St Helens Community Safety Partnership

Domestic Homicide Review

Overview Report

Report into the death of Amy (pseudonym)

October 2018

Author and Domestic Homicide Review Chair - Stephen McGilvray 2019

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Contents

	Page
Foward	
Glossary.	4
Introduction.	7-8
Scope.	8
Key lines of enquiry.	8-9
Confidentiality.	9
Methodology.	9
Involvement of Family and Friends.	9
Contributors to the Review.	11
Parallel Reviews.	13
Equality.	14-15
Background Amy and Brian.	15-19
Summary of key events.	19-23
Overview.	23-24
Analysis	24-39
Conclusions.	39-40
Recommendations.	40-41
Action Plan.	Appendix A

Glossary

AAFDA	Advocacy After Fatal Domestic Abuse.
CCG	Clinical Commissioning Group.
CGL	Change Grow Live (provider of substance misuse services)
DHR	Domestic Homicide Review.
IDVA	Independent Domestic Violence Advocate
IOPC	Multi Agency Risk Assessment Conference.
MeRIT	Merseyside Police Risk Identification Tool
IMR	Independent Management Review
MARAC	Multi Agency Risk Assessment Committee
PTSD	Post Traumatic Stress Disorder
RASAC	Rape and Sexual Abuse Centre.

Risk Assessment Grades

- Gold — Victim is at high risk of serious physical assault or homicide
- Silver — Victim is at medium risk of serious violence
- Bronze — Victim is at standard risk of future violence

VPRF1	Vulnerable Person Referral Form
WINGS	8-week support program for survivors of domestic abuse.

Foward

The Panel wish to express their deep condolences to Amy's parents, her two sons and to other members of her family and friends. The Panel also wish to thank them for their valuable assistance in completing this Review which they provided in the hope of preventing other families suffering such tragedy.

Amy was a funny girl, bubbly, and fun to be around. She loved her children.

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Independent Author: Stephen McGilvray 2019

1. Introduction

1.1 This report has been undertaken following the death in 2018 of Amy during a domestic incident involving her partner Brian at her home address in St Helens Merseyside.

1.2 In 2018, Merseyside Police received an emergency telephone call from Amy, made from her home address, during which she indicated that Brian was also present. During the call Amy stated that Brian had been "*arguing with her and grabbing her*" and was now refusing to leave her home. Shortly after the call began Amy was then heard screaming and saying that she had been stabbed and couldn't breathe.

1.3 Emergency services attended the address and discovered Amy in the bedroom of her home suffering from multiple stab wounds. Despite the efforts of the Doctor on board the Air Ambulance which attended the scene and administered aid Amy died at her home.

1.4 A Coroner's Inquest later recorded the cause of Amy's death as multiple stab wounds.

1.5 Brian had left the scene prior to Police Patrols arriving but was arrested a few days later and charged with Amy's murder.

1.6 Brian pleaded guilty to the manslaughter of Amy in January 2019, but this was not acceptable to the Crown Prosecution Service and a murder trial was set for May 2019. In May Brian pleaded guilty at Liverpool Crown Court to the murder of Amy and was sentenced to life imprisonment with a minimum term of 21 years.

2. Scope of the Review

2.1 In accordance with the statutory guidance for the conduct of Domestic Homicide Reviews (DHRs), the Panel agreed that the purpose of this DHR was to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working.

Key lines of enquiry

2.2 The DHR Panel agreed the focus of this Review should be upon the following Key Lines of Enquiry.

A. How effective were the risk assessment processes, in particular the contextual assessment of risk?

B. How effective was the sharing of information relating to Amy and Brian between Warrington and St Helens.

C. Were the elements of Control and Coercion within domestic violence recognised and responded to by agencies and the general public.

D. The level of training given to staff within agencies in regard to all elements of domestic abuse and risk assessment.

2.3 On the basis that important contextual information, including that Amy had previously had cases heard at MARAC in Warrington, it was agreed by the Panel that the time period of this Review would be 2014 – 2018.

3. Confidentiality

3.1 Prior to Home Office approval for the publication of this Review its findings are confidential and information is available only to the Panel's participating professionals and their line managers.

3.2 Following discussion with Amy's parents the following pseudonyms were agreed by the Panel and are used throughout this report to protect the identity of the individual(s) involved.

Amy	female partner in relationship. Deceased	Aged 30 years
Brian	male partner in relationship. Perpetrator.	Aged 24 years
Colin	ex-partner of Amy.	Aged 32 years

4. Methodology

4.1 In late November 2018 Merseyside Police notified St Helens Community Safety Partnership of the fatal incident. Members of the Community Safety Partnership agreed the requirement for a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016. The Home Office were notified of this decision.

4.2 As a result of the Community Safety Partnership decision the Chair of the DHR Panel was commissioned in December 2018.

5. Involvement of Family, Friends, neighbours, and the wider community.

5.1 The Chair of the Review in company with a representative from Advocacy After Fatal Domestic Abuse (AAFDA) spoke to the parents of Amy at their home in Warrington. The pseudonyms to be used within this report and the reasons for pseudonyms were discussed with and agreed by Amy's parents at this first meeting.

5.2 At this meeting it was striking how much Amy's parents could say about the relationship between Amy and her ex-partner Colin compared to how little they knew about her relationship with Brian.

