‘Juliet’
Safeguarding Adults Review

Author: David Mellor

1.0 Introduction

1.1 Juliet (a pseudonym) was a White English woman who died at her partner Gary's (also a pseudonym) address in Taunton in August 2022. She was 63 years of age. Juliet had been living primarily at her partner's address for several years. She also had her own tenancy in Taunton but she stayed in this property only intermittently. Partner agencies became concerned that Juliet was experiencing domestic abuse from Gary in the form of violence which often arose when she refused his demands for sexual intercourse. She also disclosed that he raped her on several occasions although she felt unable to support any prosecution. Professionals became concerned that Juliet may be experiencing coercion and control from Gary who also appeared to be financially exploiting her.

1.2 Juliet had been dependent on alcohol for several years which appeared to be a factor in her self-neglect. At times, her alcohol dependency also appeared to be a barrier to Adult Social Care acknowledging that she may have care and support needs although she was eventually assessed as having eligible care and support needs in March 2021. Safeguarding concerns began to escalate from 2020 and agencies worked together to make her property, which she appeared to have largely abandoned for several years, habitable again whilst also providing support to help Juliet live independently in the property. On another occasion, the Police obtained a Domestic Violence Protection Order (DVPO)[1] which prevented Gary from abusing Juliet for a time. However, Juliet tended to gravitate back to Gary and the risks which arose from her relationship with him continued until her death.

1.3 Following careful consideration of whether the criteria for conducting a Domestic Homicide Review (DHR)[2] had been met, Somerset Safeguarding Adults Board decided to commission a Safeguarding Adults Review (SAR) to explore the events leading up to the death of Juliet and appoint an independent reviewer with experience of conducting both SARs and DHRs. David Mellor was commissioned to conduct the SAR. He is a retired chief officer of police, a former Safeguarding Adults Board chair and has 12 years' experience of conducting SARs and DHRs. He has no connection to services in Somerset.

1.4 It is understood that no inquest has been held.

1.5 Somerset Safeguarding Adults Board wishes to express its sincere condolences to Juliet's family and friends.

[1] A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency.

[2] A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or (b) a member of the same household as herself/himself, held with a view to identifying the lessons to be learnt from the death.

2.0 Terms of Reference

2.1 The time period covered by the SAR is from 11th August 2020 to 10th August 2022, but historical information has been included where this provides relevant context.

2.2 The following issues were explored by the SAR:

Understanding of the person:

- How well were Juliet's needs understood as an individual?
- To what extent was this information recorded/communicated between organisations?

Actions Taken:

- Did multi-agency meetings take place, and did all relevant organisations/services participate?
- What decisions about Juliet's care were made.
- Where were these meetings recorded?

Communication:

- How well were Juliet's needs understood and was the intersecting impact of these effectively considered.
- How did organisations share their knowledge of Juliet's circumstances with other agencies?
- Did the multi-agencies respond to Juliet's self-neglect in a trauma informed way, and did they take an intersectional approach?
- What was the impact of Covid 19 on both Juliet's ability to access information and support and agency's ability to provide services to her?

Appropriate Services/Support:

- How appropriate were the services/support offered or provided?
- Were relevant enquiries made in light of the types of abuse?
- Were there any gaps in what was considered/offered?
- Was the work undertaken by services consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults?
- Was there any unconscious bias preventing agencies/professionals providing the best support to Juliet?

Risk Assessment:

- How effectively were the risks associated with self-neglect assessed and managed in conjunction with the other types of abuse?
- How well were variances in risk managed, understood and communicated?
- Were all relevant civil or criminal interventions considered and/or used?

Impact of protected characteristics:

- Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

Good Practice:

- Is there good practice to highlight?

Key Issues:

- What were the key issues in communication, information sharing, risk management or service delivery that impacted on this case?

Lessons and Learning:

- What are the main issues (lessons) identified for the way in which organisations work to safeguard and promote the welfare of people who self-neglect, whilst experiencing other abuse in their home.

3.0 Summary of key events

3.1 Juliet was born in 1959 and lived in a harbour town in Somerset with her parents. She had two brothers who were around a decade older than her who left the family home to join the army as teenagers. Juliet's nephew has contributed to this review and said that she had a very close relationship with her mother, who he felt may have unintentionally stifled Juliet's ability to acquire the skills necessary to maintain a home environment and prepare meals, by 'wrapping her in cotton wool' as a child and as a young adult. Her nephew said that Juliet often clashed with her father.

3.2 Juliet's nephew described his aunt as a very sociable person, who enjoyed a joke and who was fun to be around. He said that Juliet liked to go out and enjoy life and that drinking alcohol was an integral part of this. He said that she became involved in sex work as a teenager and he felt that her parent's decision to move from the harbour town where Juliet was born to Taunton when Juliet would have been around 20, was due in part to their wish to help Juliet make a fresh start. He said Juliet didn't 'do great' at school and that, as far as he was aware, Juliet's fairly brief employment in a cake factory in Taunton was her only period of employment. He suggested that a barrier to further employment was the frequency with which she sustained fractures of her wrists and ankles, describing her as 'accident prone'. Her nephew said that Juliet married 3 times and had no children. He has no knowledge of her first marriage but said that she left her second marriage because her husband 'beat her up'. He recalled that his father (Juliet's brother) helped her to leave that relationship.

3.3 Juliet married for a third time in 2007, which was also the year in which her tenancy in a Somerset Council Sheltered Housing[3] property began - in a flat located on the same road as her parent's address. Juliet's mother had died in 2000, and her father, who she may have informally cared for, died around 2011. Juliet's nephew felt that the death of her mother, when Juliet would have been 41 years of age, had a significant impact on Juliet both emotionally and in terms of the loss of her mother's support.

3.4 The Police recorded approximately 20 domestic abuse incidents involving Juliet and her third husband over the period 2008 to 2017. Her husband was prosecuted for assaulting her on one occasion. Both Juliet and her third husband appeared to be alcohol dependent. Juliet was briefly open to the community mental health team early in this relationship for suicidal ideation which was attributed to 'marital problems'. Juliet's GP records indicate that she suffered domestic abuse in intimate relationships for over 30 years.

3.5 Juliet first disclosed drinking heavily 'for the past year' in 2013. In addition to alcohol dependence, Juliet experienced depression, was a heavy smoker and was diagnosed with Chronic Obstructive Pulmonary Disease (COPD), was registered partially sighted in 1995 and had also been diagnosed with fibrosis and sclerosis of the liver. She had a relatively low number of contacts with primary care and tended to seek medical support via the ambulance service and attendance at the hospital 1 emergency department (ED).

3.6 Juliet was first referred to Adult Social Care in 2015 after her brother raised concerns with her GP about serious self-neglect. Contact was achieved with Juliet's brother but Adult Social Care were unable to obtain a reply from Juliet via a home visit or phone calls. Juliet's third husband contacted Adult Social Care in 2018 to express concern for her welfare as she was in a new relationship (believed to be with Gary) and was said to be drinking up to 3 bottles of vodka each day. The following year Juliet contacted Adult Social Care to request support to return home as she said that Gary had taken money from her bank account and told her to leave his address and so she was unable to get home. The focus of Adult Social Care and the Police at that time appeared to be on supporting her to return home and no further action appeared to be taken about Juliet's report of possible financial abuse.

3.7 Gary was a White Irish male who was 2 years older than Juliet. Gary did not respond to an invitation (by letter) to contribute to this SAR and so it has not been possible to seek his consent to share his medical records. However, he appears to have had a history of strokes, mobility issues, some hearing loss and appeared to be dependent on alcohol.

