010.

1.5.2 The characteristic relevant to this review is sex.

1.5.3 Kelly was 57 years old and of white British heritage when she died. She was in a heterosexual relationship. None of her six adult children (whom she did not share with Michael) had been raised by her.

1.5.4 Women's Aid[3] reported on the key statistics:

There are no reliable prevalence data on domestic abuse, but the Crime Survey of England and Wales (CSEW) offers the best data available. According to these data, for the year ending March 2020, an estimated 1.6 million women aged 16 to 74 experienced domestic abuse in the last year (Office of National Statistics, 2020). However, it is essential to note that these data do not consider important context and impact information, such as whether the violence caused fear, who the repeat victims were and who experienced violence in a context of power and control. When these factors are considered, the gendered nature of domestic abuse becomes much more apparent.

On average, the police in England and Wales receive over 100 calls relating to domestic abuse every hour. (HMIC, 2015)

According to CSEW data for the year ending March 2018, only 18% of women who had experienced partner abuse in the last 12 months reported the abuse to the police.

1.5.5 The latest figures published by the Office of National Statistics[4] report that in the year ending March 2021, 73% of domestic abuse-related crimes, the victim was female.

1.5.6 The figures report increased domestic abuse-related crimes from 13 per 1,000 to 14 per 1,000 population.

1.5.7 Safe Lives[5] reports that women are more likely to be victims of severe domestic abuse than men, with 95% of those referred to the Multi-Agency Risk Assessment Conference[6] (MARAC) or accessing an Independent Domestic Abuse Advocate.

1.5.8 They also report abuse victims to have an increased rate of drug use and alcohol misuse, with at least 20% of high-risk victims of abuse using drugs and alcohol.

1.5.9 A case analysis of domestic homicide reviews found substance misuse common in intimate partner and adult family murders[7]. It is important to note that Kelly's case is not subject to homicide. Nevertheless, the findings reveal the prevalence of substance misuse in domestic abuse-related crimes.

1.5.10 Further research found that women who have experienced gender-based violence are 5.5 times more likely to be diagnosed with a substance use problem. [8]

[3] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/how-common-is-domestic-abuse/
[4] https://www.ons.gov.uk/peoplepopulationandcommUnity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2021
[5] https://safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse
[6] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf
[7] http://repository.londonmet.ac.uk/1477/1/STADV_DHR_Report_Final.pdf
[8] https://pubmed.ncbi.nlm.nih.gov/21813429/

1.5.11 The government published the Tackling Violence Against Women and Girls' strategy in July 2021[9]. The strategy focuses on reducing the prevalence of violence against women and girls and improving the support and response to victims and survivors.

1.6 Terms of Reference/Key Lines of Enquiry

1.6.1 The full Terms of Reference are highlighted in section 4.2. This review aims to identify the lessons from Kelly's case and take action to respond to those lessons: to prevent deaths related to domestic abuse and ensure better support for individuals and families.

1.6.2 The Domestic Abuse Bill received Royal Assent and was signed into law on 29th April 2021. The Act provides a Legal definition of Domestic Abuse:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

(a) A and B are each aged 16 or over and are personally connected to each other and
(b) the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional or other abuse; it does not matter whether the behaviour consists of a single incident or a course of conduct.
"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—
(a)acquire, use or maintain money or other property, or
(b)obtain goods or services.
(5) For the purposes of this Act, A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 The DHR method is prescribed under the Home Office guidelines.[10]

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1033934/Tackling_Violence_Against_Women_and_Girls_Strategy_-_July_2021.pdf
[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.7.2 The review panel comprised agencies from Cumbria, as Kelly resided in Cumbria at the time of her death.

1.7.3 At the first review panel meeting on 12 May 2022, the panel shared brief information about agency contact with Kelly. The panel established the review period from May 2022 to January 2022, considering that this period covered increased police callouts.

1.7.4 The approach adopted was to request agencies provide a chronology to determine which agency would need to provide an IMR or reflective summary.

1.7.5 Agencies were contacted concerning their involvement with Kelly and Michael. Eleven agencies returned nil contact; seven submitted IMRS/reflective summaries, and eight submitted chronologies.

1.7.6 The IMRs were authored by professionals independent of case management or service delivery. They allowed the panel to analyse the contact between Kelly and Michael and produce the learning for this review. Additional questions were sent as appropriate to the agencies to enhance the panel's awareness of the agency's input. The IMRs have informed the recommendations in this report. In addition, the IMRs have helpfully identified changes in practice and policies over time and highlighted areas for improvement not necessarily linked to the terms of reference for this review.

1.7.7 The panel met five times, with the first meeting on 12 May 2022, and subsequent discussions on 7, 21, 24 September, and 24 October 2022. A practitioner event was held on 18 November 2022, and the final meeting was held on 2 December 2022.

1.8 Involvement of Family, Friends, Neighbours and Wider Community

1.8.1 The chair and the review panel acknowledged the vital role that Kelly's family could have in the review.

1.8.2 Kelly had a public health funeral[11] that her siblings and four of her six children attended.

1.8.3 The family liaison officer attempted unsuccessfully to contact Kelly's eldest daughter at the outset of the review. They ultimately hand-delivered a letter explaining the review and providing contact information for the CCSP and the chair. However, no contact was received.

1.8.4 The panel agreed that further contact would be made at the final draft point to allow the family an additional opportunity to contribute if they so wished. A police officer contacted Kelly's sister, who had provided the coroner's antecedent statement[12], and she consented to share her contact information with the chair.

1.8.5 The chair contacted Kelly's sister. She is six years older than Kelly and moved out of the family home at 18 when she married.

[11] https://www.gov.uk/government/publications/public-health-funerals-good-practice-guidance/public-health-funerals-good-practice-guidance
[12] Covers the relative's personal background and any information about the deceased health or the events surrounding their death.

1.8.6 According to Kelly's sister, Kelly began using drugs when she was 14 or 15 years old. Alcohol became a problem fifteen years ago. When Kelly's first child was 13 months old, the sister assumed responsibility for his care. All six of Kelly's children, the youngest of whom is 19, were cared for by family members. Kelly had limited contact with them since the children were unwilling to communicate with her. After Kelly's death, the eldest son remarked, "How is he meant to grieve for someone he never knew?"

1.8.7 The sister said their mother died fifteen years ago, and when she saw Kelly at the hospital, she did not recognise her. According to her, Kelly had undergone a drastic transformation, and the family had little contact with her.

1.8.8 Kelly's sister had not seen her for five years and indicated that the family had attempted to help her and had taken her into their house, but it had not worked out.

1.8.9 Kelly lived in the same estate as her eldest daughter and her brother (who had assumed caring responsibility for the daughter). Everyone knows one another in their community, and Michael's sister contacted Kelly's daughter. Michael's sister informed them that Kelly had prepared the Sunday dinner, and everything was fine. The family was unaware that Kelly was in the hospital until someone told them. They visited Kelly in the hospital.

1.8.10 The sister suspected that the eldest daughter might have additional information regarding Kelly's life; however, she was on holiday, and the sister would call her upon her return. I agreed to inform the sister of the report's development and share this information with her and the daughter as appropriate.

1.8.11 According to Kelly's sister, the family suspected Michael might have frightened Kelly. However, other than what the police had told her, she had no additional knowledge about the relationship.

1.8.12 The daughter did not contact the chair. Kelly's sister did not wish to receive a copy of the review. Michael was not contacted due to the unavailability of his contact information.

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Letter/Other
Adult Social Care The lead agency for making enquiries for Adults with Care and Support needs who are at risk of abuse and Neglect: Care Act 2014	Chronology and Reflective Summary
Cumbria Constabulary	Chronology and IMR
Cumbria Northumberland Tyne & Wear NHS Foundation Trust	Chronology and IMR

One of the largest mental health and disability trusts in England. Providing mental health, learning disability and neurological care for people across the north of England, as well as some national specialist services	
North Cumbria Integrated Care **Cumberland Infirmary** **Carlisle** They provide hospital and community health services to half a million people and are responsible for delivering over 70 services across 15 main locations.	Chronology and IMR
North West Ambulance Service	Chronology and IMR
Probation Service	Chronology and IMR
Recovery Steps Cumbria A drug and alcohol recovery service provides treatment and recovery support for individuals (aged 18 years and above) and their family members affected by substance misuse (including alcohol, illicit drugs, and over-the-counter and prescribed medication).	Chronology and IMR
Riverside Housing Social Housing	Chronology
Warwick Square Group Practice GP practice, including Out-Of-Hours	Chronology and Reflective Summary

1.10 The Review Panel Members

1.10.1 The independent panel members for this review were the following:

Name	Role	Organisation
Anna Bates	Head of Housing	Castles and Coasts Housing Association
Becky White	Area Manager	Recovery Steps Cumbria
Detective Inspector Matthew Belshaw	VAWG Inspector	Cumbria Constabulary
Gemma Qi	Safeguarding Advisor	North Cumbria Integrated Care Cumberland Infirmary Carlisle
Sheona Duffy	Acting Named Nurse	Cumbria Northumberland Tyne& Wear NHS Foundation Trust
Sean Carroll	Senior Probation Officer	Probation Service
Sarah Edgar	Domestic Homicide Review DC	Cumbria Constabulary Police
Sarah Joyce	Service Manager Safeguarding	Adult Social Care - Cumbria
Sharon McQueen	Safeguarding Practitioner	North West Ambulance Service
Susan Mein	Deputy Designated Nurse for Safeguarding	North East and North Cumbria Integrated Care Board
Vikki Pattinson	Housing Services Manager	Riverside Homes
Parminder Sahota	Independent Chair/Author	PS. Safeguarding LTD

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent author who has worked in Safeguarding and Domestic Abuse for the last ten years and received DHR Chair training by Advocacy After Fatal Abuse in 2021. She is a mental health nurse who has worked in the NHS

for over 20 years. She is interested in crisis work and working with adults diagnosed with personality disorders. She works in an NHS Trust as the Director of Safeguarding, Prevent, and Domestic Abuse.

1.11.2 Parminder Sahota is independent of all agencies involved and had no prior contact with any family members or the CCSP.

1.12 Parallel Reviews

1.12.1 A Coronial Inquest was held in Spring 2024:

A mum of six who refused treatment for ten days after suffering a broken collarbone due to a fall in her partner's flat in Carlisle died in hospital from sepsis.

Kelly, 57, died in January 2022, five days after paramedics convinced her of the gravity of her condition. She died of sepsis from an infected wound, compounded by end-stage liver cirrhosis and kidney failure.

A statement submitted to the Coroner's Court by Kelly's daughter told of a 'sad story of someone's life'. She said that her mother developed a drug habit in her teens, and although she 'never gave up trying, she never made any difference to her life'.

Linda had been involved with Recovery Steps Cumbria for issues with drug and alcohol dependence and was prescribed methadone. Reported having not taken heroin for 14 years.

