SAR REBECCA

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BURY SAFEGUARDING ADULTS BOARD
Bury, Greater Manchester

Contents

Introduction

1.1. Rebecca[1] died in early March 2022, aged 28. She had been admitted to hospital in cardiac arrest, having been found unresponsive at home. An inquest in March 2023 found that the arrival of paramedics was timely and that they commenced cardiopulmonary resuscitation on arrival. This was ongoing on arrival at hospital; however, despite appropriate advance life support measures, Rebecca died.

1.2. The inquest recorded that post-mortem and toxicology analysis had found that Rebecca had ingested methadone in addition to pregabalin[2], codeine, diazepam[3] and promazine[4] prior to her death. Cause of death was recorded as 1a respiratory depression and 1b mixed drug use. The inquest found no evidence that Rebecca intended to end her life or that there was any third party involvement in her death. A recording of the inquest has been made available for the purposes of this review.

1.3. The SAR referral was submitted in early March 2023 by a named nurse, adult safeguarding, Manchester University NHS Foundation Trust (MFT), after Coroner observations at the inquest. The referral suggested that there might have been missed opportunities to support and safeguard Rebecca who had experienced domestic abuse, exploitation, possible financial abuse and cuckooing. In the month before her death she had been attacked with a machete in her accommodation. Throughout her young adult life there were episodes of domestic abuse, threats, reported thefts, and drug-seeking behaviour, self-harm and suicidal ideation. Some overdoses were stated to have been intentional.

1.4. A high impact learning assessment had been completed by MFT, prompted by the coronial inquest. This had identified that some staff lacked knowledge of safeguarding processes, and awareness of arrangements that could be made for transfer of vulnerable patients between hospital sites in order to facilitate access to treatment. There was an apparent lack of curiosity about the circumstances surrounding the machete attack, even though some of Rebecca's history was known. It had also found that Greater Manchester Police (GMP) were not notified of the assault by MFT and there was a lack of curiosity about the attack[5].

1.5. As a result of initial screening to ascertain whether the criteria in section 44 Care Act 2014 were met, Bury Safeguarding Adults Board (BSAB) concluded that a mandatory safeguarding adult review[6] would be commissioned since it appeared that Rebecca, an adult with care and support needs, had died as a result of abuse/neglect, including self-neglect, and that there were concerns about how services had worked together to safeguard her.

1.6. Key lines of enquiry were set for the review, again drawn from the initial screening of the referral, namely:

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[1] Rebecca's family requested that her given name be used for this safeguarding adult review.

[2] Used for epilepsy, neuropathic pain and anxiety.

[3] Used for muscle pain, convulsions, anxiety, panic attacks and alcohol withdrawal.

[4] An anti-psychotic used for agitation and restlessness.

[5] GMP were aware, however, of the assault.

[6] Section 44 (1) (2) (3) Care Act 2014.

1.6.1. Were appropriate safeguarding and criminal justice processes undertaken in response to disclosed risk of domestic abuse, exploitation by others and/or self-neglect?
1.6.2. Is there evidence of effective risk assessment, care planning and risk management in response to historic and ongoing life events?
1.6.3. To what degree were Rebecca's behaviours normalised and accepted within care planning and risk management processes, and is there any evidence of unconscious bias?
1.6.4. Management of dual diagnosis and managing co-occurrence regarding historic and ongoing drug and alcohol abuse.
1.6.5. What systems and processes are in place in agencies to safeguard individuals who are assessed as high-risk victims of domestic abuse?
1.6.6. Immediate action to ensure the safety of adults at risk and share any learning appropriately.

1.7. These key lines of enquiry reflect concerns arising from the initial screening of the referral, namely about how services responded to repetitive episodes of domestic abuse, the effectiveness of multi-agency risk management, and the absence of referrals of adult safeguarding concerns. It was also suggested that assumptions and/or stereotypes about Rebecca might have affected how services responded.

1.8. In line with the statutory guidance[7] that accompanies the Care Act 2014, Rebecca's family were invited to contribute to the review. Rebecca's father and her two sisters have met virtually with the independent reviewer to share their memories and concerns. They have also shared documents that they have obtained as a result of their own inquiries in an effort to understand what happened and to hold agencies to account. Their distress at the loss of Rebecca remains raw and the independent reviewer hopes that this review, which they recognise focuses on learning, will provide some comfort, resolution, and assurance that lessons will be learned.

1.9. Again, in line with the statutory guidance, a virtual learning event was held, attended by practitioners, operational managers and senior leaders from across the services that had been involved with Rebecca. These services also contributed chronologies of their involvement and reflections on good practice and on practice shortcomings. The chronologies focused on the period from 1st January 2020 to the date of Rebecca's death in early March 2022. Significant events prior that period were also provided for added context.

[7] DHSC (2023) *Care and support statutory guidance, updated 19th January 2023.* Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Rebecca's human story

2.1. Rebecca had been looked after by the local authority as a young person (aged 13) at the request of her family (section 20, Children Act 1989). This appears to have been triggered by her use of drugs, initially marijuana, and the family's difficulties in managing her behaviour and keeping her safe. Children's Social Care records date from September 2008. There are reference to school exclusions and to placement breakdowns as a result of going missing, misuse of drugs and the influence of her boyfriends. She maintained contact with her family. Relationships were not always straightforward or easy, although leaving care records observe improvement.

2.2. Her life experience as a young person and young adult included substance misuse, domestic abuse, mental and behavioural disorder, and suicidal ideation, diabetes, exploitation and cuckooing, and self-neglect. In 2014 there is a record of Rebecca having made a housing application on leaving a women's refuge. Rebecca was known to the children's social care leaving care service between June 2010 and December 2015, during which she had the same leaving care practitioner. She spent some time in refuge accommodation as a result of domestic abuse. At this time her mental health and substance use fluctuated.

2.3. Children's social care records contain references to referral orders being supervised by the youth offending service as a result of convictions for assault and being drunk in public. These records also reference that Rebecca was known to Early Break drug services, experienced drug withdrawal symptoms in 2010 linked to cannabis, cocaine and amphetamines, was misusing alcohol in 2011 and yet in 2015 had been drug-free for a year. The records state that Rebecca did not acknowledge the links between her drug use and mental ill-health episodes. This suggests that there were conversations that focused on the backstory to her substance misuse but, if so, the detail of this expression of concerned curiosity has not been recorded.

2.4. Her primary care records from 2008 reference Rebecca as a looked-after young person and a history of self-harm (from 2009), drug (heroin) misuse (2010), and depression linked to domestic abuse (2014). The same records list diagnoses as mental and behavioural disorder linked to multiple drug use/psychoactive substances, acute and transient psychotic disorder (2018) and emotionally unstable personality disorder (2021). On a new patient form completed during 2019, Rebecca self-reported ADHD, bipolar disorder, schizophrenia, manic depression disorder and hallucinations.

2.5. GMP records from 2007, when Rebecca would have been 13, contain warning markers for mental health and self-harm, violence, and high-risk domestic violence. Not all the markers would have been added at the same time, meaning that the recorded picture developed over time. She had several convictions for assault, criminal damage, public disorder and being drunk and disorderly. She was known to probation services up to 2015, having completed nine-month supervision for common assault. Police record systems also reference to use of Class A drugs and to being both a perpetrator and victim of domestic abuse.

2.6. Rebecca was known to ACHIEVE, a substance misuse service, between September 2019 and August 2021. Her reported history included multiple substance use, including heroin and crack cocaine, and significant trauma. These records note that her family provided support but that relationships could be strained. Rebecca was known to Pennine Care NHS Foundation Trust (PCFT) from 2016, during which time she had five care coordinators. Both the family and PCFT records

observe that Rebecca had a good relationship with the first of these care coordinators. At times PCFT records observe that she was "*abstinent*."

2.7. There is always a backstory being substance misuse and mental distress. A risk assessment completed by a care coordinator in January 2020 recorded that Rebecca lived in a downstairs flat with her dog. She suffered with acute anxiety, depressions and auditory hallucinations. The then diagnosis was mental and behavioural disturbance due to poly substance misuse. She had experienced significant trauma, namely physical, sexual and emotional abuse form a former partner who was imprisoned. The psychological and physical damage that Rebecca sustained was described as "*significant*." Rebecca had experienced further traumatic personal relationships, involving harassment, threats, intimidation, domestic abuse and allegations that she was being targeted for money and injected with amphetamines. Her childhood had been difficult but, despite tensions said to arise from her substance misuse, her family had remained supportive both financially and practically.

2.8. Her family raised concerns, for example with a mental health care coordinator, of people entering her flat and using the property for using and selling drugs. They believe that the agency response was "*disinterested*." They allege that Rebecca felt threatened and that a partner injected her with drugs. They have described experiences when she was abused and tortured by gang members, sustaining significant injuries. Her father and sisters attributed her mental health "*meltdown*" to this experience. The trauma of having been held captive was referenced at the learning event. The family also believe that she experienced financial abuse and that her acquisition of prescription drugs was exploited by others. They believe that she was "*coerced into getting medication*."

2.9. As a result of a cardiovascular event Rebecca's mother never regained consciousness but survived for three years before passing away in May 2022. The impact of this on Rebecca is one aspect of an unheard story.

2.10. Her family believe that assumptions about Rebecca's character were made, which mirrors concerns expressed by BSAB partners when this review was commissioned. Her father and sisters have described that Rebecca could be "*hard work*" and "*a pain*" but she was "*still a daughter and sister*." Her family have described her as "neither angel nor devil."

2.11. At the inquest Rebecca was described as "*emotionally damaged and very vulnerable.*" Her family were recognised as a source of support on which she could count, at times advocating for her, at times supporting her to attend appointments. The Coroner recognised that Rebecca was a "*very vulnerable individual*" who was taken advantage of and who experienced trauma and tragedy. Nonetheless, the inquest concluded that she knew where to seek support, knew how to escalate concerns about her health, and had the mental capacity to take decisions about treatment shortly before her death. The inquest concluded that Rebecca had not intended to take her own life on the basis in part that she had sought help when low and had not taken all the medications that she had available at the time.

Section Three: Rebecca's lived experience (January 2020 to March 2022)

Violence, threats and domestic abuse

3.1. The GMP extended chronology reveals the level of violence that surrounded Rebecca. In 2020 the GMP chronology records at least four incidents when Rebecca was assaulted by a boyfriend. On none of these occasions did she provide evidence, support prosecution or consent to onward referrals. Sometimes she denied that assaults had taken place; on one occasion she is recorded as having refused examination by paramedics after she had been thrown down stairs. On two other occasions Rebecca was also recorded as the assailant.

3.2. Also in 2020 there are three GMP records of Rebecca reporting being threatened, with her boyfriend appearing to have broken the terms of a domestic violence protection order on one occasion. She would not always disclose details; at other times she stated that she owed money and there was evidence of damage to her accommodation. GMP sent information on one occasion to a housing officer because of concern about her living conditions.

