Nottingham City Safeguarding Adults Board Safeguarding Adults Review 'Valentina'

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1. Introduction

1.1. This Safeguarding Adult Review (SAR) explores the sad circumstances of Valentina's death. Valentina had mental health needs; she had a diagnosis of Emotionally Unstable Personality Disorder and physical health needs due to her diabetes.

1.2. Valentina died in 2019, having taken a deliberate overdose of her insulin. At the time of taking the overdose, Valentina felt overwhelmed by stressful life events. Valentina had been the victim of sustained domestic abuse from her ex-partner. In the months leading up to her death, Valentina had also been attempting to claim Personal Independence Payment (PIP) through the Department for Work and Pensions (DWP). Problems within this process caused her extreme anxiety and distress. This additional stress significantly increased her risk of self-harm and suicide.

1.3. Valentina received a high level of support from her family and from agencies. The Nottingham City Safeguarding Adult Board (NCSAB) believed that there was learning about how agencies had worked together in relation to supporting Valentina and reducing the risks of harm arising from stressful events.

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together.

2.2. The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again*'.[1]

2.3. The Care Act stipulates that Safeguarding Adults Reviews should be completed within 6 months of initiating it, unless there are good reasons for a longer period being required. This review was delayed due to legal proceedings and the Covid pandemic. The terms of reference recognised the passage of time since Valentina's death and learning also considered changes that have occurred since that time.

2.4 NCSAB commissioned an independent author to carry out this review. The author is an experienced chair and author of reviews, holding a professional background in mental health social work and safeguarding adults. The author is independent of NCSAB and its partner agencies.

2.5. The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[2]. The principles apply to the review as follows:

[1] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014 (updated January 2022)*
[2] Ibid

Empowerment:	Understanding how Valentina was involved in her care; Involving her family in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether reasonable and proportionate responses were provided to risks presented; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

3. Valentina and the Background for this Review

3.1. Valentina was a white British woman in her twenties when she died in 2019. Valentina was found unconscious in her home following a deliberate overdose of insulin. She died in hospital having been in a coma for ten weeks. The Coroner was unable to determine whether Valentina intended to die.

3.2. Valentina's family describe her as a vibrant, bubbly person who once met, would not be forgotten. Sadly, Valentina had been troubled by her mental health for most of her life. She had experienced trauma as a child, and this affected her psychological wellbeing into adult life. Valentina also had type 1 diabetes, diagnosed as a young child. This impacted on her physical and psychological wellbeing. Valentina had used her insulin as a means of self-harm from a very early age and she had been supported by Child and Adolescent Mental Health Services.

3.3. By early adulthood, Valentina was experiencing multiple difficulties and had many episodes of self-harm. A diagnosis of an Emotionally Unstable Personality Disorder was established which Valentina accepted.

3.4. Valentina's personality disorder meant that she experienced high levels of anxiety and agoraphobia. She could become quickly overwhelmed by day-to-day stresses of life. Valentina had difficulty managing her emotional responses. This led to impulsive and high risk/reckless behaviours, including self-harm and suicidal behaviours. Valentina could struggle with relationships, and this would extend to her family. However, they understood her challenges and sustained their love and support for her throughout. Valentina was reliant on this support from her family as well as the support of a few trusted professionals.

3.5. Valentina was an intelligent woman who had had successful employment. She wanted to be able to go out to work, be financially independent and socialise. Sadly, her mental health prohibited this. Latterly, she struggled to cope with going out at all. Despite her personal challenges, Valentina could be very caring toward others. Her family recalled an incident a few months before she died. Someone collapsed outside her house. Despite her anxiety about leaving her house, she went out to help them, staying with the person to care for them.

3.6. Valentina was very self-critical, blaming herself for her mental health difficulties and believing she was a failure. Like many people, Valentina used substances and alcohol as a coping mechanism and had a long history of this. Sadly, it had the adverse effect and exacerbated her mental health difficulties.

3.7. In the years leading up to her death, Valentina was struggling to cope with multiple significant stress factors in her life. Her use of alcohol and cocaine increased, and Valentina's risk of self-harm and suicide was a constant feature.

3.8. Valentina was a survivor of domestic abuse. This had a major impact on her mental health. She had experienced multiple abusive relationships for many years. She was first known to Women's Aid when aged 19[3]. She had experienced significant trauma within previous intimate relationships including allegations of rape. In the last years of her life, Valentina was experiencing physical, psychological and sexual domestic abuse from a man she had had a relationship with, referred to within this review as 'Dave.'

3.9. In 2015, Valentina became pregnant with Dave's baby.[4] Her pregnancy was difficult due to her physical health needs, and she was supported by a specialist midwife.

3.10. Valentina's family described her deep love for her child. She was determined to build her child's resilience by letting them know how much they were loved. Sadly, Valentina struggled to provide her child with the care she wanted to due to her mental health difficulties, self-harming behaviours and use of substances. Valentina's child was also exposed to the continued domestic abuse from Dave towards Valentina. These factors necessitated involvement of Children's Integrated Services. Valentina recognised she needed help in parenting. Her parents recall Valentina asking them to adopt her child. In 2018, the Court made a Child Arrangement Order for the child to be cared for by Valentina's parents.

3.11. Understandably, Valentina found the separation from her child very difficult. Not being able to be the parent she wanted to be, was a significant stress factor for her. In her mind she had failed. Records indicate that this pain was exploited by Dave through continued psychological abuse relating to her parenting abilities.

3.12. Valentina's parents were always clear that they were only providing care for her child as a temporary measure until she could take back her role as primary care giver. Valentina was desperate to achieve this before her child started school. She was committed to tackling her mental health and social circumstances, but also felt the pressure of making this recovery in a relatively short period.

3.13. Valentina had a high level of support from her family. Her parents would provide her with food and pay bills when she ran into difficulties. Valentina also lived in a house owned by them.

[3] At the time of their involvement, Women's Aid was provided by Women's Aid Integrated Services WAIS and this is the service referenced through this report – they have since changed their name to Juno Women's Aid

[4] The gender and name of Valentina's baby is anonymised

Valentina's sister provided substantial social and emotional support, particularly when Valentina was in crisis.

3.14. Valentina's life was plagued by unremitting domestic abuse from Dave. During the last three and a half years of Valentina's life, the severity and recurrent nature of the abuse to Valentina by her ex-partner had resulted in six referrals to the Multi-Agency Risk Assessment Conference (MARAC)[5].

3.15. Valentina received support from many agencies during this period. This included her GP, Health Visitor, Adult Social Care; Adult Mental Health Services and Children's Integrated Services, Police and Women's Aid Independent Domestic Violence Advisors (IDVA's).

3.16. Valentina had been receiving benefits including Disability Living Allowance (DLA) due to the effects of her diabetes. When Personal Independence Payments (PIP) were introduced to replace DLA, Valentina voluntarily applied for PIP. She experienced significant challenges with the application process; she could not progress her PIP claim and her claim for DLA was stopped. Valentina accrued significant debts and was struggling to manage financially. This additional stress, on top of her other life stress factors, significantly increased her episodes of self-harm and the risk of suicide.

3.17. At the time of Valentina's death, Valentina was due to attend an assessment with a health professional for a PIP claim. Valentina was highly anxious about this prospect. Her Community Psychiatric Nurse (CPN) had attempted, unsuccessfully, to persuade the DWP agent Capita, to revise their decision and allow the assessment to be carried out at her home. In the week before Valentina was due to attend the assessment for her PIP claim, she took a large overdose of insulin. Valentina was found, in a coma with the appointment letter by her side. Sadly, Valentina did not recover and died ten weeks later.

3.18. The Coroner was highly critical of DWP and Capita and issued those agencies a Regulation 28 Report to Prevent Future Deaths.[6] This review does not seek to duplicate the Coroner's inquest but does draw upon the findings. This review examines how agencies worked together to support Valentina. It considers whether there were opportunities to have reduced the significant stress that led her to self-harm and sadly resulted in her death.

3.19. The review also considers the changes that have been put in place since Valentina died and additional learning that can improve future multi-agency responses to people in similar circumstances to Valentina.

[5] MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors
[6] Duty to provide a report to prevent future deaths. Provided under regulation 28 Coroners (Invetigations) Regulations 2013.

4 Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1 The NCSAB commissioned this SAR having carefully considered the criteria for a SAR[7] and the criteria for holding a Domestic Homicide Review (DHR).[8] The NCSAB decision was that due to the complex circumstances surrounding Valentina's death, a SAR rather than a DHR was the most appropriate vehicle for learning. However, the terms of reference (TOR) had significant weighting toward understanding Valentina's experience as a survivor of domestic abuse and agencies' response to this. The review benefitted from the contributions from specialist domestic abuse services and commissioners.

4.1.2. The review has focused on the period 1ST January 2016, the date when records about Valentina's abusive ex-partner began- until October 2019, when sadly, Valentina died. However, agencies were asked to also provide information of relevance to the TOR before that date. The specific areas of enquiry are as follows:

Terms of Reference

1. Was Valentina's experience of domestic abuse recognised by agencies in a timely manner or were opportunities missed for earlier intervention?

2. Was the support offered by agencies sufficiently attractive to encourage Valentina to engage and did it meet her needs as a survivor of domestic abuse? Did each agency recognise their responsibilities in respect of supporting Valentina and undertake them as contractually or statutorily required? Did they also meet their wider responsibilities towards Valentina as a young mother with complex and enduring mental health needs?

3. Did practitioners raise the possibility of Valentina experiencing domestic abuse as part of their routine enquiries? Did they explore further if domestic abuse was disclosed? When recording incidents of domestic abuse between Valentina and her partner (or previous partners) where they treated separately or identified as part of a wider pattern of escalating behaviour?

4. Was the primary perpetrator identified and the risk they posed managed effectively, including following internal and multi-agency procedures? Were the offender's needs recognised and where they consulted as part of this process?

[7] Section 44 *Care Act 2014*
[8] DHRs introduced within the Domestic Violence, Crime and Victims Act 2004. Home Office: Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf [Accessed November 2021]

5. Did professionals working with Valentina recognise, and respond to, the likely impact upon her mental health of being a survivor of domestic abuse? Did they similarly account for the impact upon Valentina's mental health when children's services made the decision that her child's needs would be best met by placing them in the care of others.

6. Did the multiagency DASH-RIC / DART / MARAC pathway perform as expected? Where there any issues or blockages that affected the care provision Valentina might reasonably have expected to receive as a consequence of her case having been through this pathway?

7. Were there any other organisational or multi-agency blockages that prevented or delayed a timely and effective response by agencies (single or multi-agency) in respect of supporting Valentina? If so, at what point(s) did these occur and what where the reasons?

8. Did those agencies involved in supporting Valentina as a survivor of domestic abuse through the criminal justice system do so as might reasonably be expected? Specifically, did they recognise, and respond to, the persistent and ongoing abuse she was experiencing from her ex-partner?

9. Did all agencies concerned have safeguarding adults' policies and procedures that provided sufficient and accurate guidance to professionals working with clients experiencing domestic abuse, such as Valentina?

10. Was the quality of risk assessment and subsequent decisions and actions arising from those assessments satisfactory? Did domestic abuse feature as a risk in these assessments?

11. Did assessments consider whether decision-making may be impaired due to mental capacity and/or mental ill health and did appropriate actions follow?