3.8 During April 2020 the South Western Ambulance Service (SWAST) referred Juliet to Adult Social Care after she disclosed that Gary had struck her on the head

[3] A Sheltered Housing tenancy is similar to a General Needs tenancy but access to this type of accommodation is limited to people who are 60+ or have a significant physical or mental health condition. These tenants live independently but receive some enhanced services from the Local Authority such as the Lifeline emergency alarm service. The Local Authority also undertake annual reviews of the information they hold about these tenants, liaise around aid and adaptations, complete Person Centred Risk Assessments and Personal Emergency Evacuation Plans where necessary.

with his open hand, knocking her to the floor. SWAST also raised concerns that Gary was financially abusive and controlling towards Juliet, who was said to be staying with Gary due to the absence of gas or electricity and 'environmental concerns' in her Somerset Council flat. Adult Social Care did not progress the SWAST referral to a Section 42 Enquiry[4] on the grounds that whilst Juliet was experiencing domestic abuse, she was not deemed to have care and support needs which prevented her from protecting herself. When contacted by the Adult Social Care locality team, Juliet said that she did not need support as Gary "does it all". SWAST also contacted the Police who assessed Juliet as at high risk of domestic abuse although the DASH[5] risk assessment template was not completed. The Police took no further action in relation to Juliet's report of assault as Gary said that her fall was accidental and Juliet's version of events was said to be 'inconsistent'.

3.9 In June 2020 Juliet attended hospital 1 after falling and banging her head after 'drinking all day'. During September 2020 Juliet again attended hospital after sustaining a tri-malleolar[6] fracture of her left ankle having apparently fallen out of a taxi.

3.10 On 22nd October 2020 the Police attended Gary's address after a neighbour reported banging and shouting and the Police established that Gary had called Juliet a slut whilst having sex resulting in a verbal argument. Both Juliet and Gary were noted to be in 'poor health' and intoxicated and Juliet had a plaster cast on her left foot, was complaining of pain and said that she wanted to die. The Police conveyed Juliet to hospital 1 where what was described as a 'social admission' took place and she was discharged the following day.

3.11 Juliet was referred to the Multi-Agency Risk Assessment Conference (MARAC)[7] after Gary's neighbour reported an incident to the Police. Juliet disclosed that Gary had hit her around the head a few times and the DASH risk assessment highlighted coercive and controlling behaviour by Gary, who was arrested but gave a 'no comment' interview. Juliet felt unable to make a statement. Juliet was again admitted to hospital 1 on 'social' grounds where she was deemed to have capacity to 'understand current concerns'. At her request she was discharged to Gary's address, with whom she said she intended to continue to reside. Her home address was described as 'uninhabitable'.

---

[4] A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This happens whether or not the authority is providing any care and support services to that adult. It aims to decide what, if any, action is needed to help and protect the adult.

[5] The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009. The DASH is a multi-agency tool used by partner agencies to focus on keeping victims and their children safe and ensuring perpetrators are proactively identified and managed.

[6] Surgery is needed to "set" the bones after a bi or trimalleolar fracture occurs. A period of non-weight bearing that lasts 2-4 months will be required to allow the bones to heal properly. Bearing weight too early on the involved leg can lead to a premature onset of arthritis in the ankle/foot complex

[7] MARAC is a meeting where information is shared on the highest risk domestic abuse cases and is attended by representatives from police, health, child protection, housing, independent domestic violence advisors (Idvas), probation and other specialists from the statutory or voluntary sectors. They share all relevant information they have about a victim, discuss options for increasing the victim's safety and create a co-ordinated action plan.

3.12 Juliet was discussed at a December 2020 MARAC meeting at which it was decided that Adult Social Care would conduct a joint visit with the sensory loss team* and she was referred to the High Impact User Group (HIUG)[8] due to her frequent hospital attendances (6 hospital attendances in the past 12 months including 3 which were domestic abuse related). Juliet had been referred to Somerset Integrated Domestic Abuse Service (SIDAS) but they had been unable to contact her as her phone was answered by a male who hung up. The MARAC requested that concerns about the condition of Juliet's home were addressed and agencies who came into contact with Juliet and Gary were to encourage them to self-refer to Somerset Drug and Alcohol Service (SDAS).

*It is unclear whether a sensory loss impairment assessment took place or not.

3.13 At the end of December 2020 Adult Social Care began their first Section 42 Safeguarding Enquiry in respect of Juliet. The origin of the safeguarding referral which led to the Section 42 Enquiry is not clear.

3.14 Following a further call from one of Gary's neighbours in January 2021, Juliet disclosed that Gary had hit her in the face after she refused to have sex with him. The Police considered a Domestic Violence Protection Order (DVPO) but this was not pursued as it was not felt to be feasible to make Gary homeless by excluding him from his home. Adult Social Care documented that Juliet did not support a prosecution as she said that she and Gary were carers for each other.

3.15 Also during January 2021 it was decided that Juliet was 'not felt suitable' for HIUG. It has not been possible to ascertain the grounds for this decision. Juliet was again admitted to hospital 1 for observations in relation to chest pain. Whilst on the ward, Juliet was contacted by an Independent Domestic Violence Advisor (IDVA)[9]. She said that she wanted to return to Gary as she had lung cancer – which was not accurate – and because he looked after her.

3.16 On 4th February 2021 a multi-agency professionals meeting was held to discuss how best to support Juliet. She was provided with hotel accommodation in Minehead whilst her property was deep cleaned, repairs carried out and the locks changed. A Notice of Seeking Possession (NOSP) was served on Gary following frequent complaints of anti-social behaviour from his neighbours, but this was not taken further as a result of concern that if evicted, he may persuade Juliet to allow him to move in with her.

3.17 Juliet returned to her home address later in February 2021. She said she felt warm, comfortable and safe there, but partner agencies were concerned that she may need substantial support to live at home independently for the first time in approximately 18 months. After complaints from her neighbours that Juliet had been upsetting them by knocking on doors asking for alcohol and money, she returned to Gary's address. There were professional concerns that the payment to Juliet of

[8] High Intensity or Impact Use programmes typically support adults who attend an Emergency Department (ED) more than expected and aim to help to reduce frequent use of urgent and emergency care services where a person's needs could be better met elsewhere, such as in community health services or social care.

[9] An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members, with the aim of securing their, and their children's, safety.

benefit arrears by the Department for Work and Pensions (DWP) may have been a factor in Gary encouraging her to return. She later advised Adult Social Care that she had returned to live with Gary because his home was warm and there was food there. Adult Social Care later visited Juliet at Gary's address and noted his home to be in a better condition than hers.

3.18 In March 2021 Juliet consented to a Section 9 Care Act assessment of her care and support needs[10] but the Adult Social Care locality team closed this request to assess Juliet on the grounds that her needs stemmed from alcohol misuse and they therefore deemed her not to have care and support needs. Adult Social Care Safeguarding then decided to undertake the Section 9 assessment which found she had eligible care and support needs. Extra Care Housing[11] was under consideration for Juliet. She was said to eat mainly pot noodles and ready meals and struggled to read cooking instructions because she was partially sighted.

3.19 Also during March 2021 Gary phoned the Police to ask for Juliet to be removed from his flat. During the call she could be heard saying that he had raped her. Both Juliet and Gary were described as intoxicated. On attendance and during subsequent visits, Juliet denied that a rape had taken place.

3.20 Also during April 2021 Juliet attended hospital 1 where she disclosed being raped by Gary following which she said she had run out of his flat and fallen down 5 steps whilst not wearing the protective boot for her earlier left ankle fracture. She also said that she had not eaten for 3 days.

3.21 The Police investigated Juliet's disclosure of rape in which she said that Gary had repeatedly asked her for sex and threatened to hurt her if she didn't have sex with him. She said that she did not want to make a formal complaint as the rape had taken place whilst they were both intoxicated. The Police made follow up calls to Juliet but she was documented to have remained adamant that she didn't wish to make a compliant. Juliet's was later heard at MARAC when no actions were identified.

3.22 By late April 2021 her Adult Social Care social worker felt that Juliet's circumstances were improving in that she had returned to her home where she had done some cleaning, was eating well and was drinking less alcohol. She had been provided with 'white goods' and the social worker felt that Juliet was beginning to 'open up' to her. Juliet disclosed that Gary often caused her pain when having sex with her, at times he would then stop but at other times he became angry with her. During a joint visit with the social worker and SIDAS, Juliet disclosed that she had engaged in sex with another male for money and said that she was worried she

[10] Section 9 requires a local authority to carry out an assessment, which is referred to as a "needs assessment", where it appears that an adult may have needs for care and support. The objective of the needs assessment is to determine whether the adult has care and support needs and what those needs may be. It is the mechanism by which local authorities assess whether a person requires some form of care and support, and whether the nature of their needs is such that the local authority will be under a duty to meet them (in other words, whether the person has "eligible" needs). Whether or not a person has eligible needs, they will receive tailored information on the services available in their local community to help meet the needs they do have.
[11] Extra Care Housing is a type of 'housing with care' which means a person can live independently whilst being assisted with tasks such as washing, dressing, going to the toilet or taking medication.

would ‘end up in the mortuary’ if Gary found out. SIDAS discussed refuge options with Juliet but the nearest refuges willing to support Juliet, given her alcohol use, were located in Wales or Wiltshire. Juliet felt unable to accept a refuge place and said that it was her own fault that Gary assaulted her.