3.3. It appears that she was not always able to control who entered and stayed in her accommodation. The degree to which Rebecca experienced coercive and controlling behaviour, or undue influence, is not clear from the chronologies. GMP's chronology records two referrals to the multi-agency safeguarding hub (MASH), and on one occasion referrals to mental health and substance misuse services. These referrals were good practice but the GMP chronology does not record their outcome, perhaps because the police were not given this information. There were two occasions when domestic abuse, stalking, harassment and honour-based violence (DASH) assessments were completed. More positively, there is evidence of Rebecca's situation having been discussed at GMP multi-agency risk management meetings.

3.4. This pattern continued throughout 2021. Five incidents when Rebecca was assaulted are recorded by GMP, including one of alleged rape. In April 2021 she attended a sexual assault referral centre. According to MFT documentation she consented to information being shared with other agencies but declined referral to an independent sexual violence advocate. In October 2021 the PCFT records an incident when Rebecca's boyfriend locked her inside her own home. She sometimes refused treatment for her injuries, for which she was deemed to have decisional capacity, and sometimes retracted allegations, including that she had not consented to sexual intercourse. On two occasions she declined to cooperate with a DASH assessment or to provide a statement following harassment by her boyfriend. When risk levels were assessed, GMP recorded them as high. If there was consideration that her retractions might be the result of undue influence, fear of consequences, and coercive and controlling behaviour, this is not reflected in the documentation provided for this review.

3.5. Harassment and threats continued episodically, which appear to have been partly related to Rebecca owing money, sometimes resulting in damage to her accommodation. She reported thefts of money or her medication. There were also occasions when Rebecca was recorded as

having instigated assaults, resulting in a domestic violence protection notice having been issued in November 2021. Application for a domestic violence protection order was refused by a court[8].

3.6. Once again referrals were sent to adult social care, mental health services and MARAC. GMP also shared information about her experiences of domestic abuse with mental health clinicians in 2021 when Rebecca was an inpatient. This was good practice. The GMP chronology for May 2021 records MARAC decisions as including liaison by an independent domestic violence advocate with the social housing association to explore the possibility of Rebecca moving, and a request that a community psychiatric nurse engage with her. It is recorded that Rebecca wished for a restraining order to be put in place but this does not appear to have been pursued. Moreover, despite clear evidence of domestic abuse and self-neglect, no referrals to the local authority of adult safeguarding concerns were made. In addition ACHIEVE and PCFT documentation for this SAR reflects on missed opportunities to complete a DASH assessment and/or to refer adult safeguarding concerns, and a lack of curiosity if GMP had done either[9]. There also appear to have been occasions when a MARAC referral was not sent according to chronologies from GMP, ACHIEVE, her GP and Northern Care Alliance NHS Foundation Trust. This latter chronology also records two occasions when DASH assessments were not completed and when referrals of adult safeguarding concerns were not sent (April 2021 and February 2022). GP reflections include an observation regarding the absence of a recorded safety plan, although more positively support was offered.

3.7. The frequency of reported assaults decreased after her relationship with one boyfriend ended. However, violence against Rebecca continued, most especially when she sustained serious injuries in a machete attack in February 2022. This appears to have been related to "*a drug deal gone wrong*." As before GMP sent referrals to other agencies. Several chronologies contain reflections about the absence of apparent curiosity about how the injuries she sustained in this attack had occurred[10], and if the risks were ongoing. Safeguarding concerns should have been referred to ensure Rebecca's safety, as acknowledged by MFT. Once again, there are also incidents when Rebecca was recorded as the assailant. Several chronologies record concerns regarding a lack of curiosity about the presence of men in her accommodation and whether she felt safe. There were occasions when she was not spoken to in a confidential safe space.

3.8. Domestic abuse is an adult safeguarding issue. It is one of the types of abuse and neglect listed in the statutory guidance that accompanies the Care Act 2014. It must be considered, therefore, by practitioners to determine whether an adult safeguarding concern should be referred to the local authority mindful of the three criteria in section 42(1) – an adult with care and support needs (whether or not these needs are being met by the local authority), is experiencing or at risk of abuse/neglect, and because of their care and support needs, is unable to protect themselves from that abuse/neglect. It is hard to imagine that Rebecca's situation did not meet these three criteria.

[8] Rebecca had been arrested and interviewed with an appropriate adult present and bailed with conditions. The first test for a DVPO was met, violence having been used. The necessity test was not met as bail conditions were in place with exactly the same protection.

[9] GMP sent referrals to Rebecca's care coordinator as per the section 75 agreement between the mental health trust and the local authority. GMP was not advised of the outcome of these referrals.

[10] PCFT have commented that Rebecca gave different accounts to staff.

3.9. At the learning event some uncertainty was expressed regarding the interface between MARAC and adult safeguarding, when to refer to either or both. Some uncertainty was also expressed about when an episode or incident might require referral of an adult safeguarding concern. One answer, of course, is the three criteria in section 42(1). When those three criteria are met, a referral to both MARAC and adult safeguarding would be appropriate, with collaboration across the two processes. It is also important to emphasise that referrals should still be made when the first two criteria appear to be met – an adult with care and support, experiencing abuse/neglect – but where it is unclear the degree to which the third criterion is met – as a result of care and support needs, the adult is unable to protect themselves from abuse/neglect.

3.10. Rebecca contacted GMP at times of crisis and when there was an immediate threat to herself. Following initial safeguarding measures being put in place, namely her arrest, the offender's arrest or section 136 Mental Health Act 1983, she never pursued any of the incidents that she reported. As a repeating pattern, that would have merited more attention than it appears to have received.

Drug-seeking behaviour

3.11. In the primary care chronology are twenty-four occasions when Rebecca requested additional or stronger medication from her GP surgery or from hospitals and "out of hours" services. She would sometimes report that she had lost her medication or her prescriptions. Reflections from Rebecca's GP include the frequency in 2021 and 2022 of potential drug-seeking behaviour. Between June 2021 and March 2022 GP records contain 78 contacts with Rebecca. There were occasions, when GPs attempted to explore and question these requests, that Rebecca became verbally aggressive and refused to continue the conversations. On occasions GPs refused to prescribe or limited the amount and/or frequency of the medication that was given because of the risks involved. There were instances when Rebecca was advised about the dangers of polypharmacy. This was good practice.

3.12. Suspicions were enhanced when someone could be hear in the background during telephone calls prompting Rebecca on what to say. GP reflections include that medication review and management corresponded with expected standards, responding within the bounds of clinical assessment. However, medication management was complex because some of the prescriptions were overseen by GPs and some by PCFT, and Rebecca could become abusive when her requests were declined or when she was referred by primary care practitioners to PCFT for medication requests regarding her mental health.

3.13. Part of that complexity was managing the cocktail of medication that Rebecca had become accustomed to, some of which had addictive properties[11]. One letter from a locum consultant psychiatrist to her GP in late May 2021 lists 13 prescribed medications. It records that Rebecca was demanding an increase in benzodiazepine and was asking for more lorazepam[12], which was declined due to the risks of addictive polypharmacy. The consultant proposed to cease depot injections since there was no evidence of effectiveness in lessening the voices that Rebecca had reported hearing. The letter also mentioned the possibility of sleep apnoea on account of

[11] GP reflection.

[12] Treatment for anxiety, acute panic attacks and convulsions.

Rebecca taking so many sedating medications. The complexity was further enhanced because Rebecca did have physical health (lower back pain and spinal disc protrusion) and mental health problems, for which medication was an appropriate treatment response. Nonetheless, GP documentation for this review reflects that Rebecca would commonly request increases in medication.

3.14. Good practice is evident in the allocation of a named GP in October 2021, which provided consistency of response, and in liaison with hospital and GP surgery pharmacists, and between "out of hours" and other healthcare services. GP records include contact from one of Rebecca's sisters advising caution and care when prescribing medication, and liaison and information-sharing between community psychiatric nurses and primary care clinicians on medication review and prescribing to manage Rebecca's mental health. Her records were flagged to highlight the risks.

3.15. However, although as noted there were occasions when concerned curiosity was expressed about her requests for more and/or stronger medication, there were also missed opportunities to attempt exploration of her apparent drug-seeking behaviour, for example when in telephone calls she appeared to have been prompted by male voices in the background, or when she was requesting medication from different sources, or when she was asking for opioid medication. There appear to have been missed opportunities to consider with Rebecca referral to substance misuse services. GP reflection includes that there is no evidence of signposting to ACHIEVE or communication from that service. There was also an occasion in February 2022 when she appeared "*drugged up*" but records do not indicate that she was asked about what substances she had taken. There were times when her sole focus was on acquiring medication, rejecting advice about seeking mental health support or attending hospital.

3.16. The extent of her drug-seeking behaviour also emerges from the chronology provided by the North West Ambulance Service (NWAS). Between April and June 2021, Rebecca made three prescription requests to the 111 service; between June and September she made 15 requests, some of which were referred to primary care. She made a further requests to the 111 service between December 2021 and January 2022. On one occasions when paramedics were called, Rebecca is recorded as "*just wanting replacement medication*." PCFT documentation also references her demands for medication and concerns about her seeking opiates (February 2022). One of her sisters at this time had once again expressed concerns about her drug-seeking behaviour and changes to her medication, which had included the additions of lorazepam and tramadol[13]. Although Rebecca was told of these concerns and the care coordinator requested an appointment with the named GP, it is clear that managing the risks was difficult. Several days later an "out of hours" doctor prescribed further opiate-based medication. The PCFT documentation records a request that record systems contain an alert about medication concerns, and an email was sent to the surgeon due to operate to treat the outcomes of the machete attack requesting minimal prescribing of benzodiazepines due to concerns about Rebecca's use of opiates, and liaison with her GP and care coordinator. Summarising, GP reflections conclude that, whilst drug-seeking behaviour was recognised, the overall response was "*to deal with it*" rather than "*to address the problem holistically*." GP reflections suggest that the care delivered was "*superficial*" and "*not effective management*" as there was "*no*

[13] A strong opioid painkiller.

specialist input from ACHIEVE or any unpicking of her life experiences." Crises were managed; "*her priorities other than medication were not explored*." PCFT documentation similarly observes a lack of curiosity about why Rebecca regularly sought opiates.

Substance misuse

3.17. Rebecca was known to a substance misuse service, ACHIEVE, during 2020 and 2021 until her case was closed in August 2021 because she had not been in contact. The possibility of drug-seeking behaviour emerges from ACHIEVE's chronology. In April 2020 one of Rebecca's sisters is recorded as having expressed concern at the volume of methadone being prescribed. The chronology record attributes this to the arrangements put in place as a result of the COVID pandemic restrictions but, in the light of what is now known, there are other hypotheses that might have been explored. In September 2020 Rebecca is recorded as having become threatening (self-harm and suicide) and aggressive during an outpatient appointment when she requested an increase in her prescription for diazepam. The following month she reported that she had lost her medication but the chronology does not indicate whether this was explored further. In December 2020 arrangements were in place for her to collect her methadone dose daily. In April 2021 the chronology records that her use of methadone was to be supervised and that it would not be prescribed until she had attended an in-person review. This was in response to a methadone overdose.