12. What factors enabled and empowered Valentina to self-protect or acted as a barrier to her doing so? To what extent were her views considered?

13. How well did agencies consider equality and diversity and adapt intervention accordingly?

14. Was there evidence of positive practice by the agencies involved?

15. What are the learning points from this review? What changes have already been made in organisational practice and what further recommendations for single agencies and the partnership will strengthen multi-agency working and reduce the likelihood of a similar situation occurring in the future?

4.2. Methodology

4.2.1 NCSAB approach to this SAR was to ensure full exploration of learning while making the most effective use of existing information and efficient use of resources. The SAR reviewed the information provided for the Coroner's Inquest, along with the Inquest findings and responses to the Coroner's Regulation 28 report. Agencies were asked to provide additional information as relevant to the TOR.

4.2.2 A learning event with agencies and practitioners involved, used structured discussion to explore good practice and learning points.

4.2.3. Understanding the experiences of those receiving support from agencies is central to learning. Valentina's family have been actively involved throughout the Coronial proceedings. Valentina's family have been committed to ensuring that there is learning from her death and generously gave their time to this review. This gave valuable insights into Valentina's experience. Their knowledge helped us appreciate the many aspects of good practice by professionals, as well as identify areas of learning and improvement.

4.2.4 SARs need to carefully consider the privacy and dignity of the people who are the subject of the review. Valentina's family requested the review be published under a pseudonym, and chose the name Valentina. Her family had given careful consideration to how information would be shared with her child at the appropriate stage, so that they could learn more about their mum. The family's preference was also to use the term 'survivor' rather than 'victim' of abuse in relation to Valentina, although we recognise that the abuse to Valentina continued until her death.

4.2.5. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement	
Department for Work and Pensions (DWP)	Valentina was in receipt of Disability Living Allowance in addition to other benefits and had been in the process of claiming Personal Independence Payment at the time of taking an overdose that led to her death.
Juno Women's Aid	Juno Women's Aid contributed to the review but were named Women's Aid Integrated Services at the time they were providing domestic abuse service to Valentina. Valentina was first referred to Women's Aid aged 19. She was re-referred in February 2016. Their Nottingham City independent domestic abuse advisor (IDVA) team, remained involved until February 2019
NHS Nottingham and Nottinghamshire Clinical Commissioning Group (NNCCG)	Provided information relating to the GP Practice where Valentina had been registered since 2015

Nottingham Crime and Drugs Partnership	MARAC is a partnership arrangement focused on coordinating care to people at highest risk domestic abuse. The MARAC Steering Group Coordinator provided information regarding the six meetings when Valentina was discussed
Nottingham and Nottinghamshire Coroner	Valentina's death was subject to an inquest. The SAR accessed the Coroner's findings and the Coroner's Report to Prevent Future Deaths
Nottingham CityCare Partnership (CityCare)	Provider of NHS community healthcare services. CityCare Health Visitor provided care for Valentina and her young child for a 2 year period, ending 2017.
Nottingham City Council Adult Social Care (ASC)	ASC were involved with Valentina from 2018, providing support for activities of daily living.
Nottingham City Council Children Integrated Service (CIS)	CIS became involved with Valentina and Dave following the birth of their child in 2015. They provided early help services and child protection measures until a Child Arrangement Order was made in 2018.
Nottinghamshire Healthcare NHS Foundation Trust (NHCT)	Valentina was supported by a range of services including inpatient and community mental health services; crisis provision and specialist services for people with a personality disorder.
Nottinghamshire Police	Police had a high level of involvement with Valentina and Dave in response to multiple incidents of domestic abuse and welfare responses to Valentina following self-harm.
Nottinghamshire Probation Service	Dave had periods on license. At the time, his Offender Management was provided by a Community Rehabilitation Company. (CRC)
Nottingham University Hospitals Trust	Provided clinical care to Valentina throughout her life due to her diabetes. NUH also provided care via their Emergency Department including responses to self-harm.

4.3. Structure of the Report

This report is structured as follows:

- Section 5 provides a summary of key events
- Section 6 provides analysis and learning relating to those events
- Section 7 reviews what changes have been put in place since Valentina's death
- Section 8 provides a conclusion
- Section 9 makes recommendations for continued improvement

5. Summary of Key Events

5.1. In **2015**, Valentina was in a relationship with Dave. She was pregnant and had been experiencing domestic abuse from him. Dave had already received a Non-Molestation Order but had continued to harass Valentina. Court imposed an 18-month Community Order with supervision along with a rehabilitation requirement.

5.2. Valentina had struggled with her pregnancy. She had received additional support from a Nottingham University Hospitals Trust (NUH) specialist midwife and Nottinghamshire Healthcare NHS Foundation Trust (NHCT) adult mental health and peri-natal mental health service. Valentina had talked about the psychological abuse she experienced from Dave. Peri-natal mental health services continued to support her during the baby's first year.

5.3. The domestic abuse from Dave continued and Children's Integrated Services (CIS) became involved in **2016**, due to concerns about the safeguarding and welfare of the baby. Their early help service, Targeted Family Support Team (TFST), supported Valentina and her baby for the next 6 months. They referred her to the Sanctuary Scheme[9] and Women's Aid. Valentina's GP had also referred her to Women's Aid who remained involved until February 2019.

5.4. The threats and harassment from Dave continued with him threatening to take their baby and shoot Valentina. Police referred Valentina to the Domestic Abuse Referral Team (DART) who identified her and her child's needs and signposted to the relevant partners for the delivery and coordination of early intervention harm reduction strategies, safety planning and interventions. Dave was made subject to another Non-Molestation Order but was soon in breach of that order. Women's Aid made a referral to MARAC. Adult Mental Health Services ended their involvement later that year.

5.5. In **February 2017**, Valentina took an overdose with a stated intention to end her life. CIS became involved again. They carried out an assessment and convened a family meeting to identify what support the family could offer. TFST became reinvolved.

5.6. Valentina had been depressed and was having suicidal thoughts. Valentina expressed fears that Dave would follow up on threats to kill her and their child but did not feel confident in reporting to police. She continued to be supported by her GP who carried out a risk assessment for safe prescribing decisions. The NHCT community mental health services (CMHS) also became reinvolved.

5.7. **In March 2017**, Dave hit Valentina on her head with a glass jar. The ambulance service made a referral to DART. Dave was arrested and charged with assault and breach of Non-Molestation Order. Despite the arrest, he breached the Non -Molestation order again the following day and was remanded to Court. Dave was convicted of Common Assault and Battery to Valentina and received an 18-month Community Order with a requirement to attend the Building Better Relationship (BBR) programme.[10]

5.8. During this period, the Health Visitor, CIS and Valentina's CPN shared concerns about her child's emotional wellbeing. They were concerned that Valentina and Dave had resumed their relationship and that Valentina's mental health had deteriorated with increased self-harm, suicidal behaviours and substance misuse. At a 'Priority Families' meeting, Valentina expressed that she was scared to fully end her relationship due to threats from Dave.

[9] The Sanctuary Scheme, offer security adaptations for adults who have experienced domestic abuse, such as reinforced doors, alarms and cameras.

[10] Building Better Relationships was introduced to probation services in 2012. The aim of this programme is to reduce re-offending and promote the safety of current and future partners and children. The programme is accredited for male perpetrators of domestic abuse within heterosexual intimate relationships.

5.9. Valentina began working with the NHCT Personality Disorder and Development Network and was open to that service for four months.

5.10. During **2017**, there were two further referrals to MARAC by Women's Aid and TFST. These followed disclosures by Valentina of rape and continued harassment by Dave, including exploiting her mental health. He was again in breach of the Non- Molestation Order. Valentina expressed feeling let down by the Criminal Justice System and had difficulties in trusting the police. Her IDVA was working with Valentina and the police to help build their relationship.

5.11. Dave was arrested for a further breach of Non-Molestation Order. The Court extended the Order. At the MARAC his Offender Manager discussed that Dave had attended the induction session for BBR. They were concerned about his lack of insight. He did not accept that his texting, phone calls and altercations with Valentina were wrong. The Offender Manager had increased Dave's reporting requirement to fortnightly supervision.

5.12. Valentina's GP was aware of the MARAC referrals and was having a high level of contact with her. They requested involvement from the NCHT mental health services. The GP and Valentina discussed her medication and negotiated safe prescribing measures – initially this was daily collection to reduce risks of over-dose but then revised to weekly as Valentina was finding going out every day stressful.

5.13. In **September 2017**, Women's Aid made a further referral to the MARAC. Dave had been texting Valentina's parents, believed to be trying to cause conflict between them and Valentina. Valentina voiced "*this is what [Dave] wants, me to feel abandoned by her parents …He wants to push me to suicide*". The MARAC discussions recognised Dave was exploiting Valentina's mental health issues. Valentina had disclosed two rapes in the last 5 months, committed by Dave in her home. At the time, Valentina was on the waiting list with the Personality Disorder Network for counselling. Police had made a referral to Adult Social Care (ASC) as agreed by Valentina.

5.14. During **October 2017,** Valentina was victim of further domestic abuse incidents. Her mental health deteriorated, along with an increased use of alcohol and cocaine. Valentina had to be admitted to hospital intensive care following a significant overdose that required the police to break in. The ambulance service and hospital alerted ASC and CIS. CIS completed a Children's Assessment. Valentina's parents had applied to the Court for a Child Arrangement Order, as advised by CIS. Valentina had given her support for this but understandably, was also distressed by the prospect. CIS provided a report to the Court recommending the Order and the Court granted an Interim Child Arrangement Order.

5.15. Valentina was being supported by ASC and NHCT and was awaiting specialist Mentalization Based Therapy (MBTi)[11] provided through NHCT. She was offered a place on the introduction to MBTi group. However, in **December 2017**, Valentina took a further significant over-dose of her insulin. She was allocated a CPN from NHCT's CMHS who took on the role of Care Coordinator. This CPN remained involved for the remainder of Valentina's life.

[11] Mentalisation Based Therapy is a type of long-term psychotherapy that helps the person make sense of thoughts beliefs and feelings and to link these to actions and behaviours. It can be helpful for people with personality disorders

5.16. Police referred into the MARAC in **January 2018** as Valentina had reported a further breach by Dave of the Non-Molestation Order. Dave was arrested, charged, and received a 20-week custodial sentence.

5.17. In **April 2018**, Dave was released from prison. Immediately on his release, he proceeded to try and contact Valentina. Valentina's mental health continued to be fragile and her GP and CPN discussed her medication plan. Valentina's father, with her consent, was asked to control her medication, providing it to her weekly.

5.18. In **May 2018**, the Court made a Child Arrangement Order for Valentina's child to live with her parents. The Court also made a Prohibited Steps Order against Dave. CIS then ended their involvement.

5.19. Dave continued to breach the Non-Molestation Order and in **June 2018**, he was issued with a Restraining Order. Women's Aid made a further referral to MARAC.

5.20. Dave persisted in contacting Valentina on social media. He received charges for three breaches of his Orders. Valentina voiced her dissatisfaction with the police response. During **July and August 2018**, Valentina took four significant overdoses having consumed alcohol, cocaine and cannabis. This, culminated in her being detained under the Mental Health Act 1983 for inpatient mental health care.