Paramedics were initially called to a flat in Carlisle in January 2022 due to a fall suffered by Kelly. They found Kelly 'calm' but 'in pain', saying she hadn't slept for days. The statement said she was 'very friendly' and offered them tea. They reported a male asleep in the same room, who Kelly said was 'fine' but had taken crack cocaine. She informed paramedics that she had fallen onto the wooden bedpost around when the male had 'pushed her'. The statement said she 'clearly needed medical attention' but didn't want to accompany them to the hospital and would go herself.

When the male woke up and left the flat soon after, she told them she felt 'safe and relaxed' and was not concerned about the male hurting her. The paramedics deemed that she had the capacity and could not force her to go to the hospital, and they left.

Another team of paramedics were called to the flat, as Kelly had had a fall a week previously and was now bleeding from the site. One paramedic reported it was 'immediately obvious she was very jaundiced'. Kelly kept insisting she was fine and would not attend the hospital despite their warnings that she could be bleeding internally, that the wound could become septic, and that she could die. They said her partner was present and 'very agitated and concerned about Kelly' and was 'talking constantly', insisting that she needed to go to hospital. Again, paramedics left as they could not force her to go to the hospital.

Kelly was finally taken to the hospital the following day after paramedics were called again due to her deteriorating condition; she finally agreed for paramedics to take her to the

hospital. Due to the wound being infected and her liver cirrhosis, she was eventually placed on end-of-life care and pronounced dead in the early hours of January 2022.

Assistant Coroner for Cumbria said a 'Home Office standard' post-mortem and investigation was carried out due to the possibility of Kelly's death being the result of a possible altercation. She said: "I cannot come to a conclusion about how (she fell), because she gave conflicting accounts. "First she said she was pushed, but then told Recovery Steps Cumbria and hospital staff she fell. "She was clearly was in an abusive relationship."

The Coroner concluded that based on the evidence presented, 'it has not been possible to determine the cause of the fall', and that her death would be classed as accidental. The Coroner said: "Only Kelly or her partner can say what happened. "We also know she's been very vulnerable, even prior to that accident, or whatever it may be. "You have to stand back as family. "You tried your best, as indeed did many of the health professionals, but someone has to want to be helped." Her daughter's statement said: "It was sad that Kelly missed the majority of all her children's lives and never met her grandchildren."

1.13 Dissemination

1.13.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Members of the Cumbria Community Safety Partnership
- Agencies represented
- Safeguarding Adult Board
- Coroners
- VAWG board

2.1 The Facts

2.1.1 Kelly experienced a fall fifteen days before her death. She initially informed NWAS that Michael had pushed her, which resulted in her hitting her shoulder on the wooden bedpost.

2.1.2 The paramedics examined Kelly following a 999 call from Michael to attend his home fourteen days before Kelly's death.

2.1.3 Kelly declined to attend the hospital despite the concern of the paramedic, who believed she had a clavicle fracture.

2.1.4 Kelly attended NCIC A&E, with the A&E report stating in attendance was her 'husband' fourteen days before her death following a two-day-old fall. NWAS responded to Kelly's injuries and fitted a sling, but she had not used it. The right arm and collarbone displayed severe bruising. Kelly was reportedly anxious about a displaced right clavicle fracture. She was discharged home with a sling and analgesia. A virtual fracture clinic appointment was planned for the following day.

2.1.5 Kelly was brought to NCIC by ambulance five days before her death in response to a call from her relatives (NCIC did not report who this was). They discovered Kelly at home with jaundice. Kelly experienced a right clavicle fracture, bruises, and a haematoma on her right side. Although Kelly's son is listed on the hospital documents, the next of kin is the stepdaughter, who requested to be contacted as Kelly's partner struggles and wants her to be the primary contact. Kelly was diagnosed with probable sepsis after discovering she consumed two bottles of vodka daily. Kelly complained of pain associated with a GCS[13] of 15. Kelly was transported to the acute medical unit (AMU) for further care and the initiation of the decompensated Liver cirrhosis bundle and completed a full body map, noting many contusions and an open fracture. On the pad, definitive per vaginal bleeding was observed. There was no indication of a blood trail. Concerns had been raised concerning the potential for sexual assault, as it was known that Kelly was in an abusive relationship. The deputy ward manager documented the intention to report safeguarding concerns; however, there was no record of this report.

2.1.6 As Kelly's condition worsened, critical care outreach was notified. The critical care team documented and acknowledged the injury. As Kelly's condition deteriorated, it was decided to provide comfort care and initiate end-of-life care. Kelly was moved to another ward to occupy a cubicle. The care plan was communicated to Kelly, and her family was notified. Later, it was stated that Kelly was sensitive to voice/pain, and treatment was discontinued. The family requested hospital attendance; the notes indicated a request for the patient's husband and sister to arrive and keep the family informed. Anticipatory drugs were administered, and Kelly appeared to be at ease. Unfortunately, Kelly passed away in January 2022.

2.2 Background Information about Kelly

2.2.1 The recording of Kelly’s voice is limited to agency records.

2.2.2 Kelly had six children removed from her care; she had intermittent contact with her eldest three children. Kelly’s parents are deceased; she has two sisters and an older brother with whom she had limited contact.

2.2.3 Although Kelly had minimal contact with her family, she was very family-oriented and, during times of stability, always spoke fondly of them, particularly of her children and sisters; Kelly’s family told her how proud they were of her, and this had a profound effect on her and was something Kelly clung to, particularly during points of relapse.

2.1.4 Kelly took pride in her appearance and, when stable in treatment, always tried to take care of herself. In recent years, Kelly had a dog who brought her joy. The dog was a protective factor for Kelly, and Kelly would take great care of her. Kelly particularly enjoyed taking her out for walks each day. Unfortunately, the dog was hit by a car and died in 2021, contributing to a decline in Kelly’s health.

[13] https://www.glasgowcomascale.org/

2.1.5 Kelly had always aspired to become a peer mentor for RSC and, when stable, would start to make positive steps toward achieving this.

3.1 Key Events from May 2021 to January 2022

3.1.1 **On 6th May 2021**, Kelly was taken to NCIC by the police; she had been drinking and told the police she wanted to die. She was referred to the psychiatric liaison service and community rehabilitation; however, the community rehabilitation was declined as Kelly was required to complete therapies. Kelly left the A&E before the psychiatric liaison service could assess her. Due to the concerns, the crisis team requested that the police conduct a welfare check. The police attended Kelly's home; she was intoxicated and described her mental health to the police officer: 'Someone has taken her brain out of her head, put it in a blender, switched it on and then put it back in her head.' The police consulted with mental health services, who agreed that Kelly could remain home.

3.1.2 **On 7th May 2021**, a shop attendant called the police to attend to Kelly, who was outside threatening to kill herself. She had been to the shop and attempted to purchase alcohol and razor blades, stating she had had enough and wanted to be with her deceased dog. Police attended, and her response to the threats of ending her life was: "Saying it is one thing, but doing it is another." The police asked her where she wished to go, and she said: "take me to the cemetery; I'll go dig my hole." Police contacted mental health services and shared information with ASC.

3.1.3 **On 8th May 2022**, Kelly attended a planned appointment with the mental health crisis team and informed them that she was drinking a harmful level of alcohol to cope with the death of her dog, and she hoped to reengage with alcohol services.

3.1.4 **8th May 2021**: Kelly's neighbour called the police following hearing a scream from Kelly's home address. The police attended and reported that Kelly was vomiting a black substance and experiencing sharp abdominal pain. The police attempted to obtain medical assistance via the Cumbria Health on-call service (which provides primary health care services in and out of hours). However, her symptoms required clinical assessment, and the police were advised to call for an ambulance. Kelly was transported to the hospital via ambulance.

3.1.5 **May 2021** – According to agency records, Michael was convicted of domestic violence before he met Kelly.

3.1.6 **On 29th June 2021** Kelly informed the mental health crisis team that she had been sexually assaulted and refused police involvement. She disclosed that she had money stolen from her bank account and expressed plans to stab the perpetrator. The police attended a residential address and found Kelly banging on the door and shouting. She was intoxicated. She disclosed that she had been a victim of a sexual assault by an unknown male at the address and could not recall when this occurred. The police could not gather any further information and subsequently closed the case. Kelly spoke of her past to the police officers and informed them she had been assaulted whilst living in London, "had kids kicked out of me," and was very upset about her dog, her only

companion. She described her dog as “everything to me” and commented, “I must have been born to be abused.” The police shared the information with the Mental Health Crisis Team and, in turn, shared it with the GP.

3.1.7 Kelly was alleged to have stolen a TV and wallet of another client of the addiction services, and a safeguarding meeting was held concerning the client. The client and Kelly had both been drinking and had had sex before the alleged offence.

3.1.8 **On 29th June 2021** – Kelly was treated at NCIC; she was intoxicated and had a fall, causing a head injury and a laceration to her right hand.

3.1.9 **On 4th July 2021** – Kelly’s neighbour called the police; she had a wound to her hand that started bleeding. Police attended, and Kelly told them the previous weekend that she had tried to cut some bread whilst intoxicated, and her hand slipped, and she cut her hand and arm with the knife. Kelly was brought to NCIC for treatment of a stab/cut with a sharp object to her hand; the wound had occurred the previous weekend and was not healing. Kelly declined stitches and was admitted to NCIC for two days; she had an open wound on her wrist and hand. She was noted to have alcoholic cirrhosis (enlarged veins in the oesophagus) of the liver and alcoholic hepatitis (an inflammatory condition of the liver caused by heavy alcohol consumption over an extended period). Kelly was discharged from the hospital.

3.1.10 **On 30th September 2021** – Police called and responded to a suspected assault with Kelly as the victim. The caller is the suspect’s mother; the police attempted to find Kelly and the suspect (the suspect is a female – she was the daughter of a friend of Kelly’s). Also present was an intoxicated male whom the female had allegedly assaulted her mother (they were all intoxicated). Neither wished to disclose any information to the police. Kelly eventually stated that the suspect had pushed her following a verbal argument, causing her to fall back and bang her head, resulting in a lump on the back of her head. Kelly refused medical treatment. The suspect was arrested.

3.1.11 **On 21st December 2021** - Kelly attended RSC (formally Unity[14])and looked very well; she was clean, smartly dressed, and presented as lucid and coherent. She reported no illicit drug use and continued to reduce her alcohol intake.

3.1.12 **January 2022** Michael called the police, wanting Kelly to attend the hospital. Kelly was heard shouting on the call, “Shut your F****** face, you B******.” Kelly informed the officers they had argued as Michael wanted Kelly to go to the hospital due to suspected COVID-19. Kelly did not disclose any safeguarding concerns and agreed to be visited by ambulance. A domestic abuse, stalking and honour-based violence and Risk Identification Checklist (DASH RIC[15]) was completed and graded as standard. Consent to share was not given; therefore, information was not transferred.