3.18. The ACHIEVE chronology also contains entries regarding her use of drugs. Her substance use is recorded as being dependent on her health. At times she reported that she was abstinent; at other times she stated that she had lapsed and had used crack cocaine or that she had experienced a seizure, possibly related to withdrawal from diazepam. It also appears that Rebecca might have used substances to manage pain and also mental distress, for example the memories of the trauma of sexual assault/rape. The risks of her misuse of alcohol and other drugs, including cannabis, were discussed. Practitioners persisted and were eventually able to persuade Rebecca to accept a safe storage box and nasal naloxone. It was believed that she was using crack cocaine in June 2021 and Rebecca reported that she had "*drug debts*." In November 2020 detox was discussed with Rebecca but deferred until she had settled accommodation.

3.19. There is some evidence of inter-agency communication, for example information-sharing and joint working between ACHIEVE practitioners and community psychiatric nurses at various points regarding missed appointments, changes of medication, tensions between Rebecca and her family, and her use of drugs, especially crack cocaine. GMP officers shared concerns with ACHIEVE in April 2021 when Rebecca had been assaulted and her money stolen.

3.20. By April 2021 Rebecca was not in contact with ACHIEVE and consideration was given to closing her case. This was discussed with a community psychiatric nurse. However, a substance misuse practitioner resisted closure and referred Rebecca to assertive outreach first. This was good practice, recognising historical risks and the need for a thorough risk assessment and offer of support. Unfortunately, the following month Rebecca declined input from the assertive outreach team and closure was agreed for three weeks thence. There is no reference at this point to whether Rebecca's mental capacity for this decision was assessed.

3.21. In fact ACHIEVE did not withdraw as planned. This was also good practice. In June Rebecca was an informal patient (Mental Health Act 1983). There was weekly contact by both mental health

and substance misuse practitioners, who met and suggested supportive accommodation as a future living option. There is no evidence that this suggestion was pursued although there is reference to risks of substance misuse being discussed with Rebecca. Thereafter joint working lapsed as a substance misuse practitioner was "*unclear if Rebecca wanted to stop using*" and her community psychiatric nurse at that time left. There was at least one failed visit and appointments that Rebecca did not attend. Rebecca's case was closed by ACHIEVE in August 2021 as she was not in contact, meaning that there was no specialist oversight of her substance misuse thereafter. As often when cases are closed because of non-engagement, a question should be asked. Was there sufficient outreach?

3.22. PCFT, in its case note review (April 2022), concluded that there is a need for a more robust dual diagnosis pathway. It refers to Rebecca having been at high risk of accidental overdose due to substance misuse (mainly benzodiazepines), and links her "*mental and behavioural disturbance*" to "*poly substance misuse*." A narrative that is recorded in the PCFT case note review is that Rebecca was "*not motivated to address her substance misuse*." However, there was no engagement by substance misuse services with Rebecca after August 2021. Nor does there appear to have been any sustained curiosity about the relationship between her substance misuse and the turmoil, violence and distress in her life.

Mental health

3.23. Throughout the period under review Rebecca was known to mental health services provided by PCFT. Between 2016 and 2021 by all accounts Rebecca had a good working relationship with her care coordinator who had an understanding of her care and support needs. During this time there is clear evidence of community mental health services working collaboratively with police, housing, ACHIEVE and independent domestic violence advocacy. Thereafter, Rebecca was allocated to at least three other care coordinators and was monitored by duty workers when she was awaiting allocation. PCFT's documentation records that Rebecca informed a team manager shortly before she died that she no longer wanted to work with her current care coordinator, describing her as "*rude and arrogant*." She was adamant that she did not want the care coordinator to visit her again because she had reduced her medication and was talking to her family, which was causing a rift. She did not give consent for the care coordinator to speak to her family. Rebecca's family have strongly suggested that at least one care coordinator disliked her. They have said that Rebecca only had a good rapport with her first care coordinator, and that subsequent community psychiatric nurses did not liaise with them. PCFT's chronological records contain entries for contact between the last care coordinator and Rebecca's sister. Rebecca's family believe that some of what has been recorded by subsequent care coordinators is incorrect.

3.24. Even before her longstanding care coordinator left, risk assessments[14] recorded sporadic and different levels of engagement. At times she engaged on a needs only basis. A person-centred approach is evident in the care coordinator responding positively to Rebecca's request that depot injections be administered at her partner's home address. Much of the focus from April 2021 after her longstanding care coordinator had left appears to have been on ensuring that she attended depot clinic, with telephone calls in an attempt to ensure medication concordance. There were some concerns about her non-concordance and her medication was administered at

[14] For example, PCFT risk assessment dated May 2020.

her home when she declined to attend clinic. The chronology records home visits, some as 72 hour follow-up after hospital admissions, with discussions regarding her mental health, medication, risks, substance misuse and safety planning. Some home visits were double handed because of perceived risks of solo working. Nonetheless, there is also evidence of a person-centred approach when, following telephone conversations during which Rebecca appeared distressed and agitated, home visits were offered and/or undertaken. She was also regularly provided with food parcels.

3.25. One change of allocated care coordinator appears to have been "*for their own safety*" when Rebecca had been reportedly hostile during a telephone call, threatening to harm other people if her needs were not met, when she was being prompted to attend the depot clinic. The available record does not expand on the nature of the concerns or threats. Reallocation on this occasion was prompt. Throughout the period under detailed review, Rebecca frequently made threats of self-harm and expressed suicidal intentions. If there were attempts to discuss with Rebecca the meaning of, or drivers behind this behaviour, that has not been recorded in the documentation provided for this review.

3.26. During reviews at outpatient appointments Rebecca would sometime deny using drugs although this was strongly suspected. From July 2021 Rebecca's sisters provided two care coordinators with support to enable her to be seen at home visits or supported Rebecca to attend appointments. This "think family" approach was good practice. Judging by the chronology, when Rebecca was seen at home, much of the focus seems to have been on administering the depot injection[15]. There are occasional references to safety netting and to mental capacity but no mention of safeguarding or her mental state or risk assessment. This gives the work an appearance of having been very procedural rather than person-centred. However, occasionally there is a more detailed record of the person-centred support that was offered and discussion of concerns regarding domestic abuse, with on one occasion agreement reached regarding a communication plan when Rebecca did not have a mobile phone. On another occasion a support plan was agreed. There were occasions when Rebecca was recorded as having been "*settled and engaged*" but there were other times when it was difficult to contact her or engage her.

3.27. A full case note from November 2021 provides one example of a home visit from the care coordinator in this time period: "*Home visit to Rebecca attended with [Housing Association] who wished to see the property due to complaints about the build-up of rubbish outside of the property. The outside of the property was cleared of rubbish by the council in June, five months ago. Rebecca appeared to have just got up and complained about having been woken so early. Attempts made at conversation with Rebecca. She said that CMHT don't do anything for her and that she doesn't know what she wants from CMHT. Rebecca stated at time of previous visit that her flat is messy as she cannot bend down. She says that she has difficulty doing everything, including cooking and cleaning, due to a cracked pelvis sustained many years ago. Rebecca denies taking any illegal drugs and feels that she does not require any support to remain abstinent. She denies that she was discharged from drug and alcohol due to non-engagement. Attempted to discuss benefits but Rebecca became angry and asked us to leave, which we did.*

[15] PCFT have commented that the provision of depot injection was part of her treatment plan and also probably supported contact with her care coordinator or other clinical workers from the Treatment Team/CMHT who were administering it.

Discussed with representatives of [the Housing Association] who are planning to give Rebecca a warning regarding the condition of both the interior and exterior of her property."

3.28. Rebecca was an inpatient in April 2021 following concerns about her mental health and self-neglect. This had followed an incident at hospital several days previously when she had been arrested for spitting at staff, resulting in police using section 136 (Mental Health Act 1983). A full mental health and risk assessment had been completed. Rebecca appears to have left the ward, effectively discharging herself. PCFT note that this meant that she was unable to engage in a discharge ward round. Information provided by Northern Care Alliance NHS Foundation Trusts records that Rebecca was afraid of returning home because of drug debts.

3.29. Rebecca was next an inpatient in June 2021, GMP having detained her initially under section 136 Mental Health Act 1983. She was discharged on the basis that she had been utilising ward leave, had good social support and would be followed up in the community by a care coordinator. Risk to others was recorded as greater than risk to herself. Rebecca expressed a wish to remain in hospital, it seems because she was in trouble with drug dealers. She threatened suicide if she was discharged. In the event, this discharge failed. She was readmitted following a further section 136 order, when there as disagreement about appropriateness of this admission. In both episodes the PCFT chronology records her behaviour as hostile and aggressive. It also reports that her father and sisters had expressed their concern about her hostility and volatility. Once again she used threats of suicide in an attempt to remain in hospital and she declined intensive outpatient support from a home treatment team. The chronology records that a full risk assessment was completed. However, the emphasis appears to have been on discharge because her mental health was assessed as not requiring further hospitalisation rather than or in addition to a focus on whether she could keep herself safe from domestic abuse, whether she was being coerced regarding supply of medication, whether she could control her own substance misuse, and whether there was a plan to support her to manage her mental distress. In short, was her expressed wish to remain in hospital an expressed need for asylum in the original meaning of the word – a place of safety, refuge or sanctuary?

3.30. Rebecca was briefly an informal patient in February 2022. This followed an overdose on 9th February, reported triggers for which were her mother's ill-health and a reduced dosage of diazepam. Rebecca had called her father who in turn requested an ambulance. The records describe that no psychotic symptoms or mood disorder were detected. A diagnosis of emotionally unstable personality disorder has been recorded. Rebecca utilised unescorted leave without safety concerns. Discharge planning appeared to trigger expressions of self-harm and suicidal ideation[16]. Again, she is recorded as having been abusive, for example when a request for additional medication was refused. There is no reference to substance misuse in the hospital notes. Again, the question arises as to whether there was sufficient focus on her safety. PCFT had been informed by one of Rebecca's sisters that she had been attacked several days previously with a machete in what her family described as a "*drug deal gone wrong*."

[16] PCFT have noted that a risk assessment in February 2022 recorded threats of suicide in the context of seeking further medication.

3.31. Towards the end of 2021 a diagnosis of schizophrenia was withdrawn[17] and administration of depot injections ceased. GP reflections again suggests that "*the efforts by the GP practice and PCFT to clinically manage Rebecca's presumed addiction to prescribed medication were unsuccessful, despite the GP practice's extensive attempts to work with Rebecca*." Diagnoses do change as clinicians develop their understanding of a patient's presentation. However, the frequent references to the absence of curiosity in agencies' contributions to this review suggest that the meaning of Rebecca's mental distress and the impact on her mental wellbeing of her life experiences were insufficiently explored and understood. Was she for some reason fabricating some illness? If her addiction was presumed, were sufficient efforts sustained to emphasise concerns about her safety from exploitation? If she was substance-dependent, there does not appear to have been any sustained attempt to engage Rebecca after August 2021.

