South Ribble
Community Safety Partnership

Executive Summary

Domestic Homicide Review

Name: Joan

Died: June 2019

Chair and Author: Ged McManus
Supported by: Carol Ellwood Clarke

Date: May 2021

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1 The Review Process

1.1 This summary outlines the process undertaken by the South Ribble Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Joan, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and their daughter in order to protect their identities.

Name	Who	Age	Ethnicity
Joan	Victim	64	White British
Brian	Perpetrator	66	White British
Kirsty	Daughter	Adult	White British

1.3 Joan and Brian lived together in South Ribble. They met in their late teens and had one child; a daughter Kirsty, who lived with them at the time of Joan's death.

1.4 Following the birth of their daughter, Joan's brother describes her relationship with him and other family members as 'sporadic'. He also describes Brian as having a controlling influence over her.

1.5 Joan had a number of long-term medical conditions which limited her mobility and affected the things that she was able to do in her day-to-day life. The panel was in no doubt that she was disabled within the meaning of the Equality Act. Kirsty helped to care for Joan but also worked and had other commitments. Brian was Joan's main carer although he too worked for some of the review period.

1.6 In some of her interactions with professionals, Joan complained that Brian was aggressive; being emotionally and financially abusive towards her.

1.7 In June 2019, Joan took her own life whilst alone at home.

1.8 An inquest was opened and adjourned immediately following Joan's death. The inquest was concluded on 2 September 2019 and the medical cause of death was recorded as suffocation.

The circumstances of Joan's death were recorded by the Coroner as:

'[Joan], who struggled with significant levels of pain, was found deceased at [address] on 9 June 2019 with plastic bags over her head, and having consumed a large quantity of her prescribed medications.'

The Coroner's conclusion, as to death, was suicide.

1.9 Following Joan's death, a referral was initially made to the Lancashire Safeguarding Adult Board for consideration of a Safeguarding Adult Review. During this process, it was discovered that domestic abuse may have been a factor in the case and the case was referred to South Ribble Community Safety Partnership.

1.10 On 22 April 2020, South Ribble Community Safety Partnership agreed the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review [para 18 Statutory Home Office Guidance][1]. The Home Office was informed on 19 May 2020.

1.11 The start of the process was delayed as a result of agency work pressures in the Covid -19 pandemic with the first meeting of the DHR panel taking place on 29 July 2020. Meetings took place using Microsoft Teams video conferencing and the panel met four times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final panel meeting took place on 23 February 2021 and the review was concluded on 14 April 2021 after Joan's brother had been given the opportunity to read and provide feedback on the report.

2 Contributors to the review

Agency	Contribution
Lancashire Constabulary	IMR
Lancashire Adult Social Care	IMR
Chorley and South Ribble CCG	IMR
Lancashire and South Cumbria NHS Foundation trust [LSCFT]	IMR

[1] Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it merges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

Lancashire Teaching Hospitals NHS Foundation Trust	IMR
gtd Healthcare	IMR
Victim Support	IMR
North West Ambulance Service	Chronology

3 **Members of the Domestic Homicide Review Panel**

3.1

Ged McManus	Independent Chair and author
Carol Ellwood Clarke	Support to Chair and author
Heather Corson	Community Safety and Safeguarding Manager, South Ribble Borough Council, Qualified IDVA
Damian McAlister	Review Officer, Lancashire Constabulary
Lorraine Elliott	Designated Lead Nurse for Safeguarding Adults & MCA, Chorley and South Ribble Clinical Commissioning Group
Liz Stanton	Refuge Manager, Clare House and Chorley Refuges
Rebecca Maylor	Business Coordinator, Lancashire Safeguarding Adult Board
Claire Powell	Area Manager, Victim Support
Dawn Sewards	Director of Governance - gtd Healthcare
Susan Porter	Specialist Safeguarding Practitioner, LSCFT

Cherry Collision	Safeguarding and MCA Named Professional, LSCFT
Rachel Holyhead	Named Nurse, Safeguarding Adults, Lancashire Teaching Hospitals NHS Foundation Trust
Bernadette Booth	Team Manager, Patient Safety and Safeguarding, Lancashire Adult Social Care
Pauline Bartholemew	Lancashire Adult Social Care
Laura Hudson	Lancashire Adult Social Care
Karen Simpson	Progress Housing [Lifeline]

3.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and author of the overview report

4.1 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board [not in Lancashire or an adjoining authority] and has chaired and written previous DHRs and Safeguarding Adult Reviews.