5.21. Women's Aid made a further referral to MARAC in **September 2018**, due to the ongoing harassment/stalking by Dave. Dave was subject to licence conditions to see his Offender Manager from the Community Rehabilitation Company (CRC), two- three times per week. He was also required to attend the BBR programme, attend unpaid work and supervision meetings. However, Dave showed no regard for two Court Orders directing him to have no contact with Valentina.

5.22. Later that month, Dave was found guilty of three breaches of his suspended sentence. His suspended sentence was extended for a further three months. Valentina was very upset that he had not been imprisoned.

5.23. Following this, Valentina disengaged with her IDVA and Women's Aid. The IDVA had no further contact with Valentina although they kept her case file open for a further four months. Although Valentina did not make any further formal reports to police of incidents of domestic abuse from Dave, Valentina's family confirmed he continued unremitting harassment.

5.24. Valentina was discharged from mental health inpatient care in **October 2018**. She was offered further care through a rehabilitation unit but declined. The day after discharge, Valentina self-harmed again.

5.25. In **November 2018**, Valentina made a claim to the DWP, for Personal Independence Payment (PIP). This was registered as a voluntary reassessment from her current benefit DLA to PIP. Once Valentina made a claim to PIP, she was required to comply with the PIP process, any non-compliance put her current DLA payments at risk of being stopped. As DWP had no record of

receiving Valentina's completed form, a reminder letter and text were sent to her in **December 2018.**

5.26. In **January 2019**, Valentina began involvement with the NHFT MBTi Service with weekly contact in preparation to begin the formal therapy. The DWP wrote to Valentina, advising her that her PIP forms had not been received and that her DLA would stop, if not contacted by her. The DWP subsequently stopped Valentina's DLA reducing her benefit payments. She continued to receive separate benefits from HMRC during this period although her income was substantially reduced.

5.27. In **March 2019**, Valentina's CPN noted a deterioration in Valentina's mental health. Valentina reported she was in debt to friends and to loan companies. The CPN contacted the DWP on Valentina's behalf, confirming that Valentina had sent the forms in some weeks ago. The DWP PIP advisor asked the DWP case worker for special consideration and to search for the forms or send more forms out. The DWP recorded on their system that the calls had been made by Valentina, rather than by her CPN. Following this call, DWP reviewed the earlier decision to stop her DLA claim but the decision remained unchanged.

5.28. Valentina's distress continued. Her home conditions deteriorated, and she had increased frequency and severity of self-harm, by cutting and burning herself, taking excess medication with alcohol. Valentina had a further period of inpatient mental health care and carried out further self-harm when on leave.

5.29. On discharge, Valentina's mental health remained poor. The harassment by Dave continued. Soon after discharge, Valentina took an insulin overdose in **April 2019** but alerted a friend to what she had done. Later that month, Valentina took a further overdose of her insulin. She called police who were concerned about her mental health as she was presenting with distorted beliefs and perceptions.

5.30. Valentina commenced a second application for PIP. As DLA was no longer in payment, the DWP registered this as a new claim.

5.31. In **May 2019**, the DWP referred Valentina's second PIP application to Capita, an independent provider who had been contracted by the DWP to assess claims for PIP. The form was accompanied by supporting letters from Valentina's CPN and from her diabetes nurse, sent by recorded delivery.

5.32. In **June 2019**, Valentina called the DWP to ask for the decisions on ending her DLA to be reconsidered. She described to the DWP staff, the impact of the last 6 months of no claim. She had £5000 of debt and said she was not able to survive without money. Her CPN also phoned DWP on several occasions and sent a report to the DWP and Capita, stating that Valentina required a home consultation due to her mental health needs.

5.33. Valentina's CPN also contacted the DWP directly to advocate on her behalf. This was successful. The DWP reinstated Valentina's DLA and Income Support Disability Premium, back paid to January 2019. Valentina's original PIP claim from November 2018 was also reopened. This meant her second claim was closed, along with the referral to Capita for that claim and the supporting letters and reports from her clinicians.

5.34. One week later, Capita wrote to Valentina in relation to her original claim. They informed her of their decision that she should attend for a face-to-face assessment for PIP at a clinic.

5.35. Valentina's home conditions had deteriorated further. Her CPN had referred her for Care and Support and ASC outreach service became involved. Valentina's CPN also spoke with her about her escalating drug use and agreed a referral to the Nottingham Recovery Network.

5.36. During **July 2019**, Valentina's family had a planned trip abroad. Her CPN was concerned about the increase risks of self-harm during this period as the CPN was also due to be on leave. The CPN arranged for cover arrangements by another CPN. Valentina was still seeing a psychologist while awaiting the MBTi therapy. Her CPN had encouraged her to attend drug's services and called to take her to an appointment, but Valentina declined to attend it. As Valentina's mental health declined, there was an increase in chaotic and self-destructive behaviours. She was seen by the team Psychiatrist, Psychologist and additional support provided by the team support worker.

5.37. Valentina's anxiety increased as the assessment appointment for PIP with Capita neared. The interim CPN contacted Capita the day before her appointment in **August 2019**, to advocate again for a home-based assessment. Capita appeared to have none of the supporting letters and reports from Valentina's clinicians that had been sent with her second claim, and limited knowledge about the complexity of Valentina's case. Valentina's father provided a copy of the original letter written by Valentina's CPN. Her appointment was rescheduled for 2 weeks hence, but Capita maintained their stance that they would not offer a home-based assessment.

5.38. When Valentina's CPN returned from leave, they again attempted to advocate with Capita for a home-based assessment. Capita declined, with the explanation that they required medical evidence. Capita also noted that if Valentina cancelled the appointment, the claim would need to be started again as she had already cancelled one appointment.

5.39. Valentina and her CPN talked about her drug use – Valentina acknowledged growing dependency but did not accept an offer to refer her to drug services. The following day, Valentina attended a meeting with a therapist at the Personality Disorder Network. She said she was looking forward to starting the therapy sessions in September. She had ongoing thoughts of suicide but no plans.

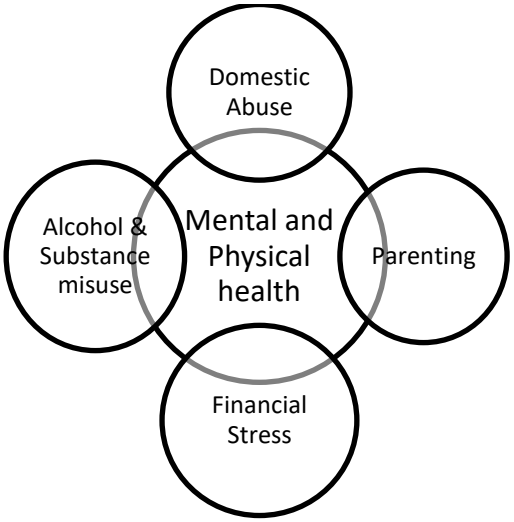
5.40. That evening, Valentina drafted some notes that had the appearance of a suicide note. She had been texting her sister but did not disclose suicidal thoughts to her.

5.41. The following morning, Valentina's sister and father gained access to her home as they hadn't been able to contact her. Valentina was unconscious. The letter from Capita requiring her to attend a face-to-face appointment in a weeks' time, was next to her. Valentina was in a coma having taken an overdose of insulin along with cocaine and cannabis. An ambulance conveyed her to hospital where she remained in a coma. While in hospital, Dave attempted to contact her, presenting himself as a family member. Hospital had been alerted by Valentina's family to this risk and had a safety plan in place that prevented his direct contact with Valentina.

5.42. Two weeks later, Capita determined they could decide Valentina's claim on the information available without further assessment and PIP was awarded. Sadly, this was too late for Valentina. She died in hospital ten weeks after her admission due to brain injury from insulin overdose.

6. Analysis and Learning

Valentina's background and the chronology of her last years, highlights the significant stress factors that she was coping with and the impact of this on her mental and physical health.



These stress factors are inter-related but for the purposes of analysis and learning for this review, are considered under the headings:

- Care for Valentina's Mental and Physical Health
- Agencies' Responses to Domestic Abuse
- Supporting Valentina as a Parent
- Agencies' Responses to Financial Stress

6.1. Care for Valentina's mental and physical health.

6.1.2. Valentina had complex physical and mental health care needs that required skilled intervention by compassionate practitioners.

6.1.3. Research indicates that people with a diagnosis of Emotionally Unstable Personality Disorder can experience discrimination by services.[12] They may experience biased, judgemental responses, their distress disregarded, and risks minimised under the false belief that their behaviour is attention seeking. These attitudes were discussed at the reviews Learning Event. Participants were clear that those practitioners supporting Valentina's physical and mental health demonstrated care, compassion, and sensitivity in how they engaged with Valentina.

[12] British Journal Medical practitioners Current healthcare challenges in treating the borderline personality disorder "epidemic 2018;11(2):a1112 https://www.bjmp.org/files/2018-11-2/bjmp-2018-11-2-a1112.pdf [Accessed September 2021]

6.1.4. Valentina received a high level of input from Primary, Community and Secondary Health services along with support from Adult Social Care. There was substantial evidence that Valentina received very good care and treatment, for her physical and mental health. This view was echoed by Valentina's family.

6.1.5. Valentina's GP was an important figure in her life. Her family commented on the complete trust that Valentina had in her GP. Her GP had taken time to build up this relationship of trust. They worked in partnership with Valentina, respecting her views and wishes whilst carrying out risk assessments and negotiating appropriate protective actions, for example, safe prescribing when Valentina was at high risk of over-dose.

6.1.6. The author of the GP report noted the flexibility and empathy shown by the GP to Valentina and their responsiveness when she was in crisis. Valentina's family were also appreciative of the way the GP involved them in her care and treatment.

6.1.7. There was evidence of the central role her GP played in coordinating her care: making appropriate referrals onto specialist services and communicating with those specialist teams in managing her care.

6.1.8. Valentina had been supported by the NUH specialist diabetes service for most of her life. The author of the NUH report, highlighted the high quality of care provided to Valentina by that service. The team worked with Valentina to enable her self-management of diabetes.

6.1.9. The NUH author did note that although Valentina's mental and physical health needs were both considered, they appeared to be addressed separately by the diabetes service. More could have been done to explore the inter-play between mental and physical health including the psycho-social stress factors that de-stabilised her and led to her misuse of insulin.

6.1.10. However, it is also recognised that it could be challenging for the diabetes service to engage with Valentina. They were often working with her at points of crisis as Valentina had difficulty adhering to appointment dates or times. The service understood this and demonstrated flexibility and responsiveness to her, ensuring her safety and liaising with her GP.

6.1.11. The NUH author felt that the separate IT record systems between NHCT mental health services and NUH created a challenge to information sharing. The NHCT mental health assessments were carried out in NUH, but records were not visible to NUH staff. That said, on the many occasions when Valentina attended NUH Emergency Department due to self-harming behaviours, there was appropriate liaison with mental health services and her GP in discharge planning. Staff were respectful of Valentina's feelings and wishes and considered her capacity at relevant points, for example when she wished to take her own discharge before being clinically recovered.