3.23 On 27th May 2021 Adult Social Care decided that Juliet would be provided with 3 hours support per week to help her maintain her home environment which could be increased if required. The SAR has been advised that it was proving difficult to commission care and support at this stage of the Covid-19 pandemic and so support was only being commissioned to meet needs which were considered essential. However, Juliet returned to live with Gary and was therefore not at her address for any visits by the home care provider. Juliet said that she no longer wanted the support package and she was closed to Adult Social Care. A protection plan had been put in place for Juliet under which she agreed to leave Gary’s address if he became angry and to call 999 in an emergency.

3.24 The following day the Police took Juliet to hospital 1 after finding her fleeing Gary’s address in a distressed state. She was treated for a head injury and discharged home. A high risk DASH was completed and she was referred to MARAC. The MARAC identified no actions.

3.25 During June and July 2021 Juliet attended hospital 1 on 3 occasions with chest pains, ‘collapse whilst intoxicated’ and ‘shortness of breath’.

3.26 During the first 2 weeks of October 2021 the Police received 6 999 calls in relation to Gary and Juliet. On each occasion they had been drinking and on one occasion Juliet was said to have fallen. On 6th October 2021 Juliet was taken to hospital 1 by ambulance with shortness of breath. She was noted to be intoxicated and left before being assessed. Juliet attended hospital 1 on 3 further occasions over the next 2 weeks after tripping and hitting her head, when experiencing chest pain and at high risk of a pulmonary embolism and after being found collapsed outside a public house with a head injury.

3.27 On 13th November 2021 Juliet phoned the Police to report that Gary had ‘kicked her out’ after she refused to have sex with him and he had threatened to kill her. Gary then phoned the Police to say that he had ‘had enough’ and had taken an overdose of medication. The Police and SWAST attended and the Police took Juliet to her home address. Both were intoxicated and when the Police recontacted Juliet the following day to obtain an account from her she was considered to be too intoxicated to provide one. A statement was later obtained from Juliet and Gary was interviewed but the matter was filed as the evidential threshold had not been met. A high risk DASH was completed and Juliet’s was heard at MARAC, which noted that she was at risk of self-harm and a high user of the hospital 1 ED. There was no reference to domestic abuse or sexual harm.

3.28 The Police applied for a DVPO after further incidents were reported to them in late November 2021 including a disclosure by Juliet to an off-duty Police Officer that she had been raped by Gary. Juliet did not support a prosecution. On 5th December 2021 Juliet was discussed at MARAC for the final time. Partner agencies were asked

to refer Juliet to SDAS and Juliet's GP was to be updated. MARAC noted that Juliet had attended the hospital 1 ED 18 times during the previous 12 months.

3.29 After the Police were called by SWAST on 14th December 2021 when Juliet disclosed that Gary had hit her in the face, a DVPO was authorised until 13th January 2022 which prevented Gary from molesting Juliet or going to her address. The Police subsequently made several 'compliance visits' to Juliet's address where she was noted to be 'safe and well' and Gary was never found there.

3.30 On 23rd December 2021 Juliet was seen by the hospital 1 psychiatric liaison team (PLT) after reporting feeling suicidal. Alcohol (1 litre of whiskey per day) and morphine use were noted. Juliet said that she did not want to discuss any concerns although she spoke about losses in her life, her ill health and her fear of dying alone. She was encouraged to take Thiamine[12] due to her alcohol dependence. She said that she wanted to return to Gary and was assessed as having the capacity to make this decision.

3.31 On 25th December 2021 Juliet attended hospital 1 after a fall in which she twisted her ankle and fractured a wrist. She was said not to be managing at home, which was described as very cold and unkempt. She self-discharged due to fears over the risk of hospital acquired Covid-19 infection.

3.32 On 8th January 2022 her GP referred Juliet to Adult Social Care after being notified of an ambulance attendance at her address after she fell and injured her back. SWAST noted a 'dirty', cluttered and poorly lit flat, uneaten food on the floor and no fresh food in the kitchen. They documented that Juliet had recently 'separated from Gary'. The GP contacted the Village Agent[13]. The Adult Social Care locality team later contacted Juliet who was considered to be able to meet her basic needs.

3.33 On 23rd January 2022 Juliet attended hospital 1 feeling suicidal and was noted to be taking her friend's morphine and was intoxicated. She absconded and was returned to the ward by security. She felt unable to participate in a hospital PLT assessment.

3.34 By February 2022 Juliet appeared to be spending most of her time at Gary's address, the gas having been capped at her flat. Somerset Council considered seeking possession of her property due to 'abandonment'.

3.35 On 9th May 2022 Juliet attended hospital 1 and disclosed that Gary had raped her but did not wish to contact the Police. She had been conveyed to hospital by an ambulance crew having experienced breathing difficulties after being 'forced to have sex' by Gary. When spoken to by the ambulance crew, Gary had answered for her but she disclosed rape after he left the room. She also said that Gary had her bank

[12] Thiamine helps to turn food into energy and to keep the nervous system healthy. The body is not able to make thiamine for itself. However, people can usually get all they need from their food. Synthetic thiamine can be used to treat or prevent vitamin B1 deficiency.

[13] The Community Council for Somerset (CCS) is a charity working throughout the County and has a team of over 60 Village Agents working across Somerset, who use their local expertise to advocate for people and provide confidential, practical community-based solutions for them.

card. She left the hospital before the Trust Safeguarding Service (TSS) could review her and so the hospital requested her GP to follow up, but it appears that the GP practice did not do so.

3.36 On 20th May 2022 the Police attended an incident at Gary's address and contacted the Emergency Duty Team (EDT) after becoming concerned that Juliet was unable to look after herself. She said that she wanted to go to a hospice because of her 'cancer'. The Police, SWAST and the GP made referrals to Adult Social Care over the next day or two. The Police took her back to her flat but SWAST were concerned that the flat was cluttered and there was a high risk of falls and of fire. The GP referred her due to mobility issues, her lack of resources and because she was said to be under threat of eviction. In response to these concerns the Adult Social Care locality team phoned Juliet on 1st June 2022 who said that she only needed someone to help her clean the house and cook meals.

3.37 On 17th June 2022 Juliet was admitted to hospital 1 after falling down external stairs at Gary's address and spraining her ankle. She was documented to 'look awful', was unable to mobilise, was vomiting and an additional fall two weeks earlier was noted. Gary advised the ward that he and Juliet had had a 'massive argument' and that Juliet needed to be in hospital. The TSS advised the ward to consider a safeguarding referral relating to domestic abuse, to liaise with the hospital social work team prior to discharge to explore care and support needs, complete a DASH assessment and provide details of domestic abuse helpline numbers. The TSS planned to make a follow up call to the ward but there is no evidence that this call was made and the SAR has received no indication that the advice provided by TSS was actioned by the ward prior to Juliet's discharge on 24th June 2022.

3.38 On 22nd July 2022 Juliet was conveyed to hospital 1 by ambulance following a possible overdose of morphine and later self-discharged when sober. She was deemed to have capacity to decide to make this decision. She disclosed to the paramedics that she kept cash stuffed in a sock to stop Gary stealing it. SWAST made a 'safeguarding referral'* to the GP as Juliet's home was cluttered and smelled of rotting food.

*Both the SWAST and GP agency reports refer to this communication as a 'safeguarding referral'. However, the communication or notification may not have been a safeguarding referral in the formal sense.

3.39 On 26th July 2022 a friend of Juliet emailed Adult Social Care to report that Juliet was residing with Gary who had been admitted to hospital 'very unwell'. A high risk of self-neglect was documented, and the friend supplied photographs of Gary's property, which appeared unclean and contained rubbish and empty alcohol bottles.