[14] Humankind took over the Addictions service was Cumbria in October 2021; the service is called Recovery Steps Cumbria; before this, Greater Manchester Mental Health Trust had the contract, and the service was called Unity. The DHR spans two services.
[15] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

3.1.13 **Fifteen days before death** – Michael called the ambulance to report Kelly had had a fall the previous evening. The ambulance noted severe bruising to her right arm and collarbone. They encouraged Kelly to attend the hospital.

3.1.14 **Fourteen days before death,** hospital X-ray: closed fracture to her clavicle; admission not required. NCIC documented a virtual fracture appointment in January 2022. However, there was no documentation regarding this appointment.

3.1.15 **Eleven days before death** – RSC saw Kelly. Kelly reported no illicit drug use, last used Heroin three years ago and was drinking a litre bottle of Stella a day. The RSC worker noted a strong smell of alcohol, although Kelly did not present as intoxicated. Kelly had sustained a severe injury to her left side, and Kelly claimed this happened from a fall onto the hardwood frame of her bed. RSC Staff noted noticeable swelling and a hematoma to the right clavicle area and across the front and back of her chest. Kelly told the staff member that she went to the hospital following this fall and was discharged the same day. Kelly said she was told she required corrective surgery to repair the break once the swelling had gone down.

3.1.16 **Six days before death**—Housing contacted the police to inquire whether they had information regarding Kelly's whereabouts. They had been dealing with the repairs and heating at Kelly's home. The police informed them that Kelly had moved in with Michael in December 2021. This was the address Kelly provided the police when she was arrested for shoplifting.

3.1.17 **Six days before death -** Michael called the ambulance, stating that Kelly had broken her collar bone a week before and the wound was bleeding. He disclosed that he also suffered from mental health issues. During attempts to triage the symptoms, Kelly could not complete the tasks asked of her.

3.1.18 An ambulance attended, and Kelly was found lying in bed. She described a fall around a week before, which caused the initial injury, and she had had another fall that day, causing the wound to bleed. Kelly appeared jaundiced and admitted to the crew that she was alcohol dependent and had consumed alcohol earlier that morning. She also stated she was on a methadone program. Kelly appeared intoxicated. However, she was orientated to her surroundings and participated in the clinical assessment. The paramedic explained that she required hospital treatment, and her condition was serious and likely to deteriorate quickly if treatment was not sought. Kelly declined to attend the hospital.

3.1.19 Michael was present and was becoming increasingly upset by her refusal. He further tried to persuade her to attend and, at one point, was described as pleading with her, but again, she refused. The more he tried, the more agitated Kelly became with him. One clinician in attendance took him to another room whilst Kelly was left with the paramedic alone.

3.1.20 Kelly told the paramedic that she did not like hospitals and was aware that her condition was serious and that it could prove life-threatening without treatment. Her wishes were to remain at Michael's home.

3.1.21 The paramedic deemed Kelly to have the capacity to reject their advice. However, Kelly did agree to contact her GP. The paramedic contacted the GP practice, and a clinical discussion occurred between the GP and the paramedic. The initial outcome was for the paramedic to continue to persuade Kelly to attend the hospital.

3.1.22 This was attempted, and Kelly declined, understanding that it was unlikely that community services would be able to meet her needs; a further call was made to the practice to update the GP that the attempts had failed, and Kelly was adamant she was remaining at Michael's home. The GP agreed that nothing more could be done and would make contact the next day. Kelly and Michael were advised to call 999 should symptoms worsen while waiting for the GP contact. Kelly consented to the paramedics for the wound to be recorded on the G-tac electronic patient record device, which could be shared if required with the GP or other medical professional for assessment.

3.1.23 **Five days before death** - the ambulance received a final call from Michael, reporting that Kelly was having difficulty breathing and that her wound was bleeding, and he could not stem it.

3.1.24 An ambulance attended, and Kelly's skin around the area was critical and necrosed, now an open fracture. Kelly was conscious and communicating. She informed the crew that an ambulance had attended the day before; however, she had refused to go to the hospital as they advised; she recognised that she required treatment and agreed to attend A&E. Kelly was made comfortable and transported to the hospital under emergency conditions. Kelly was handed over to hospital staff to commence her treatment.

3.3.23 **Five days before death** Kelly was admitted to the NCIC due to experiencing another fall two days ago. She had a wound over her right clavicle and stated that she had been bleeding for two days; an open fracture was evident. She was admitted to NCIC with an unspecified fall, pleural effusion, and acute renal failure. Alcohol cirrhosis and oesophageal varies without bleeding in diseases. Continued drinking is associated with the eventual development of cirrhosis in approximately 20% of individuals. Survival rates of 70% are reported at two years and ten years.[16]

3.324 **Three days before death** - Kelly was transferred to another ward to receive end-of-life care and sadly died.

4.1 Analysis of Agency Involvement

4.1.1 This section analyses the key organisation's individual management reviews and information.

[16] https://pubmed.ncbi.nlm.nih.gov/8974353/

Adult Social Care

4.1.2 ASC made several attempts to engage Kelly through Care Act Assessments[17] and to gather information concerning Safeguarding Adult Concerns[18].

4.1.3 ASC consulted with RSC; Kelly declined all offers of assessment by ASC. The panel considered that an assessment with RSC may have been appropriate. The police requested a joint visit, and RSC maintained contact with the police throughout.

4.1.4 Kelly attended her appointments with RSC and appeared to have a good relationship with them. Consideration should have been given to ASC attending RSC appointments to support involvement.

4.1.5 The guide produced by Alcohol Change UK[19] considers using the Care Act Safeguarding Adults S42 legal framework to make enquiries to safeguard vulnerable, dependent drinkers. Concerning Kelly's declining offers of a Care Act assessment, the guide highlights that a mental capacity assessment should also occur. Kelly did not engage with assessments (although several attempts were made), presenting a challenge to assess her capacity concerning her care and support needs.

4.1.6 In line with Alcohol Change UK guidance and Care Act, 2014 S.42 guidance, a Safeguarding Adult concern was raised and logged for further enquiries. Unfortunately, Kelly died before her views and wishes could be established. A multi-disciplinary approach had previously been undertaken.

Cumbria Constabulary (Police)

4.1.7 Kelly had been known to the police for many years. The police's accessible historical intelligence shows records from 1992, with child protection records from 2002 showing involvement with Children's Services and the Police for Child Neglect. The records in 2007 referred to domestic abuse and Kelly being intoxicated. There were many entries in 2007 showing "parents fighting outside school", "Kelly causing issues with her parents", and "ongoing problems, Kelly banging on a house door". Each entry mentioned Kelly being drunk. Many entries also referred to Kelly being under the influence of drugs and coming to the police's attention.

4.1.8 The police had been involved with Kelly as both a suspect and victim of crime on several occasions over the years, and the police had been involved in safeguarding Kelly's life, both towards herself and her child, over the years.

4.1.6 Kelly reported being a victim of a sexual assault on 29 June 2021. The police could not gather further information, and the case was closed. The Crown Prosecution Service provide details on when crimes progress. Without enough evidence, the case is not passed to the Crown Prosecution Service, and no further action is taken.[20]

4.1.7 The Rape Crisis report[21] on the statistics of sexual assault highlight the following:

[17] https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/
[18] https://www.scie.org.uk/care-act-2014/safeguarding-adults/
[19] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf
[20] https://www.cps.gov.uk/rasso-guide/how-we-make-decision-what-do-your-case-0
[21] https://rapecrisis.org.uk/get-informed/statistics-sexual-violence/

- One in four women has been raped or sexually assaulted as an adult.
- One in six children have been sexually assaulted
- One in twenty men has been raped or sexually assaulted as an adult
- In March 2022, 70,330 rapes were recorded, with only 2,223 cases where charges were brought.

4.1.8 The panel agreed that support[22] should be offered to all victims despite no further action being taken. The available resources in Cumbria are: 'The Bridgeway[23],' 'The Birchall Trust[24],' and 'Victim Support Cumbria[25].' If Kelly or the victims are not referred to support programmes, they may develop negative self-perceptions and perceptions of the services. Consequently, they may be less inclined to report future crimes, which may hinder access to support.

4.1.9 The investigation log documented the officer's conversation with Kelly about a referral to an ISVA; no referral was recorded. However, the officers would not have submitted the referral without the individual's consent.

4.1.10 Furthermore, the code of practice[26] for Victims of Crime in England and Wales significantly emphasises victims' rights. It highlights their entitlement to be referred to victim support agencies for individualised assistance and services.

4.1.11 The Victim Commissioner Report emphasised that decisions to cease prosecution and take no further action can have profound consequences for survivors, as they frequently perceive that substantial evidence has been disregarded. In addition, they discovered that survivors place a high value on the assistance provided by victims' agencies and independent sexual violence advisors.

4.1.12 The Rape Crisis report[27] underscored the profound consequences on the lives and well-being of both victims and survivors:

- physical health
- mental and emotional health
- behaviour and habits
- job and finances
- daily routine
- social life
- sleep
- relationships of all kinds – both romantic and non-romantic
- sex life

[22] https://www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/
[23] https://www.thebridgeway.org.uk/
[24] https://www.birchalltrust.org.uk/
[25] https://www.victimsupport.org.uk/cumbria/
[26] https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime/code-of-practice-for-victims-of-crime-in-england-and-wales-victims-code
[27] https://rapecrisis.org.uk/get-informed/about-sexual-violence/impacts-of-sexual-violence-and-abuse/

4.1.13 Kelly had numerous interactions with the police, and these were typically while she was intoxicated. The absence of referrals may also impede access to support services.

Cumbria Northumberland Tyne and Wear NHS Foundation Trust

4.1.14 Kelly's contact with CNTW was brief; police had contacted the services to report that Kelly had disclosed a sexual assault and had plans to shoot the alleged perpetrator and herself.

4.1.15 Kelly declined mental health assessments and had no further contact with the service during the review period.

North Cumbria Integrated Care Cumberland Infirmary

4.1.16 Kelly attended the services more than ten times during the review period and contacted numerous health professionals and NCIC colleagues. During the contacts with NCIC, there was no indication, concerns or disclosures of domestic abuse highlighted to or by staff. However, there is no evidence that Kelly was routinely asked about her safety and if she was experiencing any abuse, which could have led to a disclosure.

4.1.17 NICE published a Quality Standard (QS116)[28] in February 2016, with the first Quality Standard Asking about domestic violence and abuse. Several reports have reinforced the need to implement 'Routine Enquiry'. Routine enquiry refers to frontline staff asking all service users about their experience of domestic abuse regardless of whether there are any signs of abuse or suspected abuse.

4.1.18 Implementing routine enquiries requires staff to be competent and confident when asking questions. A pilot project[29] conducted with GPs revealed an attitudinal change and made them feel more comfortable about asking about domestic abuse. The Domestic Abuse Statutory Guidance[30] outlines the responsibilities of individual agencies to identify and respond to domestic abuse, noting that agencies should invest in specialist training to ensure victims receive effective and safe responses.