6.1.12. NHCT Mental Health Services had extensive involvement with Valentina. Valentina received care from Crisis and Inpatient Services when her self-harming behaviours could not be safely managed in the community. Family reported that Valentina found the inpatient care over-whelming and their management of her diabetes dis-empowering. However, NCHT inpatient services had to balance her autonomy to manage her diabetes with the potential risk of

continued self- harm. Valentina also found the change of personnel in the crisis team too difficult to engage with, needing time to build trust with individuals.

6.1.13. At times Valentina communicated her anger and frustration to professionals regarding not feeling supported by mental health services. NHCT Community Mental Health Services (CMHS) recognised the challenges she had and worked hard to keep her engaged. The evidence indicated that Valentina received a very high standard of care by CMHS, a view shared by her family.

6.1.14. CMHS recognised that in her latter months, Valentina was at ongoing risk of self-harm and suicide. This was well articulated in her records. The intent behind Valentina's self-harming behaviours varied. At times she would wish to die but at other times, the harm was a response to distress, and communicating this to others. CMHS had helped Valentina establish a safety plan to seek help and she used this well, alerting her father and sister or messaging a friend. Her experience demonstrates the complex picture and challenges of risk management that is common to many people with personality disorders.[13]

6.1.15. The CMHS worked intensively with Valentina toward risk reduction, providing additional support from the multi-disciplinary team at points of crisis and working closely with her GP. There was good demonstration of working in partnership with Valentina. Services frequently considered Valentina's capacity to make relevant decisions, maximised her involvement and that of her family who advocated for her when she was unwell. There was also good demonstration of least restrictive care[14] through positive risk taking i.e. weighing the potential benefit or harm in supporting her risks within the community.

6.1.16. Valentina's mental health care was coordinated by her CPN, working with others in the team and with Social Care who provided support in activities of daily living.

6.1.17. Valentina's family commented upon the role that the CPN played as '*outstanding*' and was much valued by Valentina and by them. The CPN built a strong therapeutic relationship with Valentina and used this to support her through crisis, enabling small steps toward recovery. The CPN understood Valentina's anxiety about engaging with professionals and made efforts to introduce new workers to Valentina in her own home.

6.1.18. As will be discussed in the following sections, there was also good evidence of the CPN working holistically, trying to help Valentina with the major stress factors in her life. The CPN tried to help Valentina address her problematic drug and alcohol, recognising the detrimental effect it had on her wellbeing.

[13] National Institute of Mental Health Borderline Personality Disorder NIMH » Borderline Personality Disorder (nih.gov) [Accessed November 2021]
[14] Partnership and Least Restrictive Care are two of the guiding principles within the Mental Health Act Code of Practice. Department of Health: Mental Health Act 1983 Code of Practice 2015 Guiding Principles. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF [Accessed November 2021]

6.1.19. The cycle of behavioural change is well established in alcohol and substance misuse services – this plots the different stages of motivation in addressing problematic substance use.[15] The evidence indicates Valentina's CPN used windows of opportunity for pre-motivational interviewing with Valentina and took practical steps such as offering to transport her to appointments with drug and alcohol service. Sadly, although Valentina wanted to manage her substance misuse, she was not ready, or able, to engage in drug and alcohol services. Valentina relied on substances as a coping mechanism. This made it difficult for her to control, while pressures such as domestic abuse continued to dominate her life.

6.1.20. Research highlights the dichotomy where women may use alcohol and substances to cope with abusive situations. However, the use of drugs and alcohol, may increase their vulnerability to domestic abuse as well as create other problems in their lives.[16] This was evident in Valentina's experience. The Stella Project Toolkit[17] highlights the need for services to work with women with co-occurring problematic substance misuse and domestic abuse, limiting the harm caused to themselves and others by the drug and alcohol use. The guidance highlights the importance of working in a way that enables choice and control and multi-agency working. Valentina's CPN did encourage Valentina's choice and control. However, a more coordinated multi-agency approach to addressing substance and alcohol use would have been beneficial as part of a domestic abuse protection plan. This is discussed further in section 6.2. below.

6.1.21. Valentina was also offered specialist psychological therapies, this being the most effective long-term treatment for people with a personality disorder. Historically, she had benefitted from the NHCT Personality Disorder Network and then latterly, been referred for their MBTi course. However, at the time of her death, Valentina had been on the waiting list for nearly two years. The waiting time was in part due to the in-depth and long-term nature of this psychotherapy and the need for preparatory work to be done. Start was also delayed as Valentina had recurring periods when her mental health was too unstable to cope with therapy, along with ambivalence about remaining on the waiting list.

6.1.22. Valentina's family viewed the input from NHCT Personality Disorder network as excellent but highlighted that Valentina needed more of it. Valentina was driven to improve her mental health in time for her child starting school and the wait to begin MBTi increased this pressure for her. However, Valentina was supported through one-to-one work with psychologists. Their assessments and interventions recognised the impact of her past and current traumas, as well as other stress factors in her life.

6.1.23. The network had also provided psychoeducation for Valentina's family in the past. This had been of great benefit in helping them to understand Valentina and the best way to help. They

[15] World Health Organisation (2003) Intervention for Substance Use: Brief Intervention for Substance Use: a Manual for Use in Primary Care -Draft https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf [Accessed November 2021]
[16] Alcohol Concern's information and statistical digest Grasping the nettle: alcohol and domestic violence Revised edition, 2010 Sarah Galvani, University of Bedfordshire https://equation.org.uk/wp-content/uploads/2012/12/Factsheet-Alcohol-and-Domestic-Violence.pdf [Accessed November 2021]
[17] Stella project Toolkit https://avaproject.org.uk/wp/wp-content/uploads/2016/08/Stella-Project-Toolkit-2007.pdf [Accessed November 2021]

felt this work with families should be available, even if the person is declining to engage in therapy. Valentina's Mother had also valued the support provided in the past by the NHCT Carers' support services.

6.1.24. Valentina's family also wished to commend Nottinghamshire Police's response to Valentina when she was in mental health crisis. Police knew her well, the vulnerabilities and risks she faced. Valentina's family recalled an incident where police responded following an episode of self-harm. The officers spent over two hours with Valentina, contacted her sister and drove her to her sister's house for care and support. Her family described the officers' nurturing and compassionate response as exemplary. Police followed up their interventions with Public Protection Notices to alert Health and Social Care within the Domestic Abuse Referral Team (DART) to incidents of concern.[18]

6.1.25. Sadly, despite the good practice in evidence by many different practitioners, ultimately the stability of Valentina's mental health was dependent upon psycho -social factors that dominated her life. This is considered in the following sections.

6.2. Agencies' Responses to Domestic Abuse

6.2.1. The chronology gives some insights into the unrelenting abuse from Dave, that Valentina experienced in the final years of her life. These recorded incidents did not capture the true extent of what Valentina was going through. What we now know is Dave continued his harassment and threats up to the point of Valentina's death. By this point, Valentina had given up reporting incidents to police and had disengaged from her Independent Domestic Violence Advisor (IDVA). She felt let down by the Criminal Justice System. Valentina expressed feeling imprisoned due to Dave's abuse. She felt a victim, not only of the abuse, but the consequences the abuse had on her mental health, problematic substance use and parenting. An exert from her IDVA records gives some insight to her experience:

'…….he took the city I grew up in and made it a place I couldn't stand to be anymore…'

[responding to comments from her IDVA that she is worthy and strong*]*
'Yeah and look where that has got me all his breaches and still out there. He is free and I am locked away'

*[*The day after court following an extension of a suspended sentence*]*
'That's what broke me. I report and do everything and then nothing happens. These orders are not worth the paper they are written on.'

6.2.2. Research highlights the correlation between domestic abuse and suicide, where those trapped by domestic abuse may see suicide as the only way out.[19]The risk of suicide should always be

[18] The DART comprises specialist professionals from Police, Health, Children's Integrated Services and Adult Social Care. The DART will share information and refer to appropriate points with individual agencies. https://equation.org.uk/product/domestic-abuse-referral-team-dart-process/

[19] Professor Sylvia Walby 'The Cost of Domestic Violence', London: Women and Equality Unit, 2004

considered by those working with survivors of domestic abuse. All agencies involved with Valentina were aware of her domestic abuse and the impact it had on her mental health, including her risk of self-harm and suicide. During the scope period, there were multiple referrals to the DART and six MARAC meetings. Despite the efforts by those agencies, they were not able to curtail Dave's abuse to Valentina.

6.2.3. The review has considered the responses by individual and collective agencies. There are many accounts of how individual practitioners tried to support Valentina, but also some points of learning. It was clear in the GP records that domestic violence was considered at each crisis point as a predisposing and precipitating factor to her mental health deterioration. Similarly, during the period that Valentina was being supported by a Health Visitor, the Health Visitor asked Valentina about domestic abuse at every contact and provided a high level of support, liaising with other agencies involved.

6.2.4. NUH had flagged a safeguarding alert in Valentina's records so that staff were aware of her high-risk domestic abuse. The alert included prompts for staff to ask questions relating to potential abuse, to complete the DASHric,[20] supported by the NUH safeguarding teams. There were some positive examples of this being effective, for example, in Valentina's last admission, staff were vigilant and disrupted Dave's attempts to contact her. However, NUH also noted some earlier missed opportunities by their midwifery and diabetes services, for staff to make further enquiries, carry out safety planning; complete DASHric forms and liaise with other agencies to safeguard her and her child.

6.2.5. Valentina's family commented on the positive role that her IDVA had taken and how much Valentina valued their support. The IDVA had had extensive contact with Valentina, but this was primarily through texts. The author of the Women's Aid report felt that the IDVA's work would have benefitted from more face-to-face contacts to understand Valentina's true circumstances. This would have improved the IDVA's ability to advocate on her behalf, as well as support work on her mental health and drugs and alcohol use and to explore housing options.

6.2.6. As outlined above, NHCT understood well the impact domestic abuse had on Valentina's mental health. Domestic abuse featured in her risk assessments and led to increased therapeutic support. Valentina's CPN accessed specialist 1:1 supervision to help her provide effective responses. There was good evidence of the CPN escalating their concerns to their MARAC representative regarding Daves continued staking and harassment of Valentina. There was also good evidence of vigilance by NHCT inpatient services, for example when Dave attempted to contact Valentina, posing as her uncle. The use of an 'alert flag' in her NHCT records, served to alert staff and a password was used that was known only to Valentina and her parents. However, NHCT also noted that there were opportunities where health practitioners could have completed a DASH risk assessment. NHCT recognised that during the scoping period, the

https://www.lancaster.ac.uk/fass/resources/sociology-online-papers/papers/walby-costdomesticviolence.pdf [Accessed November 2021]
Aitken, R & Munro, V. 'From Hoping to Help', 2020. http://wrap.warwick.ac.uk/112043/ [Accessed November 2021]

[20] The Domestic Abuse, Stalking and Harassment and 'Honour'-based violence Risk Indicator Checklist (DASH RIC) form that should be used by all non-police workers in Nottingham and Nottinghamshire who receive a disclosure of domestic abuse. The form helps assess risk and make an appropriate referral for support, including to the MARAC.

DASHric/MARAC pathway was not fully embedded in NHCT and this was reflected in the low numbers of referrals into the MARAC from their services.

6.2.7. Adult Social Care noted that the response to the referrals related to Domestic Abuse was appropriate and in line with best practice. However, their author felt that domestic abuse was not considered sufficiently in the Standard Needs Assessments aimed at supporting Valentina in her activities of daily living. Safeguarding minded practice needs to be integral to all interventions and this was not sufficiently demonstrated.