4.2 Carol Ellwood Clarke retired from public service [British policing] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

4.3 Both practitioners served for over thirty years in different police services [not Lancashire] in England. Neither of them has previously worked for any agency involved in this review.

5 Terms of Reference

5.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

5.2 Timeframe under Review

The DHR covers the period 1 May 2018 to Joan’s death in June 2019

5.3 Case Specific Terms

Subjects of the DHR

Victim: Joan, aged 64 years

Joan’s husband: Brian, aged 66 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[2] did your agency identify for Joan?
2. How did your agency assess the level of risk faced by Joan from Brian and which risk assessment model did you use?
3. What knowledge did your agency have that indicated Joan could be at risk of suicide as a result of any coercive and controlling behaviour?
4. How can your agency demonstrate that professionals understand what coercive and controlling behaviour is and the impact it has on victims?
5. What services did your agency provide for Joan and/or Brian and their daughter; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?
6. Was a carer's assessment offered and/or completed? If not, should it have been offered and completed.
7. What signs of carer breakdown did your agency identify and what was done to address the issue.
8. How did your agency ascertain the wishes and feelings of Joan and Brian about her victimisation and his alleged behaviour and were their views taken into account when providing services or support?
9. What did your agency do to safeguard Joan from domestic abuse?
10. How effective was inter-agency information sharing and cooperation in response to Joan and Brian and was information shared with those agencies who needed it?
11. What did your agency do to establish the reasons for Brian's alleged abusive behaviour and how did it address them?
12. Was there sufficient focus on reducing the impact of Brian's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?
13. Are there any examples of outstanding or innovative practice arising from this case?

[2] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

14. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Joan and Brian?

6 Summary chronology

6.1 Joan

6.1.1 Joan was born in Preston and was the eldest of three siblings. When Joan was about five, her father obtained employment working on the Concorde project in Bristol and the family moved south. When Joan was about eleven years old, the family moved back to the Preston area.

6.1.2 Joan did not pass the eleven plus exam that was in place in the area at the time and her brother felt that this affected her badly, as she was quite intelligent and was expected to pass the exam. During her teenage years her brother remembers that Joan was often in conflict with their father. When she left school at fifteen, Joan obtained work at a petrol station and continued to work there until she met Brian a few years later.

6.1.3 Once Joan and Brian had their daughter Kirsty, they reduced their contact with Joan's family and the family would only be in touch sporadically, for example by text messages and short telephone calls. Joan was invited to join her brother on trips to visit their mother, who by then lived on the south coast of England, but she never accepted the invitation. No reason was ever given, and Joan's brother was not sure if this was Joan's decision alone or if she was influenced by Brian. On one occasion, after inviting Joan, he was contacted by Kirsty who told him to leave Joan alone and stop bothering her.

6.1.4 Joan's brother recalled that as an adult, Joan had often been unwell. Most conversations with her were dominated by a discussion about how she was feeling and her medical conditions. He thought that some of the illnesses may have been due to her mental state as opposed to purely physical conditions and was aware that over the years the couple had spent significant amounts of money on private medical consultations.

6.1.5 In 2010, Joan fell and hurt her back when the door of a dishwasher that she was opening developed a fault. Subsequently, she suffered from a range of medical conditions which severely affected her day-to-day life and left her in severe pain. These included chronic back pain, osteoporosis, gout, asthma, spondylitis, sciatica, and depression. As a result of her medical conditions Joan had limited mobility and need assistance to complete some day to day

tasks such as cooking, cleaning and washing. In her later years she did not leave home alone as she needed assistance.