3.40 On 1st August 2022 Juliet's friend contacted the Police via 999 to report that Juliet had rung her whispering that Gary had hit her and that she was scared. The friend went to the address and was refused entry by Gary who shouted at her. Police attended and both Juliet and Gary – who were intoxicated - denied the incident after being spoken to separately. A 'medium' (officer perceived) DASH was completed.

3.41 On 3rd August 2022 Juliet's friend sent a further email to Adult Social Care outlining self-neglect concerns. Adult Social Care decided to initiate a Section 42 Safeguarding Enquiry which was allocated to a social worker on 8th August 2022. Also on 8th August 2022 Juliet's friend re-contacted Adult Social Care requesting an update. The friend said that she had been unable to contact Juliet and that Gary had told her not to contact Juliet. She offered Juliet a place to stay if required. Juliet's friend was invited to contribute to this SAR but did not respond to the invitation.

3.42 On 10th August 2022 an ambulance crew attended Gary's address and Juliet was found deceased. The Police attended and concluded that there were no suspicious circumstances.

4.0 Analysis and findings

1. Actions Taken:

1a Did multi-agency meetings take place, and did all relevant organisations/services participate?

4.1 During the two year period on which the SAR primarily focusses, one multi-agency professionals meeting was held in addition to the MARAC meetings. This professionals meeting took place on 4th February 2021 at a time when professionals were working together intensively to support Juliet to leave Gary's address and return to her own property (Paragraph 3.16). In attendance were Adult Social Care (who had initiated a Section 42 Safeguarding Enquiry just over a month earlier which was ongoing), the Police, Anti-Social Behaviour team, IDVA, Sheltered Housing team and Hospital Resettlement Service. The GP practice was invited but sent apologies. The only service with substantial contact with Juliet which was not invited were SWAST. It could have been a valuable option to have invited SDAS. Though not engaged with Juliet, they could have provided valuable advice to the meeting and considered opportunistic approaches to engaging with Juliet.

1b What decisions about Juliet's care were made.

4.2 The professionals meeting decided to offer Juliet temporary accommodation in Minehead whilst her flat was made habitable through actions including reconnecting the gas supply, deep clean and change of the locks. The Village Agent was also to be involved in supporting Juliet once she returned to her flat. This professionals meeting had been prompted by the MARAC meeting held in December 2020 which identified a comprehensive range of actions including the escalation of concerns about the condition of Juliet's flat (Paragraph 3.12). The professionals meeting made good initial progress and Juliet was able to return to her flat from Minehead and said that she felt warm, comfortable and safe there (Paragraph 3.17) but professionals were aware that there was a risk that she may find living independently in her flat quite challenging and may return to Gary's address, which she did just 9 days after returning to her flat from Minehead. Factors which appear to have contributed to Juliet's decision to return to Gary were the payment of substantial benefits arrears to her by the DWP, a situation which Gary appears to have become aware of and exploited (alleged by Juliet's nephew in his contribution to the SAR), and hostility from some of Juliet's neighbours to her return to her flat. Earlier completion of an

assessment of her care and support needs may have allowed a package of home care to be provided to Juliet which could have helped her to remain in her flat.

1c Where were these meetings recorded?

4.3 From the chronologies submitted to this SAR, Adult Social Care and the Sheltered Housing team documented details of the meeting and the substantial follow up work required.

Other meetings:

4.4 In addition to the 4th February 2021 professionals meeting, Juliet was discussed at MARAC meetings on 7 occasions during the period on which this SAR focusses. As stated the first of these MARAC meetings held in December 2020 was the catalyst for the subsequent professionals meeting. That first MARAC meeting adopted a holistic approach to Juliet, referring her to the High Impact User Group (HIUG) which was a very appropriate referral given Juliet's tendency to access healthcare by attending the hospital 1 ED; referring her to Adult Social Care - which may have led to the initiation of a Section 42 Safeguarding Enquiry; requesting Adult Social Care to visit Juliet with the sensory loss team given that she was partially sighted and asking agencies in contact with both Juliet and Gary to encourage them to self-refer to SDAS.

4.5 The subsequent 6 MARAC meetings at which Juliet was discussed took place during 2021 and did not appear to adopt as holistic an approach as the first December 2020 MARAC meeting. The templates for 3 of the MARAC meetings have been shared with the SAR and include the information gathered from partner agencies in respect of Juliet and Gary, an analysis of current risks followed by agreed actions. The information gathering appeared comprehensive, but the analysis of risk was not always conducted in sufficient depth or considered how risks might intersect. For example a 2021 MARAC meeting documented one of Juliet's disclosures of rape by Gary and also noted Gary offending history. (Avon and Somerset Police have also advised the SAR that Juliet was often 'half naked' when officers attended incidents). Gary's offending history does not appear to have been taken into account when considering the risks to Juliet which that MARAC meeting documented only to be 'high user of ED services re alcohol use' and 'alcohol dependent'. Also the possibility that rape may be an aspect of coercive and controlling behaviour by Gary does not appear to have been considered and the risk to Juliet of economic abuse from Gary also appears to have been overlooked. None of the MARAC templates mention Juliet's risk from self-neglect.

4.6 In recognition of an apparent increase in the number of cases heard at MARAC in which the victim has complex needs, SafeLives produced *Managing cases with complex needs at MARAC* (1). This guidance acknowledges that such cases also account for the large majority of repeat cases heard at MARAC – as with Juliet. A recommendation from *Managing cases with complex needs at MARAC* which may help to address the issue of complex cases and the limited time available at MARAC to fully consider such complex cases is to arrange a professionals meeting as an action from MARAC. A professionals meeting would increase the likelihood of all

relevant risks to the victim – and the intersecting impact of those risks - being fully considered.

Recommendation 1 (Safer Somerset Partnership)

That MARAC should consider the option of requesting a professionals meeting to be held in complex cases, particularly where a victim with complex needs is repeatedly being referred back to MARAC. When requesting a professionals meeting, the MARAC should identify a lead agency and preferably a co-ordinating worker.

4.7 Although this point is not included in the *Managing cases with complex needs at MARAC* guidance, MARAC chairs should also consider whether a large number of repeat cases coming to MARAC could be an indication that 'the system' may not be working for the particular victim.

Recommendation 2 (Safer Somerset Partnership)

Where cases are being repeatedly referred back to MARAC, the MARAC chair should consider whether or not this may be an indication that they system is not working for the victim and request that a professionals meeting is held.

4.8 As stated Juliet was referred to the HIUG for which she was 'not felt suitable' (Paragraph 3.15). It would have been helpful if a more detailed rationale had been documented for deciding that Juliet was not suitable. The current Somerset NHS Foundation Trust HIUG terms of reference have been shared with the SAR. The stated purpose of the HIUG is 'to identify people presenting differently or more frequently than expected to the Emergency Departments of the Trust's two hospital sites, thereby creating high intensity use'. Impact is identified by the HIU Team on the basis of the number of attendances within the previous 3 months and a review of annual attendances. The Terms of Reference goes on to state that 'safeguarding the person will be at the forefront of all decisions and discussions'.

4.9 Given the frequency with which Juliet attended hospital 1 ED and the fact that she primarily accessed health care by calling the ambulance service (SWAST attended Juliet 35 times during the period under review and conveyed her to hospital 1 ED on 20 occasions where she disclosed rape, domestic abuse and there was evidence of self-neglect) one might have thought that Juliet would have met the criteria for HIUG when considered by them in January 2021 or subsequently, given that the frequency of her hospital attendances did not abate.

Recommendation 3

That Somerset NHS Foundation Trust ensures that the High Intensity User Group (HIUG) criteria are consistently applied and that the grounds for deciding that a person does not meet the criteria for HIUG comply with policy and are fully documented. The Trust should conduct an audit of referrals to HIUG which are declined on the grounds that they do not meet the criteria.

4.10 No multi-agency meeting was held to progress the first Section 42 enquiry commenced by Adult Social Care in late December 2020. Somerset Safeguarding

Adults Board's (SSAB) guidance on what happens after a safeguarding referral is made envisages a planning discussion to share and consider information across agencies (2). The SSAB guidance also sets out the factors which will contribute to the decision to hold a strategy/planning meeting, many of which did not apply[14] at the time the Section 42 enquiry began in respect of Juliet.