6.2.8. Police were responsive to the incidents that Valentina reported. The author of the Police report felt that there had been some inconsistencies in the risk assessment gradings made by their officers. Most incidents were graded as medium risk although others, with similar situations were graded high. Dave's manipulative behaviours led to a complex picture. At times, the breach had occurred when Valentina had initiated contact. Valentina made contact to prevent Dave from contacting and harassing her family as a means of further emotionally abusing her. Dave would also present himself as a 'rescuer' when Valentina was threatening suicide although police recognised this and pursued charges. The police author's view was that officers in general, made appropriate decisions and actions to mitigate risk.

6.2.9. Valentina struggled to have confidence in police and felt her experiences of stalking and harassment were minimised. However, Valentina's family recognised that officers were often constrained by what information Valentina was willing to share and the difficulties in locating Dave. They viewed police as very supportive and non-judgmental.

6.2.10. There was also learning about the effectiveness of multi-agency working. Referrals were made to the MARAC appropriately and in a timely way, including use of professional judgement regarding level of risk. All agencies contributed good quality research to the MARACs and the MARAC was effective in bringing this information together. However, there were limitations in the quality of action planning that followed. The MARAC action plans would have benefitted from greater structure in terms of addressing the key issues arising from the discussion; detailing the different aspects of risk, and then setting out each parties' role in a protection plan linked to those risks. There was a tendency for generalised 'feeding back' or 'continued support.' There was limited evidence of measurable or timed outcomes and not all agencies reported back on outcomes from previous actions.

6.2.11 Contributors acknowledged that the volume of the MARAC referrals affected the capacity for more detailed discussion and planning. At that time, there was not extended time available for discussions of repeat referral cases. Developments in this area are noted in section 7 below. Learning from this review indicates the Community Safety Partnership should review the quality of MARAC action plans and determine whether a different format would aide a more structured risk assessment, taking due account of sector guidance.[21]

6.2.12. Agencies also recognised the need for multi-agency working beyond the MARAC. The author of the Women's Aid report referenced the danger that the MARAC is seen as a panacea for

[21] Safe Lives MARAC action plan example https://safelives.org.uk/sites/default/files/resources/MARAC%20action%20plan%20example%20FINAL.pdf [Accessed November 2021]

domestic abuse. The MARAC can only be as effective as the quality of the protection plan and the *ongoing* collaboration between professionals that occurs *within* and *out with* the MARAC to follow through on that protection plan. There was limited evidence of this.

6.2.13. Agencies referenced the tendency to view Women's Aid IDVA as the service that was carrying out the work on domestic abuse rather than seeing this as a multi-agency responsibility. The reality was that though the IDVA had extensive in-direct contact with Valentina, they only had five face-to face visits with her. There was limited information within the Women's Aid records of other professionals involved. Though a MARAC action in September 2018, had been for liaison between the IDVA and Offender Manager, this coincided with Valentina ending contact with her IDVA. There had been very limited communication between the IDVA and other agencies involved beyond the discussions at the MARACs.

Learning Point 1:
Multi-agency working in domestic abuse, needs to extend beyond information sharing at the MARAC. Effective outcomes in reducing risks are dependent upon:

I. the quality of information shared
II. the quality of protection plan that arises from that information
III. ongoing collaboration and coordination between key agencies, beyond MARAC meetings.

Recommendation 1.1.
Nottingham Community Safety Partnership should assure the quality of the MARAC protection plans, auditing against relevant sector guidance/quality markers for effective domestic abuse protection plans.

The Partnership should use the audit findings to review the current format of the MARAC meetings and action plan template, with the aim of facilitating more robust and structured protection planning.

6.2.14. The use of interventions to curtail Dave's abusive behaviours, was explored in some detail at the review Learning Event. Dave took little heed of the legal sanctions used. There were at least twelve occasions when police took action against Dave for breaches of the various orders, he was made subject to. We know that this record of breaches was a mere shadow of what Valentina actually experienced. Police talked of their frustration in not being able to do more to contain Dave's abusive behaviours.

6.2.15. The Magistrates' Court did use the range of sanctions available to them for the relevant offences, but the Crown Prosecution Service's case was dependent upon the evidence available to them.

6.2.16. Agencies recognised that the whole picture of unremitting abuse had not been clearly collated. Police reflected that the breaches were dealt with as stand-alone offences. There was no indication of stepping back to assess a pattern of offending. The Women's Aid records similarly did not collate well, Valentina's history of abuse.

6.2.17. Although Valentina had stopped reporting the abuse to police, she continued to talk to her CPN and to her IDVA about incidents of harassment. Valentina did not want to report the incidents to the police though was encouraged to do so. Some incidents had been referred to the DART. ASC commented that the work undertaken by ASC on receipt of the DART referrals, followed risk assessment and decision-making processes appropriately. However, NHCT noted that although they had significant involvement with Valentina, they were never notified of any standard/medium risk domestic abuse incidents from other agencies. NHCT do not have a practitioner within the DART and were not aware of the IDVA's referrals to the DART. This raises questions about the effectiveness of information sharing at that time, beneath the threshold for the MARAC.

6.2.18. This lack of agencies building a picture of all known incidents of abuse, was a significant missed opportunity. Guidance reinforces that sharing information gives the opportunity to understand and identify risks accurately. [22] This supports effective safeguarding and informs decisions about suitable services. The guidance discusses proportionate sharing, '*It may be that information is shared with one, two or three agencies before you are satisfied the risk is such that the information should be shared widely to ensure the best multi agency response.'* Practitioners may be limited in what information they can share without consent, where the incident is assessed as medium or standard risk. The DASH guidance emphasises where possible, sharing information with consent but also emphasises provisions to share information in circumstances where the adult is vulnerable, pregnant or has children.

6.2.19. All of this was very pertinent to Valentina. Had the full picture of the nature, frequency and severity of abuse been collated, this may have provided the necessary evidence to pursue prosecution for a Stalking or Controlling/Coercive offence. Sentencing guidelines considers aggravating factors, such as vulnerability of the victim, previous convictions and offences committed whilst on bail.[23] Sentencing for coercive control gives a greater range of sanctions available to the Courts, with a maximum of five years custody.

6.2.20. It is not clear to what degree practitioners discussed this with Valentina to inform her decisions about reporting incidents to the police. Valentina's father confirmed that had Valentina's had faith that there would be consequences to Dave's actions, she would have been more likely to have disclosed and agreed for that information to be shared. Respecting her decision not to report to the police, should not have prevented practitioners sharing information between agencies about the continued harassment.

Learning Point 2:
There was a missed opportunity for agencies to collate information about all incidents. This may have built evidence for a Stalking or Controlling/Coercive Behaviour offence, offering more extensive legal sanctions.

[22] Safe Lives Sharing Information to Reduce the Harm Caused by Domestic Abuse: A Practitioner's Guide https://safelives.org.uk/sites/default/files/resources/A%20Practitioner%27s%20Guide%20to%20GDPR%20-%20England%20%26%20Wales%20version.pdf [Accessed November 2021]
[23] Sentencing Council Controlling or coercive behaviour in an intimate or family relationship Serious Crime Act 2015, s.76 https://www.sentencingcouncil.org.uk/offences/magistrates-court/item/controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship/ [Accessed November 2021]

There needs to be effective systems in place to share information about all domestic abuse incidents both within the MARAC and below this threshold. Practitioners need to develop competence and confidence in applying information sharing guidance to support effective decision making and safeguarding practice.

Recommendation 1.2.
The NCSAB and Nottingham Community Safety Partnership should review mechanisms to strengthen multi-agency responses to domestic abuse for incidents below the threshold for MARAC. This should include a feasibility/cost/benefit analysis for DART to use ECINS[24] for non-MARAC cases and include consultation with agencies partnered in the DART.

6.2.21. The heavier legal sanctions could have given greater protection to Valentina and an opportunity to engage Dave in more in-depth, offence related work. Probation discussed the limitations of short sentences in making any meaningful change in offending behaviours, particularly when there is no Rehabilitation Activity Requirement to give one-to-one oversight by an Offender Manager. During the scope period, there had been ten different sentences passed that had no oversight by an Offender Manager. This limited the relationship that the Offender Manager was able to establish with Dave and therefore their ability to influence change.

6.2.22. In the last few months of Valentina's life, Dave had been attending the 'Building Better Relationships' programme. His Offender Manager had informed the MARAC of their concerns about Dave's attitude, his rigid and concrete thinking and that he was likely to need intensive BBR. In the latter months of their engagement. Dave gave the outward appearance of being something of a 'model' attendee at the BBR programme. He attended each session, appeared to be insightful, was reflective about his behaviour and on the surface, was motivated to change.

6.2.23. What we now know, is that during this time, Dave continued to harass Valentina in insidious ways, calculated to cause distress. Her family gave an example of him putting ten pence into her bank account so he could add a reference about himself; this signalled that he was still there, still controlling her. Because agencies and Valentina, had not shared information about these behaviours, Dave's Offender Manager remained unaware of his continued abuse.

6.2.24. Dave had been very delayed in beginning the BBR programme. This was first made a requirement in March 2017, but it was not until later in 2018, that he had any meaningful engagement with the programme. This was due to a period in prison; due to his shift patterns and inability to drive having been disqualified due to cannabis use. Valentina gave this as an example of how his needs were considered while she felt hers were dismissed.

6.2.25. BBR is the only HM Prison & Probation Services (HMPPS) domestic abuse accredited programme for service users in the community.

[24] Empowering Communities Inclusion and Neighbourhood Management System (ECINs) a cloud hosted profile (person) based multi-agency case management system. It is designed to facilitate closer and more effective partnership working by allowing for the secure storage of information in a single place that multiple agencies can access. It facilitates real time updates and can also create and then issue automatically tracked tasks between users and agencies.

It was accredited as an effective programme for male perpetrators of domestic abuse within heterosexual intimate relationships. BBR aims to increase a perpetrator's understanding of why he abuses his partner, improve his pro-social relationship skills, and reduce his risk factors.

6.2.26. Valentina's sister questioned the efficacy of BBR. She felt it merely taught Dave the right things to say rather than change his behaviours. There is a risk that perpetrator programmes can increase the risk of abuse to survivors and so victim support is often built into programmes such as BBR. At the time when Dave first commenced the BBR in 2017, Nottingham's Women's Safety Worker scheme was in its infancy. There was no record of Dave's probation officer completing a referral during the period Dave was on the BBR – it was not standard practice at that time.

6.2.27. An inspection of Community Rehabilitation Companies (CRC) work with perpetrators of domestic abuse, reported in 2018.[25] This report was critical of the CRC's work with offenders, finding that Offender Managers were not empowered to deliver a good quality domestic abuse service, with restrictions on resources and driven by targets of the CRC private companies. The inspection found Offender Managers had unmanageable workloads, and many needed more training and oversight. While staff were generally responsive to the offenders' requests to postpone attendance, such as employment obligations, the inspection questioned the scrutiny of evidence to support these requests. As a result, some domestic abusers were excused from BBR inappropriately.