6.1.6 The many complexities of Joan's medical conditions meant that she was often admitted to hospital, had many home visits from medical professionals and carers, and was prescribed strong painkillers throughout the duration of the review period.

6.2 Brian

6.2.1 The DHR Chair wrote separately to Brian, Kirsty and Joan's brother inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[3] leaflet. No reply was received from Brian or Kirsty. At the end of the process the independent chair again wrote to Brian and Kirsty informing them of the progress of the review and inviting them to get in touch. On this occasion Brian did contact the chair. Brian outlined the stress that he had been under caring for Joan and how it had impacted on him, for example by increasing his drinking. He denied that he had ever been abusive to Joan in any way.

6.2.2 From November 2009 to June 2010, Brian suffered from severe depression, suicidal ideation and increased alcohol use requiring two voluntary inpatient admissions to support detox and alcohol management.

6.2.3 During the course of Joan and Brian's long marriage, there had never been a report of domestic abuse to the police. Brian was visited by the police on two occasions in 2018, as a result of welfare concerns raised by third parties, but other than that he was not known to the police and had no criminal record for any matter.

6.2.4 On 4 July 2018, Brian's employer contacted the police regarding a concern for his welfare. The police were told that he was under a lot of pressure as his wife struggled with her mental health. He was not receiving any help and couldn't cope. Brian was also thought to have issues with alcohol and had previously expressed suicidal thoughts. Police conducted a welfare check at Brian's home and found that he was safe and well in bed. No further action was taken.

[3] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

6.3 The relationship

6.3.1 Joan and Brian were married in 1974 and lived in their own home in South Ribble. For many years they jointly ran an electrical business but closed this in 2009. Joan told a medical professional that the reason for the sale was because of Brian's drinking. The couple both obtained other employment; Joan worked in a Sherriff's office dealing with debtors and Brian worked on the maintenance team at a school.

6.3.2 Kirsty helped to care for Joan but also worked and had other commitments. Brian was Joan's main carer although he too worked for some of the review period.

6.3.3 Joan's brother thought that Brian had a controlling influence over Joan. For example, she gave up her job and was not allowed to wear makeup or dress up in nice clothes. Both Joan and Brian enjoyed drinking alcohol but didn't go out to do so: largely staying at home. Brian brewed strong home-made beer and the couple would stay in and drink at home. Brian worked as an electrical contractor but gave that up after a fall out with his business partner. Joan assisted in the business.

6.3.4 In April 2018, Joan was visited at home by a social care support officer [Adult Social Care] and a number of home adaptations and aids were agreed. A referral was made to N-Compass[4] for carer's assessments for Brian and their daughter. By early May, Joan and Brian had purchased and had fitted a stairlift.

6.3.5 On 16 May 2018, an offer was made by Adult Social Care to arrange for carer visits one hour per day to assist Joan. Joan personally declined the offer as she didn't feel comfortable with strangers entering the house.

6.3.6 On 6 June 2018, Joan was admitted to Royal Preston Hospital [Lancashire Teaching Hospitals NHS Foundation Trust]. Joan was anxious and stated that she couldn't cope and would kill herself. She said that she had previously tried to suffocate herself. A safeguarding alert was made to Lancashire County Council Adult Social Care. The alert stated that:

'Husband was refusing to accept care services and was refusing to give Joan her medication. It stated that Brian was alcohol dependent and controlling of all aspects of Joan's care. It was stated that Brian had declined a Plan of Care

[4] https://www.n-compass.org.uk/our-services/carers/the-lancashire-carers-service

which had been requested. The frailty team were concerned about how the situation at home was affecting Joan's anxiety levels'.