3.32. The PCFT records occasions when information was shared between agencies and services, including with GMP about domestic abuse, her GP and pharmacists regarding prescribing and medication reviews, and a housing association regarding neighbour disputes and required repairs. The PCFT chronology records that a care coordinator visited Rebecca in November 2021 with a worker from the housing association. In mid-February 2022 her care coordinator liaised with staff in an accident and emergency department regarding concerns domestic abuse and her seeking opiate medications. Information-sharing and liaison were attempts to meet Rebecca's needs and to manage obvious risks. However, what is missing in response to Rebecca's lived experience of mental distress and, indeed also, substance misuse and domestic abuse, is a routine coming together of <u>all</u> the practitioners and services involved in multi-agency risk management meetings.

3.33. PCFT completed its own case note review in April 2022. It identified good practice in the form of frequent contact with Rebecca, including cold calling to support her engagement, and management of her drug seeking behaviours. It also commended the frequent contact with Rebecca's sisters. Amongst identified areas of concern was her care plan that was judged to be relevant but out of date and requiring review, and lack of support from substance misuse services in the three months before Rebecca died.

Accommodation

3.34. Across the chronologies are references to Rebecca's living situation. There are references to a community psychiatric nurse arranging a "*deep clean*" and to her accommodation being a "*poor environment*." For example, ACHIEVE documentation records in February 2021 that a housing association had declined to move Rebecca because of the state of her accommodation. Paramedics in April 2021 recorded the presence of clutter (level 5/6 on the clutter rating scale) and drug products. PCFT records report in January 2020 that Rebecca's home environment was chaotic and required a deep clean. She had requested a move but was said to be unwilling to

[17] When Rebecca registered as a new patient, the GP chronology records that she self-reported several conditions, including schizophrenia. The GP chronology records an MDT meeting in December 2021 at which it was recorded that she did not have schizophrenia and that her depot injections would cease, and other medications would be reviewed. PCFT have stated that they have no record of a diagnosis of schizophrenia. Their records for 2020 and 2021 carry descriptions of mental and behavioural disorder due to multiple substance misuse, and emotionally unstable personality disorder, borderline type. GMP in a reflective entry for February 2022 observe that Rebecca had stated that she was schizophrenic, "*which she was not*."

engage with a housing officer to obtain a property move. PCFT records also report that her property was cleared/cleaned in May 2021 and that similar concerns were present again by November 2021. Similarly, in February 2022 paramedics recorded that her home was "*unkempt*" with evidence of drug use by people who were not resident there. There are references to disputes and assaults involving neighbours, with other residents expressing concern about the use of drugs in her home and the rubbish outside. There are references to self-neglect and to complaints about domestic disturbances inside and outside her home, on some occasions resulting in criminal damage to her property.

3.35. In May 2021 one decision from a MARAC meeting was that an independent domestic violence advocate should contact the housing association to explore a transfer for Rebecca. GP records note that Rebecca had received a warning from the housing association regarding anti-social behaviour and the condition of her property. GMP records note that concerns about Rebecca's living condition and mental health were discussed at daily risk management meetings, with liaison with the housing association in December 2021 about anti-social behaviour, drug use and rubbish outside her home. GMP records also note that Rebecca reported harassment by a neighbour in September 2021 which was discussed in a multidisciplinary team meeting.

3.36. The extended chronology from ACHIEVE observes that there was a lack of curiosity regarding Rebecca's living conditions, and that it is unclear if cuckooing of her home was ever formally considered. In the period under review there were no referrals to the local authority for a care and support assessment (section 9 Care Act 2014). Rebecca was someone with care and support needs on account of her mental ill-health and substance misuse. Following an assessment of her care and support needs, she might have been eligible for support, not least to help her maintain a habitable home environment that she could also use safely. However, no referral was made to adult social care by any of the other services/agencies involved.

3.37. Rebecca rented her accommodation from Irwell Valley Homes (IVH). Their chronology from January 2020 onwards reinforces the concerns about Rebecca's living environment. Thus, in January 2020 IVH staff liaised with Rebecca's care coordinator for assistance with property cleaning. Rebecca wished to move as a result of threats. The care coordinator advised of their intention to commission a care package but there is no record of any Care Act 2014 assessment that would have preceded this. It was only in March that IVH staff were able to speak with Rebecca who agreed to continue to bag unwanted items for removal.

3.38. IVH have recorded neighbour concerns about accumulating rubbish in May 2020 and a belief that Rebecca might have vacated the property; her family confirmed that this was not the case. In July, welfare calls were made to offer Rebecca support and to check on her safety; this was good person-centred practice. Rebecca is recorded as stating that she had support in place. IVH practitioners liaised with Rebecca's care coordinator to propose a risk management meeting and a referral for tenancy support to bag and clear rubbish.

3.39. In December 2020 IVH received a request from GMP to make the property secure following Rebecca reporting threats of violence. An IVH practitioner contacted Rebeca's father. In April 2021 there was further contact with Rebecca's father and a care coordinator. Rebecca was an inpatient at that time and there were concerns about the condition of the property (rubbish and drug paraphernalia). Rebecca's father is recorded as having requested help with clearing the rubbish and securing a move. It is here that concerns were expressed that Rebeca was a victim

of cuckooing. The care coordinator is recorded as stating that Rebecca was drug free and that a referral would be sent to MARAC.

3.40. IVH have recorded a MARAC referral in June 2021 and information that Rebecca had been charged with assault when an inpatient. During a home visit Rebecca requested a move due to domestic abuse. IVH requested a risk assessment from Rebecca's new care coordinator who outlined current issues and risks, as a result of which advice was for staff to visit in pairs. The care coordinator is recorded as stating that they would arrange a crisis clean and then convene a multi-agency meeting. IVH staff also liaised with Rebecca's IDVA who advised that Rebecca had not engaged and her case would be closed. Later in June IVH twice sought an update about arrangements for a crisis clean but no update was available. The second update request followed a repairs operative having raised concerns which prompted a safeguarding referral to the care coordinator. This was good practice.

3.41. An IVH home visit in July 2021 found the property to be a health and safety hazard, requiring a deep clean. The rear of the property had been cleared, however. Details of companies for a crisis clean were sent to the care coordinator. Later that month, IVH followed up the need for a crisis clean with the care coordinator and requested a safeguarding meeting because of the concerns.

3.42. In September 2021 IVH referred an adult safeguarding concern via ASC, citing Rebecca's physical and mental wellbeing, risk of domestic abuse and the condition of her property. This referral was followed up in October when IVH were informed it had been passed to the community mental health team.

3.43. An IVH practitioner made a joint visit with Rebecca's care coordinator in November. The alleged perpetrator of domestic abuse was present. Rebecca is recorded as having been abusive and aggressive. The workers left when requested to do so. An attempted joint visit with GMP officers was unsuccessful. Contact with Rebecca's father resulted in plans for a joint visit. This was attempted in early December, with a GMP officer also present, but Rebecca was not at home. IVH requested that the care coordinator arrange a professionals' meeting to implement a joint action plan following discussion at MARAC. A care plan created by GMP was received. The professionals' meeting decided that Rebecca should be supported to attend an appointment with her consultant psychiatrist, the safeguarding referral would be closed and property clearance would continue. A joint visit with the care coordinator was also planned.

3.44. Also in December a police officer called IVH to confirm that there were no cuckooing concerns but Rebecca had been given a warning about anti-social behaviour. She had requested repair to a window and had denied taking illegal drugs. She had a new boyfriend.

3.45. In February 2022 IVH were informed of the machete attack by GMP. There were unsuccessful home visits, in between which Rebecca stated that she did not feel safe. Her backyard had been cleared. Details of a care plan and safeguarding referral made by GMP were received. The care coordinator advised that Rebecca was back with her former partner.

3.46. Whether or not her accommodation was taken over (cuckooing), the evidence suggests that Rebecca was not in control of who had access. It appears that she did not want to be alone, or feel safe on her own, and yet she was at risk from and abused by those in her company. Although there was liaison between the services involved, it took some considerable time for the

condition of the property to be rectified. Although adult safeguarding concerns were referred, it is hard to see how interventions attempted to ensure her safety. IVH staff felt it necessary to chase for updates both about the safeguarding referrals and arrangements for a crisis clean.

Section Four: Revisiting the key lines of enquiry

4.1. Specific key lines of enquiry were set for this review. This section draws on information provided by Rebecca's family and the services involved, and from contributions from practitioners and managers at the learning event, to summarise available learning.

4.2. *Were appropriate safeguarding and criminal justice processes undertaken in response to disclosed risk of domestic abuse, exploitation by others and/or self-neglect*? GMP have observed that Rebecca was a "*high risk domestic abuse victim*." Referrals were sent for MARAC, with a summary of information shared, risk assessment and agreed actions available for May, November and December 2021 meetings. GMP have stated that evidence-based, victim-less prosecutions were considered but "*not deemed applicable*", perhaps because GMP were never given sufficient information to identify offenders and/or for lack of statements or medical evidence. "*The lack of progression in relation to the criminal offences meant that there was never any redress for the offences committed against Rebecca*." GMP referrals of adult safeguarding concerns were sent to Rebecca's care coordinator, as per the aforementioned section 75 agreement. Under the provisions of section 42 Care Act 2014, the local authority remains responsible for the outcomes of adult safeguarding enquiries conducted on its behalf by other organisations. How the local authority is assured of such outcomes is currently being reviewed.

4.2.1. ACHIEVE have commented that there is little evidence of referrals to MARAC or support from that service in response to Rebecca's experience of domestic abuse. It has suggested that emphasis was placed "*on Rebecca making lifestyle choices as opposed a trauma-informed approach considering the impacts of significant trauma on people's relationship forming, attachments and normalising of abusive behaviours*." ACHIEVE have acknowledged that "*there were undoubtedly missed opportunities to refer into social care for Care Act assessments*", and there was "*the potential of desensitisation to Rebecca's ongoing chaotic lifestyle that might have impacted on this*."

4.2.2. MFT have recorded that the sexual assault referral centre completed a DASH risk assessment for referral to MARAC, with information being shared with Rebecca's GP and the local authority. "*However, further opportunities to explore issues in relation to domestic abuse and potential exploitation were missed at all other MFT attendances resulting in no safeguarding actions being taken*." MFT safeguarding processes determine that physical assaults should prompt professional curiosity, further questioning, documentation and referrals, including any police involvement, but documentation suggests that this procedure might not have been followed as Rebecca stated that she had reported herself. There is also no documentation to suggest that self-neglect was considered.