5.3 They did describe how Amy's personal appearance deteriorated during her relationship with Brian. They described how Amy used to wear make-up and was always well dressed. Her friend described Amy as always well-groomed, but Amy changed to wearing little make up and had few clothes during her relationship with Brian. Amy's parents believed that Amy was "*neglecting herself*". A friend who met with Amy in September 2018 describes her appearance as "*wearing no make-up, she was pale and looked poorly*".

5.4 Neighbours describe the relationship between Amy and Brian as volatile, with frequent shouting which could be heard between the "*thin walls*" of the properties. Neighbours did state that the shouting always came from Brian. Following these arguments Brian would often leave/be told to leave the flat and sometimes would have his clothes thrown out of the window onto the street by Amy.

5.5 Friends describe Amy prior to her relationship with Brian as being fun to be around. This changed and the friends noted that Brian did not like Amy speaking to friends on the phone and would always be there when Amy was talking to friends on the phone.

5.6 Following the fatal incident, Amy's friend of 12 years standing, described to Police "*I believe that Amy was being abused mentally and physically by Brian and what happened to Amy was because she was trying to leave him and he was thinking if he couldn't have her, no one could.*"

5.7 Because of the control and coercion that family and friends disclosed to Police during their murder investigation Amy's parents and a group of friends supported by AAFDA also met with the Chair of this Review to explore factors which inhibited the reporting of control and coercion within an intimate relationship and ways in which agencies could overcome this.

5.8 Following his sentencing an opportunity was provided to Brian, via the National Probation Service, to meet with the Chair of this Review but this was declined as he "*feels unsettled and just needs to settle in a long-term establishment before he can cooperate with this process*".

5.9 Efforts were also made to speak to the parents of Brian, themselves victims of domestic abuse by Brian, however, they have moved from the Warrington area and no new contact details were available to arrange that meeting.

6. Contributors to the Review.

6.1 A DHR Panel was established by St Helens Community Safety Partnership and comprised of the following agency representatives:

- Stephen Mc.Gilvray, Independent Chair of DHR Panel
- Beverley Hyland, Merseyside Police
- Neil Fairhurst, Torus Group (Housing)
- Jacquie Byrne, Torus Group (St Helens IDVA Service provider)
- Jackie Hodgkinson Named Professional Adult Safeguarding NWBH
- Nina Ellament, Principal Solicitor Peoples Services St Helens Council,
- Helen Newton, Clinical Commissioning Group.
- Dr. Michelle Loughlin, St Helens Council, Assistant Director Public Health
- Simon Cousins St Helens MBC Equalities Officer
- Martina Palmer Refuge (Providers of IDVA Service in Warrington)
- Rachel Fance Change Grow Live (Substance Misuse Service provider)
- Sue Wallace Cheshire Constabulary
- Beverley Jonkers St Helens MBC Community Safety Partnership
- Dean Lawrence Warrington MBC Children's Services.

Warrington CSP were offered but did not take a place on the panel and undertook to provide assurance that any lessons identified as part of the review would be considered and embedded into practice locally.

6. Individual Management Reviews

6.1 The following agencies completed Individual Management Reviews:

- Change Grow Live (CGL)
- Cheshire Constabulary
- Merseyside Police
- North West Boroughs HealthCare Trust
- Refuge, Warrington
- St Helens Clinical Commissioning Group
- St Helens MBC Housing Options
- Torus Housing
- Warrington MBC Children Services.

7. Chair of the Domestic Homicide Review Panel

7.1 St Helens Community Safety Partnership commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in December 2018. Stephen McGilvray is also the author of this Overview Report.

7.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years but he has never been employed by St Helens MBC. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of

domestic abuse victims and their children. During the period this unit was under Stephen's management the team achieved CAADA Leading Lights accreditation for the quality of its systems and risk management processes.

7.3 Whilst Head of Community Safety Stephen also had management responsibility for the Integrated Offender Management Unit a multi-agency collocated team of Police, Probation, and Substance Misuse workers whose role was to reduce the level of threat and risk posed by offenders, including perpetrators of domestic abuse.

7.4 Stephen has successfully completed the Home Office training course for Chairs of DHR's. He was responsible for the development of a reciprocal agreement with a neighbouring Authority in relation to the Chair and writing of reports following the work of DHR Panels and has Chaired and completed Overview Reports for several Domestic Homicide Reviews as well as taking part in a number of Serious Case Reviews.

7.5 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 14 years ago that Stephen retired from Merseyside Police and it is 39 years since he worked as a Police officer in St Helens.

7.6 Before undertaking this Review Stephen McGilvray has not had any involvement with the individual people subject to this Review, nor is he employed by any of the participating agencies.

8. Parallel Reviews

8.1 There were two further reviews completed parallel to this Review.

8.2 Firstly a Review of the treatment and care delivered to Amy by North West Boroughs Health Care. This Review concluded that a lack of holistic and more in-depth assessment may have contributed to Amy not gaining appropriate support when she was struggling with her mental health and social situation. Additionally, there was a missed opportunity to share information with other services involved to ensure Amy's mental health and social circumstances were being adequately monitored.

8.3 The Review also concluded that there was learning in respect of how this case was managed following assessment which will be disseminated Trust wide.

8.4 Actions reflecting their conclusions following this review by North West Boroughs Health Care are included within the Action Plan section of this report included at Appendix A.