6.3.7 On 3 July 2018, a social worker telephoned Joan following her discharge from hospital on 29 June 2018 in response to a request for assessment. Brian answered and informed the social worker that the family were at crisis point and Joan had been discharged from hospital without any support. He said that both himself and his daughter were on the verge of a breakdown as their mental health was suffering due to the lack of assistance. A care package of one hour visits each morning was agreed for the next two days. However, Brian later called an ambulance as Joan was in severe pain and she was admitted to hospital. During this admission, Joan said that Brian was drinking more and refused support. She was frustrated that a care package had not been resolved. Joan was discharged on 19 July 2018.

6.3.8 On 6 July 2018, a third party contacted the police following a conversation with Brian who was concerned about his wife coming home from hospital. He had said that he couldn't cope and it would be better if he wasn't here. An officer attended at Brian's home and found he was safe and well. Brian stated that he was working with Adult Social Care and they were going to provide a care package. He also stated that he resided with his daughter who was supporting him. The officer did not identify any other additional support that was needed and no further action was taken.

6.3.9 On 24 July 2018, Joan was admitted to hospital. During this admission, she raised concerns about Brian's drinking. A referral was made to N- Compass for a carer's assessment.

6.3.10 On 6 August 2018, Brian attended a GP appointment where he discussed that he was not coping well, was depressed and was drinking alcohol in excess.

6.3.11 Following the GP appointment, Brian was referred to LSCFT Minds Matter service. A 6-week course of talking therapy commenced 15 August 2018 to support anxiety and depressive disorder. At this time, Brian reported he was undertaking 2 jobs as well as caring for his wife, and although social care had arranged for carers to visit twice a day, Brian was struggling with this and was signed off work due to sickness. He felt down and miserable most days, he identified goals to get back to work, there was evidence of good engagement: no alcohol or substance misuse were noted. This was a timely appropriate intervention.

6.3.12 On 4 September 2018, at a GP appointment, Brian was drunk and had been suspended from work. He attended the practice for a review the following day and said that he had drunk a whole bottle of gin the night before. At a further appointment of 26 September 2019, Brian said that he was drinking 80 units of alcohol per week and had now left work.

6.3.13 On 2 November 2018, Joan telephoned Adult Social Care [Emergency Duty Team]. As a result of the call, a safeguarding alert was recorded. Joan said that:

- Neither husband nor daughter were assisting her to go to bed.
- She tried to get into bed herself which resulted in her spraining her wrist.
- She stated that her daughter shouted at her, called her a burden, that she didn't love her, hates her and wishes she was dead.
- Joan stated she was frightened of falling and is living on a knife edge.

The Emergency Duty Team spoke to Kirsty who said that she was struggling and felt her support was 'never good enough' for her mother. Crisis Care was arranged, providing four visits over the weekend, finishing late on the Monday evening.

6.3.14 On 20 November 2018, during a telephone consultation with a GP, Joan was distressed about her family situation. The doctor documented that Joan appeared to be very controlling and demanded that her daughter be her main carer.

6.3.15 On 27 November 2018, during a GP visit to see Joan at home, Brian was drunk and abusive. The GP found his behaviour frightening and checked that Joan and her daughter were ok. They declined any further support at that point.

6.3.16 On 7 January 2019, Joan activated her lifeline alarm and spoke to staff at the Progress monitoring centre. An ambulance was called and Joan was admitted to Preston Royal Hospital.

6.3.17 During the evening of 8 January 2019, an incident occurred when Brian was visiting Joan on a ward. Joan was visibly upset and told staff that Brian was an alcoholic and was not coping well. Brian was asked by staff if he needed help or needed to see a doctor but grabbed his bag and left before returning later. Joan told staff that Brian had grabbed her and made threats to hurt himself. She also told staff that Brian had previously said to her that she

'should just die'. Staff contacted the couple's daughter to check on Brian's welfare.

6.3.18 On 9 January 2019, the hospital safeguarding team was informed and a DASH[5] risk assessment was completed with Joan indicating a score of 10 – standard risk. The DASH noted ongoing emotional and verbal abuse. Joan said that she was hiding money in an attempt to curtail Brian's alcohol consumption and that she wanted him to leave the family home. A referral was made to Lancashire Victim Support.