6.2.28. It is not clear to what degree these inspection findings were relevant to the BBR work with Dave.

6.2.29. The BBR programme was due for evaluation and re-accreditation for use by CRCs in 2019. In the HM Prison and Probation Service's response to that inspection report[26] the action plan promised: '*HMPPS and MoJ are committed to evaluating BBR and plans are in place to start work in 2019/20 to establish the most appropriate evaluation approach.*'

6.2.30. An update on that action plan dated November 2019, simply stated: *'The feasibility study to assess the most appropriate methodological approach for an evaluation of BBR remains on track for delivery by the end of 2019/20'*

6.2.31. Since this time, there has been radical changes in the Probation Service and CRCs are no longer in existence.[27] The National Offender Management office confirmed that the Covid pandemic has caused delays to evaluation activity. MoJ Data & Analysis continue to scope the potential of a good quality reoffending impact evaluation.

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[25] Domestic abuse: the work undertaken by Community Rehabilitation Companies (CRCs) A thematic inspection by HM Inspectorate of Probation September 2018 https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2018/09/Report-Domestic-Abuse-the-work-undertaken-by-CRCs.pdf [Accessed November 2021]

[26] HM Prison and Probation Service Domestic Abuse HMIP Action Plan https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958559/Domestic_Abuse_thematic_HMPPS_Action_Plan__FINAL_UPDATE_November_2019_.pdf [Accessed November 2021]

[27] HM Government Strengthening Probation, Building Confidence https://www.gov.uk/guidance/strengthening-probation-building-confidence [Accessed November 2021]

An independent study of BBR, 'Building Better Relationships? Interrogating the 'Black Box' of a Statutory Domestic Violence Perpetrator Programme'[28]has been critical of BBR, concluding:

'*BBR was not necessarily redressing male perpetrators' reasons for violence, and sometimes aggravating the difficulties behind them in ways that were not conducive to better relationships. …..I concluded that coercive and superficial interventions that do little more than tinkle with (supposedly) faulty cognitions were unlikely to provide abusive men with the internal and external resources they needed to build better relationships*.'

6.2.32. As BBR remains a main programme for rehabilitation within the reunified National Probation Service, it seems imperative that its efficacy is formally evaluated. A national recommendation is made to this effect.

Recommendation 2

6.3. Support to Valentina as a Parent

6.3.1. The focus of this section is the support offered to Valentina as a parent. It is not the remit of this review to examine the child protection arrangements that were made, or the decisions that led to those arrangements, save to note, a child's welfare is paramount.[29] The risks surrounding a child's exposure to domestic abuse; parental substance misuse and mental health needs, are well documented[30] and there is no doubt that Valentina's child was vulnerable to this trio of risks.

6.3.2. As outlined in section 3, Valentina had great love for her child. She was distressed that she could not be the parent she wanted to be. Valentina was hard on herself, feeling she had failed as a parent by not being the main care giver. Sadly, she did not give herself credit for the protective parenting she demonstrated. Valentina had a good understanding of the impact her mental health could have upon her child. She recognised that she needed help from others. She talked about the network she could contact to ensure the safety of her child if she was too unwell to care for them: professionals such as her Health Visitor, her GP, perinatal psychology, the hospital as well as her family. Ultimately, she set her needs aside and was courageous in asking her family to temporarily take care of her child for her.

[28] Building Better Relationships? Interrogating the 'Black Box' of a Statutory Domestic Violence Perpetrator Programme A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities School of Social Sciences 2020 Nicole Renehan https://www.research.manchester.ac.uk/portal/files/188959394/FULL_TEXT.PDF [Accessed November 2021]

[29] HM Government Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf [Accessed November 2021]

[30] NSPCC learning https://learning.nspcc.org.uk/children-and-families-at-risk/parental-substance-misuse [Accessed September 2021]

6.3.3. The evidence indicates that Valentina was supported well by services in relation to parenting. Her Health Visitor from CityCare, GP, CMHS and Children's Integrated Services (CIS) worked closely together with good evidence of 'Think Family'[31] in their interactions.

6.3.4. Valentina had a high level of support from the same Health Visitor who developed a good rapport with her, gave additional support if her parents were away and attended the GP with her to add support. The Health Visitor also recognised the complexity of her mental health needs and sought specialist advice from mental health services. CIS TFST provided additional support in parenting as well as in relation to domestic abuse, through safety planning, referring to specialist domestic abuse agencies and to the MARAC. CIS reflected that as concerns increased, this should have been escalated to Social Care at an earlier stage to carry out a Children's Assessment. However, when it was escalated, there was good partnership working with all agencies.

6.3.5. Agencies recognised the key role Valentina's family provided, both as a source of support to her as a parent, and as an important protective factor to her child. This was explored through Priority Family meetings and led to supporting Valentina's parents to obtain the Child Arrangement Order. CIS noted that while remaining child focused, agencies were also highly sensitive and responsive to the impact upon Valentina that this separation would have. Valentina's child had been spending increasing time being cared for by Valentina's parents, but agencies worked with Valentina's family to keep her at the centre of her child's life. When the Court granted the Child Arrangement Order, CIS ended their involvement, and a different locality Health Visitor became involved. However mental health services increased their support to Valentina, and her role as a parent continued to feature in their therapeutic and safeguarding interventions. One example was when Valentina required an in-patient admission, her CPN advocated for admission locally to maintain contact with her child and family.

6.3.6. Notwithstanding the good practice that was demonstrated, agencies also highlighted two key learning points.

- **A Child is Not a Protective Factor**

6.3.7. Mental health practitioners recognised that Valentina was motivated to think of her child's needs, and this helped her to focus on her mental health recovery. However, the NHCT author was rightly critical of practitioners' referring to her child as 'a protective factor,' against self-harm and suicide. This reiterates findings from a recent Child Safeguarding Practice Review from Nottinghamshire.[32]

Learning Point 3:
Adults need to provide protective factors to the child; a child should never be described or viewed as a protective factor for the parent. This risks a child viewing themselves as responsible for their parent's wellbeing and safety – a responsibility no child or young person should have.

[31] Social Care Institute for Excellence At a glance 9: Think child, think parent, think family 2012 https://www.scie.org.uk/publications/ataglance/ataglance09.asp [Accessed November 2021]

[32] sn20childsafeguardingpracticereviewfor.pdf (nottinghamshire.gov.uk)

- **Risks from Domestic Abuse in Child Contact Visits**

6.3.8. Valentina's Health Visitor recorded an incident, pre the Child Arrangement Order, where Valentina was providing the supervision for Dave to have contact with their child at her home. Dave was subject to a non-molestation order due to the repeated incidents of harassment and stalking behaviours. He had not sought contact with their child through the Family Courts.

6.3.9. The circumstances surrounding this incident are not clear. However, CityCare highlighted that Dave may have been using the contact visit as a means of continuing coercion and control over Valentina. Valentina subsequently talked about being fearful of ending all contact with Dave due to the threats from him. Sadly, we also know that post-separation, Valentina was subject to physical and sexual assault from him in her home. This exemplifies the very difficult decisions that survivors of domestic abuse can be faced with in trying to keep themselves, and their children safe.

6.3.10. Research highlights the prevalence of domestic abuse post-separation with over 75% of women, continuing to be abused by their former partners. Child contact was a point of vulnerability for on-going post-separation violence and abuse.[33] CityCare highlighted the need for practitioners and agencies to recognise risks from contact visits and escalate this into multi-agency safety planning.

6.3.11. The author of the GP report also noted the need for GPs to be professionally curious in relation to contacts between a child and a perpetrator of domestic abuse. This was not evident in the GP records in 2017 when the child was staying with Dave, despite extensive documentation about domestic violence. However, there was also little documentation about professional or strategy meetings for Valentina and her child, which would have helped the GP to understand and help to manage risk.

Learning Point 4:
Practitioners need to be mindful of the prevalence of domestic abuse in the post-separation period. Child contact arrangements are a point of vulnerability and increased risk to the victim of domestic violence, and to children and young people involved. This must be factored into multi-agency safety planning.

6.4. Agencies' Responses to Financial Stress

6.4.1. Financial concerns had long been an area of stress for Valentina. Valentina had been on DWP benefits including Disability Living Allowance and Income Support Disability Premium, along with Child Tax Credit and Child Benefit. She struggled to manage on this income. Valentina's parents provided financial support, at times coming to her rescue if she was unable to pay essential bills. Valentina's house was rented from her family. Though Valentina did not receive any help towards her rent as she was living in accommodation owned by her family, having a secure

[33] Cathy Humphreys & Ravi K. Thiara (2003) Neither justice nor protection: women's experiences of post-separation violence, Journal of Social Welfare and Family Law, 25:3, 195-214

tenancy was important for her and her child - moving from that accommodation to escape Dave was a daunting prospect for her.

6.4.2. Despite her ongoing financial pressures, Valentina had managed to some degree, albeit supported by her family. However, Valentina's stress over finances became magnified when she voluntarily applied for PIP, the disability benefit that was being introduced to replace DLA. The following gives a very summarised version of what occurred before examining the learning points arising from this.

6.4.3. When Valentina applied for PIP, she was required to co-operate with the PIP process or risk losing her DLA payments. The DWP had no record of receiving Valentina's PIP completed form (although Valentina maintained this had been sent). Having prompted her to respond, the DWP terminated Valentina's DLA claim. With the reduction of her DWP benefits, she quickly accrued significant debts**.**

6.4.4. Valentina began a second claim for PIP. This was sent to Capita, who acted as assessors on behalf of the DWP. The claim form was accompanied by more supporting information from her CPN and Diabetes team. Capita decided that Valentina needed to attend their clinic for an assessment. They declined her, and her clinician's repeated requests to carry out a home-based assessment due to her mental health needs. Capita had determined that a home-based assessment was not appropriate due to information they had regarding Valentina's self-harming behaviours.

6.4.5. After receiving a distressing call from Valentina, and several calls from her CPN, her DLA was reinstated and backdated. The DWP also reinstated Valentina's first PIP claim. The partially completed assessment by Capita for her second PIP claim was closed and a new assessment process initiated for her first claim.

6.4.6. Capita then notified Valentina that she must attend clinic for an assessment for that first PIP claim. The Capita assessor had not accessed the information that was linked to her second PIP claim, about Valentina's mental health or the need for a home-based assessment. Despite further advocacy by Valentina's clinical team, Capita maintained this requirement although did offer a different appointment date. A week before this appointment, Valentina took the over-dose that resulted in her being in a coma. Capita subsequently determined that they had sufficient information for her claim and PIP was awarded. Sadly, Valentina never benefitted from PIP. She died ten weeks later.

6.4.7. Valentina's interactions with the DWP and Capita had a profound impact upon her:

i) The stress arising from the additional financial pressures and debt incurred from taking high interest loans
ii) Sense of impotency that she could not effect change and that her mental distress was not recognised
iii) Debilitating anxiety at the prospect of leaving her house to be assessed by unfamiliar professionals but untenable consequences if she declined

6.4.8. The review notes that the DWP had no knowledge of Valentina being a victim of domestic abuse. This would not have affected any decisions relating to her claim for PIP or review of DLA

although potentially may have been considered as 'good cause' for delays in submitting required information.

6.4.9. The Coroner was highly critical of the DWP and Capita. The Coroner issued a Regulation 28 report to Prevent Future Deaths. He referenced twenty-eight problems in processing Valentina's PIP claim and detailed the impact that this had upon her mental health. The Coroner did not accept that these were individual human errors but found systemic problems in the conduct of the DWP and Capita.