4.2.3. "*GP records demonstrate a positive response to the disclosure of domestic abuse by her partner. The administration team supported Rebecca to report the incident to the police. However, there isn't any evidence that the DASH risk assessment was completed and there's no record of staff discussing a safety plan with Rebecca*." More positively Rebecca's GP completed a safeguarding referral to Adult Social Care.

4.2.4. The GP contribution to this key line of enquiry observes that there is information within primary care records that alludes to potential risk/exploitation from others, both neighbours and men that she knew. However, "*it is unclear what if any action were taken by agencies to explore the risks to Rebecca from neighbours and associates either with her or as a multi-agency partnership. There is reference to an MDT meeting in December 2021, where it appears that the information discussed was of the perspective that Rebecca and others were acting in an anti-social way. There is no evidence of information-sharing or multi-agency discussions when Rebecca was attacked in February 2022*."

4.2.5. "*Primary care records demonstrate that staff within the GP practice identified Rebecca's self-neglect, although there doesn't appear to have been any actions taken. It doesn't appear that this was viewed as a safeguarding concern*." The GP contribution here concludes with the opinion that, whilst "*Rebecca's behaviour was sometimes volatile and potential drug seeking in nature, she was viewed as a person needing to be managed, rather than a person in need of support/protection*."

4.2.6. Adult Social Care's comment in relation to this key line of enquiry was "*unknown*" since referred safeguarding concerns were passed on to PCFT. It should be noted, however, that where adult social care cause adult safeguarding enquiries to be conducted by another service, the local authority remains responsible for the standards, quality and outcomes of those enquiries.

4.2.7. PCFT have provided detailed information and commentary on adult safeguarding. In January 2020 a safeguarding concern was received from GMP after Rebecca had reported a theft and there were concerns around the state of her property. Rebecca had denied any domestic abuse issues to police. Then she had reported that a man had threatened to petrol bomb her house but she didn't want to take this further. GMP had offered a fire safety assessment and letter box guard but Rebecca had refused both. A Care Programme Approach meeting was held on 11th March at which she was not accepted for CPA+ enhanced support, and supported accommodation and appointeeship were discussed[18]. "*While mental capacity was noted in the risk assessment there is no evidence of a formal capacity assessment being undertaken*." The adult safeguarding referral was closed and no further action was deemed required in relation to the condition of the property as the housing association had offered to support Rebecca but she didn't engage with them**.** Department for Work and Pensions do not have any record of appointeeship having been progressed. Their records show that Rebecca made three claims for universal credit in 2020, all of which were rejected because of security check failures. From April 2020 she received employment and support allowance. This was paid until April 2022, six weeks after her death.

4.2.8. PCFT's next entry refers to events in late April 2021. A safeguarding alert was raised by GMP and NWAS who attended the property following Rebecca being assaulted. She had posted suicidal comments on social media. NWAS found her collapsed after taking all her medication. She denied that this was a suicide attempt to her care coordinator. No further action was deemed to be required and the safeguarding concern was closed. PCFT have concluded from a record of discussion between the care coordinator and advanced

[18] Attendees were consultant psychiatrist, care coordinator, Achieve worker, and CMHT manager/senior. There were apologies from the criminal justice mental health practitioner (PCFT).

practitioner that "*safeguarding was considered in consideration of suicidality but should have considered the other concerns regarding substance use, poor home conditions, self-neglect, and harm from others*."

4.2.9. When Rebecca had been an inpatient in April 2021 she had disclosed historic domestic abuse but had denied any current concerns. When an inpatient in June 2021 PCFT have stated that the risk of domestic abuse and safeguarding concerns were both reviewed. "*Rebecca identified that she had historically been a victim of domestic abuse, but a presenting risk of domestic violence was not identified. Rebecca had reported sexual, emotional, and physical abuse from an ex-partner, she stated that he had served a prison sentence and received a restraining order*." Rebecca had said that she wanted to remain in hospital "*so there aren't drug dealers banging my door down.*" PCFT records also note that she had been racially abusive and threatening towards others during both admissions to the ward. "*These statements were captured in her risk assessments and although they were not specifically identified as factors that caused her to be at risk of retaliation/harm from others, they were documented as they related to risks. Rebecca was assessed as having the capacity to make decision independently and she had demonstrated that she could independently advocate for herself to ensure her needs were appropriately met*." Rebecca was offered home treatment team support upon discharge from hospital but she declined and was believed to have the capacity to make that decision.

4.2.10. The next PCFT entry here relates to November 2021. A safeguarding concern was received from her GP relating to domestic abuse. Rebecca had rung the police from the GP surgery. PCFT records note that the care coordinator had tried to contact Rebecca via telephone after receiving the alert. A multidisciplinary team meeting was held[19] and it was documented that she had stopped contact with the perpetrator and was willing to engage with domestic violence services. She was on bail at this time, having been arrested as a perpetrator of domestic violence. No further action is recorded.

4.2.11. On 1st March 2022, PCFT received a police referral relating to when Rebecca had been attacked in early February with a machete and sustained injuries to her hand. This was forwarded on to a consultant psychiatrist. There is no information in the notes to indicate that this was triaged as adult safeguarding. The final safeguarding entry relates to 9th February 2022. This was raised by NWAS and related to self-neglect following paramedic attendance for an overdose. The PCFT entry found "*no evidence of any follow up regarding this safeguarding and the alert remains open*."

4.2.12. PCFT have offered the following observations. "*Some of the safeguarding alerts were responded to appropriately but it appears there were some missed opportunities when the safeguarding process should have been considered. For example there was an incident with her partner threatening via text that he was going to get someone to put her windows in and attack her with a hammer. Her windows were subsequently put through. Police did conduct a welfare check but Rebecca wasn't there. There was a documented conversation between care coordinator and Rebecca's sister about the incident relating to threat of smashed*

[19] PCFT record of discussions lists those involved: community safety officer, Housing Association (Chair) Safenet, GP, police constable, community co-ordinator, Housing Association, consultant psychiatrist, care co-ordinator and Integrated Neighbourhood Lead MDT.

windows as a means to get rehoused so this could have been a factor in the decision making. There was documented concern about Rebecca losing her accommodation, living conditions, drug use, pressure on family at this time and risk from others. The care coordinator tried to convene a multidisciplinary team meeting with other professionals who were involved but not within safeguarding framework. The care coordinator has documented the difficulty in getting other agencies together." In respect of professionals' meetings in relation to concerns about Rebecca experience of domestic abuse and mental health, and involvement with substance misuse and anti-social behaviour, GMP have advised that there are no minutes on their electronic files.

4.2.13. IVH in their chronology have recorded occasions when they referred and subsequently sought updates about the outcomes of adult safeguarding concerns. There were other occasions when IVH staff liaised with care coordinators about their concerns relating to Rebecca's wellbeing, safety and living conditions. Only one professionals' meeting is recorded in the IVH chronology.

4.2.14. In summary, some services did refer adult safeguarding concerns, for example her GP, NWAS and GMP. There were many occasions in which it might have been reasonable for services to have referred adult safeguarding concerns.

4.2.15. Rebecca's family believe that there were "*massive safeguarding failings*." They point to many instances when Rebecca could not keep herself safe, especially highlighting the aftermath of the machete attack. For them it was no surprise that she expressed suicidal thoughts, felt unsafe and wanted to stay in places of safety, on this and other occasions.

4.3. *Is there evidence of effective risk assessment, care planning and risk management in response to historic and ongoing life events*? ACHIEVE have commented that there is evidence of care planning, risk assessment and review. It has stated that there was good communication with mental health services. PCFT have commented similarly, namely that risk assessment was updated on six occasions across a two-year period. It has stated that the risk assessments were detailed, clearly identifying historical and current presenting risk. The first care coordinator completed a very detailed care plan in October 2019. It "*identifies her diagnosis, prescribed medication, physical health, occupational activity and social inclusion, activities of daily living, financial and housing, substance misuse and alcohol and safeguarding concerns.*" However, this care plan was not updated annually as care programme approach policy requires.

4.3.1. PCFT's contribution to this key line of enquiry includes a contribution from one hospital ward, reflecting a time when Rebecca was an inpatient. It states that "*Rebecca's actions and behaviours were regularly reviewed, she consistently presented with substance misuse as a feature of her presentation*. *Her medical needs were addressed in a timely manner, staff regularly engaged with Rebecca and there is evidence that all necessary policies and processes were followed as expected*." The hospital ward acknowledges "*an incident where Rebecca went to a bridge post discharge on the 11th June 2021 and the police viewed this a as significant incident; however, clinicians who had prior knowledge of Rebecca's presenting risks and her care and treatment under inpatient services did not feel a further period of inpatient care was indicated. The Police disagreed with this view and placed Rebecca under section 136 Mental Health Act 1983 and she was subsequently admitted to hospital. We acknowledge that the communication between PCFT staff and GMP fell below the expected*

standard. This will be addressed through local process; however, we are unable substantiate the possibility of unconscious bias 2 years post incident."

4.3.2. MFT have observed that Rebecca's medical history was recorded together with care planning around her medical needs but not her social history. MFT's analysis reflects that this led "*to a lack of understanding in relation to her lived experience. There is no evidence of information sharing from other agencies to inform risk management."*

4.3.3. GMP have advised that all domestic abuse incidents were appropriately risk assessed and Rebecca was referred to MARAC on three occasions. PCFT's criminal justice mental health team, and PCFT's access team, in their chronologies, have recorded receipt of care plans from GMP, following domestic abuse incidents, all of which were shared with the community mental health team.

4.3.4. The GP contribution is reflective and candid. Thus, "*within the GP records, there is evidence of professional curiosity at times, although this is not consistently evidenced. It is difficult to ascertain whether this is due to limited time for the practice to complete detailed records of each conversation or if the conversations focussed solely on her clinical presentation at times.*" This might be explained, partly, by the GP taking communication from external agencies into account when speaking with Rebecca and not, therefore, asking specific questions. Examples of missed opportunities to express professional curiosity are given. "*There are some injuries disclosed where there are unrecognised concerns and there isn't evidence of professional curiosity. For example, Rebecca disclosed in October 2021 that she was climbing out of a house window when she has hurt her ankle. There isn't any information to demonstrate curiosity here, why was Rebecca climbing through the window, which floor was she on, did she have to jump etc. Rebecca also disclosed cutting herself on multiple occasions, and there is limited information regarding her behaviour or mental state at these times*."

4.3.5. The GP practice has confirmed that it "*attempted to risk manage Rebecca's addiction to prescribed medication, although this was just one element of Rebecca's life and it weaved between other identified risks, such as the potential risk of exploitation, which may have been for the purpose of accessing her medications*." It observes that no specific templates are used within primary care to risk assess, care plan or risk manage. Thus, it comments that "*if Rebecca had been seen by a staff member who wasn't familiar with her and her history, this would be of concern, as there aren't any documents available which clearly identify the risks and what the plan should be. However, the GP practice did have a flag on her record informing staff not to prescribe her with opioid medication and to be allocated to a specific GP if possible, therefore evidencing that the practice recognised that Rebecca's clinical and care management required consistency wherever possible*."