6.3.19 Lancashire Victim Support called Joan the following day with an offer of support and assessment. Joan said that she was in hospital at the time so it was not convenient to do an assessment and she did not want any support. It was agreed that the worker would send her a text message with contact details should her circumstances change, or she changed her mind. The text message was sent and the case closed.

6.3.20 On 10 April 2019, Joan was admitted to Royal Preston Hospital. Over the weekend of 13 – 14 April 2019, Joan made a number of disclosures to staff that Brian was emotionally and verbally abusive towards her and that he handled her roughly. She repeated her previous concerns about his alcohol consumption and said that she did not want him to visit her.

6.3.21 On 15 April 2019, Joan showed staff text messages from her daughter indicating that Brian was intoxicated. The information was shared with Joan's named social worker. A member of staff began completing a DASH risk assessment but was called away to a medical incident and the process was not completed.

6.3.22 On 25 April 2019, a safeguarding alert was made to Adult Social Care by staff at Royal Preston Hospital. The alert identified that:

- Husband, is being financially and verbally abusive
- Husband has never been violent but is becoming increasingly aggressive and out of control which is getting worse

6.3.23 On 26 April 2019, Joan was discharged from hospital. She had been reluctant to go home and extensive discussions took place about an appropriate care

[5] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC]

package. The hospital discharge letter to Joan's GP stated that the discharge had been delayed due to "husband's violent tendencies". Guardian Homecare, a care agency, was asked by Adult Social Care [CATCH team] to provide four visits per day to Joan until 1 May 2019. The purpose of the visits was to support Joan with washing, dressing and meals. This crisis provision is intended to be a short-term service until an appropriate care pathway can be identified by Adult Social Care.

6.3.24 On 28 April 2019, an out-of-hours GP provided by gtd Healthcare visited Joan at home. The doctor noted that Joan was highly anxious, continuously talking and complaining about numerous things, including hospital treatment, medication burning in her gullet, Brian spending all their money on drinking, family members leaving her alone and not coming to listen to her. Brian told the doctor that Joan was driving everyone mad with non-stop complaining. Joan was refusing medication for anxiety as she did not feel that this was a problem. The doctor noted that Joan was highly anxious but had no ideas of self-harm. Appropriate medication was prescribed and the doctor completed a consultation report which was sent to Joan's own GP.

6.3.25 On 29 April 2019, Guardian Homecare received a report from the attending care worker that Joan did not require any care support that morning, but that Joan had highlighted that she was anxious and upset because of her husband drinking and spending her money. She said he was always drunk. Joan also played the carer a recording of a conversation between Joan and her daughter the night before, and the conversation was quite abusive. The concerns were reported to Adult Social Care. Staff from Adult Social Care [CATCH team] visited the following day and carried out an assessment with Joan which resulted in a request for reablement care and a referral for a carer's assessment for Joan's daughter.

6.3.26 On 12 May 2019, a safeguarding alert was made to Adult Social Care by Guardian Homecare. The alert stated that:

- Joan is scared of Brian, who is threatening violence.
- Joan is scared of disclosing abuse for fear of repercussions and scared to contact police in case Brian finds out.
- Joan's daughter drags her to bed.

This alert was made as a result of concerns that Joan raised directly with a care worker who was visiting to provide reablement care.

6.3.27 On 17 May 2019, Joan was taken to hospital following an intentional mixed overdose of oxycodone and diazepam. Brian was seen to have a bottle of vodka in his bag. He fell asleep in the emergency department relatives' room and was later found asleep in a corridor. He was verbally aggressive to staff and was escorted off site. Joan said, *'she didn't feel her family wanted her anymore and she would be better off dead'*. She was admitted to the hospital for assessment.