4.1.19 As part of the safeguarding service improvement plan, NCIC has implemented the following –

- NCIC Domestic Abuse guidance was written in July 2020 and is due for review in July 2022. It is readily available to staff via the trust intranet site on the Safeguarding guidance page.
- A seven-minute briefing on domestic abuse is available to all NCIC employees on the trust intranet site. It provides a clear, easy-to-read flow chart explaining what domestic abuse is, what to do, and whom to contact for support.
- NCIC domestic abuse awareness session and DASH/MARAC information – The safeguarding team attended NCIC emergency care departments to

[28] https://www.nice.org.uk/guidance/qs116/chapter/quality-statement-1-asking-about-domestic-violence-and-abuse
[29] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf
[30] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

provide training on domestic abuse, DASH and MARAC and increase awareness of the importance of routine enquiry.

- NCIC intranet domestic abuse pages and support have dedicated intranet pages for staff to use with information regarding domestic abuse, safety planning and signposting to support services. This includes DASH and MARAC information and the safeguarding team's contact details for advice and support.
- Countdown to Christmas campaign – In November 2020, A campaign highlighting domestic abuse and increased cases in the run-up to Christmas. Four newsletters were created during the campaign, each focused on a different aspect of domestic abuse. Routine enquiry is embedded in practice following a previous DHR. Highlighting the number of missed opportunities for staff to ask – how safe do you feel? The campaign also included information on safety planning and how to support someone to leave.
- MARAC attendance weekly. Our MARAC referral rate continually increases, evidencing the increased awareness of domestic abuse, DASH, and MARAC within our clinical settings. The safeguarding team continue to prioritise MARAC attendance and has completed MARAC Chair training.

North West Ambulance Service

4.1.20 NWAS provided Kelly with pre-hospital emergency medical care, treatment and transport, and medical advice via the 111-telephone triage and referral service on several occasions, both within and outside the timeframe examined.

4.1.21 Kelly presented with various symptoms and disclosed experiencing mental health issues and alcohol and substance misuse as part of her medical history.

4.1.22 During the period explored, Kelly had six face-to-face contacts with NWAS Paramedic Emergency Service. Kelly made one 999 call; the other five were by the Police or Michael.

Recovery Steps Cumbria

4.1.23 Kelly was a long-term client of RSC, a drug and alcohol service referred in September 2015. Kelly's engagement with the service was described as poor. She came to her current case manager after threatening to kill her previous case manager. Kelly could become very frustrated and angry, which resulted in her being excluded from most pharmacies in Carlisle.

4.1.24 Kelly initially engaged with substance misuse services for support concerning heroin use. However, she had reported no illicit drug use for several years and had been stable on an opiate substitute prescription. At the time of her death, Kelly was prescribed 30ml methadone daily, which she took under supervision at her community pharmacy. Within the past ten years, Kelly had struggled with her alcohol use, which was the focus of her recovery.

4.1.25 Kelly had difficulty attending the pharmacy because she had to travel some distance, but she managed to stay in treatment. During the COVID 19 pandemic, when RSC

conducted phone reviews, she engaged well, and RSC medics agreed to reduce her collections daily to enable her to stay in treatment.

4.1.26 RSC referred Kelly to ASC; Kelly declined input from ASC.

4.1.27 Kelly was admitted to NCIC on 19 March 2021 with abdominal pain and was discharged on 7 April 2021, undergoing alcohol detox. On discharge from the hospital, she refused any assistance from ASC. She collected one dose from her community pharmacy but did not attend and fell out of the prescribed treatment. At this time, Kelly's phone was broken.

4.1.28 RSC requested the police conduct a welfare check on 6 May 2021, and Kelly was found at her address. RSC spoke to her when the police were with her, and she agreed to attend RSC the next day for a screen and a review.

4.1.29 Kelly did not attend RSC, raising concerns for her welfare. Police conducted another welfare check on 6 May 2021, and she was home but heavily intoxicated. An ambulance was called, and she was assessed at NCIC and later discharged. The decision was made to discharge Kelly from RSC and let her re-refer should she wish.

Warwick Square Group (GP)

4.1.30 The GP proactively contacted Kelly to attempt to engage with appointments.

4.1.31 Kelly only attended some appointments.

4.1.32 The GP recognised Kelly as a complex patient who was hard to engage and would present under the influence of alcohol. To support engagement, the practice tried to be consistent with continuity of care from the same GP.

4.1.33 The practice has services to support vulnerable patients. However, Kelly did not meet the criteria because she was too complex or did not want to engage with them.

4.2 Overview

This report section analyses terms of reference (ToR) to confirm that they have been addressed and met.

4.2.1 Kelly received input from the following agencies during the period under review:

1. Cumbria Constabulary
2. Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
3. North Cumbria Integrated Care
4. Recovery Steps Cumbria
5. Warwick Square Group

4.2.2 **TOR 1**: Were local domestic abuse and adult safeguarding procedures followed by agencies contacting Kelly?

Analysis

4.2.3 Kelly was subject to fifteen separate police involvements, the first in May 2021 and the last in January 2022.

4.2.4 During these eight months, logs were generated, Safeguarding Reports (SAF) were submitted, and crimes were recorded and investigated. On each occasion, the correct safeguarding procedures were followed, attending officers correctly assessed and recognised the risks, and any subsequent investigation received the proper and appropriate attention and assessment.

4.2.5 The attending officer submitted an SAF report and graded it as low/medium/high; a trained officer reviewed this assessment in the safeguarding hub, and the grading was always agreed upon. There were no instances where the risk was minimised or misinterpreted.

4.2.6 The benefit of this further review was that the staff in the safeguarding hub could recognise where support could be provided. Even when other support avenues had been closed, such as ASC, the SAF reports were shared due to the number of previous Vulnerable Adult (VA) concerns and the fact that she was struggling with her mental health—this was after attending officers had commented that her decline was the worst they had seen.

4.2.7 It is evident that within the reporting period, addiction services played a pivotal role in flagging concerns about potential domestic abuse and self-neglect that Kelly was experiencing, particularly in the month leading up to her death. In addition, the staff teams followed organisational and service policies in response to the risks.

4.2.8 Cumbria, Northumberland, Tyne and Wear Foundation NHS Trust (CNTW) Trust has a Domestic Abuse policy for staff. The policy clearly explains what actions must be undertaken when domestic abuse is suspected or disclosed. Staff are expected to complete the Safe Lives Checklist[31], make appropriate referrals to the MARAC, referring to Independent Domestic Abuse services and other agencies as appropriate.

4.2.9 The policy provides a guide staff must follow when receiving disclosures from perpetrators. In addition, the Trust Safeguarding and Public Protection (SAPP) team can provide advice, support, and supervision as required.

4.2.10 CNTW practitioners had two face-to-face contacts with Kelly during the period under review. The documentation reflects that domestic abuse and safeguarding concerns were considered, as Kelly was known to be vulnerable due to collateral shared by partner agencies. However, Kelly did not engage in assessment with CNTW services, potential safeguarding issues were not explored with her, and no further action was required at these contacts.

[31] https://safelives.org.uk/resources-library/dash-risk-checklist/

4.2.11 NWAS attended to Kelly at Michael's address on four occasions and was able to review her physically.

4.2.12 Kelly sustained a shoulder injury due to what she described as an assault despite her reasoning of self-defence.

4.2.13 NWAS clinicians recognised that a potential crime had occurred. However, Kelly refused to accept any help or intervention, so clinicians did not share this with social care.

4.2.14 When a crime has occurred or been identified, it is NWAS's routine practice to record this information with the police, and the police are informed that it is without the patient's consent. The clinicians involved in this one contact in January 2022 failed to do this, which did not follow NWAS domestic abuse policy and procedures. This has been identified as a missed opportunity. Kelly refused to engage with some of the options offered her, which should not have been a barrier to reporting and sharing this information to allow further risk assessment—procedures currently in place guide staff faced with this situation.

4.2.15 In January 2022, Kelly was transferred to the inpatient services after her NCIC admission. Concerns were recorded in the ward's notes four days before Kelly's death, which should have triggered the implementation of safeguarding adult procedures. Despite noting that a referral must be made, there must be evidence that this has been performed. Concerns were not communicated to the trust's safeguarding team, and no internal incident report had been filed. This was found and escalated within the care group due to a review of Kelly's records for the DHR process. At the trust patient safety panel, concerns were expressed, and a decision was reached to declare a significant event. Those involved have been informed of the procedure and the available safeguarding support and supervision.

4.2.16 **TOR 2**: Were any other options for perpetrator disruption or victim safety planning available to your agency/agencies during this review? If so, why were they not considered, or were there barriers to using them?

Analysis

4.2.17 Eight separate crimes were recorded during the review period, with Kelly either a suspect or a victim.

- CRI00105187- Sexual Assault- Victim
- CRI00106096- Criminal Damage- Victim
- CRI00115371- Common Assault- Victim
- CRI00124325 Common Assault Suspect
- CRI00124833- Theft/Shoplifting- Suspect (Linked to the above)
- CRI00128396- Manslaughter- Victim

4.2.18 Due to Kelly's acute concerns, particularly in January 2022, RSC addressed the risks through emergency and statutory services.

4.2.19 Within Cumbria, some services, such as victim support and independent domestic abuse advocates, can be accessed to work with domestic abuse victims. These services were not consulted regarding the last incident relating to Kelly; however, upon review of Kelly's police case file, there may have been some opportunities to reach out and involve these services following previous incidents within Kelly's treatment.

4.2.20 Within RSC, each site has specialist Safeguarding and MARAC leads for staff to contact and use. In addition, SystmOne, RSC's electronic patient record system, has the Domestic Abuse Risk Indicator Checklist (RIC) template built into it, making it easier for staff to use. However, there is no evidence of an RIC being completed for Kelly.

4.2.21 RSC contacted the police and ASC following their concerns about Kelly's relationship with Michael. Therefore, it would be expected that the RIC should have been completed. The purpose of recording the RIC would support the referral to MARAC based on the score or professional judgment. This would also trigger a referral to Victim Support or an Independent Domestic Abuse Advisor.

4.2.22 CNTW clinicians reflected during contact that Kelly was at increased risk due to her substance use, which was noted in the electronic record.

4.2.23 During CNTW contact, Kelly was not known to be a victim of domestic abuse; however, information shared by the police regarding Kelly's vulnerability to exploitation was documented within the electronic record for reference.

4.2.24 The alleged person causing harm was unknown to CNTW during the period under review.

4.2.25 Four days before Kelly's death, the NCIC recorded concerns in the ward notes that Kelly may have been the victim of a sexual assault. Although Kelly was in a safe location at the time, it would be prudent to implement a safety plan to support her, given the level of concern until an investigation could be initiated. The safeguarding policy was not enforced, and neither safety planning nor perpetrator disruption was considered. This should have included reporting concerns to police and statutory partners.