4.11 Juliet was not considered at any of her GP Practice safeguarding meetings. These meetings would have given the opportunity for the GP Practice to review their contacts with Juliet in the context of information received from other agencies and assess if further action was required from primary care. This could have prompted contact with partner agencies to discuss current concerns and may have instigated multi-agency working/meeting as well as highlighting the need for targeted enquiry into domestic abuse. The SAR has been advised that there are now more formal opportunities to discuss adult safeguarding concerns in Juliet's GP practice, although one of these opportunities is at the end of the GP practice child safeguarding MDT, which suggests that ensuring sufficient focus on adult patients about whom there are safeguarding concerns remains a 'work in progress'.

Recommendation 4

That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases.

4.12 The SAR has been advised that Juliet was not discussed as part of the Somerset One Team process[15] although her partner Gary was discussed in that forum, primarily as a result of the concerns about his anti-social behaviour towards neighbours.

4.13 The SAR has also been advised that Juliet was not escalated to a MARM[16] meeting, which at that time would have been known as the 'What to do if it's not

[14] A decision to hold a strategy/planning meeting or discussion will be based on the following factors:

- The risk to the adult allegedly being harmed
- The risk to others from the person causing harm or alleged to have caused harm
- Whether several organisations have concerns and need to share information
- Whether there may be a number of investigations by different organisations
- Whether there may be legal or regulatory actions
- Whether the allegation involves a member or staff / volunteer, or the safety of a service
- Whether the situation could attract media attention
- Where a crime may have been committed
- Where institutional abuse is suspected or alleged

This list is not exhaustive

[15] One Teams have been working in Somerset since 2013 and are structured on an award winning model that provides an effective means of agencies working closely together to support vulnerable communities and to reduce overall demand on the public sector. Their aim is to work in Somerset's most vulnerable communities and provide co-ordinated front-line multi-agency working to efficiently provide sustainable solutions for families and individuals that prevent problems escalating and costs increasing to the public sector.

[16] A MARM meeting is likely to be useful to any professional who is working with an adult who is experiencing an unmanageable level of risk as a result of circumstances which create the risk of harm but not relating to abuse or neglect by a third party.

Safeguarding' process, which could have been of value in providing a collaborative approach to risk sharing.

4.14 Looking back at agency involvement with Juliet, once fairly intensive multi-agency work had not succeeded in changing the dynamic by May 2021, thereafter partner agency involvement was largely characterised by a 'response and referral' approach (with the exception of the DVPO obtained by the Police in December 2021) which did not appear to be sufficiently sensitive to indications that Juliet's health and wellbeing was beginning to deteriorate markedly. As observed by the independent reviewer in other statutory reviews, professionals appeared to become a little 'stuck' after various options had been tried without improving the lived experience of the person. Juliet's nephew has advised the SAR that he felt that his aunt was 'unhelpable' and gradually 'gave up on life'. There is no indication that professionals took this view but after their efforts to support Juliet did not succeed, they appeared somewhat disempowered.

2. Communication:

2a How well were Juliet's needs understood and was the intersecting impact of these effectively considered.

4.15 Professionals struggled to gain any depth of understanding of Juliet's needs. The agencies she was most frequently in contact with were SWAST, Hospital 1 ED and the Police which meant that she was likely to come into contact with a range of different professionals rather than a consistent professional. She had limited contact with her GP practice. Somerset Council as her housing provider had a great deal of contact with her although much of this was by telephone as she began to spend the majority of her time away from her tenancy. An Adult Social Care student social worker worked very constructively with Juliet for several months during 2021 and felt that Juliet was 'opening up' to her about her relationship with Gary and her alcohol dependence (Paragraph 3.22). Juliet was also seen by the hospital 1 psychiatric liaison team on one occasion when she was unwilling to discuss current concerns although she spoke about losses in her life, her ill health and her fear of dying alone (Paragraph 3.30).

4.16 Juliet's care and support needs were assessed by Adult Social Care Safeguarding in March 2021 and the Police completed numerous DASH risk assessments although many of these were completed on the basis of the officer's observations and information held by the Police in relation to previous incidents, as Juliet was often considered to be too intoxicated to answer the DASH questions at the time of the incident. BRAG[17] assessments were completed by the Police less consistently than expected.

4.17 There is some evidence of the intersecting impact of Juliet's needs being considered. Professionals recognised that supporting her to sustain her tenancy

[17] The BRAG tool was introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping the Police Lighthouse Safeguarding Unit (LSU) to triage and signpost or refer to appropriate partner agencies. It should be used alongside other assessment tools (such as the DASH).

could reduce the pull factor to Gary's address. Additionally, Somerset Council Housing later held off seeking possession of Juliet's property on the grounds that it represented a safe haven for her. However, as stated the MARAC often did not appreciate the range of risks to which Juliet was exposed and so the intersecting impact was therefore overlooked.

4.18 However, Juliet's relationship with Gary was complex and at times she stated or implied that he was her carer (Paragraphs 3.15 and 3.17) or that they were carers for each other (Paragraph 3.14).The Domestic Abuse Act statutory guidance advises that 'disabled victims' (defined by the guidance as including, but not limited to, victims with physical or sensory impairments, mental health issues, learning disabilities, cognitive impairments, long-term health conditions and neuro diverse victims) can face additional risks of abuse where the perpetrator is using the victim's particular vulnerabilities to exploit them such as denial of health services (3). Disabled victims may also be more likely to continue living with the perpetrator (4). There is no indication that Adult Social Care considered Gary as Juliet's carer, which could have enabled them to offer him support as a result of his caring responsibilities. A carer's assessment could also have helped professionals to better understand the dynamics of the relationship and the extent to which subtle forms of domestic abuse were present in the carer relationship.

2b How did organisations share their knowledge of Juliet's circumstances with other agencies?

4.19 There was much satisfactory information sharing about Juliet's circumstances by organisations. The points at which there appeared to be the fullest appreciation of Juliet's circumstances was at the time of the December 2020 MARAC, the February 2021 professional's meeting and the period when Adult Social Care Safeguarding were involved with Juliet from December 2020 until May 2021.

2c Did the multi-agencies respond to Juliet's self-neglect in a trauma informed way, and did they take an intersectional approach?

4.20 Self-neglect research completed by Braye, Preston-Shoot and Orr (5) (6) (7) emphasises the importance of a relational approach in order to help professionals 'find the person'. This proved challenging for professionals who were in contact with Juliet. There were many intersecting complexities in her life which professionals did not become fully aware of and may have limited their ability to work with Juliet in a trauma informed way. Juliet's nephew emphasised the importance of Juliet's relationship with her mother who he felt may have unintentionally stifled Juliet's ability to acquire the skills necessary to maintain a home environment and prepare meals, by 'wrapping her in cotton wool' as a child and as a young adult (Paragraph 3.1). GP records indicated that Juliet may have experienced domestic abuse in intimate relationships for over 30 years (Paragraph 3.4) which could have been a factor in her alcohol dependence (8). Juliet's nephew has disclosed that she was a sex worker for a time. If she was a street sex worker, research indicates that this is a highly marginalised and stigmatised group who carry an extremely high unmet burden of health need including the respiratory disease and health problems related to alcohol dependence apparent in Juliet's circumstances (9).

2d What was the impact of Covid 19 on both Juliet's ability to access information and support and agency's ability to provide services to her?

4.21 Juliet was referred to Adult Social Care during the first Covid-19 lockdown (Paragraph 3.8). At that time easements contained within the Coronavirus Act 2020 meant that local authorities did not have to carry out detailed assessments of care and support needs but would be expected to assess what care needed to be provided as soon as possible (10). There was an increase in domestic abuse related offences during the pandemic although it was not possible to directly attribute the increase to the pandemic (11). The most intensive period of multi-agency working to support Juliet from December 2020 until May 2021 took place during the second and third Covid-19 lockdowns. During what was a period of unprecedented challenge for all partner agencies, professional efforts to support Juliet do not appear to have been adversely affected by the pandemic – with one exception. The home care package approved for Juliet consisted of 3 hours support per week to help her maintain her home environment (Paragraph 3.23) which may not have been sufficient. As stated, the SAR has been advised that, during that phase of the pandemic, it was proving difficult to commission care and support and so commissioned support was limited to essential needs only. The care provider was unable to provide any care and support to Juliet as they never found her at home. The option of providing care for her at Gary's address could have been considered although that would not have been consistent with professional efforts to support her to leave Gary and sustain her own tenancy.