4.3.6. The efforts to manage Rebecca's use of "*serious medications*", some of which had respiratory effects, was acknowledged by the Coroner in her conclusions. Managing and safely reducing prescribed medication, especially when it was proving to have no benefit, was a challenge, especially with the risk that Rebecca would source it from elsewhere. It required close collaboration between primary care and secondary mental health care services. Rebecca's family continue to question the safety of some prescribing, believing that

some drugs should not have been given together, not least because of the risks of respiratory depression.

4.3.7. Finally, the GP contribution here notes the limited reference within primary care records of multi-agency information-sharing or working together. "*Although there is reference to one safeguarding referral being made and two MDT meetings (active case management), there is limited information as to what was discussed and what the multi-agency risk management plan was. There are no minutes of the meetings within Rebecca's GP records. The GP record of the MDT meeting describes discussion that started with Rebecca being vulnerable to the focus of the meeting changing to how can we manage Rebecca and her behaviour going forward*."

4.3.8. The IVH chronology provides clear evidence that risks relating to Rebecca's physical and mental wellbeing, domestic abuse and the condition of the property were recognised and shared with other services, especially her care coordinators, and sometimes with her father. Some joint visits were undertaken, not all of which were successful, and plans were constructed during MARAC meetings and the one professionals' meeting in December 2021 to which IVH refer. However, IVH had to chase for updates about how safeguarding risks were being addressed.

4.3.9. The theme of engagement is a running thread through this review. Issues relating to engagement were also cited in SAR Alice and SAR Michael, completed by Bury Safeguarding Adults Board and discussed further below (section 4.15 and 4.16). Those attending the learning event from across different services described what was referred to as "*considerable work*," including outreach, to encourage Rebecca to engage. ACHIEVE, for example, extended the normal timescales in their non-contact pathway in the hope that Rebecca would engage. Uncertainty was expressed about what more could be done when someone does not engage. There were complex interlocking issues to disentangle, hence the importance not just of referrals but of bringing all those involved together to share information and to construct and subsequently review risk mitigation plans. Taking a leaf from the Making Every Adult Matter (MEAM) approach used with people experiencing homelessness, this is the "*team around me*" with Rebecca assisted to attend and to contribute. This would have been part of an approach in which relationship-based and trauma-informed practice is embedded alongside concerned curiosity.

4.3.10. Hope was expressed that one recent development would support collaboration on safety and care planning in response to risk, namely the development of a new IT system across MFT and GMMH. It was hoped that this would become more comprehensive over time. This relates to MFT's IT system to which only certain specific GMMH teams have access and the facility to add documentation.

4.4. *To what degree were Rebecca's behaviours normalised and accepted within care planning and risk management processes, and is there any evidence of unconscious bias*? GMP records evidence the attempts made to contact Rebecca, and the outcome of conversations with her, for example when she reported theft of her medication, which she subsequently found. GMP officers clearly recognised her poor mental health and were aware of the risks to her of domestic abuse. GMP have commented that "*mandatory training has been completed in relation to 'Think Victim' from 2020, to ensure that every victim of crime receives the service they are*

entitled to and to avoid unconscious biases." GMP also launched the Adult at Risk Policy and Procedure in May 2020, the aim of which is to support staff who have responsibility to investigate and take action when an adult is believed to be at risk of or suffering abuse.

4.4.1. ACHIEVE have suggested that there was an acceptance of her "*chronic chaotic*" situation, and that practice had become "*desensitised to the chaos of her life and living circumstances*." It was seen as her responsibility to make "*positive choices.*" ACHIEVE has also commented on the difficulty in assessing Rebecca's mental capacity when there has been significant trauma over which addiction is overlaid.

4.4.2. The GP contribution suggests that violent incidents became normalised by all the agencies involved. For example, both the GP and MFT reflective contributions observe that there was a lack of curiosity about the machete attack, with an absence of information-sharing and risk management or safety planning. The GP contribution also mentions one occasion when the response of a care coordinator to concerns raised by primary care staff was experienced as "*dismissive*." Panel members supporting this review have also commented on the difficulties of information-sharing across local authority boundaries.

4.4.3. PCFT have observed that risk was continuously assessed and reviewed. It has stated that these "*risk assessments reflect Rebecca's complex presentation and at times there has been mention of illicit substance use without any evidence of this (even when it has been noted the Rebecca has denied drug use). Therefore, it could be seen that some of her behaviours were at times automatically linked to her drug use when this was not necessarily explored fully; however, it has been noted that her reporting was at time incongruent with her presentation and reporting to other agencies*."

4.4.4. A repeating theme across agency documentation is missed opportunities to express professional curiosity. Another is missed opportunities to refer adult safeguarding concerns. At least one agency, ACHIEVE, has questioned whether this was an outcome of staff becoming desensitised.

4.4.5. Rebecca's family clearly believe that her "*good side*" was overlooked and that she was dehumanised. She could be, in their view, both a "*pain*" but also "*amazing*." The family believe that there were occasions when services "*did not get the basics rights*", for example with respect to her serious injuries sustained as a result of the machete attack, or when she was vulnerable as a result of expressed suicidal ideation or domestic abuse.

4.5. *Management of dual diagnosis and managing co-occurrence regarding historic and ongoing drug and alcohol abuse*. ACHIEVE have observed that the service has a co-occurring policy that includes guidance on working with other agencies. PCFT have reflected that "*there is clear evidence of multi-disciplinary working with ACHIEVE (drug and alcohol team) and sharing information between teams*." However, it will be recalled that ACHIEVE ended their involvement with Rebecca in August 2021. PCFT have also commented that "*it is difficult to know what drug treatment was being provided, other than methadone as an opiate substitute, but there was a clear issue in relation to benzodiazepines as Rebecca was asking for increased prescribing from GP and felt that this contributed to her crisis presentations. There is a documented conversation between CMHT and the Achieve worker where it is reported that her drug choices were often stimulants, but what joined up clinical work was completed between the two services is unclear*."

Finally PCFT have noted that, whilst Rebecca was an inpatient in February 2022, there was no documentation of staff making contact with substance use services to seek/share information though substance use was suspected.

4.5.1. MFT have noted that, whilst Rebecca was in an emergency department on 19th February, she was reviewed by the Mental Health Liaison team (MHLT). "*It is unclear why a referral was made but following this review the MHLT did not feel there was any identifiable role for them and referred to the emergency department medical team. There is no documented evidence of communication between the MHLT and clinical team regarding historic mental health concerns or drug/alcohol misuse*."

4.5.2. The GP contribution here reflects that "*Rebecca's potential dependency on prescribed drugs is prevalent throughout the chronology period. She would regularly contact the practice and services out of hours in attempts to access additional medication. Best practice was demonstrated throughout by all agencies by issuing weekly scripts and only by rare exception issuing one dose of medication based on clinical judgement at the time of her presentation. A key focus was around safe prescribing*." The contribution further reflects on the occasions when Rebecca described physical injury or mental health deterioration but did not follow the advice given. It comments that "*it is hard to decipher whether non-engagement with health referrals/advice is because Rebecca was solely seeking medication or whether Rebecca's complex needs* (including poverty) *had an impact on her ability to fully engage*." It concludes, referring to risk assessment and care planning, that "*there isn't evidence of a holistic health and social needs assessment being undertaken and how each risk could be mitigated against*."

4.5.3. The GP contribution is particularly candid. It refers to professional practice guidance issued in 2013 by the Royal College of Anaesthetists. This acknowledges not all patients take medicines as intended and advises that the patient should be considered in the context of their complexity. "*Had this been considered, it would have been a fair expectation for the GP practice to be gaining additional support from specialist agencies (such as substance misuse) to review Rebecca around her emerging dependency to prescribed medication.*" It concludes that the GP practice communicated and worked collaboratively with Rebecca's mental health team to address her potential drug seeking behaviour. However, there isn't any reference to ACHIEVE referrals being made and there isn't any evidence that the GP practice requested any advice/support from ACHIEVE with how to manage Rebecca's complex needs.

4.6. *What systems and processes are in place in agencies to safeguard individuals who are assessed as high-risk victims of domestic abuse*? ACHIEVE, GMP, MFT and PCFT all refer to their policies on adult safeguarding and domestic abuse, and to the training offered to their staff. PCFT and Adult Social Care refer to routine attendance of their staff at MARAC.

4.6.1. PCFT have commented that staff have been advised to complete a DASH risk assessment and to consider referral to MARAC. It has pointed to referrals to independent domestic violence advocates. It has advised staff to consider referral to adult safeguarding "*if felt necessary so any risks can be identified and managed under the safeguarding process*."

4.6.2. The GP contribution to this specific key line of enquiry is the most candid. It reflects that "*it is hard to evidence whether Rebecca was considered someone 'who has needs for care and*

*support, who is experiencing, or at risk of, abuse or neglect **and** as a result of their care needs - is unable to protect themselves'. Strategy meetings could have been an option when Rebecca had presented to the practice and disclosed domestic abuse, to ensure she was in a place of safety and identify any needs that were unmet*." It further identifies that, within primary care, "*it has been recognised that the offer surrounding domestic abuse was limited*." Staff within primary care had access to safeguarding level 3 training, which incorporated domestic abuse and to domestic abuse bespoke training. Staff also have access to safeguarding advice and support from NHS Greater Manchester Bury locality safeguarding team.

4.6.3. The GP contribution also observes that, prior to Rebecca's death, "*it had been recognised that there is a gap in information sharing between MARAC and primary care. As there isn't a primary care representative on MARAC, information sharing doesn't flow from primary care into the meeting or vice versa following the discussions*." It notes that since Rebecca's death, NHS Greater Manchester have commissioned pilot support services specifically for primary care, and with the local authority have invested funding into Safenet, which is the service commissioned to provide the IDVA service. "*Safenet have been requested to provide training to each GP practice, offer support and advice as required when concerns arise and complete DASH risk assessments when disclosures are made within primary care and the person consents to further input. Safenet will also act a conduit for information sharing between MARAC and primary care, to bridge this gap and ensure the GP practices have the necessary information to risk assess and care plan appropriately*."

4.7. *Immediate action to ensure the safety of adults at risk and share any learning appropriately*. Adult Social Care has acknowledged a point made above (section 4.2.6), namely a lack of oversight of section 42 Care Act 2014 processes regarding safeguarding within PCFT. "*The systems for oversight are further complicated by the lack safeguarding screening and enquiries being recorded on the Bury ASC system despite agreement that this should be the case*." It has acknowledged that the local authority has not been able to discharge its responsibility for oversight of section 42 enquiries and has undertaken that "*this will be picked up via internal review with Bury ASC senior leadership team to ensure that this systems and review/audit issue is managed going forward*." At the learning event it was observed that monthly reports are now sent to the local authority that provide updates on adult safeguarding concerns that have been triaged to mental health providers. However, participants at the learning event also questioned whether referring on adult safeguarding concerns from the local authority to secondary mental health services, when a care coordinator was allocated to a case, should always be the automatic response. This might discourage care coordinators from referring adult safeguarding concerns and/or mean a missed opportunity to look afresh at a complex and challenging case.