4.2.26 **TOR 3:** Were service responses to Kelly affected by the COVID-19 pandemic (review relevant contact/response with current impact)?

Analysis

4.2.27 Like many health and social care services, RSC adapted its service offer throughout the pandemic. In short, a risk methodology was applied, whereby if a service user were deemed high risk, they would be seen face to face where practicable. If they were

considered low-risk, contact would predominantly be had via telephone or videoconferencing.

4.2.28 Due to Kelly's complex presentations, she was deemed high risk, and from reviewing her case file, the treatment provided to Kelly was unaffected by the pandemic. If anything, the pandemic worked in Kelly's favour as the service was cautious not to discharge people as readily as standard; it felt safer to try multiple ways to re-engage Kelly, as opposed to giving her a treatment break, meaning that when she was ready to seek help and engage, the service was there for her.

4.2.29 The effects of COVID-19 restrictions on CNTW practices increased across several services during the period under review; however, the review notes that Kelly had access to continued support within CNTW mental health services; as such, this would not be deemed to have significantly impacted her care provision.

4.2.30 **TOR 4:** Was information shared promptly and to all appropriate partners during the period covered by this review?

Analysis

4.2.31 The police information was shared promptly with partners. The police shared information beyond what would be expected, in terms of being shared with partners in Health and directly with Kelly's GP and calling for her case to be reopened with ASC after she was closed. This is good practice by the Safeguarding Hub reviewing officers.

4.2.32 RSC had been proactive throughout Kelly's treatment regarding sharing appropriate information with relevant parties. Evidence is contained within her case notes relating to referrals to adult safeguarding, appropriate contact with the police when it was deemed Kelly was at risk, both from herself and others, liaison to Crisis Mental Health Services and referrals to Mental Health Services, and regular contact with Community Pharmacies.

4.2.33 As the provider with whom Kelly engaged the most, RSC struggled to engage other services in Kelly's care and treatment. This was for assorted reasons, including that Kelly was reluctant to engage with primary care to address her physical health issues. In addition, services deemed her to have capacity at times of increased substance use. Some services stated they could not work with Kelly until her substance use needs were met.

4.2.34 The NHS provides services that should be available to all. However, those belonging to inclusion health groups, such as drug and alcohol dependence, often face difficulties and barriers to accessing services.[32] It is suggested that the services may need more resources to support them, and staff feel uncomfortable dealing with people in such groups. The services will also have policies and practices that exclude people from these groups.

[32] https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health

4.2.35 NCIC notes that despite front-line practitioners identifying possible safeguarding concerns, these needed to be communicated to the internal safeguarding team, police, or statutory partners.

4.2.36 There is evidence of information sharing and multiagency collaboration between the NCIC's safeguarding team, RSC, and the police. For example, RSC contacted the NCIC's safeguarding team to obtain an update on its service users' causes of death. This prompted the NCIC's safeguarding team to check admission records and detect injuries and presentation delays. The NCIC Safeguarding team communicated its concerns to the medical examiner and police.

4.2.37 **TOR 5:** Can agencies identify areas where the existing legal and policy framework could be improved at the national or local level?

Analysis

4.2.38 The individuals of Cumbria would benefit from agencies implementing a protocol regarding a joined-up multidisciplinary approach to working with and addressing the needs of people with multiple complex needs, including substance misuse. Unfortunately, it is often the case whereby services see substance use as the problem and will not work with someone until they stop using substances, which is unrealistic and adds to the stigma surrounding drugs and alcohol. It is often the case where the Substance Misuse service is trying to manage the complex needs of an individual in isolation due to other services pulling out or not accepting referrals. Working in a trauma-informed way with people who often have had adverse experiences must be done in collaboration, not in isolation.

4.2.39 Knowledge about substance misuse, its impact on cognitive function, and the distinction between addiction and individuals exercising unwise decisions is required. A system-wide approach to training and development in this domain would be advantageous. The chair suggests RSC could facilitate the distribution of primary awareness material concerning substance abuse throughout the agencies.

4.2.40 Dame Carol Black completed an independent review concerning drug treatment and recovery. She highlighted the need for a coordinated approach with multiple agencies to invest in and improve treatment, employment, housing, and how people with addictions are treated in the criminal justice system.[33]

4.2.41 Following the review, the government published a new drug strategy, accepting Dame Carol Black's recommendation. The strategy aims to reduce drug-related deaths and proposes a range of evidence-based treatments.

4.2.42 Therefore, best practices in this area would include ensuring that statutory agencies receive training on assisting individuals who present with alcohol intoxication or dependency, promoting multi-agency collaboration, and, where necessary, seeking specialised care.

[33] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

4.2.43 **TOR 6:** What was the sequence of events up to the date of the death?

Analysis

4.2.44 This is noted in the key events.

4.2.45 **TOR 7:** Information: What knowledge/information did your agency have that indicated that those involved might be victims and perpetrators of domestic abuse, and how did your agency respond to this information?

Analysis

4.2.46 In early January, eight days before Kelly's death, the police reported two separate calls, which indicated the potential for domestic abuse in the relationship between Kelly and Michael. However, no specific disclosures were made.

4.2.47 The first incident was related to an argument between the pair regarding Michael's insistence that Kelly attend the hospital due to suspected COVID-19, which she was reluctant to do.

4.2.48 The call handler recorded Kelly shouting, 'Shut your f***ing face, you b*****d'.

4.2.49 The attending officers considered the situation and spoke to both parties separately to ensure no domestic abuse. They submitted a relevant Domestic Abuse SAF report. They took appropriate action in calling an ambulance to attend to the address and check Kelly over due to the concerns being raised by Michael.

4.2.50 The second incident was a call from RSC; they informed police that Kelly had recently had a fall and had broken her collarbone. Kelly also had jaundice due to withdrawals from drinking. The caller wanted to make officers aware that when attending RSC, it was noticed that Michael was eager to get Kelly out of there for an unknown reason. They appeared to disagree on several discussions. The caller wanted this logged in case of any calls for service. The caller had no concerns for welfare at the time but wanted to make officers aware

4.2.51 The second call was added to the log but was not linked to the previous SAF about the verbal argument.

4.2.52 Whilst this is not necessarily a significant issue if the officer receiving the call had reviewed this previous safeguarding report, they might have had some context around the potential for disagreement and also potentially recognised that this relationship is a volatile one which may require some further support, albeit that no criminal offences were being disclosed. The professional making the call had no concerns for welfare at that time.

4.2.53 Kelly's RSC records showed that over the years, there had been several occasions where Kelly had been in an abusive relationship, both as the victim and perpetrator.

The most up-to-date information that RSC came across in this review indicated a potential concern about domestic abuse in early January 2022 after the pharmacist contacted the service due to being concerned over Kelly's physical presentation when she collected her methadone earlier that day. The pharmacist also gave information about a concern they had following Michael and Kelly attending the Pharmacy two weeks prior.

4.2.54 RSC staff spoke with Kelly the next day and arranged for her to come to the office for a medical review. Michael attended the site with Kelly and was verbally abusive towards the administration staff; he tried to stop Kelly from entering the consultation room alone but eventually left the building.

4.2.55 There were several concerns with Kelly's presentation at the RSC appointment, including her visible shoulder injury. She informed the Independent Prescriber that she hit her shoulder on the bed frame. Kelly denied feeling unsafe with Michael and stated she could manage herself. "His bark was worse than his bite".

4.2.56 Due to the above concerns and the information received by the Community Pharmacy the previous day, RSC made an adult safeguarding referral and contacted 101 due to safeguarding and potential domestic abuse concerns.

4.2.57 On 29 June 2021, Psychiatric Liaison Team practitioners received information that Kelly attended A&E and had declined a referral to the team, denied self-harm and reported an accidental injury. However, A&E staff shared that Kelly had reported a recent sexual assault, that money had been stolen from her bank account, and that she had expressed plans to assault the perpetrator. Safety planning was agreed upon with A&E staff, confirming that A&E would alert safeguarding. In addition, information regarding Kelly's vulnerability was noted within the CNTW electronic record.

4.2.58 On 3 July 2021, CNTW were contacted by the police to report that Kelly had reported a sexual assault and planned to shoot herself and the unnamed perpetrator. In the telephone contact with the crisis clinician, Kelly denied experiencing a mental health crisis or imminent plans to harm herself. She declined a mental health assessment but agreed to safety planning with the police. Information regarding the contact was shared with the GP, and the clinician wrote to Kelly confirming crisis and contingency planning.

4.2.59 On 10 July 2021, the police shared information with the crisis team that Kelly had been found lying in the street. In discussion with the crisis clinician, Kelly denied mental health difficulty and agreed that the police could accompany her to a friend's property. Information regarding the contact was shared with the GP and RSC.

4.2.60 CNTW was made aware of Kelly's vulnerability to abuse following information shared by partner agencies, and this was alerted within the electronic record on 29 June 2021. The review noted that CNTW clinicians did not have direct contact with Kelly during or before her death in 2022; however, the concerns from partner agencies were recorded in the CNTW electronic record.

4.2.61 NCIC on 20 January 2022, the paper records note that Kelly experienced worrying per vaginal bleeding, and NCIC inquired about suspected sexual assault. Additionally, they were aware that Kelly was in a violent relationship. There were no other domestic violence-related entries in the files.

4.2.62 Although staff had documented their concerns and believed she was experiencing domestic abuse, there is no evidence that the concerns were acted upon. For example, no formal safeguarding procedures were followed, and no ongoing information-sharing referrals were made.

4.2.63 There was no evidence of routine enquiry before the admission, and nothing was documented regarding domestic abuse.

4.2.64 **TOR 8:** In considering your response, think about the impact of abuse upon Kelly and, specifically, respond to the following (where possible):

4.2.65 **TOR 8a** To what extent did Kelly consider herself a victim?

Analysis

4.2.66 Kelly made several vague disclosures to officers in July 2021 when she was intoxicated in the A&E department, which was not recorded on a subsequent SAF referral.

4.2.67 Kelly was intoxicated and gave information about her past – she talked about being assaulted extensively whilst living in London. She specifically said that she "had kids kicked out of me".

4.2.68 Kelly also commented, “I must have been born to have been abused".

4.2.69 The police responded correctly and identified her as a victim when appropriate. This related not only to when she was a victim of crime but also to her vulnerabilities.

4.2.70 There is historical information referenced within the case file of RSC that indicated there were times when Kelly did see herself at risk of domestic abuse. There are accounts of Kelly feeling safe when her ex-partner was sentenced to prison and her previous involvement in MARAC.

4.2.71 More recently, within the timeframe of this review, Kelly did not feel she was a victim; there were accounts of her statement to workers that she could look after herself and explain her decision-making process surrounding her risks and vulnerabilities. However, Kelly recognised that when she was heavily under the influence of alcohol, she could not guarantee her safety and experienced gaps in her memory.