8.5 Secondly a review was completed by the Independent Office for Police Conduct (IOPC) and the terms of reference for the review were.

> "*To investigate the Merseyside Police response to an emergency call made by Amy on the day of her death".*

8.6 That Review has now been concluded. Its finding was that.

> "*During the investigation no evidence was obtained to indicate that any Police Officer may have behaved in a manner that would justify the bringing of disciplinary proceedings or committed a criminal offence."*

9. Equality

9.1 Equality and diversity issues were considered throughout the work of this Review. It was the desire and practice of the Panel that all family members and friends interviewed as part of the Review were treated with respect and dignity.

9.2 The Review also considered if any of the Protected Characteristics as defined by the Equality Act 2010 were factors in the relationship between Amy and Brian and impacted upon their decision-making processes. The analysis and conclusions drawn from this Review clearly indicate that some of the Protected characteristics clearly were factors within the relationship and their decision making. These issues are explored in more detail within this Review, but the Review felt that Amy was discriminated against in the following areas. Disability. Amy suffered from PTSD (Pot Traumatic Stress Disorder) the result of a previous violent and abusive relationship and Brian harassed and degraded Amy through his actions during the relationship. Amy furthermore was subjected to sexual harassment by Brian who used her desire to obtain the release of her children from a guardianship care order and back into her own care as a tool against Amy to meet his own sexual demands.

9.3 The Review explored these areas with the friends and family and in its analysis of the relationship which led to Amy's death.

9.4 During the work of the Panel no challenges had to be made by the Chair to any Panel member for a breach of equality standards.

9.5 Amy and Brian subject of this DHR were partners. Both are white British adults with English as their first language.

10. Background of Amy and Brian.

Amy

10.1 Amy lived most of her life in Warrington and her family and friends remain in the Warrington area. Amy has one sibling, an older brother.

10.2 Whilst living in Warrington Amy lived in a variety of private rented and Housing Association properties. At other times she lived with family and was also homeless for a short period of time before moving to live in St Helens. Amy was the

sole tenant of this property in St Helens and Brian was listed as an occupant only. She remained in this one property, a Housing Association flat, from 2017 until her death.

10.3 Amy was unemployed at the time of her death and from leaving school only had two short periods of employment working in warehouses.

10.4 Amy was in a relationship with Colin from 2011 until 2016 and she began a relationship with Brian in 2017. There is no record of a cross-over of relationship between Colin and Brian. Amy's relationship with Colin was not continuous. It was ended and resumed on several occasions which led to further incidents of domestic abuse.

10.5 During the period 2011 – 2016 and Amy's relationship with Colin he was physically and sexually violent and controlling. Amy disclosed to her G.P. and Cheshire Constabulary that Colin had sexually assaulted her. Amy reported incidents to the Police however charges were always dropped by the Crown Prosecution Service.

10.6 During the course of her relationship with Colin Amy was assessed as a high-risk victim of domestic abuse on three separate occasions and her case was referred to MARAC in Warrington each time, the last being in August 2014.

10.7 The 2014 MARAC focused upon an incident during which it is reported that Colin grabbed Amy by the hair and hit her repeatedly on the head with a beer bottle. The bottle did not smash but did cause Amy to lose consciousness. Later that same evening Amy was upstairs in bed when Colin returned home drunk. He came into the bedroom restarted the earlier argument and then kicked the bedroom door causing damage. Amy told Colin to get out of the house at which point, whilst the two were stood at the top of the stairs, he grabbed her by the throat and started to strangle her. Amy states that she felt as if she was about to lose consciousness and to free herself, she felt it necessary to throw herself down the stairs. Colin fell down the stairs with her and whilst at the bottom he bear hugged her preventing her from leaving the address. He put his hand over her mouth, and she had to bite him in order to break free. When he released her, she ran to a neighbour and called the police. Amy's children witnessed these incidents.

10.8 With the support of Refuge in Warrington during the course of their relationship Amy did obtain a Restraining Order and a Non-Molestation Order against Colin.

10.9 Amy has two children aged nine years and seven years, and Colin is the natural father of the youngest child. Children's Services in Warrington were concerned with the levels of physical abuse being witnessed by the children and took action to safeguard them.

10.10 In 2014 both children were made subject to a Child Protection Plan under the category of neglect. In 2015 both children were removed from Amy's care and placed into Foster Care. Finally, in August 2016 both children were made subject of a Special Guardianship Order to live with Amy's parents where they continue to live to-day.

10.11 Amy received intermittent support from the IDVA Service in Warrington between June 2014 and May 2017 during her relationship with Colin and there is evidence of a close working relationship between Children's Services, Cheshire Constabulary and the IDVA Service in Warrington in support of Amy.

10.12 Due to the impact of her relationship with Colin Amy was diagnosed with PTSD and received treatment and medication from her G.P. and Mental Health Treatment Services to assist her management of this.

10.13 Amy began a relationship with Brian in 2017, there are no children from this relationship. Following a period in emergency accommodation at the YMCA in Warrington Amy moved to the Housing Association address in St Helens with Brian in 2017.

10.14 During the early months of their relationship Amy contacted the Police twice to report domestic abuse incidents involving herself and Brian. Following the fatal attack during the murder investigation family and friends provided strong evidence that, during the relationship with Brian, Amy was subject to high levels of coercion and controlling behaviour by Brian.