6.4.10. This review is not going to restate every aspect of the Coroner's findings but does use those findings, along with additional reflections from contributors to this review, to summarise learning. These are grouped under inter-related contributory factors:

6.4.11. Section 7 details Improvements made.

- **Understanding Mental Health**

6.4.12. The DWP author reflected that the DWP had not sufficiently considered Valentina's mental health needs as a disability that may have impacted on her ability to engage with her PIP claim. This meant that reasonable adjustments were not made.

6.4.13. Valentina had needed additional support in making her PIP claim. The DWP did use an 'additional support marker' to alert those interacting with the claimant to the need for additional support. However, at the time, the guidance stated that the claimant would not have additional support needs if they had help completing the forms from someone, such as a representative, a community psychiatric nurse etc. A marker was not set for Valentina when she first applied for PIP because it was recorded that she had support from a health or social care worker.

6.4.14. Valentina had given her CPN's contact details as her named professional support. However, her CPN was not contacted when Valentina was clearly having difficulties in progressing the claim and experiencing high levels of distress.

6.4.15. The information that had been sent in by Valentina's clinical team regarding how Valentina's diagnosis of personality disorder affected her, did not prompt consideration of an additional support marker for her second claim. Nor was it sufficiently taken into account by Capita in carrying out their assessments. The decision made by Capita that Valentina must attend a clinic-based assessment was not well-founded as there was sufficient evidence to make a recommendation on the evidence already available. Furthermore, it did not take sufficient account of Valentina's mental health needs. The Coroner referenced the abundant medical evidence that an assessment outside of the home would exacerbate her mental health against a background of two recent overdoses. However, Capita maintained their insistence she attend a clinic.

6.4.16. It appeared that the barrier to carrying out a home-based assessment was based on a view that Valentina's self-harming behaviour may present a risk to Capita's assessing staff. The guidance that was in place at that time prohibited home-based assessment for claimants who had a history of self-harm using a blade of any sort. The guidance had the good intent of protecting PIP assessors. However, it was not a well based risk assessment. Valentina did have a history of self-harm with a blade, but only when on her own. There was no risk to others.

6.4.17. The DWP subsequently examined Capita's decision. The DWP concluded that it was poorly evidenced and would not have met their required standards regarding risk management. Had Capita staff spoken with Valentina's CPN, they would have been assured that staff were not at any risk and provided guidance on the best way to engage with Valentina during a home-based assessment.

6.4.18. DWP recognised that they may not have considered the impact of Valentina's disability on her ability to engage with the assessment process to her PIP claim.

Learning Point 5:

A person may be defined as having a disability within the meaning of the Equality Act 2010, if they have physical or mental impairment that has a substantial, and long-term adverse effect on their ability to carry out normal day-to-day activities. This definition applies to people with a mental health need, such as a personality disorder.
Public authorities must have due regard to the need to eliminate discrimination, harassment and victimisation and advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. This means:

I. Not discriminating against the person

II. Removing or minimise disadvantages the person might have because of their disability

III. Taking steps to meet the needs of people with a disability that are different from the needs of people who don't

IV. Taking steps to encourage people with a disability to participate in public life or any other activity in which their participation is disproportionately low.

- **Person Centred Approaches**

6.4.19. When Valentina telephoned in June 2019 DWP recognise that more action could have been taken to resolve the case. At that time, call handlers were not trained in mental health, particularly the sensitive communications needed to de-escalate anxiety. The DWP did have a 'Six Point Plan' to help staff support customers with mental health conditions, but this guidance was targeted for customers who were believed to be at risk of self-harm or suicide.

6.4.20. Valentina's family observed that some DWP staff were flexible and compassionate in their responses, trying to work round systems and find ways to help. However, in their experience, this was the exception. Valentina experienced a DWP system that felt rigid and dismissive of her. She felt powerless and had no way of proving that she had returned her claim forms and the supporting medical evidence. The Coroner referred to the institutional working assumption at the DWP that documents which are not on the claimant's file are missing because the claimant failed to send them in.

6.4.21. The Coroner viewed staff responses to be due to errors in the system rather than cultural issues.

6.4.22. At the time the DWP did have Vulnerable Customer Champions in place, but this was not a well-established role. There is no record of staff escalating concerns about Valentina to the Vulnerable Customer Champions.

Learning Point 6:

Responding to people in distress requires personal qualities of empathy, care and compassion. In addition, practitioners may need:

i) Training and guidance to understand the impact of mental health needs and
ii) Skills and time to offer effective responses to people in mental health distress.

- **Multi-agency Working**

6.4.23. Valentina's CPN had a wealth of knowledge about Valentina's needs and risks and tried to convey this to the DWP and Capita staff. They were tenacious in their attempts to advocate for Valentina. Their actions, and the actions by their CPN colleague who covered in their absence, have rightly been commended by Valentina's family, the Coroner, by NHCT and by all those contributing to this review.

6.4.24. The CPN reflected on how difficult it had been for them to navigate their way through the DWP processes. They described this as a daunting and exhausting process which had not been helped by the DWP and Capita's explanations. The CPN had provided the information in three reports to explain why Valentina should not be required to attend a face-to-face appointment. Her notes record that when she sought specific information about what else was needed to change the decision, the response was that she could not be given this information.

6.4.25. When Capita was progressing Valentina's re-instated first claim, they repeated the need for further evidence. The extensive verbal information that was being provided by the CPN (to supplement written information) was not recognised as clinical evidence by the Enquiry Centre agent, despite the CPN's professional expertise.

6.4.26. Agencies reflected on the need for staff to feel confident to escalate concerns about assessment outcomes and to be knowledgeable about escalation routes. The emphasis on this may be usefully incorporated into work currently being led by the NCSAB on navigating complex situations.

Learning Point 7:

The review highlighted the importance of accessing knowledge and expertise held by multi-agency partners when carrying out assessments. Where there are differences of professional opinion, all practitioners need to feel confident to make professional challenge and understand the escalation routes to do so.

- **Resilient Systems**

6.4.27. Despite the wealth of verbal and written information provided by Valentina's clinicians, this was not well recorded within the DWP and Capita systems, to make it accessible to decision makers.

6.4.28. The records of the CPN's contacts with the DWP were too brief and at times inaccurate, for example recording a call as being from Valentina rather than her CPN. The records did not detail the concerns that the CPN was expressing.

6.4.29. The information provided by the CPN regarding the unsuitability of a face-to-face assessment was recorded in Capita's running record, but not in prominence where Capita could recognise this as a key factor in their assessment.

6.4.30. When Valentina's second claim ended and the first claim re-instated, the supporting evidence linked to the second claim was not available on the system to the PIP assessor for the re-instated claim.

6.4.31. There was a rigidity within the system, so that a request for a changed assessment process could not be made without a change of circumstances – even where the original decision was wrong. The guidance required new written information. In Valentina's situation, there was no new information to provide – what was needed was for the original decision to be revised based on the evidence that had already been submitted.

Learning Point 8:
Robust record keeping is essential to facilitating well-reasoned decisions and safeguarding people with additional vulnerabilities. Records must accurately reflect interactions and provide sufficient detail to enable evidenced based decisions that take due account of risk factors.

All organisations need to set standards for record keeping, as relevant to role, and make these competence requirements for staff explicit.

6.4.32. The Coroner's view was "*The failure to administer the claim in such a way as to avoid exacerbating [Valentina's] pre-existing mental health problems was the predominant factor, save for her severe mental illness, affecting a decision taken by [Valentina] to take an overdose of her prescribed insulin …. In doing so, it was at the least [Valentina's] intention to place her life at risk and to cause herself serious physical harm*. [Redacted]

Recommendation 3

7. What Has Changed?

7.1. Responses to Domestic Abuse

7.1.1. At a local level, there have been developments made by individual agencies as well as improvements in multi-agency responses to domestic abuse.

7.1.2. Nottinghamshire Police is now using dedicated police staff to respond to medium risk domestic abuse cases where the victim has declined to share information with partners such as Women's Aid. Those staff make Safe and Support calls within the first two weeks of a report, confirming safe contact numbers, providing the victim with contacts for Neighbourhood Policing and discussing a Safe and Support plan.

7.1.3. Nottinghamshire Police has also taken a proactive stance with offenders, with their Neighbourhood Policing Team making themselves visible to offenders who are subject to Stalking Protection Orders or charged with high-risk domestic abuse offences.

7.1.4. In 2021 Nottinghamshire Police and Women's Aid, began a pilot of a Domestic Abuse Partnership Car. The car operates at weekend evenings and is staffed by a police officer and an IDVA. They follow up all domestic abuse incidents where the victim is reluctant to engage. This aims to help the victim engage with the criminal justice process as well as ensuring safeguarding and support is in place. This partnership arrangement builds on a successful model of a mental health street triage car.

7.1.5. Within the Probation Service, Partner Link Worker (previously known as Women's Safety Workers) referrals are now standard practice when a service user is completing BBR. Referrals can be made in regard to the victim of the offence, current partner(s) and for any new partners. The BBR will make contact with Probation Officers if the referrals have not been completed.

7.1.6. NHCT has strengthened organisational responses to domestic abuse through appointing a strategic lead and a Safeguarding Lead, with a specialism in domestic violence and abuse and MARAC. NHCT has developed training, policy, and quality assurance processes to improve application of the DASHric/MARAC pathway. The NHCT Trustwide Integrated Safeguarding Service has developed a single point of contact for staff to access support and advice on

safeguarding and domestic violence and abuse concerns and developed a Think Family competence framework.

7.1.7. NUH has rolled out more training for clinical staff, with bespoke training for their Diabetes service. NUH has also improved the access to electronic records by their midwifery staff to safeguarding documents. NUH has employed a Mental Health Matron to provide additional support to staff in caring for patients with mental health needs.

7.1.8. CityCare is contributing to work with Early Help service to review the DART pathway and guidance for staff.

7.1.9. The Community Safety Partnership has introduced a pilot for MARAC repeat referrals i.e. where a case is heard three times or more within twelve months. This enables more in-depth discussions to explore the reasons and agencies' roles in risk reduction measures that support the victim and manage the offender. The outcomes from the pilot are positive, with IDVAs reporting interventions are improving safety for survivors. 86 % of cases heard at the repeat panel, were not referred back and for the remaining 14% of cases, there was reduced frequency of referrals.

7.1.10. The MARAC has also used ECINs[34] to automatically flag outstanding actions from MARAC and generate reminders to the relevant agency. The MARAC Steering Group is also alerted if the relevant action is not completed. This has proved successful and completed actions within agreed timescales is now at 98-100%. This review indicates there may be value in extending this to the DART to improve partnership working below the threshold of MARAC

Recommendation 1

7.1.11. Nationally, a Domestic Abuse Risk Assessment tool (DARA) for first response police officers was piloted by some police forces. The evaluation report concluded there was improved risk grading decisions and that victims appeared to be more prepared to disclose coercive and controlling behaviour to officers using the piloted risk tool. However, it still required an understanding of coercive control for the tool to be most effectively used.[35] Nottinghamshire Police is awaiting the final outcomes from the pilot to determine whether this should be adopted locally.