4.2.72 Kelly’s history showed a distinct pattern of increased substance use when she formed a new relationship; at these times, her physical and mental health deteriorated, often leading to disengagement with the service.

4.2.73 Kelly did not appear to perceive herself as a victim of domestic abuse or at risk of harm at the hands of Michael.

4.2.74 She described herself as being alcohol dependent and recovering from drug addiction and mental health issues. Clinicians have recognised these factors as requiring further probing around her ability to keep herself safe.

4.2.75 This highlights the need for professionals to cultivate professional curiosity and have systems and cultures in place to support this.

4.2.76 Professional curiosity is the act of a practitioner who actively seeks to understand an individual's circumstances rather than relying on a single source of information or making assumptions. It involves a combination of observing, hearing, asking direct questions, verifying, and reflecting on the information that has been received.

4.2.77 All responses to Kelly from NWAS have been triaged appropriately, which aligns with the Ambulance Response Program 2017, the nationally recognised operational response within Ambulance Services.

4.2.78 Kelly's interactions with NCIC services missed opportunities to conduct routine enquiries. The patient's voice is not indicated in any of the patient's records.

4.2.79 **TOR 8b:** Did Kelly understand that the risks she faced impacted her decision-making?

Analysis

4.2.80 There have been times within her treatment when Kelly had differing views on her vulnerability, and the steps taken by the service differed in response to the risk, balanced against Kelly's wishes.

4.2.81 A review of the chronologies demonstrates that Kelly reported a depressive illness and expressed intermittent suicidal ideation; however, during communication with CNTW, she denied ongoing symptoms and declined to engage with the support offered despite clinicians attending and attempting to engage her.

4.2.82 Mental capacity is assessed on every patient contact, and domestic abuse encompassing control and coercive behaviour, as well as fear of reprisal, is recognised to have a potential impact on a victim's mental capacity to access the support offered.

4.2.83 Women's Aid[34] highlights that domestic abuse is not always physical— coercive control creates a pervasive sense of dread and invisible chains in all elements of the victim's life. It deprives individuals of their liberty, reduces their capacity for action, and restricts their human rights.

[34] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

4.2.84 Given the above, it is feasible that Kelly and other victims may be unaware of coercive control. Kelly had been subjected to physical domestic abuse in her previous relationships. Consequently, the concept of domestic abuse may not have been wholly comprehended in terms of coercion and control. Kelly and victims in comparable circumstances may also come to regard their relationships as part of the typical ups and downs of relationships.

4.2.85 Kelly had retracted her initial report of domestic abuse and claimed that Michael was defending himself. Consequently, this may be interpreted as an attempt to minimise control or 'victim blaming', believing she caused the assault.

4.2.86 Citizen's advice[35] reported emotional barriers, such as low self-esteem, self-blame, dread, guilt, love, and commitment, as well as practical, financial, or physical barriers, can make it difficult for victims to leave or report an abusive relationship.

4.2.87 Kelly had been consistent throughout contact with NWAS, demonstrating her ability to make decisions clearly and her determination to achieve her desired outcome. She chose when and where medical interventions would take place.

4.2.88 Attending NWAS clinicians placed Kelly at the centre of their decision-making. They attempted to assist her and keep her safe within their scope of practice, considered her wishes using all medical options available and safeguarding pathways.

4.2.89 During the one contact where Kelly described the assault, clinicians attempted to get support by raising concerns with social care.

4.2.90 **TOR 9:** Does your agency have any information that helps understand the possible 'triggers' in Kelly's life that may have led to her alcohol misuse and life circumstances?

Analysis

4.2.91 The information that has been reviewed shows evidence of a long history of entrenched substance misuse spanning over 20 years.

4.2.92 Kelly first came to the attention of addiction services due to opiate addiction. Consequently, Kelly was placed on Opiate Substitute Treatment (OST) to address this; Kelly was able to find her optimised dose of 30ml of oral methadone and remained stable within her OST. However, Kelly had periods of polysubstance use, which surfaced around new relationships with her partners heavily influencing Kelly. There were historical reports of sexual assaults that Kelly was a victim of, some of which the police had been able to take forward and investigate.

4.2.93 In recent years, Kelly's primary need was her alcohol use, which was the main focus of her treatment at the time of her death.

[35] https://www.citizensadvice.org.uk/cymraeg/amdanom-ni/our-work/policy/policy-research-topics/justice-policy-research/domestic-abuse-policy-research/domestic-abuse-victims-struggling-for-support/#:~:text=Victims%20can%20face%20emotional%20barriers,themselves%20from%20an%20abusive%20relationship.

4.2.94 Kelly was in poor physical health and had unmet healthcare needs; she could not address her presenting needs at the time due to being under the influence of substances. It would appear that there was a perpetuating cycle of substance use and ill health, both physical and mental.

4.2.95 On her first contact with CNTW clinicians in October 2020, Kelly reported being treated with RSC. She reflected that she was experiencing a deterioration in her mental health following the death of her dog and completed a triage with the team. Unfortunately, Kelly did not engage in a full mental health assessment with CNTW, so little is known about her life story or "triggers."

4.2.96 In 1986, she gave birth to a son; Kelly first encountered NCIC services through maternity services. Kelly was worried about substance abuse and Social Services' involvement. Kelly has an extensive alcohol and substance abuse history and a husband who tragically died of an overdose in London.

4.2.97 Kelly struggled to maintain strong connections with her six children who were not in her care and her immediate relatives. There is also clear evidence of Kelly's mental health decline, during which she struggled to engage with services to obtain treatment. Kelly most certainly experienced some level of trauma due to her life events.

4.2.98 **TOR 10:** Were practitioners alert to potential domestic abuse indicators and aware of what to do if they had concerns about a victim or perpetrator?

Analysis

4.2.99 The police review determined appropriate consideration as given.

4.2.100 SystmOne has robust risk assessment functions, including the RIC template for all staff. However, the service would benefit from a formal domestic abuse training offer as a standalone course instead of being contained within the current safeguarding and mental capacity training.

4.2.101 At contact in May 2021, CNTW clinicians knew that Kelly's substance use and intermittent suicidal ideation placed her at increased risk of vulnerability. However, indicators of domestic abuse were not evident.

4.2.102 The Domestic Abuse Act 201 and Women's Aid[36] state: 'Domestic abuse isn't always physical. Coercive control is an act or pattern of assault, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten the victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.'

4.2.103 **TOR 11:** Have your agency policies and procedures for identifying domestic abuse and dealing with those concerns? Were these assessment tools, practices, and

[36] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

policies considered adequate? Was it reasonable to expect staff to fulfil these expectations given their level of training and knowledge?

Analysis

4.2.104 The police confirmed they have Policies and Procedures for identifying domestic abuse. The Constabulary uses the DASH Risk Assessment Tool to identify risks in a domestic abuse situation, and officers are taught about this tool during their initial police training. They know they are expected to use this risk assessment tool for Domestic Abuse incidents. It is reasonable for all officers in the organisation to use the DASH RIC and learn about the domestic abuse policy and procedures.

4.2.105 The police review concluded that the policies and procedures around domestic abuse were followed, and officers considered their policing powers and procedures when dealing with Kelly and Michael.

4.2.106 However, the police have identified that no SAF report was submitted eight days before Kelly's death following the call from RSC. The reviewing officers in the safeguarding hub will not have revisited the log to which this information was attached and would not have known about it. However, RSC noted no immediate concerns for Kelly's safety.

4.2.107 RSC has an up-to-date Domestic Abuse and Sexual Violence Policy for all staff, which details guidance and best practices. In addition, the service uses an incident management system called 'The Hub'. This system contains all incidents, safeguarding concerns, complaints, and feedback, and managers and directors track and sign off on all information.

4.2.108 Addictions Services have identified Safeguarding and MARAC Leads within each locality to provide specialist advice and support to staff regarding domestic abuse. In addition, specialist safeguarding supervision is available to all Addiction service staff every month, during which the team can discuss complex safeguarding cases.

4.2.109 RSC has an Integrated Governance Board to support oversight, review, and learning from all incidents across the service. Within the Board structure, a specialist Safeguarding Practice Subgroup has been set up to support the development of safeguarding practice and ensure learning identified from internal and external reviews is embedded within the future approach.

4.2.110 All staff have full training on internal systems, policies, and procedures.

4.2.111 CNTW Trust has a Domestic Abuse policy for staff to follow. The policy clearly explains what actions must be undertaken when domestic abuse is suspected or disclosed. Staff are expected to complete the Safe Lives Checklist, make appropriate referrals to the MARAC, referring to Independent Domestic Abuse services and other agencies as appropriate.

4.2.112 The policy guides staff on what to do when receiving perpetrators' disclosures. In addition, the Trust SAPP team can provide advice, support, and supervision as required.

4.2.113 NCIC staff have access to the trust's Domestic Abuse policy, Safeguarding policy, and intranet pages. The intranet site provides guidance about domestic abuse, including DASH and MARAC referral information, signposting to external support services, routine inquiry, and safety planning.

4.2.114 All NCIC employees receive mandated safeguarding training and have access to face-to-face and online safeguarding adult level 3 training. This training focuses on safeguarding procedures, domestic abuse, DASH, and MARAC referrals.

4.2.115 **TOR 12:** What were the key points or opportunities for assessment and decision-making in this case? Have reviews and decisions been informed and professional, keeping with organisational and multi-agency policies and procedures?

Analysis

4.2.116 The police noted instances where the Safeguarding Hub's actions exceeded expectations, particularly with their work to reopen the ASC case based on the police officer assessments at the scene. This is considered good practice.

4.2.117 Multiple timely assessments of Kelly and her presenting needs were conducted, following the RSC service policy. Kelly received more frequent reviews in response to her increasing risks and vulnerability, particularly in medical reviews conducted by a clinician.

4.2.118 This report has referenced the difficulty of engaging some agencies; the absence of a robust multidisciplinary approach could negatively impact the quality of care and treatment that addiction services could provide to Kelly.

4.2.119 At referral from partner agencies, including the police and acute hospital staff, CNTW clinicians attended and attempted to engage Kelly in assessing her mental health; however, Kelly declined to engage on each occasion. CNTW did not observe signs or symptoms of significant mental health illness; however, she noted that her substance use placed her at increased risk of deteriorating mental health.

4.2.120 NWAS vulnerable person policies and procedures are reviewed regularly in line with government changes to legislation; learning identified from reviews is further shared through staff bulletins and presented at the area learning forums to improve practice within frontline clinical teams.

4.2.121 **TOR 13**: Were joint assessments to assess substance misuse, mental ill-health, and domestic violence abuse?