10.15 The Panel could find no examples of Amy showing violent resistance to any of her abusive partners.

Brian.

10.16 Brian lived all of his life in Warrington and he has two siblings a younger brother aged 19 years and an older sister aged 26 years with whom Brian and Amy lived for a short period of time at the start of their relationship following a period of homelessness.

10.17 Brian's parents believe that he was drug dealing at 16 years of age and indications are that he himself was a poly-drug user from that time on with Cannabis, Cocaine, and Ecstasy combined with alcohol being his drugs of choice. Brian was at times abusive towards his parents but they always remained supportive, including financially, towards him.

10.18 In 2014 Brian became a father but the child was made subject to a Child Protection Plan and Brian has had minimal contact with his daughter since birth.

10.19 The mother of Brian's child was 17 years old and described by Children Services as vulnerable. She became pregnant early in their relationship. Following Amy's death, she detailed to Police Officers investigating the murder, the controlling nature of Brian. He controlled her use of her mobile phone and use of social media checking the calls to see whether there were any other boy's names included.

10.20 Additionally she reported that Brian also used to exercise control over what she wore in public. She told Police that she thought that Brian had targeted her deliberately because she was a vulnerable person.

10.21 The controlling behaviour shown towards this ex-partner was repeated when Brian began his relationship with Amy. A friend of Amy's says that Amy had told her that "*Brian was very controlling, manipulative and extremely jealous*."

10.22 In 2015 whilst living in Warrington Brian self-referred himself to Pathways, a substance misuse treatment provider commissioned by Warrington Public Health for

support with cannabis, ecstasy, and cocaine use. Whilst attending initial appointments, despite assertive outreach workers attempts to re-engage him, Brian regularly failed to attend for appointments or group session work and was discharged from their service due to non-engagement.

10.23 During initial assessment whilst receiving support Brian's domestic violence risk was assessed by Pathways. This included the risk of physical violence, emotional abuse, and financial abuse from or to a partner. Brian did not disclose any current or historical domestic violence to the assessment worker and there was no previous recorded risk and no indicators of domestic abuse identified during case record reviews or interviews.

10.24 At age 21 Brian was sentenced to a 12 month term of imprisonment imposed in 2016 for an assault during which he stabbed another male with a bottle.

10.25 Since leaving school Brian had several jobs working as a warehouse operative and working as a labourer for members of the Travelling Community. He was employed for periods of time when he was in a relationship with Amy but was unemployed at the time of this incident.

11. Summary of key events.

11.1 Amy was in a relationship with Colin between 2011 and 2017. During that time, she suffered physical abuse and controlling behaviour resulting in a lasting mental health impact, being diagnosed as suffering from PTSD. Colin's controlling behaviour continued up to Amy's death in 2018.

11.2 The first record Panel members hold regarding Amy and Brian's relationship was in January 2017.

11.3 Throughout Amy and Brian's relationship disputes followed the same pattern. A dispute occurring between them, followed by Brian leaving the house only to

attempt to regain entry several times throughout the night. There were frequent break-ups during the relationship only for it to recommence a short time later.

11.4 During the early months of their relationship 999 calls were made to the Police on two occasions by Amy.

11.5 In March 2017 after both had been drinking it was reported that Brian became verbally abusive and threatening towards Amy. The caller taking the 999 call to Police could clearly hear Brian shouting in the background demanding Amy hand him the telephone. This incident was risk assessed by officers from Cheshire Constabulary who assessed Amy as being at medium levels of risk from future domestic abuse. Medium risk is where "*there are identifiable indicators of risk of serious harm.*" The rationale for this level of risk was the concern that Amy was clearly heard saying that she required Police assistance and her partner demanding her to hand the phone to him.

11.6 A few weeks later an argument ensued when Brian entered the premises at which Amy was living uninvited and refused to leave when asked by Amy to do so. This was also reported to Police by Amy.

11.7 In April 2017 Amy arranged to attend a housing appointment at St Helens, during which she was supported by a Warrington IDVA. Brian attended the appointment with Amy. Amy was interviewed by an officer from the Councils Housing Options Service in St Helens. Following a letter confirming the domestic abuse which Amy had previously suffered being submitted to the Housing Options Service by the IDVA Amy was registered in the Councils Choice Based Lettings Scheme (Under One Roof). Thereafter, Amy bid upon the property in St Helens and at the end of May 2017 became the tenant.

11.8 At this meeting with Housing Options the IDVA was able to talk to Amy privately and asked Amy about her new relationship with Brian and she did not raise any concerns about him currently.

11.9 In October 2017 having taken up residence in St Helens, Amy registered with a local G.P. G.P. records show that when first registering with the practice Amy did not disclose any information about past or current problems or about past or current

medication on her patient medical forms. The new patient registration documents used by the practice includes a question specifically asking about any history of domestic violence. A review of the registration form shows that this question was not answered by Amy but there is no information available to show that this omission was followed up by the G.P. practice.

11.10 Amy had previously disclosed to Cheshire Constabulary Officers who responded to her calls for assistance that she was suffering from PTSD as the result of her previous relationship with Colin. She had been prescribed medication to ease her anxiety by Mental Health Services in Warrington.