6.3.28 On 20 May 2019, whilst in hospital, Joan was assessed by a Mental Health Liaison Practitioner [Lancashire and South Cumbria NHS FT].
Joan said she was in pain, she felt a burden to her family and believed they did not want her at home. She described the relationship with her husband as strained and said that he became angry with her when he had consumed alcohol. Joan said she relied on her husband and daughter to provide her care.

6.3.29 On 24 May 2019, Joan was to be discharged from hospital but did not want to go home. She went to the toilet, wrapped her mobile phone charger cable around her neck but then called for assistance. Joan was seen again by a Mental Health Liaison Practitioner. She said she did not want to go home describing Brian as an alcoholic. Joan denied that there was any violence and declined permission for a safeguarding alert to be made. Joan declined a follow-up from the Home Treatment Team [as per the plan made from assessment on 20 May] although she accepted their contact number should she change her mind. It was noted that Joan had capacity[6] to make these decisions.

The ward staff were advised there was no change in Joan's mental state and that she could be discharged home with the plan for community services as per her previous assessment.

6.3.30 On 31 May 2019, Joan was discharged from hospital.

6.3.31 On 3 June 2019, Joan was seen by a GP and Advanced Nurse Practitioner at home. Brian was present. A plan was made to expedite a psychiatry appointment and to arrange a multi-disciplinary meeting.

6.3.32 On the evening of Friday 7 June 2019, Joan was visited at home by an out-of-hours GP provided by gtd Healthcare. This followed a series of contacts with 111 and health professionals as Joan was unable to cope with the pain she

[6] Mental Capacity Act 2005

was experiencing. She requested a change of medication and was prescribed oxynorm[7] liquid. The GP prescribed more than would be normally recommended by gtd Healthcare in order to ensure that Joan had sufficient medication to last over the weekend.

6.3.33 On 9 June 2019, Brian called the ambulance service. He said that he had been out for around two hours to pick his daughter up and came home to find Joan deceased. Paramedics arrived within a few minutes and confirmed that Joan was deceased.

6.3.34 Joan had two plastic bags tightly over her head secured with a Velcro type fastener. A postmortem examination confirmed that she had suffocated and also had multiple drugs in her system.

6.3.35 The police investigation into Joan's death included examination of her telephone and laptop computer. Joan's telephone contained a number of texts to her daughter, who was at that time away from the family home, stating that she was in a lot of pain. One example was:

"Yr father has been a pig today. Disyrict nurses were supposed to be coming by order of Gp but they havent come. Waited all day. Gonna have to drug myself up. If i cant stand pain. Ill have to ring 999. During night. Receptionist said [Brian] only rang at 1.20 today. If he had rung earlier they would of come no proplem. He is drinking still behind my back. He knows i cant check on him in conservatoy. Been in agony all day. Miserable gonna have to ring and go on my own. x why did he not just let me end it. I cant take this constant pain. Luv u so much"

6.3.36 On the day that Joan took her own life, she sent messages to her daughter saying that she was in agony and that she was dreading another night.

6.3.37 Internet searches on Joan's computer, under her username, showed that several suicide related websites had been visited on 7 June 2019: two days before her death. Searches included:
"can u kill yourself with oxynor",
"watch s to poison yourself",
"kill me quick" "im still here",

[7] OxyNorm liquid contains oxycodone hydrochloride. Oxycodone belongs to a group of medicines called opioid analgesics. OxyNorm liquid is used to relieve moderate to severe pain.

"help for suicidal thoughts"
"how many pain killers to kill yourself"
"injury profiles: suicide attempt (wrist lacerations)" "how do you slit your wrists" "is cutting your wrists the best way of suicide"
"how to support someone with suicidal thoughts"
South Ribble Crisis Team was also searched for along with advice on how to complain about your GP.

6.3.38 On 16 June 2019, Brian was interviewed by the police in relation to a suspicion that he had aided and abetted Joan's suicide. Brian answered all the questions that were put to him and the police found that there was no evidence to pursue a case against him.