Analysis

4.2.122 When referrals were made via SAF reports, they were always shared with the relevant agencies, and the alcohol misuse and mental health issues were always central as to why the referrals were made in the first instance. There are instances of officers calling the Mental Health Single Point of Access line while with Kelly and remaining with her until they could speak to someone on the Single Point of Access. They continued to wait with her until those professionals could talk to Kelly and assess her over the phone. This is considered good practice.

4.2.123 RSC did not conduct a joint assessment during the period being reviewed in this report. The last Mental Health Assessment was completed in May 2021, following twenty-one referrals made by different agencies, including police, NWAS, and A&E, in the past twelve months before the assessment. Following the review, it was deemed that mental health services had no role at that time.

4.2.124 Kelly declined a mental health assessment with CNTW clinicians when offered whilst she attended A&E in May 2021; however, due to concerns about her safety, a welfare check was requested from the police. At police contact, Kelly denied acute difficulties. However, at subsequent contact with the Crisis Team in the following days, she did not consent to a mental health assessment and was deemed to maintain the capacity to decline. Whilst in acute inpatient services, Kelly again declined a mental health assessment despite Psychiatric Liaison Team staff attending and attempting to engage and encourage her.

4.2.125 Kelly was referred to mental health services for assessment and support throughout her attendance at NCIC. As demonstrated by CNTW's timeline. In addition, a safeguarding adults alert was added to Kelly's emergency care records, indicating that she is a vulnerable adult known for drug and alcohol services.

4.2.126 **TOR 14:** Should the information your agency knows have led to a different response?

Analysis

4.2.127 Whilst addiction services have acted appropriately on all information presented, more emphasis could have been put on further probing about domestic abuse. Case file records show that questions regarding domestic abuse were asked, and tools such as the RIC were not routinely used. From reviewing Kelly’s records, completing an RIC every time she formed a new relationship, at a minimum, could have been deemed appropriate.

4.2.128 Further emphasises that professional curiosity would allow practitioners to explore every potential indicator of abuse or neglect and attempt to understand Kelly's daily life, including her routines, thoughts, emotions, and relationships.

4.2.129 The information contained in Kelly's NCIC medical records, beginning with her admission five days before her death, should have resulted in the police being notified of concerns, referrals to statutory partners, internal incident reporting, and notification of the NCIC safeguarding team. There is also no evidence that Kelly was ever asked

about her relationship or if she felt safe. As she was critically ill at this time, it is uncertain whether she would have been able to respond to these enquiries.

4.2.130 **TOR 15:** How accessible were the services for Kelly?

Analysis

4.2.131 Often, when police interacted with Kelly, they were not the primary agency she needed. Nevertheless, they were able to signpost and make the relevant referrals after the interaction.

4.2.132 This has often meant contacting the Single Point of Access line or being referred to a more appropriate agency following an SAF referral.

4.2.133 RSC accommodated Kelly's needs well; the service was open and accessible to Kelly at all times. Decisions were taken over the reporting period to keep Kelly open to the service even when she was not engaging due to her level of risk and need.

4.2.134 The review notes that during contact with the police and acute services, Kelly was encouraged to engage with mental health services, and clinicians made attempts to offer support for her mental health.

4.2.135 **TOR 16:** Were the identified needs unmet or conflicts between Kelly's requirements and her response to these?

Analysis

4.2.136 The only incident where Kelly's identified needs were unmet was during the criminal investigation into her alleged sexual assault. (This incident did not refer to Michael).

4.2.137 The investigation was conducted correctly, with the correct level of supervision and proportionate attempts to complete actions. Still, Kelly needed help attending the appointments to take her statement.

4.2.138 It is unclear why Kelly did not attend her appointments. It is unknown at this time if factors such as alcohol consumption were considered when arrangements were made. Appointments were made for her to attend the police station. Kelly did not attend appointments that had been made at her home address or accept arrangements to pick her up and transport her to a location to speak to her.

4.2.139 The alleged perpetrator was never identified and never arrested or interviewed.

4.2.140 The crime was recorded on Kelly's limited information in her various intoxication states. It was never suitable to register an official complaint or first account from her due to her ongoing levels of intoxication. Therefore, the police could not secure Achieving Best Evidence, the preferred method of evidence gathering from a victim of a sexual assault.

4.2.141 The same can be said for the other individuals identified during the investigation, and their levels of intoxication or ability to recollect events also frustrated the investigation moving forward.

4.2.142 Kelly had unmet and unmanaged physical health needs; Kelly was reluctant to engage with primary care, meaning her health deteriorated as a result. However, RSC continued encouraging Kelly to see her GP and seek specialist advice where required.

4.2.143 Notably, a vulnerable person's ability to maintain their safety from abuse by others may be reduced; in Kelly's case, this was further complicated by her substance use disorder.

4.2.144 The chronologies reflect that contact with Kelly during her relationship with Michael was characterised as assertive.

4.2.145 **TOR 17:** Was there any additional action that could have been taken, and would it have made a difference? (Missed opportunities?)

Analysis

4.2.146 The police could have investigated whether she attended other appointments and whether they might have spoken with her there as well – for instance, at RSC or GP meetings, which could have provided the necessary information following the reported sexual assault.

4.2.147 Although the NWAS clinicians failed to report Kelly's assault to the police, they spent considerable time gaining information about her relationship with Michael and her way of living. They identified factors that may have put Kelly at higher risk (mental health, alcohol/drug misuse) of repeated incidents, recognised that these factors could cause an escalation, and reported this information using safeguarding pathways to social care with Kelly's consent. This demonstrates a good understanding of the indicators of domestic abuse despite the reporting pathway not including the police.

4.2.148 Learning around the need for consent against the level of risk with the individual clinicians involved in the contact has been completed. The NWAS clinicians have reflected on Kelly's refusal, which they perceived was a barrier to reporting to the police compared to the need for information sharing with partner agencies to assess the level of risk posed to protect the victim. The two clinicians involved accepted the knowledge required to enhance the domestic abuse procedures and should have utilised senior support available to ensure the most appropriate outcome was achieved.

4.2.149 NCIC found no indication of routine inquiry or professional curiosity when Kelly visited the services. Thirteen days before her death, when Kelly presented with her initial clavicle injury, a routine enquiry was not conducted. Staff may have facilitated Kelly's disclosure of any mistreatment she was facing. There is a minimal indication of professional enquiry on how Kelly received the injuries and the reason for the delay in her presentation.

4.2.150 **TOR 18:** Capacity and resources: Were there issues about capacity in your agency that impacted the ability to provide services to Kelly, the alleged perpetrator, or any other relevant persons? Did these issues affect the agency's ability to work effectively with other agencies?

Analysis

4.2.151 Kelly received responses from the police to all incidents.

4.2.152 All officers who engaged with Kelly throughout this period did so professionally and recognised the safeguarding concerns, whether from mental health or domestic abuse.

4.2.153 The effects of COVID-19 restrictions on practices increased across several services; the review notes that Kelly had access to continued support within CNTW mental health services, so this would not be deemed to have significantly impacted her care provision.

4.2.154 **TOR 19:** Are there lessons to be learned from the case relating to how your agency safeguards victims and promotes their welfare or how it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for working, training, management, and supervision in partnership with other agencies and resources?

Analysis

4.2.155 No criminal incidents concerning Kelly or Michael were missed. While officers assessed the situations, safeguarding was at the heart of their decision-making.

4.2.156 Nevertheless, a minor concern is how the call handler managed the report from RSC.

4.2.157 While the police recorded RSC's concerns, they did not submit an SAF to instigate a further review by the safeguarding hub.

4.2.158 The added information was essentially the same as from the SAF generated post-domestic argument in early January 2022. However, a further SAF may have elevated the situation for a more serious intervention.

4.2.159 It is expected that the comments from RSC to the call handler regarding the fact that there were no concerns for welfare at that time meant that whilst a SAF was considered, it was not relevant at that time due to a fellow professional citing no problems, and to log for information.

4.2.160 The benefits of an SAF would allow an extra level of attention and a complete picture to be considered.

4.2.161 However, the fact that there were no concerns for welfare would have meant that the would-be SAF would have been graded low risk, so it is unlikely that it would have been shared further.

4.2.162 The addictions service has robust safeguarding processes and policies. However, they have identified an area within RSC that needs to be improved further and developed regarding domestic abuse and the completion of the RIC assessment tool.

4.2.163 NWAS safeguarding practitioners complete a weekly audit of concerns where clinicians have identified domestic abuse. This allows for better knowledge of the number of cases reported within the five geographical areas NWAS covers and highlights when numbers fluctuate regionally, prompting further review into the cause. The audit further helps measure the impact of the training clinicians receive on understanding the broader definition of domestic abuse. Professional curiosity has been adopted, and responses to those patients align with current policy.

4.2.164 As part of supervision, clinicians have dedicated one-to-one shifts throughout the year with a clinical leader and have the opportunity to discuss safeguarding topics and enhance their knowledge of best practices. They also attend yearly mandatory training covering safeguarding procedures and expected approaches, including responding to domestic abuse incidents and dealing with disclosure.

4.2.165 **TOR 20:** Identify good practices where responses may have exceeded the required standards.

Analysis

4.2.166 The reviewing police officers in the Safeguarding Hub have exceeded the required standards by ensuring that relevant information on safeguarding reports is shared with as many people as possible.

4.2.167 They have gone to the lengths of identifying Kelly's GP and sharing the information with them.

4.2.168 Furthermore, the diligence in the case of her being closed to ASC and comments of the attending officer on the scene regarding her demeanour and current state have instigated a sharing of information to ASC, and her case file is being re-opened.

4.2.169 This is a perfect example of diligence and good partnership working.

4.2.170 It was noted during the review that the RSC team working within the service had gone beyond their response to Kelly and her present needs. Whilst the service is experienced in collaborating with people with multiple complex needs, the team faced many challenges to ensure Kelly’s safety and to try and collaborate with her to decrease her alcohol use and focus on her physical and mental health. This can be

evidenced by the decision not to discharge Kelly from the service through periods of disengagement.

4.2.171 The service promptly assessed risk and shared concerns as and when they arose. The case file notes show the focus on information sharing and engaging with other services.

4.2.172 RSC has been proactive, highlighting the nature of fluctuating capacity to other professionals. However, this has yet to have the desired effect; it is recognised nationally that more focus should be spent on training and developing broader service knowledge and skill sets about addictions, mental capacity, and decision-making.

4.2.173 Partner agencies, including the police and NCIC, recognised that Kelly's substance use disorder placed her at increased risk of mental health deterioration and referred her to the Crisis and Psychiatric Liaison teams. Despite Kelly's declining support for her mental health, CNTW clinicians endeavoured to engage her in assessment, allowing the opportunity to build a rapport with the team so that she may feel more able to engage with support in the future. A taxi was arranged to encourage her to access support, and letters containing crisis and contingency planning were shared with her following telephone triage contact.