11.11 Early in 2018 Amy began to disclose to services in St Helens the previous levels of domestic abuse she had suffered during her relationship with Colin and the continuing impact this was having upon her. In January 2018 Amy disclosed to the Housing Association that having split up from Brian she no longer felt safe living alone at the St Helens address, now that Colin was trying to contact her. This resulted in a referral being made to the Domestic Violence Team.

11.12 In February 2018 Amy disclosed to her G.P. that she had previously been subject to domestic violence and was now suffering from stress related problems. The disclosure resulted in her G.P. referring Amy to Adult Mental Health Services in St Helens. The referral to Mental Health Services detailed, Amy's continual harassment by her ex-partner. The domestic abuse she suffered during that previous relationship. Furthermore, that she was now in a relationship with another male (Brian) and was currently experiencing domestic abuse within that relationship the relationship was "*unstable*", and that the *"situation was escalating*".

11.14 Each of the referrals from the G.P. contained the same risk factors as the original referral made in February 2018 stating that contributing factors to Amy's mental health needs were.

- Continual harassment by ex-partner
- Domestic abuse from her ex-partner.
- She was currently in a relationship, but it was unstable
- The *"situation was escalating*"

11.15 Following each referral the Adult Mental Health Team tried to make contact with Amy by phone and when that failed by letter. All efforts by the Mental Health Team were unsuccessful until August 2018 when they did speak with Amy.

11.16 When contact was finally made, Amy confirmed to the Mental Health Team that in addition to suffering from PTSD as a result of her relationship with Colin she was now in an unstable relationship with Brian.

11.17 Amy made little contact with IDVA services or with family and friends during her relationship with Brian. Friends and family believing this was the result of his controlling behaviour imposed upon Amy however, this was not reported to any agency and no service was alerted to these beliefs/risks.

11.18 On 22nd September 2018 after receiving information from a friend Amy contacted Merseyside Police via the 999 emergency telephone system and described how a friend had received a text message from Brian saying that he was going to come to Amy's house and would "*Take her down and ruin her*" Amy described how she was trying to end the relationship with Brian and believed that "*He would make sure no one else could have her if he could not*" adding that she was concerned that "*he (Brian) would kill her one day*". The risk faced by Amy as a result of this incident was graded by the MASH, who reviewed the vulnerable person form (VPRF1) submitted by the officer who attended the incident,.as Bronze, "*Victim is at standard risk of future violence*". No Police enquiries were made of Amy to establish why she had such beliefs and concerns regarding future risks raised in the 999 call neither was any Police contact made with Brian regarding his threats.

11.19 The following day 23rd September 2018 Brian attended Amy's home and demanded to be allowed in. Amy again contacted Police using the 999-emergency telephone line. Brian did not gain entry and had left the scene prior to Police patrols attending Amy's home. At this time Amy asked the Officers to refer her for support and sign postings were made to mental health services and the NCDV.

11.20 On 8th October 2018 a MARAC referral in respect of Amy was submitted by the Domestic Abuse Team. This followed a report regarding messages that Amy had received via text from friends that Colin, currently serving a prison sentence,

knew where she now lived and would be coming to find her once released. This referral form graded the level of risk faced by Amy as Gold/high, but the MARAC submission did not include any reference to Amy's current relationship with Brian and the risks she faced within that relationship. Specifically, the events of two weeks previous.

11.21 The Panel are only able to identify one action resulting from this meeting which was for the IDVA to refer Amy to RASASC (Rape and Sexual Abuse Centre) which this record shows that they did but Amy did not engage with RASASC. There are no minutes available to show that Amy being unable to engage with the MARAC action plan resulted in a reassessment of risk at the next MARAC meeting.

11.22 On 22nd November 2018, two days before Amy's death, she attended her Grandma's funeral and the wake following the funeral which was held at a social club in Warrington. At the wake friends and relatives of Amy reported overhearing telephone calls Amy was receiving from Brian demanding that she return home immediately. Amy did not return immediately but when she did during the evening of 22nd November 2018, she was assaulted by Brian resulting in a black eye. Information regarding this assault was shared by Amy with friends only. No one reported this matter to Police or other agencies.

11.23 On 24th November 2018, Brian stabbed Amy to death at her home.

12. Overview.

12.1 Amy began her relationship with Brian in 2017. However, the Panel felt it important to review the period from 2014 up to Amy's death in 2018. Events during 2014 – 2017, when in a relationship with Colin, provide context within which agency responses during the period of her relationship with Brian were made and have been analysed by the Panel. Based upon advice from the DHR Enquiries Team at the Home Office only summaries of that period appear within this Overview Report.

12.2 Incidents involving Amy were heard at MARAC in Warrington on three occasions the last being in 2014 and all of these focussed upon incidents taking place during the relationship between Amy and Colin.

12.3 Communication between agencies in Warrington in support of Amy was good and she received support from Warrington IDVA service which included attending a domestic abuse awareness course. With their support Amy obtained a non-molestation order against Colin and had additional security installed in her property.

12.4 When Amy's case was reviewed at St Helens MARAC in October 2018 the MARAC referral was based upon the assessment of risk Amy faced from her ex-partner Colin's controlling and coercive behaviour. This control was achieved through the use of social media whilst serving a custodial sentence at that time, and the PTSD Amy was suffering as a result of her earlier relationship with Colin.