7 Conclusions

7.1 By the time of her sad death, Joan had suffered from multiple medical conditions which resulted in severe pain for many years. The complexity of her physical and mental health was challenging for professionals and she had many contacts with medical and social care professionals.

7.2 During the course of Joan and Brian's long marriage, there had never been a report of domestic abuse to the police. Brian was visited by the police on two occasions in 2018, as a result of welfare concerns raised by third parties, but other than that he was not known to the police and had no criminal record for any matter.

7.3 The DHR panel were mindful of information from Joan's family that Brian may have had a controlling influence on Joan and recognised that many domestic abuse incidents are never reported. One report for example states:

'On average victims experience 50 incidents of abuse before getting effective help'[8]

Nevertheless, agencies were not aware of allegations of domestic abuse until June 2018, when Joan first alleged abuse whilst in hospital.

7.4 Prior to that time, Brian had appeared to be supportive, for example earlier in 2018 he had obtained a stairlift so that Joan could more easily move around the house. Joan's brother told the chair of the review that the couple had spent thousands of pounds on private medical assessments over the years.

[8] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

7.5 Once Joan began making disclosures of domestic abuse during 2018 and 2019, the main response of agencies was to make safeguarding referrals to Adult Social Care. This was a reasonable response from Preston Royal Hospital on two occasions. In addition, hospital staff conducted a DASH risk assessment on one occasion which did not result in further action beyond a referral to Victim Support. A call from Joan herself, to Adult Social Care, resulted in a third safeguarding alert and a fourth was raised by Guardian Homecare, a care agency which had been asked only a few days previously to be alert to the possibility of abuse.

7.6 The response of Adult Social Care across the four safeguarding alerts was to focus on Joan's health and social care needs. The allegations of abusive behaviour were assumed to be caused by the pressure brought about by Joan's medical needs. Brian and to some extent the couple's daughter Kirsty, were caring for Joan and the allegations were seen as signs of carer breakdown.

7.7 Adult Social Care focussed on relieving the perceived carer breakdown. In the course of the first safeguarding investigation, Brian was spoken to about the issues but Joan was not. Across all four safeguarding alerts there was no direct action to deal with allegations which amounted to domestic abuse and each alert was dealt with in isolation. There was no referral to a domestic abuse agency and there is no evidence that a domestic abuse professional was consulted at any time.

7.8 Assumptions were made that Brian's excessive alcohol consumption was as a result of the stress of the family situation. Whilst this may have exacerbated his use of alcohol, Brian had long-standing issues with excessive alcohol consumption and this information would have been available if sought. Similarly, no thought was given to the possibility of domestic abuse pre-existing the development of Joan's care needs.

7.9 The need for carer's assessments was recorded on five occasions and is said to have been actioned by making a referral on four of them. Only one referral was received by the organisation responsible [N- Compass] and when contacted by them, Brian and Kirsty declined support. Given that the approach to managing the four safeguarding alerts in relation to Joan's circumstances was said to be around carer breakdown, it is remarkable that so little was done to ensure that Brian and Kirsty had support to enable them to be effective carers.

7.10 Several agencies contributing to the review concluded that a multi-agency meeting would have been helpful in addressing the complexities of the family

situation. The panel agreed with that assessment and also thought that the input of a domestic abuse professional into the case would have been helpful.

7.11 The panel reflected on the differing information it had reviewed, with reports of domestic abuse from Joan, which were completely denied by Brian. The panel had no way of reconciling the differences, but noted that Joan's voice was clearly seen in contemporaneous records which the panel thought were an accurate reflection of Joan's views.

7.12 The panel could not draw a direct line between Joan's reports of abuse and her death. Joan clearly had a complex set of conditions that meant that she suffered intolerable pain despite being prescribed appropriate medication. Her texts and internet searches in the days prior to her death indicated that she was in pain and may have researched ways of taking her life. The panel did however recognise the impact on Joan due to the behaviour by Brian that she complained of and thought that had that behaviour been addressed, Joan may have been able to feel more positive about her life.

8 Learning identified

This multi-agency learning arises following debate within the DHR panel.