4.2.174 **TOR 21:** The reports should consider any equality and diversity issues pertinent to Kelly and the alleged perpetrator, e.g., age, disability, gender reassignment, marriage, civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

Analysis

4.2.175 Please refer to section 1.5.

5.1 Conclusion

5.1.1 The purpose of this review is to establish the facts that led to the death of Kelly in January 2022 and 'articulate life through the eyes of the victim[37].

5.1.2 Kelly was a 57-year-old female; she was a mother to six children and had a dog she was devoted to. Kelly's children had been in care; sadly, her dog died a year before.

5.1.3 Kelly had a long history of contact with substance use; she had used heroin in the past and benzodiazepines. Kelly was on a dose of 30ml methadone, maintaining her abstinence from Heroin. However, recently, her substance use was related to alcohol misuse.

5.1.4 Kelly had previously been in domestic abuse relationships and had stated, "I must have been born to be abused". Kelly was in a new relationship with Michael and had moved in with him in December 2021.

[37] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

5.1.5 The relationship came to the police's attention in early January 2022 following a verbal altercation between the pair. No further action was taken. However, the police referred to ASC and completed an SAF form. They also shared information with the GP.

5.1.6 Fifteen days before she died, Kelly sustained a fall. She initially disclosed to NWAS that Michael had pushed her onto the wooden bedpost. However, this was retracted, and she informed agencies that she had fallen.

5.1.7 Kelly did not receive treatment for the injury; she was advised to use a sling, which she did not.

5.1.8 Kelly reported Michael's "bark is worse than his bite"; she did not believe he would hurt her. However, concerns were reported following the pharmacist's observation of Kelly while in Michael's company. RSC staff also witnessed Michael not wanting Kelly to be seen alone.

5.1.9 Kelly's case was not discussed with a domestic abuse specialist. However, the police and RSC addressed and appropriately referred Kelly to ASC.

5.1.10 The review identified that services had acted promptly and appropriately to support Kelly in accessing services.

5.1.11 RSC and the GP highlighted the lack of services for persons in similar circumstances to Kelly, for example, alcohol and substance misuse and hard-to-engage users.

5.1.12 The police are establishing a Multi-Agency Tasking and Coordination (MATAC) strategy to combat repeat domestic violence offenders. MATAC focuses its efforts on perpetrators. Since November 2004, MATAC has been entrenched in Northumbria and has produced effective outcomes.[38] This coordinated effort may have helped Kelly and others.

6.1 Lessons to be Learnt

6.1.1 The review noted the following themes:

Trauma-Informed Care

6.1.2 Drug and alcohol use is a set of coping skills to suppress underlying issues, usually some trauma. Adopting a trauma-informed approach has been evidenced as the preferred method for services to respond effectively to these complex issues.

6.1.3 Trauma-informed care suggests that service and practice responses must be designed to recognise and respond to the experience of complex trauma in the lives of the people with whom they interact. In addition, the underpinning assumption is that it involves relational and strengths-based ways of addressing trauma's impact.[39]

[38] https://www.governmentevents.co.uk/working-together-to-combat-domestic-abuse-the-benefits-of-multi-agency-cooperation/
[39] https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Developing-and-leading-trauma-informed-practice.pdf

6.1.4 Agenda's research reported that one in twenty women had experienced extensive physical and sexual violence as a child and adult.[40] Therefore, it highlights a link between trauma and addiction and the requirement for practitioners to be aware of the trauma's impact and prevent re-traumatisation.

6.1.5 Kelly had disclosed trauma, reporting to have been beaten, sexually assaulted, and a previous victim of domestic abuse and had her kids had been removed from her care.

Alcohol and Domestic Abuse

6.1.6 Alcohol has been linked with crimes, such as domestic abuse. It is part of the trilogy of risk: Alcohol/substance misuse, poor mental health and domestic abuse –risk indicators that increase the risk of harm.

6.1.7 Alcohol was cited as a common theme in a sample of 39 DHRs, with fifteen identifying the victim as experiencing alcohol problems and fifteen with both the victim and perpetrator.[41]

6.1.8 The awareness of alcohol is commonplace in such tragedies. It requires services to ensure they have processes to identify victims/perpetrators who present with alcohol issues and work with multiple agencies to respond to this. The guide produced by AVA[42] may provide a baseline for good practice.

6.1.9 Kelly described being a dependent drinker and successfully abstaining from illicit substances while on a methadone programme. Her previous partners had been either dependent drinkers or using illegal substances.

6.1.10 People who misuse substances may surround themselves with others who misuse both to receive validation and satisfy their need for belonging. Consequently, the need to address these enablers' dual nature can impact clients.

Professional Curiosity

6.1.11 Professional curiosity is being interested in the individual and listening to their story without judgment or assumptions.

6.1.12 Cumbria Safeguarding Children Partnership[43] highlights the importance of improving decision-making and reducing risks. Further work performed by Cumbria Safeguarding Children Partnership, Safer Cumbria, and Cumbria Safeguarding Adults Board resulted in producing material designed to increase practitioners' professional curiosity.[44]

6.1.13 Services demonstrated they wished for Kelly to receive help; the ambulance crew suggested alternative transport to convey her to the hospital. RSC was aware of her wishes and strengths.

[40] https://alcoholchange.org.uk/blog/2019/women-and-alcohol-why-we-need-a-trauma-informed-response
[41] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf
[42] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf
[43] https://cumbriasafeguardingchildren.co.uk/professionalcuriosity.asp
[44] https://www.cumbria.gov.uk/elibrary/Content/Internet/327/949/38407/44846101828.pdf

6.1.14 The practitioner event highlighted the difficulty of patient databases. Since agencies use different databases, they are only sometimes aware of the services a person receives. Therefore, reliance is placed on the individual to reveal this information.

6.1.15 For all services engaging with people in similar complex situations, Kelly may consider using professional curiosity to agree to the care plan collaboratively.

Routine Enquiry Re: Domestic Abuse

6.1.15 Victims of domestic abuse often come to the attention of healthcare professionals, and thus, they are ideally placed to identify domestic abuse.[45]

6.1.16 To support practitioners with facilitating enquires a research paper[46] revealed the following findings:

- Interpersonal relations – Listening skills, Trust, Empathy
- Safety Privacy and confidentiality, home visits
- Validation

6.1.17 Kelly was not asked about domestic abuse, with NCIC assuming the person bringing her to the hospital was her husband. As previously stated, most victims will not disclose that they are experiencing domestic abuse and have reported feeling relieved to be asked.

6.1.19 Safe Lives produced guidance on how to conduct a routine enquiry[47].

Alcohol and Capacity

6.1.20 The case concerning Tower Hamlets V PB (2020) involved a 52-year-old male with a history of alcohol misuse and whether he could decide on his care and residence.[48]

There were several key points arising from the case[49]:

- If an individual has the capacity to make decisions around care and residence and is content to remain in the placement while being able to access alcohol, local authorities may feel that they have no other option than to let that individual take risks with their health that the local authority is uncomfortable with.
- The real question is how alcohol consumption affects individuals' decision making capacity in other areas. Capacity assessments should consider the individual's ability to understand, use, retain and weigh information about the consequences of their alcohol consumption and how that affects their decision-making in other vital areas, including care and support. The effect on their health and potential risk to their life will be part of that consideration.

[45] https://safelives.org.uk/sites/default/files/resources/Domestic%20abuse%20guidance%20for%20virtual%20health%20settings-%20C19.pdf

[46] https://link.springer.com/content/pdf/10.1007/s10896-020-00236-3.pdf
[47] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC196400/

[48] https://www.39essex.com/vice-presidents-judgment-on-capacity-and-alcohol-dependence/
[49] https://invicta.law/news/capacity-to-make-decisions-on-care-and-alcohol-dependency/

- If an individual cannot understand, use, retain and weigh information because of their dependency on alcohol, they will lack the capacity to make those decisions. However, where the individual clearly understands the risks to their health presented by their use of alcohol, it is likely to be found by courts that they will have the capacity to make decisions about care and support. This will apply whether an individual does not have a realistic view about how to moderate or manage their drinking. As long as the individual understands the risks posed by heavy drinking, although the decision may be considered unwise, it does not mean they cannot necessarily make it.

6.1.21 The case demonstrates the need to balance capacity with unwise decisions.

6.1.22 Alcohol Change UK has produced a guide to further support practitioners in understanding the legal frameworks. It should be shared with all agencies to inform them of their legal responsibilities better and safeguard dependent drinkers.

7.1 Recommendations

Single Agency Recommendations

Recovery Steps Cumbria

7.1.1 Implementing a standardised multidisciplinary approach for people with multiple complex needs across all agencies within Cumbria would be beneficial.

7.1.2 System-wide training regarding upskilling practitioners on substance misuse, to be delivered by Recovery Steps Cumbria.

7.1.3 Standardised use of the RIC within Recovery Steps Cumbria as an evidenced-based screening tool for Domestic Abuse.

7.1.4 A System-wide review of the application of the Mental Capacity Act and safeguarding powers for dependent drinkers is required.

North Cumbria Integrated Care NHS Foundation

7.1.5 Training will be offered on domestic abuse and routine enquiries to educate staff on the importance of routinely asking patients about their safety.

7.1.6 The clinical area involved in non-reporting of safeguarding concerns will be encouraged to complete face-to-face Safeguarding Adults level three, and compliance will be reviewed via the Safeguarding team and shared with care group leads.

7.1.7 NCIC will continue working on the trust initiative—how safe do you feel? and embed it firmly into practice.

7.1.8 NCIC would like to improve the information-sharing process with substance misuse services when those attending our emergency care department are in crisis.

7.1.9 The review identified themes that may support practitioners in responding to adults presenting in similar circumstances to Kelly. These have been used to support the following recommendations:

Recommendation one – Trauma-Informed Care

7.1.10 The senior leadership must invest in and support organisations to adopt a trauma-informed strategy. The leadership group develops the plan for a trauma-informed organisation. This will entail consideration of patient participation, clinical and non-clinical staff training, and establishing a safe environment.

Recommendation two – Compassionate Curiosity

7.1.11 The three boards have developed guidelines for practitioners to strengthen and cultivate their curiosity around their practice. The guidance must be evaluated, and mechanisms put in place to assess its impact, including staff and patient feedback on its use.

Recommendation three – Routine Enquiry

7.1.12 Responding to domestic violence is everyone's responsibility. To enable organisations to carry out their responsibilities effectively, all staff must obtain the necessary training to identify victims/survivors and ensure they receive the support required. This will necessitate the implementation of information-sharing protocols and efficient systems for recording and directing victims/survivors to the appropriate services. Organisations must be able to efficiently extract the necessary data to guarantee compliance with this obligation.

Recommendation four – Alcohol and capacity

7.1.13 Safer Cumbria to collaborate with the Cumbria Safeguarding Adults Board to raise awareness among system-wide practitioners about dependent with impaired mental capacity and executive functioning.