12.5 The risks faced by Amy from Brian were not considered by MARAC on 18th October 2018.

12.6 Four weeks after the MARAC to which Amy's case had been referred Brian stabbed Amy to death.

13. Analysis

13.1 Analysis was completed on the keys lines of enquiry agreed by the Panel at its initial meetings.

A. How effective were the risk assessment processes, in particular the contextual assessment of risk?

13.2 There were a number of points at which assessments into the risks faced by Amy could have been made yet they were not. If taken these missed opportunities may have increased the support available to Amy and also controlled the risks presented by Brian.

13.3 Notwithstanding the duty to share information in cases of a MARAC to MARAC referral. The Panel discussed during this Review the fundamental question of who the responsibility lay with to make further enquiries in respect of cases which are to be considered at MARAC. In particular enquiries with other Boroughs/Authorities who may hold important contextual information which may in turn result in better informed actions being taken to reduce current levels of risk from further domestic abuse.

The following incidents illustrate these points.

13.4 A MeRIT risk assessment checklist for use when assessing the future level of risk from domestic abuse is widely available within agencies forming part of the St Helens Community Safety Partnership.

13.5 In February 2018 G.P. records show that Amy disclosed that she was suffering

- Continual harassment by ex-partner
- Domestic abuse.
- Was currently in a relationship but it was unstable
- The *“situation was escalating*”

13.6 Her G.P. recognised that Amy required further support and referred her to Mental Health Services. The G.P. despite what was disclosed by Amy, did not complete a domestic abuse risk assessment checklist (MeRIT) or make a referral of Amy into domestic abuse support or safeguarding services.

13.7 Between the initial referral to Mental Health Services in February 2018 and August 2018, when contact was finally made with Amy by Mental Health Services, two further referrals were made by Amy’s G.P. to the Adult Mental Health Team. On each of the first two referrals the Mental Health Services Team attempted to engage with Amy by telephoning her and on each of the first two occasions the Mental Health Services closed the case and referred it back to Amy’s G.P. because contact with Amy attempted by telephone had failed.

13.8 Following the first referral Mental Health Services made two attempts to contact Amy. Both calls were made on the same day and staff did not manage to talk to Amy. The referral was closed at that point and returned to her G.P.

13.9 After the third time that Amy's G.P. made a referral to Mental Health Services they were successful in contacting Amy and completed a telephone triage assessment. The outcome of this triage assessment was that Amy would be sent a leaflet describing the services of a support centre for females suffering domestic abuse so that Amy may refer herself for support and secondly that consideration be given for Amy to engage with the personality disorder pathway.

13.10 It was the same referral that was sent to Mental Health Services on all three occasions. In notes from her G.P. and Mental Health Services there is an absence of the phrases "*In an unstable relationship*" or "*the situation is escalating"* being further explored or defined either by Amy's G.P. or Mental Health Service and in spite of referral pathways being in place for the G.P. to refer into domestic abuse services, (via Safe 2 Speak) no record exists of a domestic abuse risk assessment form (MeRIT) being completed by either G.P. or Mental Health Services.

13.11 Following this Review the G.P. practice have agreed an action to increase the use of MeRIT risk assessments. This has been included within the list of actions included at Appendix A.

13.12 The primary method of contacting clients used by Mental Health Services when completing a triage assessment is by telephoning them. However, should telephone contacts fail the Service will then write to the client asking them to contact the Service.

13.13 Brian's controlling behaviour, particularly a partner's use of her mobile phone and his paranoia about who she was making calls to or receiving calls from, was revealed for the first time to Police by his previous partner during the murder investigation. During one Mental Health Service attempt to contact Amy, the telephone call was answered but the person refused to speak. This did not cause Mental Health Services to increase their level of concern for Amy or to deviate from their standard means of communication with clients.

13.14 Taking all these facts together it is possible that the person answering the call made to Amy's phone was Brian and it is possible that by just using the telephone and sending a letter as a means of establishing contact with a client may have put Amy at greater risk from further abuse within an "*unstable relationship"*. It is acknowledged by the Trust that there may have been a range of reasons why Amy did not respond to contacts made by the Mental Health Team including the controlling behaviour of her partner. "*If Amy was being controlled by her partner, she may have been unable to seek help in relation to her mental health, or the failure to respond may have been reflective of an increase/decrease in the severity of Amy's mental health symptoms*."

13.15 Although Trust procedures were followed in this case. On review it is acknowledged by the Trust that in light of the severity of Amy's mental health symptoms and the information about domestic abuse contained in the G.P. referral if no contact could be established via the telephone triage a home visit should have been arranged and Amy should have been seen face to face to ensure a comprehensive assessment by the Mental Health Team was completed.

13.16 In April 2017, Amy attended a meeting at St Helens MBC Housing Options and Advice Service in company with Brian and an IDVA from Warrington Refuge. This meeting was not part of a region/borough MARAC to MARAC referral process. (The last MARAC to consider Amy's risk prior to this meeting took place in Warrington in 2014.) Amy disclosed at that meeting that she "*had fled*" physical and controlling abuse from an ex-partner in Warrington. The IDVA was asked at this meeting by Housing Options to provide a letter confirming that Amy had suffered domestic abuse and their support for Amy's housing application which the IDVA later did.

13.17 Housing Options did enhance Amy's housing eligibility banding based upon the evidence, provided by the IDVA letter, that she had suffered domestic abuse.