4.22 The author of the primary care IMR observed that caution needs to be applied to the increased use of telephone/video contacts with patients with complex needs and known domestic abuse post pandemic as these types of consultations do not allow for assessment of home situations or fully consider safety issues relating to domestic abuse.

3. Appropriate Services/Support:

3a How appropriate were the services/support offered or provided?

4.23 There is learning for agencies arising from the services which were not offered to Juliet. She was at high risk of falls and sustained injuries which were attributed to falls on several occasions (Paragraphs 3.8, 3.9, 3.20, 3.26, 3.31 and 3.37). SWAST documented Juliet's high risk of falls (Paragraph 3.36) but there is no indication that Juliet was referred or signposted to the range of falls prevention and support services available in Somerset[18]. Not all agencies represented at the practitioner learning event arranged to inform this SAR appeared to be aware of local falls prevention and support services.

Recommendation 5

That the providers of the range of falls prevention and support services in Somerset complete a 7 minute briefing on the services they offer and how to access them and that this 7 minute briefing is promoted on the Somerset Safeguarding Adults Board website.

[18] Please see https://www.somerset.gov.uk/care-and-support-for-adults/falls-prevention-and-support/

4.24 There was no offer of support from an independent sexual violence advisor (ISVA)[19] or any referral to a sexual assault referral centre (SARC) when Juliet disclosed rape by Gary. The SAR has been advised that Juliet was often affected by alcohol when the Police attended incidents in which she disclosed rape but that opportunities were missed to discuss ISVA support with her when she was revisited when sober. The police service nationally has recognised the need to improve the quality of rape investigations (12). Of particular relevance to this SAR are the findings of a 2021 Joint Thematic Inspection of the Police and Crown Prosecution Service's response to rape, particularly that some victims with protected characteristics[20] may face greater barriers when reporting rape offences (13), that there were inconsistent levels of referrals to support services, and especially in the effective involvement of ISVAs (14) and that victims of rape are more likely to continue to engage with the police and support an investigation when an ISVA is involved (15). Juliet also disclosed rape to SWAST and hospital 1 on one occasion but said that she did not wish to report this to the Police (Paragraph 3.35). Practitioner learning event attendees considered the question of whether there was any obligation on the professionals to whom Juliet disclosed rape to share this information with the Police and the consensus was that reporting a disclosure of rape to the Police without the consent of the victim was a very sensitive issue. Juliet's nephew had advised the SAR that, in his opinion Gary wanted Juliet for sex and access to her benefits and that on one occasion he (Juliet's nephew) strongly advised Gary that when Juliet said "no" to sex, she meant "no".

Recommendation 6

That Avon and Somerset Police provides a report to Somerset Safeguarding Adults Board setting out their efforts to improve the quality of rape investigations including consideration of the support provided to victims with protected characteristics and victims who appear alcohol dependent.

4.25 The Care Act was not always applied appropriately to Juliet. In March 2021 the Adult Social Care locality team closed a request for a Section 9 assessment of Juliet as she was not considered to meet the 'has physical or mental impairment' criteria for eligibility as the locality team deemed that her needs stemmed from alcohol misuse and were therefore not care and support needs (Paragraph 3.18). The SAR was advised that training has been provided around alcohol and dependency and eligibility for care and support. There is a 7 minute briefing on vulnerable dependent drinkers on the SSAB website[21] as well as a 2020 report entitled *Safeguarding Vulnerable Dependent Drinkers England and Wales* (16) which is relevant to Juliet.

[19] Independent Sexual Violence Advisers (ISVAs) play an important role in providing specialist tailored support to victims and survivors of sexual violence. An ISVA is an adviser who works with people who have experienced rape and sexual assault, irrespective of whether they have reported to the police. The nature of the support that an ISVA provides will vary from case to case and will depend on the needs of the individual and their particular circumstances.

[20] The characteristics that are protected by the Equality Act 2010 are age, disability, gender reassignment, marriage or civil partnership (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation. (Juliet was partially sighted).

[21] Please see https://somersetsafeguardingadults.org.uk/wp-content/uploads/20220517-Vulnerable-Dependent-Drinkers-One-Page-Briefing.pdf

She could have been considered to be a highly vulnerable dependent drinker, in that she presented a very high level of risk to herself and others partly as a result of her drinking and its long term negative effects on her wellbeing, through experiencing self-neglect, being at risk of domestic and sexual abuse from Gary and making extensive use of emergency services. Gary may also have been a highly vulnerable dependent drinker in that he presented a very high risk to others, particularly Juliet, also appeared to be self-neglecting and made extensive use of emergency services. *Safeguarding Vulnerable Dependent Drinkers England and Wales* recommends that a local multi-agency group with senior representatives from key agencies should take responsibility for ensuring that chronic, highly vulnerable, dependent drinkers are protected and supported by the appropriate and stepped use of legal powers including the Care Act, the Mental Capacity Act and the Mental Health Act 2007 and that there should either be a standing multi-agency group for the management of chronic dependent drinkers or that this task should be allocated to an existing multi-agency group or there should be good systems which allow for the swift convening of a multi-agency risk management meeting around a particular person (17). If any such approach had been in place, this may have increased the likelihood of further efforts being made to safeguard Juliet after the initial multi-agency impetus subsided from May 2021.

Recommendation 7 (Safeguarding Adults Board)

That Somerset Safeguarding Adults Board reviews the options for the management of chronic dependent drinkers recommended by Safeguarding Vulnerable Dependant Drinkers England and Wales and considers which option(s) should be implemented across Somerset.

4.26 There is no indication that Gary was offered any of the available services which support recommendations of domestic abuse in order to address his behaviour as a perpetrator. It is not clear why this was the case. It is accepted that it can be challenging for professionals to engage domestic abuse perpetrators in conversations about the support they need, particularly if they do not perceive themselves to be domestic abuse perpetrators.

Recommendation 8 (Safer Somerset Partnership)

That the Safer Somerset Partnership considers how best to increase professional awareness of the services which provide support to perpetrators of domestic abuse and how to refer or encourage self-referral to these services.

3b Were relevant enquiries made in light of the types of abuse?

4.27 The safeguarding referral Adult Social Care received from SWAST in April 2020 was a missed opportunity to carry out a Section 42 Enquiry (Paragraph 3.8) and relevant enquiries were not always evident when there were indications of financial abuse (Paragraphs 3.6, 3.8, 3.17 and 3.35). Juliet's nephew has advised the SAR that Gary always had Juliet's bank card which he used to withdraw cash from her bank account. The nephew said that Juliet told him that Gary wouldn't give her the bank card back. Adult Social Care initiated 2 Section 42 Safeguarding Enquiries during the period under review but received several other referrals which indicated

continuing concerns about Juliet. Records do not indicate that workers who considered these other referrals reviewed Juliet's previous records and repeatedly deemed that she had no care and support needs, despite there being evidence on the records to the contrary.

Recommendation 9 (Somerset Adult Social Care)

That Somerset Adult Social Care should reinforce the requirement to check the records the service holds of any person who is the subject of a safeguarding referral so that an informed decision can be made about whether the person appears to have care and support needs.

3c Were there any gaps in what was considered/offered?

4.28 Please see the response to question 3a above. In addition refuge provision for Juliet, given her alcohol use, was limited (Paragraph 3.22). The number of refuge services in England has been decreasing although the number of bed spaces in refuges in England has increased. The percentage shortfall in refuge spaces against the Council of Europe recommendation of one space per 10,000 population has decreased from 34.1 in 2015 to 30.3 in 2020 (18). Despite the well known links between mental health issues, drug and alcohol use and the experience of domestic abuse, there is a well-documented lack of commissioned refuge spaces to meet the needs of these victims of domestic abuse (19).

3d Was the work undertaken by services consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults?