7.1.12. The Domestic Abuse Act 2021 came into force.[36] The Act brings in many provisions including a statutory definition for domestic abuse, emphasising abuse can be emotional, economic, controlling or coercive, as well as physical. It also places duties upon Local Authorities to provide accommodation- based support to victims and their children.

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[34] Empowering Communities Inclusion and Neighbourhood Management System (ECINs) a cloud hosted profile (person) based multi-agency case management system. It is designed to facilitate closer and more effective partnership working by allowing for the secure storage of information in a single place that multiple agencies can access. It facilitates real time updates and can also create and then issue automatically tracked tasks between users and agencies.

[35] College of Policing 2018 Piloting a new approach to domestic abuse frontline risk assessment Evaluation report https://whatworks.college.police.uk/research/documents/da_risk_assessment_pilot.pdf [Accessed December 2021]

[36] Home Office Domestic Abuse Act 2021: Overarching Factsheet https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet [Accessed November 2021]

7.1.13. Of particular significance to Valentina's circumstances, the Act provides additional sanctions for offenders and extends the controlling or coercive behaviour offence to cover post-separation abuse. Nottinghamshire Police volunteered to be one of the Forces piloting the new Domestic Abuse Protection Notices and Orders. The pilot will test the policy aims of simplifying the complex landscape of protective orders; providing better protection for victims and their children; and reducing repeat and serial offending by perpetrators. This initiative by Nottinghamshire Police is particularly welcome given the resonance it has with Valentina's experience.

7.2. Developments by DWP

7.2.1. The DWP has made many improvements subsequent to Valentina's death.

7.2.2. The DWP has worked with staff to improve understanding of the wide range of mental health issues that benefit claimants may face. This includes training on mental health, behaviour and relationships to help staff improve interactions with claimants. All newly recruited PIP & Employment Support Allowance staff have this delivered as part of their initial training prior to contact with a claimant. The DWP has also developed their training and guidance on domestic abuse.

7.2.3. The DWP discussed the work they had done to build a culture of care and compassion. The Vulnerable Customer Champions role has been strengthened, giving higher level of access to information and guidance and providing post holders with accredited training. The DWP has also introduced Advanced Customer Support Senior Leaders (ACSSLs) to provide escalation routes for cases involving customers requiring advanced support. Although PIP is a national process, the ACSSLs work within geographical areas, building local partnerships to help provide support to claimants who may be most vulnerable.

7.2.4. The DWP has strengthened the scripts of call takers for initial calls to highlight vulnerabilities. There are now three variants for support markers: 'Additional Support Indicated', 'Additional Support' or 'Historic Additional Support'. The Additional Support Markers are watermarked across all records. The DWP has also added additional steps where there is a non-response to a PIP application, including follow up phone calls, letters and deferring the disallowance to enable further consideration of any support needs. PIP case managers are now empowered to use lots of avenues to gather evidence. The "holistic decision making" involves decision-makers proactively contacting claimants to gather evidence and spending more time considering all evidence available to them before making a decision.

7.2.5. Improvements have also been made to the assessment process by Capita. A process has been put in place that allows assessments to be paused – even when an appointment has already been scheduled. This will allow for the type or location of the assessment appointment to be reviewed, whether or not new evidence has been submitted by the claimant.

7.2.6. The DWP has made their quality assurance processes more rigorous. Enhanced Quality Checks has seen an improvement in the quality of recording.

7.2.7. The DWP Advocacy Team has also been offering training to partner agencies to equip practitioner with the knowledge and skills to support claimants, including an overview of process and information about escalation and appeals. This was positively evaluated and is now being rolled out nationally.

7.2.8. DWP's Voice of the Customer Active Learning network generate case examples and discussion points to prompt team talks on aspects of a customer's journey. Organisational learning is also provided through the Internal Process Review Group that looks at individual cases and a Serious Case Panel that draws out themes. The elements of learning from Valentina's case have been discussed with Senior Officials and DWP have offered to share the final report with the Serious Case Panel members.

7.2.9. The DWP shared an anonymised case study that demonstrated the difference that these changes have made. The claimant 'S' was in receipt of PIP. She had struggled with anxiety, depression and a personality disorder for many years. When S submitted a form to review her benefit, the PIP case manager was concerned S had written about self-harming behaviour. The PIP case manager contacted the Vulnerable Customer Champion (VCC) for guidance and support. They added an Additional Support Marker to S's records and supported the case manager when they phoned S.

7.2.10. During a lengthy phone call, the case worker was concerned about S's thoughts of suicide. They used the DWP's Six Point Plan that guides staff in these circumstances. They called an ambulance and S's GP. The VCC then supported the case manager to review S's PIP claim. S was awarded PIP at an enhanced rate without further assessment. The VCC also escalated the case through their Customer Experience and Advance Support Team and a locality based Advanced Customer Support Senior Leader liaised with Adult Social Care and Mental Health Services who provided S with support. The PIP case manager subsequently contacted S to ensure she knew how to contact them in the future. S's mental health is now much improved.

7.2.11. This was a positive example of improvement made. It is clearly important that these improvements are sustained and consistently applied. At the time of this report, The Parliamentary Work and Pensions Committee had launched a survey to hear about first-hand experiences of the assessment processes for Personal Independence Payment (PIP) and Employment and Support Allowance (ESA). The survey was part of the Committee's inquiry examining the effectiveness of the application and assessment processes for benefits paid to disabled people and people with long-term health conditions, amid continuing concerns about the problems being experienced by people making claims.[37]

7.2.12. It is a welcome development that DWP is increasingly contributing to Safeguarding Adult Boards around the Country and to SAR's as is evidenced in this review. However, DWP has stated that:

'*the Department does not have a statutory safeguarding duty or legal duty of care, the safety of claimants is of great importance to us and the Department provides staff with training and*

[37] UK Parliament Committees November 2021 MPs want to hear your experiences of applying for PIP and ESA - Committees - UK Parliament

guidance to help them identify those who require further support beyond the provision of benefits and to signpost to services who can provide expert support e.g. NHS'

7.2.13. Given the numbers of vulnerable people that the DWP supports, it is important that there is strong interface between learning that occurs through the DWP's Internal Process Review Group, DWP Serious Case Panel and the multi-agency learning carried out by SABs. This will ensure that DWP, as non-statutory partners, refers cases to the relevant SAB where criteria for a SAR appear to be met; and that SABs alert DWP where a SAR has identified learning that DWP needs to feed into their internal learning processes. This will strengthen processes to meet Care Act statutory guidance:

14.167 The following principles should be applied by SABs and their partner organisations to all reviews:

- *there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice*

A recommendation is made for a national protocol between Safeguarding Adult Boards and the DWP toward that end.

Recommendation 4

8. Conclusions

8.1. This review has documented the very sad circumstances of Valentina's life.

8.2. Valentina's life was marked by challenges that any person would struggle to cope with. Valentina's mental health needs meant that these challenges were all the more difficult for her. We do not know whether it was Valentina's intent to die. What does seem clear is that the combined stress factors in those final months of her life had become too much for her to bear.

8.3. Valentina was reliant on others to help her to cope with those significant stress factors. The review has highlighted some excellent practice by committed, skilled and compassionate practitioners. However, the review has also highlighted many areas of learning in that period leading up to her death.

8.4. There was learning about direct practice. There was also learning about the organisational and multi-agency systems that were in place. These did not support staff to help Valentina and in some instances, actively contributed to her problems. The review has highlighted actions that could have reduced Valentina's risks of self-harm and suicide.

8.5. Valentina's family are driven to ensuring that her death leads to change. Many changes have already been made that will make difference to others in similar situations as Valentina. The recommendations made by this review, take account of, and aim to build on these improvements.

9. Recommendations

Recommendations
Recommendation 1: Procedural Development **Coordinated responses to Domestic Abuse:** I. Nottingham Community Safety Partnership should assure the quality of the MARAC protection plans, auditing against relevant sector guidance/quality markers for effective domestic abuse protection plans. The Partnership should use the audit findings to review the current format of the MARAC meeting and action plan template, with the aim of facilitating more robust and structured protection plans. **II.** The NCSAB and Nottingham Community Safety Partnership should review mechanisms to strengthen multi-agency responses to domestic abuse for incidents below the threshold for MARAC. This should include a feasibility/cost/benefit analysis for DART to use ECINS for non-MARAC cases and include consultation with agencies partnered in the DART.
Recommendation 2: Monitoring and Review **National Recommendation – Evaluation of Building Better Relationships Programme** HM Prison and Probation Service needs to evaluate the efficacy of Building Better Relationships Programme to assure the programme is delivering the intended outcomes of reducing offending by male perpetrators of domestic abuse within heterosexual intimate relationships. The NCSAB should use the National Escalation Protocol,[38] for the National Network of Safeguarding Adult Board Chairs to escalate this issue as a matter requiring a national response.
Recommendation 3: Staff Support i) Learning from this SAR should be used across the NCSAB and Community Safety Partnership, highlighting good practice that was demonstrated as well as areas for development. ii) The DWP should share this SAR through their new internal case review governance processes so that the learning can be used at a senior organisational level, to drive whole system improvements.

[38] National Network of Safeguarding Adults Board Chairs National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021

Recommendation 4: Procedural Change

National Recommendation – Develop a protocol between DWP and Safeguarding Adult Boards

The NCSAB Chair should escalate the recommendations from this SAR, using the agreed national escalation protocol, to the National SAB Chairs network.[39] The aim of the escalation is to ensure that a protocol is developed to achieve the following outcomes:

i) The DWP to consider whether any case under internal review, may meet criteria under the Care Act section 44 for a Safeguarding Adult Review and make referral to the relevant Safeguarding Adult Board

ii) Chairs of Safeguarding Adult Boards should identify where any SARs they have commissioned, indicate learning relevant to DWP. This should be referred through the relevant DWP channels so that the DWP Internal Process Review Group are sighted on that learning and themes can be considered by the DWP Serious Case Panel to inform organisational change

iii) The protocol should be evaluated within 12 months of implementation to understand effectiveness of application and outcomes achieved.

DWP representatives contributing to this SAR, should share findings with the DWP Serious Case Panel.

Agencies should provide the NCSAB with progress reports on their recommendations within 6 months of this review.

Sylvia Manson

Date: June 2022

Sylman Consulting

[39] National Network of Safeguarding Adults Board Chairs National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021

Glossary

- ASC Adult Social Care
- BBR Building Better Relationships
- CSAAP Correctional Services Advice and Accreditation Panel
- CIS Children's Integrated Services
- CPN Community Psychiatric Nurse
- DART Domestic Abuse Referral Team
- DASHric The Domestic Abuse, Stalking and Harassment and 'Honour'-based violence Risk Indicator Checklist
- DLA Disability Living Allowance
- DWP Department of Work and Pensions
- ECINs Empowering Communities Inclusion and Neighbourhood Management System
- HMPPS Her Majesty's Prison and Probation Services
- IDVA Independent Domestic Abuse Advisors
- MARAC Multi-Agency Risk Assessment Conference
- NHCT Nottinghamshire Healthcare NHS Foundation Trust
- NNCCG Nottingham and Nottinghamshire Clinical Commissioning Group
- NOM National Offender Management
- NUH Nottingham University Hospitals Trust
- PIP Personal Independent Payment
- TFST Targeted Family Support Team

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About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting.

Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.

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