13.18 There is no record showing that based upon this disclosure of domestic abuse or, the further information provided by the IDVA from Warrington, that Housing Options made any enquiries with other housing agencies in Warrington who had previously supported Amy with her housing needs. Housing Options did not make a

referral of Amy to domestic abuse services in St Helens or assess the future risk that Amy faced from domestic abuse.

13.19 The Housing Association which provided Amy with her accommodation did not complete an assessment of risk from domestic abuse faced by Amy at the time of granting her tenancy.

13.20 On the basis that Amy's eligibility for housing was enhanced because she had suffered domestic abuse, there appears to have been a gap in completion of risk assessment between the Housing Options Service and the Housing Association/provider.

13.21 Since commencing this Review and reflecting upon such gaps the Housing Association have created a new post, of New Tenancy Officer whose role it is to identify vulnerabilities of new tenants and make the appropriate referrals for support. Thus, providing support to new tenants faced with the challenges Amy was facing at this time.

13.22 On 22nd September 2018 Brian used Amy's mobile phone to text her friend. In the text he stated that he was coming "*to take Amy down and ruin her*. This was shared with Amy by her friend and Amy then made a 999 call to Merseyside Police. During this call Amy disclosed to the Police call handler that she was attempting to end the relationship with Brian and that she believed Brian's attitude was that if he could not have her no one else will. Amy also told the Police call handler that she was concerned he (Brian) would kill her one day.

13.23 The call handler's record made before closing the incident shows that Police Patrols attending the incident concluded that there was nothing of a threatening or aggressive nature in the text message. Secondly that Amy was not in fear of Brian by virtue of him not having his own means of transport from his home in Warrington. On this point the Panel felt that there had been a failure to complete a comprehensive risk assessment around Brian's access to transport from Warrington to St Helens.

13.24 Police who attended the incident completed a form VPRF1 and the level of risk faced by Amy was assessed as being at level Bronze.

13.25 Despite Amy's concern that one day Brian would kill her being recorded on the call handler's log of the incident, it was not recorded on the VPRF1 nor did Officers attending question why she had such concerns.

13.26 Neither is there any evidence available to show that a Police Officer ever contacted Brian to seek explanation of his text message to Amy's friend "*Going to take her down and ruin her*" nor that they advised him as to his future conduct.

13.27 Amy contacted Police by 999 again on 23rd September 2018 because Brian was now at the front door to the flats where she lived and was pressing the buzzer. The call handler noted that Police records showed that a Domestic Violence Protection Order (DVPO) was pending against Brian following an assault of Amy by Brian in June 2018. This information regarding the DVPO was incorrect. There was no record of this on other Police systems and no DVPO was ever pursued. Officers believe that the circumstances of this incident failed to meet the criteria required to obtain a DVPO.

13.28 Section 24 of Crime and Security Act 2010 gives Police Officers the power to issue a Domestic Violence Protection Notice (DVPN) to a perpetrator if they have reasonable grounds for believing that the perpetrator has been violent towards or has threatened violence towards a victim and the issue of a DVPN is necessary to protect that person from violence or threat of violence from the perpetrator.

13.29 The record of the call showed that the Police officer who attended the incident completed a VPRF1 in accordance with Force policy.

13.30 The record of the Police log of 23rd September 2018, made by the person answering Amy's 999 call shows that no cognisance was taken of the 999 call made by Amy the day before and the threat within the text message to state he was coming to take Amy down and ruin her. Neither is there any evidence to show that these two incidents taking place on consecutive days had been considered together when assessing the level of risk Amy faced. Rather it appears that they had been treated as separate unconnected incidents.

13.31 In all cases where a Police Officer attends a domestic dispute Merseyside Police policy requires that officer to complete a form VPRF1 which is then submitted

to the MASH where staff will make further risk assessment using the domestic abuse risk assessment sheet (DARAS) which will then result in the categorisation of risk (Gold, Silver or Bronze). MASH will then manage that risk through the implementation of various options.

13.32 MASH policy is that for the MASH risk assessment to be contextual and accurate the address history for both parties should be examined. If either party has moved from another Force area enquiries should be made with that Force in addition to conducting Police National database record checks.

13.33 The MASH risk assessment following the incident on 22nd September 2018 incorrectly records that Amy was not a repeat victim of domestic abuse at the hands of Brian. (Merseyside Police responded to a 999 call from Amy in June 2018 made during a dispute with Brian at her home.) Overall it would appear that there is an absence of contextual risk included within the investigation into the risk faced by Amy carried out by the Police and the MASH in September 2018 who appear to have viewed each incident in isolation.

13.34 Records show that following the incident on 23rd September 2018, Amy was again assessed as facing a Bronze level of risk of future domestic abuse and that signposting was made for Amy to Mental Health Services and the NCDV. Records show that no contact was made with Mental Health Services by Amy over this incident.

13.35 There are no records available to the Panel to illustrate that the policy that MASH should make checks to accurately contextualise the level of risk faced by Amy was followed. Since this Review began new systems have been brought into being which link information held by Merseyside, Cheshire and North Wales Police Forces and make the information, such as that required in this case regarding previous domestic incidents, more readily available to each of the three Forces enquiring of it.

13.36 The failure to include any risks posed by Brian in the MARAC assessment of October 2018 following the incidents of 22nd and 23rd September 2018 compounds the above omissions.