4.7.1. PCFT have observed that Rebeca had a lot of contact with the CMHT. She had a good relationship with her first care coordinator/community psychiatric nurse for five years. Thereafter she had several different care co-ordinators in a short space of time due to staffing issues in the CMHT. "*This could have impacted on her ability to build up a therapeutic relationship with her allocated worker*." Nonetheless, PCFT have highlighted that staff continued to try and maintain contact and regularly re-visited the property when needed to administer depot injections and deliver food parcels. PCFT have pointed to instances when services collaborated and shared information but this did not occur within a "*team around the adult*" approach. This would have been more effective in picking up and

responding to the incongruence in how Rebecca reported her substance misuse to different services.

4.7.2. PCFT have indicated that there were occasions when safeguarding could have been considered. When safeguarding concerns were investigated, PCFT consider that "*sometimes there was focus on one issue rather than looking at the whole*." As Rebecca was deemed to "*have capacity*", consideration could have been given to escalation using a high risk protocol. PCFT have observed that no contact was made with the Trust's safeguarding team to discuss or escalate concerns. PCFT have committed to continuing to "*deliver substance misuse training to staff working on inpatient wards to ensure knowledge on this subject matter remains current and relevant*." A new protocol is being developed for joint working between ACHIEVE and community mental health teams. This includes training sessions relating to substance misuse for CMHT.

4.7.3. ACHIEVE have pointed to communication with community mental health practitioners during their involvement with Rebecca, including updated risk assessments and reporting concerns about missed appointments. Since Rebecca's death, staff have undergone trauma-informed training but ACHIEVE have acknowledged that their forms and available legal frameworks do not effectively support trauma-aware practice.

4.7.4. ACHIEVE have noted that in 2020 inpatient detox was discussed and appeared to have been denied as staff wanted Rebecca to be in supported accommodation upon discharge. "*This is not an exclusion criteria for referral into detox. People at risk of eviction and people who are homeless are much less likely to be considered for Inpatient detox due to a lack of stability upon discharge, meaning a significantly higher chance of relapse.*" ACHIEVE have suggested that Rebecca was not considered appropriate for inpatient detox due to her chaotic and sporadic engagement in illicit substance misuse and the absence of a period of stability, meaning that "*it was unlikely that inpatient detox would have been of realistic benefit*." ACHIEVE have stated that there has been a change in practice more recently, with inpatient detox more likely to be offered as a first line treatment offer; however, there is still preparation work that is required in relation to this.

4.7.5. ACHIEVE have referred to the impact of the pandemic. "*The impact of COIVD restrictions in 2020 cannot be denied, from supervised daily pick up of methadone, to 3 times a week pick up was a big jump which was assessed and did revert back to daily pick up later on in the year. It is important to clarify the intensity of the concern COVID presented to services in March 2020 in relation to this decision making process*."

4.7.6. GMP have stated that national crime reporting standards were complied with. GMP shared concerns about Rebecca's living conditions, domestic abuse, mental health and alcohol misuse, including at daily risk management meetings in March 2020 and September 2021 but "*it is unclear of any Sec 42 enquiries commenced following the referrals made*." Some but not all incidents involving a boyfriend were recorded by GMP as domestic abuse; when risk assessments were completed, risk was assessed as either medium or high. Referrals to MARAC followed some domestic abuse incidents. GMP have acknowledged that it was sometimes difficult for officers to establish who the victim was and who the perpetrator in some incidents, which might have influenced whether or not referrals were sent to MARAC.

4.7.7. GMP have noted that there was some professional disagreement in June 2021 between health services and police regarding whether Rebecca should be admitted following detention under section 136 Mental Health Act 1983. "*A problem-solving record was created which is good practice*." GMP have concluded by noting the work "*between agencies regularly sharing information and acting together. However, the impact of that work is not clear form the GMP chronology as matters did not appear to improve for Rebecca. It appears that agencies made attempts to engage Rebecca but following initial incidents of crisis the engagement could not be maintained*."

4.7.8. MFT have commented on good practice concerning recognition of domestic abuse, safeguarding and information-sharing from the sexual assault referral centre team. However, it acknowledges the lack of professional curiosity about the circumstances of Rebecca's attendance at MFT and her past medical history. MFT have highlighted poor information-sharing about her past medical history between MFT staff and the mental health liaison team, which impacted on safeguarding. A lack of funds prevented Rebecca from attending for medical treatment in February 2022.

4.7.9. MFT have completed a high impact learning assessment around practice in February 2022. This found that locum staff in the emergency department lacked knowledge of safeguarding processes; referral/clarification was lacking that the police were notified following the machete assault; lack of professional curiosity after noting passed medical history and the circumstances of her attendance following injuries sustained in the machete attack; and lack of awareness for the process of patient transfers and taxi provision for vulnerable patients to and from other MFT sites. In May 2023 MFT wrote to the Coroner to confirm that all the elements in the action plan that was devised from the high impact learning assessment had been completed. The learning had been shared with staff. The process for ordering transport has been reinforced, including in a newly designed induction booklet for agency staff. Training has been delivered on recognition of safeguarding concerns and safeguarding audits have been completed. Details of available safeguarding support have been displayed.

4.7.10. GP reflections include the observation that "*it appears the GP practices and other agencies attempted to manage and contain Rebeca, instead of exploring her past, her present and what Rebecca would see for her future*." The GP contribution observes that "*Rebecca had multiple complex needs which primary care services are not designed to be able to respond to. The system is challenged in terms of time and resources. Additional time was given to Rebecca when allocating appointments where possible, as the staff were aware that depending on Rebecca's presentation at the time, the appointment could take anywhere between 20 minutes to 1 hour. This impacted on other patients and the clinical staff's ability to write contemporaneous records of the contacts. The GP practice attempted to address the concerns there and then, by referring to safeguarding or contacting the police; however, there isn't evidence of ongoing attempts to manage the risks, except for the potential drug seeking behaviour Rebecca was displaying.*"

4.7.11. The GP practice recognised and attempted to manage Rebecca's potential drug seeking behaviours, liaising with the pharmacist and the mental health team about the best way to move forward safely with Rebecca. This was good practice. However, the drug and alcohol service were the missing link to those discussions. The GP contribution acknowledges that there is little evidence within the GP records of multi-agency working and recommends

improved information-sharing and a greater focus on multi-agency risk management that focuses on support and protection rather than just management and containment.

4.7.12. The need for greater professional curiosity appears again as a theme. The GP contribution also recommends that "*single and multi-agency risk assessment processes, care planning and risk management could be strengthened when working with adults who have multiple complex needs*." GP practice staff have had level 3 safeguarding training but additional training on working with people with multiple complex needs would be beneficial, particularly to see individuals holistically and to reinforce the importance of utilising the support and expertise available in other agencies. It would also help staff to manage aggressive and abusive behaviour.

4.7.13. At the learning event several reflections were offered about the learning to be taken forward. One related to the need to ensure that when referrals were made and when care plans were in place, all the agencies involved needed to be informed of outcomes. A second was the need to nominate a lead agency and key worker in complex cases, to coordinate the multi-agency effort. The third was to embed a "*team around the person*" approach since not everyone would have had training on, for example, mental health or mental capacity.

4.7.14. Finally, it should be noted that the Coroner was critical of the time that had appeared to elapse before some of the available learning had been disseminated to improve practice. The Coroner's comments were clearly directed at MFT's high impact learning review.

4.8. In addition to the learning that emerges from the key lines of enquiry, there are other features to highlight that emerge from the chronologies of agency involvement. The first relates to "*think family*." Rebecca's family sometimes expressed concerns, for example about her drug-seeking behaviour, and sometimes helped practitioners to make contact with her. The IVH chronology lists several occasions when Rebecca's father helped to facilitate contact. There were clearly tensions, illustrated for example when Rebecca complained that the family were withholding money from her so that she could not spend it on drugs. However, there were also occasions when Rebecca sought support from her family. What is not clear from the chronologies is whether there was any sustained family work, for example to explore what circle of support Rebecca's family could provide and that she might have been willing to accept.

4.8.1. Rebecca's family believe that there were occasions when, in their experience, "*nobody would listen when we said this is happening*." They believe that there has also been a lack of total candour when they have sought information to help them understand what happened in the run-up to her death and why.

4.9. The second feature involves mental capacity and particularly executive functioning. Northern Care Alliance NHS Foundation Trust records that Rebecca was deemed to have capacity in September 2021 when as an inpatient she refused assessment and self-discharged, having complained of chest pain and panic attacks which she attributed to not having her medications. In February 2022 the Trust observe the absence of a mental capacity assessment when Rebecca had been admitted following what appeared to have been an intentional overdose.

4.9.1. NWAS clearly documented capacity assessment April 2021 when Rebecca refused to be taken to A&E. PCFT have recorded that Rebecca's mental capacity was reviewed in April

2021 following domestic abuse assaults by her boyfriend. PCFT have also documented conversations relating to Rebecca having mental capacity to make decisions about engagement with services, and there was a referral for CPA+ at this time. She was not found to meet criteria for this approach[20]. She remained, therefore, under CPA.

4.9.2. PCFT have highlighted the theme of adult safeguarding for people who are deemed to have mental capacity in relation to chronic self neglect and dual diagnosis. PCFT have questioned whether executive function is considered in terms of decision-making. Executive functioning is relevant here because of Rebecca's lived experience of trauma and its impact on her ability to make decisions. PCFT have commented that "*the line between an unwise decision and a decision made due to the impact of previous trauma is notoriously difficult to quantify and leads to difficult situations for practitioners who have the best interests of patients at heart*." ACHIEVE also noted an occasion when Rebecca's executive capacity was not considered.

4.9.3. Guidance has been issued that highlights the relevance of executive functioning, acknowledging the impact of trauma and also substance misuse on such executive functioning skills as emotional and impulse control, self-monitoring, planning and task initiation. "*Practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction – for example people with traumatic brain injury. Structured assessments of capacity for individuals in this group (for example, by way of interview) may therefore need to be supplemented by real world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability Practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction – for example people with traumatic brain injury. Structured assessments of capacity for individuals in this group (for example, by way of interview) may therefore need to be supplemented by real world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability*[21]*."*

4.9.4. Court of Protection judgements also highlight the relevance of executive functioning. For example, in A Local Authority v AW [2020] EWCOP 24, the court noted the ability to think, act and solve problems include the functions of the brain which help us to learn new information, remember and retrieve the information we've learned in the past, and use this information to solve problems of everyday life.