8.1 Narrative

The panel thought that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

Learning

Professionals will be better able to manage risk if they are familiar with research linking domestic abuse and suicide

8.2 Narrative

The panel thought that there was evidence of elements of coercive and controlling behaviour in the case that had not been recognised by practitioners.

Learning

Practitioners need to be provided with appropriate support and training in order to be able to recognise and act upon signs of abuse. Evidence provided by contributing agencies of training on coercion and control is inconsistent.

9 Panel Recommendations

9.1 Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.

9.2 Agencies contributing to the review should provide South Ribble Community Safety Partnership with detailed information on their plans to train staff in the coercion and control elements of domestic abuse.

9.3 The learning from this review should be shared with Lancashire Safeguarding Adult Board.

Single agency recommendations are shown in the action plan at Appendix A. It should be noted that all learning points for Adult Social Care are to be taken forward in a single action.

Appendix A Action Plan Joan DHR South Ribble Community Safety Partnership

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
South Ribble Community Safety Partnership							
1	Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.	Local					
2	Agencies contributing to the review should provide South Ribble Community Safety Partnership with detailed information on their plans to train staff in the coercion and control elements of domestic abuse.	Local					
3	The learning from this review should be shared with Lancashire Safeguarding Adult Board.	Local					

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
Single Agency recommendations							
Clinical Commissioning Group							
	Robust use of Carer's Register and "Think Family" approach.	Local	Practices to be reminded about the importance of coding of medical records to clearly identify vulnerabilities.	CCG	All practices are reminded to keep problem lists uncluttered for clarity of thought. Coding of records will be undertaken in a staged approach with priority patients coded.	April 2021 To commence April 2021 due to mass vaccination programme	
	Domestic abuse enquiry, use of professional curiosity.	Local	Routine enquiry about domestic abuse, in a safe environment to be carried out by clinicians in primary care as per NICE Guidance PH50. Utilise key messages from a recent DHR to avoid duplication of efforts.		Recirculate the Sample DA policy to all practices. Practices will receive a training update session from Lancashire Victim Support Service to support routine enquiry being embedded in primary care.	April 2021 April onwards 2021	
	Management of complex cases and use of multi-disciplinary meetings.	Local	Access to case supervision from GP Lead/ CCG / LSCFT safeguarding professionals.		Circulate LSCFT Safeguarding duty line number to support in the management of complex cases in children and adults.	April 2021	

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					LSCFT Safeguarding team requested to provide presentation update to primary care teams regarding their role.		
	Guidance for non-attendance where vulnerability is a feature.	Local	Utilise key messages and learning from previous DHR Adult E.		Was not brought policy is reviewed and circulated to Primary care.	April 2021	
	Safety of practitioners when lone working.	Local	Use of Flag or Special Alerts in medical records to be embedded across primary care to identify risk factors.		Lone working policy to be reviewed to establish if information sharing is included. Circulation of lone working policy to remind practices regarding safety of practitioners and information sharing.	April 2021	
	Effective responses to communication and information sharing between Primary Care and gtd via use of special patient notes.	Local	Primary Care and gtd to work together to ensure that gtd have access to all relevant information where appropriate to support information sharing and response to safeguarding and domestic abuse.		Information sharing in response to safeguarding and domestic abuse is strengthened by new information sharing process.	April 2021	
Victim Support							

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
	Victim Support will review its policy and processes to ensure that where appropriate a referrer is notified when a victim declines support.		Policy to be amended.	Victim Support	Staff are trained in new policy.	June 2021	
Adult Social Care							
	Adult Social Care should review its policy and processes in relation to cases where domestic abuse is disclosed and produce a new pathway and guidance for staff dealing with such cases. The introduction of the new pathway should be supported by case audit to ensure that appropriate progress in implementing the pathway is maintained.		New pathway written and agreed.	Adult Social Care	Staff are trained in new pathway. Audit plan in place.	July 2021	

End of overview report 'Joan'