4.29 In addition to the departures from policy and procedure already highlighted, Juliet's GP practice was unable to carry out targeted clinical enquiry into domestic abuse at every contact, given that the majority of their contacts with Juliet were by phone. At times the co-ordination of action by the Hospital 1 ward, the Hospital 1 Trust Safeguarding Service and Juliet's GP did not lead to an effective response to documented concerns (Paragraphs 3.35 and 3.37)

3e Was there any unconscious bias preventing agencies/professionals providing the best support to Juliet?

4.30 It is possible that there may been a degree of unconscious bias in relation to Juliet's alcohol dependence. She is referred to as an 'alcoholic' in two of the individual management reports (IMR) submitted to this SAR which is a term in common usage but which may promote stigma. The author of the Police IMR observed that domestic abuse incidents attended by officers may have been minimised due to Juliet's level of intoxication which was sometimes a barrier to officers obtaining consistent details from her. The SAR has been advised that Avon and Somerset Police's domestic abuse policy is to be amended to ensure officers consider intoxication more carefully when responding to domestic abuse incidents.

4.31 The potential for unconscious bias towards older victims of domestic abuse is considered in Paragraph 4.37.

4. Risk Assessment:

4a How effectively were the risks associated with self-neglect assessed and managed in conjunction with the other types of abuse?

4.32 Much practical support was provided to Juliet in an effort to reduce the risk of self-neglect. For example Somerset Council Housing undertook a number of deep cleans, provided her with white goods and reconnected her gas supply and paid off her gas arrears. (Juliet's nephew has advised the SAR that he and his father also 'gutted' his aunt's flat and bought her a new cooker). As stated there was a strong multi-agency focus on supporting Juliet to sustain her own tenancy to reduce the pull factor to Gary's address and provide a safe haven for Juliet. Professionals were aware that Juliet needed support to maintain her tenancy and when living independently, was at risk of self-neglect. However, Juliet was frequently taken back to her own property by the Police and on one occasion by SWAST, in order to safeguard her from domestic abuse. This may have inadvertently increased her risks from self-neglect. Whilst there was professional attention to the risk of self-neglect when Juliet was living independently in her own property, the risk of self-neglect whilst living with Gary appeared to receive less attention until a friend of Juliet began raising specific concerns with Adult Social Care about the risk of self-neglect to Juliet whilst living with Gary in the weeks prior to Juliet's death (Paragraphs 3.39 and 3.41). When living with Gary, Juliet's risk of self-neglect may have been masked to an extent by a focus on the risks of domestic and sexual abuse and because Gary's home may have been perceived by professionals to be in better condition than Juliet's flat (Paragraph 3.17).

4.33 Generally, professionals did not doubt Juliet's capacity to decide not to accept support. Assurances that she could cope were often accepted despite long term evidence to the contrary. SWAST assessed Juliet as lacking capacity to decide not to attend hospital on 3 out of 35 contacts with them. The impact of long term alcohol consumption on Juliet's capacity could have been considered by professionals, such as mental health decline including intensified emotions, anxiety, fear and loss of mental capacity (20), the increased risk of frontal lobe damage to dependent drinkers (21) and the possibility that the compulsion associated with addictive behaviour could be seen as overriding her understanding of information about the impact of her drinking (22). She was assessed as having the capacity to make the decision to return to Gary on the only occasion she was seen by the Hospital 1 psychiatric liaison team (Paragraph 3.30) although her capacity to keep herself safe within her relationship with Gary does not appear to have been assessed, nor was the possibility that the presence of coercion may have rendered her unable to make a material decision at a relevant point in time. The protection plan agreed with Juliet by Adult Social Care in May 2021 envisaged that she would leave Gary's address if he became angry and would call 999 in an emergency (Paragraph 3.23). At times, professionals appeared to perceive Juliet to have more autonomy in her relationship with Gary than may actually have been the case.

Recommendation 10

That Somerset Safeguarding Adults Board write to NHS England to propose that they develop an e-learning module on the impact of acute and longitudinal alcohol use on mental capacity for delivery locally.*

*It has been announced that NHS England will be abolished although the process is expected to take 2 years.

4b How well were variances in risk managed, understood and communicated?

4.34 Partner agencies recognised an escalation in risk to Juliet in late 2020 by referring her to the December 2020 MARAC followed by the professionals meeting in February 2021. The Police responded to an escalation in reported incidents of domestic abuse from October 2021 by obtaining a DVPO. However, the escalation in concerns about Juliet which were apparent from May 2022 until her death 3 months later did not receive a concerted multi-agency response although Adult Social Care initiated a Section 42 Enquiry just before Juliet died.

4c Were all relevant civil or criminal interventions considered and/or used?

4.35 The SAR has been advised that the Police considered evidence-led prosecutions[22] on several occasions but the evidential threshold was never met. Typically, evidence of injuries sustained, recordings of 999 calls (which Juliet rarely made) and body worn video evidence could help to build an evidence-led case.

4.36 The DVPO obtained in December 2021 prevented Gary from molesting Juliet or going to her address (Paragraph 3.29). This had the effect of reducing the risk of domestic abuse to Juliet for the month during which the DVPO applied but inadvertently increased her risk from self-neglect (Paragraph 3.31 and 3.32) and may have adversely affected her mental health (Paragraphs 3.30 and 3.33). Looking back, it would have been helpful if a stronger multi-agency approach had been adopted to capitalising on the breathing space the DVPO allowed. For example further support could have been offered to help Juliet live independently in her own property and this period may have represented a good opportunity to assess Juliet's capacity to keep herself safe in her relationship with Gary and consider the extent to which her capacity to make such decisions was compromised by indications of coercion and control from Gary.

Recommendation 11

That Avon and Somerset Police and partner agencies adopt the following approach in relation to Domestic Violence Protection Orders (DVPO):

***Immediate Safety:** The police's objective during the night is to ensure the immediate safety of the Domestic Violence Protection (DP) individual.*
***Follow-Up Process:** Early the next morning, information sharing with agencies involved with the DP, and activation of the Multi-Agency Risk Assessment*

[22] Evidence-led prosecutions are prosecutions that enable the prosecution team to deliver justice without requiring the support of the victim.

Conference (MARAC) for consideration of actions or a S42 referral. If there it is deemed not to be a MARAC case, a MARM should be arranged.
Lead Agency and Key Worker: *In cases of complexity and repetitive patterns, there should be a consideration for a lead agency and a key worker to coordinate efforts.*

5. Impact of protected characteristics:

5a Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

4.37 Disability: Juliet was partially sighted. It is unclear what impact this had on Juliet's life. Her nephew did not feel that it was significant. However, Juliet disclosed that she struggled to read cooking instructions (Paragraph 3.18). Her partial sightedness may have affected many other aspects of her life such as the use of her bank card (which Gary appeared to control), her frequent falls and her ability to access services by telephone or online. The December 2020 MARAC meeting requested Adult Social Care to conduct a joint visit with the sensory loss team, but it is unclear whether a sensory loss impairment assessment took place (Paragraph 3.12).

4.38 Age: Juliet was 63 at the time of her death. Research shows that older victims of domestic abuse are likely to have lived with the abuse for prolonged periods (23) (Juliet had lived with abuse for over 30) and over many decades the victim may have internalised the abuse and concluded that 'this is just the way it has always been'. On one occasion Juliet told professionals that it was her own fault that Gary assaulted her (Paragraph 3.22). It is noted that many of the domestic abuse call outs were made by neighbours rather than Juliet herself. The SAR has been advised that an Older Person IDVA pilot project is currently running in Somerset which aims to increase recognition of the needs of older victims of domestic abuse and upskill professionals so that they can respond more effectively to their needs.

4.39 Sex: Domestic abuse research has found the difference between men and women to be stark, with men significantly more likely to be repeat perpetrators and men significantly more likely than women to use physical violence, threats and harassment (24).

6. Is there good practice to highlight?

- Police body worn video reviewed to inform this SAR demonstrated that an empathetic approach was taken by officers responding to incidents involving Juliet.

- After the Adult Social Care locality team decided not to progress a Section 9 assessment, Juliet's Adult Social Care safeguarding worker operated outside normal processes to complete the Section 9 assessment themselves.