4.9.5. The theme of trauma appears as a running thread through this review, not just in relation to executive functioning. At the learning event, although some of those attending had received training on trauma, a sense was conveyed that trauma-awareness was not consistently informing practice. There was an awareness that mental capacity could fluctuate and/or be adversely affected by trauma and abuse, and clearly recognised was the traumatic effect of what Rebecca experienced – "*it must have been horrendous for her*"; what appeared less clear was how practitioners and services should respond to this recognition.

[20] *CPA Plus – 'is designed for those patients who are primarily managed in the community who are identified as having severe and enduring mental illness with complex and serious needs and identified as dangerous and high risk to others as a result of their mental disorder (individuals who may pose a risk to public protection). The CPA plus framework will provide an enhanced process for managing the presenting risk in the community setting.' (Pennine Care NHS Foundation Trust, Care Programme Approach Policy)*

[21] NICE (2018) Decision-making and mental capacity guidance (para 1.4.19).

4.9.6. Trauma and associated fear were also emphasised at the inquest. Referring to the machete attack, the Coroner highlighted the fear that Rebecca must have felt, and also the "*critical pain*" that she would have experienced in her hand. The postponement of treatment for her injuries must have been distressing for her. As this review has emphasised, there is always a backstory to self-neglect, here substance misuse. The inquest recognised that reliance on alcohol and other drugs, both prescribed and non-prescribed, could be a form of "*escapism from horrible life events*."

4.10. A third feature is legal literacy. The chronologies clearly identify the use of some provisions in law relating to domestic abuse and Rebecca was also detained under section 136, Mental Health Act 1983. There is, however, no record of legal advice having been sought, for instance in relation to whether inherent jurisdiction might have been an option to consider as Rebecca's decision-making and safety were negated by her experience of coercive and controlling behaviour. Guardianship (section 7 Mental Health Act 1983) might have been another option worthy of consideration. Finally, it is worth highlighting that consent is not required before referral of an adult safeguarding concern (section 42, Care Act 2014), and that section 11 (2) (b) empowers a local authority to carry out an assessment of care and support needs without consent when an adult is experiencing or is at risk of abuse and neglect.

4.11. A fourth feature of best practice, especially in complex and challenging cases, is the use of multi-agency risk management meetings, and the appointment of a lead agency and key worker to coordinate how services work together. Several chronologies refer to a multidisciplinary meeting towards the end of 2021 that appears to have focused on the discontinuation of Rebecca's depot injections and on how to contain her behaviour. There were multidisciplinary meetings prior to Rebecca's discharge when an inpatient but these meetings were not multi-agency; not every practitioner or service with a potential contribution to make to meeting her health, housing, safety and social care needs were present. Indeed, there are references in agency documentation to the difficulties of bringing services together and to the absence of any collation of the significant events and episodes as Rebecca experienced them. In late May 2021 an Integrated Neighbourhood Team meeting, involving ACHIEVE, Rebecca's GP and the community mental health team, concluded that a strategy meeting of all involved services should be arranged. IVH does not appear to have been represented at this meeting, Its chronology for the following month records that the care coordinator would arrange a multi-agency meeting but this does not appear to have happened.

4.11.1. GMP have included in their documentation the MARAC operating protocol, namely: "*MARAC works on the basis that initial safeguarding activity has already been undertaken. This activity is then reviewed together with information from the victim's Independent Domestic Violence Advisor (IDVA). Agencies present at MARAC will share any information they have around the case and the MARAC Chair will summarise the current risk posed. Actions are then volunteered by relevant individual agencies on the strict understanding that those actions will be undertaken. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. The role of the IDVA is to provide bespoke support and advice to victims of domestic abuse, this can include safety planning right through to support at court.*"

4.11.2. There are several problems with sole reliance on this approach. The first is the assumption is that initial safeguarding activity has already been undertaken. There was a lack of curiosity at times about assaults and threats of harm, and there were missed opportunities to refer adult safeguarding concerns. The second is that not all agencies were present at MARAC discussions. The third is that it appears that there was little if any change in approach despite the repetition of domestic abuse incidents. MARAC should not be a substitute for multi-agency risk management meetings.

4.11.3. At the learning event participants reported some good outcomes from the use of multi-agency risk management meetings. However, it did not always appear easy to engage services that might have a contribution to make, and obtaining legal advice had also been experienced as an obstacle to planning. Some services were also employing multidisciplinary team meetings but these might not always involve all the services with information to share or a contribution to make, and might not have sufficient awareness of when to move practice into a more formal safeguarding arena.

4.12. Agency capacity issues should also be flagged. Reference has already been made to the challenges faced by primary care staff when responding to Rebecca, and to the turnover of staff in community mental health. NWAS have also reported that in October 2021 there was a delay in paramedic attendance because of significant demands on that service at the time. There were numerous clinician call-backs to mitigate the impact of the delay. In PCFT, due to issues with recruitment and retention of staff, there was reliance on agency staff within the CMHT and two of Rebecca's care coordinators were locums. PCFT have observed that "*there are potentially going to be issues when staff are not permanent in terms of the culture in a team, standards of work, level of investment and continuity*."

4.12.1. At the learning event practitioners and managers referred to significant pressures within services. They pointed to disinvestment in services, such as substance misuse, and the challenges of recruiting and retaining experienced staff. Demands on provision were increasing, with practitioners and managers highlighting concerns about service capacity. These pressures were experienced as undermining the effectiveness of safeguarding.

4.12.2. Rebecca's family have acknowledged the pressure experienced by agencies. However, they do not regard it as acceptable that, on one occasion, treatment for her injuries following the machete attack was postponed because of staff shortage in the anaesthetics team.

4.13. Finally, those attending the learning event were particularly aware that working with Rebecca had taken place within the midst of the COVID pandemic that had required agencies to depart from normal ways of working. Some of those attending the learning event felt that this had particularly impacted on multi-agency discussions of complex, challenging and repetitive cases.

4.14. Of the many traumatic episodes in Rebecca's life, one in particular draws together all the different themes that have been explored in this review – the impact of trauma on mental health and on mental capacity, safeguarding in a context of lived experience of domestic abuse and violence, entrapment, and the backstory behind substance misuse and drug-seeking behaviour. This incident is the machete attack. An operation to seek to repair the damage that Rebecca sustained was delayed. When there was an attempt to reposition the

tendons that had been damaged, Rebecca could not tolerate this procedure under a localised anaesthetic. An operation scheduled to perform this operation under general anaesthetic was then postponed because of a shortage of specialist staff. There is also an absence of documentation to confirm whether or not the dressings were changed. Whilst an apology was given at the time for the postponement of the operation, and has been given subsequently to Rebecca's family by MFT, Rebecca had to return to her own accommodation where it is highly likely that she felt fearful of further attacks. It is by no means clear that sufficient attention was given to exploring Rebecca's safety with her. Whilst medication was provided to attempt to manage the physical pain, the mental scars required a highly person-centred response.

4.15. Bury Safeguarding Adults Board have completed two safeguarding adult reviews that reported findings similar to those that emerge in this review. SAR Alice focused on an older women with dementia where there was evidence of self-neglect (hoarding). SAR Michael focused on a younger man who misused substances and, perhaps like Rebecca, did not like to be on his own. Indeed, at the inquest, the Coroner in her conclusions suggested that, despite being taken advantage of in her own home, Rebecca was frightened of being on her own and needed people around her.

4.16. These earlier reviews highlighted shortcomings in multi-agency working and professional curiosity. There was little evidence of thorough and collaborative risk and mental capacity assessments, including in Michael's case a lack of professional understanding of executive capacity. In SAR Michael especially there was criticism of the failure to refer to ACHIEVE and to mental health services, and of the label "*did not engage*." An update was recommended of the pathway for receiving and triaging section 42 referrals[22]. The importance of addressing family concerns and of taking a whole family approach was also highlighted.

4.17. As was recognised at the learning event, the findings in Rebecca's case, therefore, do not appear unique; rather, looking across the three reviews, there appear to be systemic issues to address. At the learning event some improvements were reported in assessments of executive capacity, referrals of adult safeguarding concerns, and communication and joint working between agencies. Nonetheless, concerns remained, with for example further improved collaboration needed between GPs and secondary mental health services, and between substance misuse and mental health services. Whilst procedures for cases involving dual diagnosis exist, practice needs to align consistently with expectations.

4.18. A process for convening multi-agency risk management meetings was in place but difficulties were reported in "*getting some agencies on board*", especially if a safeguarding label was not attached or the case was not open to an invited service. Attitudes of "*being lumped with this meeting*" had been encountered.

[22] A Head of Service now maintains oversight of decision-making and section 42 outcomes to ensure compliance with local authority responsibilities.

Section Five: Conclusions and Recommendations

5.1. Rebecca's family understandably continue to grieve, to find it hard to relive what happened, and to seek answers. They are aware that this review is designed to identify learning and to make recommendations for practice improvement and service development. The family continue to explore other avenues also to hold agencies accountable. Rebecca's father has told the independent reviewer that the family "*want honesty*".

5.2. The second national analysis of safeguarding adult reviews[23] has found missed opportunities to provide bereavement support for families when a family member with care and support needs has died in circumstances where there was abuse and/or neglect (including self-neglect) and concerns about how services worked together to protect them. **Recommendation One:** BSAB should consider how commissioned bereavement services can offer support to the family/friends when required as part of the SAR process.

5.3. The independent reviewer hopes that this review will provide some assurance that, through the implementation of its recommendations, Rebecca's father and sisters will find some solace and closure; that, through implementation of the recommendations, there will be a positive legacy in Rebecca's name. The recommendations are derived from the findings in the key lines of enquiry.

5.4. **Recommendation Two:** BSAB should seek assurance from the community safety partnership regarding the effectiveness of MARAC where adult safeguarding concerns are raised in parallel with the domestic abuse.

5.5. **Recommendation Three:** BSAB should seek assurance from partners regarding the outcomes and sharing of outcomes within safeguarding, including section 42 enquiries.

5.6. **Recommendation Four:** BSAB should consider introducing a risk management framework to support people who present with multiple complex needs and risks. Where appropriate, training, support and management oversight should be provided to ensure practice is trauma-informed, recognises the impact of coercion and control on decision-making, and demonstrates professional curiosity, outreach and making safeguarding personal.

5.7. **Recommendation Five:** BSAB should seek assurance from partners about the quality of risk assessments and risk management in cases where there are repetitive concerns. This should include assurance that specialist safeguarding and legal advice is being sought from named role holders in NHS Trusts, the ICB and the local authority. It should include assurance that multi- agency risk management meetings are being used consistently and effectively.

5.8. **Recommendation Six**: BSAB should consider using the escalation protocol established between the National Network for SAB Chairs and DHSC to request that, in the revisions to the MCA Code of Practice, sufficient guidance is given on the inclusion of executive functioning, coercion and control, and the impact of trauma in mental capacity assessments.

[23] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. with Spreadbury, K., Taylor, G., Hopkinson, P. and Rees, K. (2024) *Second National Analysis of SARs*. London: Local Government Association and ADASS.