- SIDAS repeatedly struggled to engage with Juliet. However, the health IDVA accomplished a joint visit with Adult Social Care in May 2021 during which it

was possible to initially discuss an individual safety and support plan with Juliet.

- The Adult Social Care student social worker used skills from a previous role to adopt a relational approach to working with Juliet.

DHR (Domestic Homicide Review) 052 'Henrietta'

4.40 The independent reviewer for SAR Juliet is also completing a separate DHR for Safer Somerset Partnership (DHR 052 'Henrietta'). This DHR also relates to the death of female (who was around 20 years younger than Juliet) who was frequently the victim of domestic abuse from her on/off intimate partner who presented himself as her carer. In that case there was also substantial involvement with a range of agencies and concerns about the victim's self-neglect and alcohol dependence. Several of the learning themes present in SAR Juliet are replicated to an extent in DHR Henrietta. The DHR Henrietta report is almost complete. There may be opportunities for Somerset Safeguarding Adults Board and the Safer Somerset Partnership to collaborate on the implementation of the recommendations from each review. Additionally, it is recommended that a learning event is arranged to jointly disseminate the learning from the 2 reviews.

Recommendation 12

That Somerset Safeguarding Adults Board and the Safer Somerset Partnership arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

Recommendations for Action:

Recommendation 1 (Safer Somerset Partnership)

That MARAC should consider the option of requesting a professionals meeting to be held in complex cases, particularly where a victim with complex needs is repeatedly being referred back to MARAC. When requesting a professionals meeting, the MARAC should identify a lead agency and preferably a co-ordinating worker.

Recommendation 2 (Safer Somerset Partnership)

Where cases are being repeatedly referred back to MARAC, the MARAC chair should consider whether or not this may be an indication that they system is not working for the victim and request that a professionals meeting is held.

Recommendation 3 (Somerset NHS Foundation Trust)

That Somerset NHS Foundation Trust ensures that the High Intensity User Group (HIUG) criteria are consistently applied and that the grounds for deciding that a person does not meet the criteria for HIUG are appropriate and are fully documented by conducting an audit of referrals to HIUG which are declined as they do not meet the criteria.

Recommendation 4 (NHS Somerset Integrated Care Board)

That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases.

Recommendation 5 (Somerset Safeguarding Adults Board)

That the providers of the range of falls prevention and support services in Somerset complete a 7 minute briefing on the services they offer and how to access them and that this 7 minute briefing is promoted on the Somerset Safeguarding Adults Board website.

Recommendation 6 (Avon and Somerset Police)

That Avon and Somerset Police provides a report to Somerset Safeguarding Adults Board setting out their efforts to improve the quality of rape investigations including consideration of the support provided to victims with protected characteristics and victims who appear alcohol dependent.

Recommendation 7 (Somerset Safeguarding Adults Board)

That Somerset Safeguarding Adults Board reviews the options for the management of chronic dependent drinkers recommended by Safeguarding Vulnerable Dependant Drinkers England and Wales and which option(s) should be implemented across Somerset.

Recommendation 8 (Safer Somerset Partnership)

That the Safer Somerset Partnership considers how best to increase professional awareness of the services which provide support to perpetrators of domestic abuse and how to refer or encourage self-referral to these services.

Recommendation 9 (Somerset Adult Social Care)

That Somerset Adult Social Care should reinforce the requirement to check the records the service holds of any person who is the subject of a safeguarding referral so that an informed decision can be made about whether the person appears to have care and support needs.

Recommendation 10 (Somerset Safeguarding Adults Board)

That Somerset Safeguarding Adults Board write to NHS England to propose that they develop an e-learning module on the impact of acute and longitudinal alcohol use on mental capacity for delivery locally.

Recommendation 11 (Avon and Somerset Police)

That Avon and Somerset Police and partner agencies adopt the following approach in relation to Domestic Violence Protection Orders (DVPO):

Immediate Safety: *The police's objective during the night is to ensure the immediate safety of the Domestic Violence Protection (DP) individual.*
Follow-Up Process: *Early the next morning, information sharing with agencies involved with the DP, and activation of the Multi-Agency Risk Assessment Conference (MARAC) for consideration of actions or a S42 referral. If there it is deemed not to be a MARAC case, a MARM should be arranged.*
Lead Agency and Key Worker: *In cases of complexity and repetitive patterns, there should be a consideration for a lead agency and a key worker to coordinate efforts.*

Recommendation 12 (Somerset Safeguarding Adults Board and Safer Somerset Partnership)

That Somerset Safeguarding Adults Board and the Safer Somerset Partnership arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

References:

(1) Retrieved from https://safelives.org.uk/resources-library/managing-cases-with-complex-needs-at-marac/

(2) Retrieved from https://somersetsafeguardingadults.org.uk/information-for-professionals/guidance-for-safeguarding-adults-in-somerset/what-happens-next/#:~:text=Following%20the%20conclusion%20of%20an,reduction%20and%2For%20public%20protection.

(3) Retrieved from Domestic_Abuse_Act_2021_Statutory_Guidance

(4) ibid

(5) Retrieved from https://www.scie.org.uk/self-neglect/policy-practice/evidence-base

(6) Retrieved from https://sussex.figshare.com/articles/report/Self-neglect_and_adult_safeguarding_findings_from_research/23351822

(7) Retrieved from https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

(8) Retrieved from https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-domestic-abuse

(9) Jeal N, Salisbury C. A health needs assessment of street-based prostitutes: cross-sectional survey. J Public Health. 2004;26(2):147–51.

(10) Retrieved from https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-thecare-act-2014/care-act-easements-guidance-for-local-authorities

(11) Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020#:~:text=Police%20recorded%20crime%20data%20show,of%20these%20offences%3B%20therefore%20it

(12) Retrieved from https://hmicfrs.justiceinspectorates.gov.uk/publication-html/a-joint-thematic-inspection-of-the-police-and-crown-prosecution-services-response-to-rape-phase-one#foreword

(13) ibid

(14) ibid

(15) ibid

(16) Retrieved from https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf

(17) ibid

(18) Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimservicesenglandandwales/november2020#:~:text=There%20were%20294%20refuge%20services,2015%20to%203%2C923%20in%202020.

(19) Retrieved from https://www.womensaid.org.uk/wp-content/uploads/2019/12/NWTA-2017.pdf

(20) Retrieved from https://basw.co.uk/sites/default/files/resources/mca_briefing_v3.pdf

(21) Frontal lobe damage – possibly - Safeguarding-guide-final-August-2021.pdf)

(22) Retrieved from https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf

(23) Retrieved from http://safelives.org.uk/practice_blog/its-our-right-be-safe-any-age-how- can-we-make-it-easier-older-victims-get-help

(24) Retrieved from https://www.welshwomensaid.org.uk/wp-content/uploads/2017/06/Who-Does-What-to-Whom.pdf

Reflection on the process by which this SAR was completed.

Chronologies of relevant contact with Juliet were provided by the following agencies:

- Avon and Somerset Police
- NHS Somerset Integrated Care Board
- Somerset Council Adult Social Care
- Somerset Council Housing
- Somerset NHS Foundation Trust
- South West Ambulance Service NHS Foundation Trust
- The YOU Trust (provider of Somerset Domestic Abuse services)

These chronologies were combined into a multi-agency chronology and sent to the independent reviewer for comment and queries.

The Safeguarding Board's SAR Sub Group set terms of reference questions on which the independent reviewer was consulted.

The above agencies then completed Information Request templates which allowed the agencies to reflect on any learning arising from their contact with Juliet.

Juliet's partner Gary was invited to contribute to the SAR but did not respond. This meant that it was not possible to ask Gary for his consent to share any information taken from his medical records with the SAR.

Juliet's nephew decided to contribute to the SAR on behalf of himself and his father (Juliet's brother). Juliet's nephew will be provided with the opportunity to read and comment on the finalised SAR report.

A practitioner learning event was arranged to inform the SAR. This event was held virtually and was facilitated by the lead reviewer. The event was well attended and generated many valuable learning points.

The lead reviewer drafted the SAR report which was submitted to the Safeguarding Board's SAR Sub Group who provided feedback which was taken into account in drafting the final SAR report.