13.37 Following a report from Amy to Police regarding the contact which was being made by her ex-partner in October 2018 the St Helens MARAC was asked to consider and manage the risk posed by Amy's ex-partner Colin who whilst in prison at the time was contacting friends of Amy's via social media asking them "*to persuade Amy to contact him.*" Colin also stated, *"that he knew where she (Amy) lived and is going to come and find her when he gets out of prison.*". Amy advised the call handler that "*she believed (what Colin was saying) as he had breached a previous restraining order several times*." The matter of Colin sending such messages via social media whilst in prison was dealt with by the National Probation Service and the Prison Service. A VPRF1 completed following this report assessed the risk faced by Amy to be Gold/high and the matter was referred to MARAC.

13.38 The resulting MARAC did not consider any additional risk that Brian posed to Amy.

13.39 The Panel have identified that the VPRF1 forms in respect of the two incidents in September 2018 both relating to risks posed by Brian were not shared by MASH with the IDVA completing the referral forms for the MARAC meeting at St Helens. Nor was information regarding the two incidents shared with colleagues in discussion of the risk faced by Amy at the MARAC meeting itself because the case was not fully heard.

13.40 The Panel explored the phrase "*not fully heard*" in relation to the MARAC meeting of 18th October 2018 to which Amy's case had been referred.

13.41 It was explained to the Panel that this was because the referral was made in relation to concerns about an historic perpetrator who was currently in prison with no imminent release date and there were no disclosures relating to current risks. This includes risks posed by Amy's relationship with Brian since VPRF1 forms relating to the incidents reported in September had not been shared with the IDVA completing the MARAC referral. Since this time staffing levels to support the functioning of MARAC locally have been increased and a review has seen the appointment of a single Chair for all Merseyside MARAC meetings.

13.42 Brian has declined to speak to the Chair of this Review. In the absence of any other evidence the Panel can only speculate about the significance of Brian's thought processes when committing this murder and the failure to include Brian's conduct in the assessment of risk at the MARAC meeting. Did Brian know Amy was attempting to end their relationship? This would have increased Amy's vulnerability, and through his "*control"* of Amy's phone was he aware that Amy's ex-partner was "*going to come and find her when he gets out of prison.*" Whilst acknowledging that evidence regarding Brian's control and coercion was not known to agencies until identified by the Police after the murder the speculation is that these factors may have been the reason Brian sent a text to Amy saying, that he was "*Going to take her down and ruin her*." and Amy's concern that Brian one day would kill her.

13.43 Even if such speculation is wrong the risks posed by Brian and Amy's ex-partner should have been reviewed together and should have merited consideration

and discussion of the risks faced by Amy at the MARAC. This did not take place and the contextualisation of risk was not considered.

B. How effective was the sharing of information relating to Amy and Brian between Warrington and St Helens?

13.44 Amy was not the subject of a MARAC to MARAC referral between Warrington and St Helens. The Panel therefore believe that it was incumbent upon agencies in St Helens, once they became aware of the domestic abuse faced by Amy, to make necessary enquiries with organisations in Warrington when establishing the contextual level of risk she faced. There were several occasions when individuals within partner agencies should have been aware of the need to make those enquires.

13.45 There is evidence to show that the sharing of information between agencies in Warrington who were supporting Amy, her children and her ex-partner was strong and effective. This in turn enabled a joined up and co-ordinated response to the issues raised by the relationship whilst Amy was living in Warrington.

13.46 In April 2017 when interviewed by Housing Options in St Helens Amy disclosed that she "*had fled*" Warrington to escape her previous partner at whose hands she had suffered domestic abuse. Aside from Housing Options St Helens requesting from the IDVA, accompanying Amy to that initial meeting, written confirmation that Amy had been a victim of domestic abuse in Warrington the Panel were unable to identify any occasion when agencies in St Helens supporting Amy, including the MASH, made contact with agencies in Warrington who had supported her in the past.

C. Were the elements of Control and Coercion within domestic violence recognised and responded to by agencies and the public.

13.47 All of the information contained within this key line of enquiry was obtained after the murder had been committed and was obtained during the Police investigation into the matter. The information was not known by any other agency and the Panel only became aware of the level of control and coercion after Merseyside Police shared this information with the Panel.

13.48 The statements obtained by the Police make clear the degree of control Brian imposed upon the females, including Amy, he was in a relationship with and whilst family and friends of Amy recognised elements of coercion and control, they never challenged Brian about it. Friends state that they did however challenge Brian over his physical abuse of Amy.

13.49 During the almost two years that Amy was in a relationship with Brian her parents rarely saw her and knew very little about Brian or the relationship between the two. The opposite is true of the period when Amy was in a relationship with her ex partner Colin. A friend of Amy's provided an explanation for this lack of contact between Amy and her parents. She says that Brian isolated Amy, made her change her phone number and would not allow her to see her family.

13.50 At no point during a combined assessment completed by Warrington Children Services in 2014 did an ex-partner of Brian disclose the extensive controlling behaviour she had suffered. In fact, the ex-partner made no disclosures regarding

domestic abuse at all. However, contained within Police statements obtained during the murder enquiry, the ex-partner revealed a history of controlling behaviour perpetrated by Brian during their relationship. Details included Brian's control of his ex-partners mobile phone contacts and usage and what the partner could or could not wear when out in public.

13.51 A friend of Amy's witnessed similar behaviour when Amy and Brian were out socially with them. "*Even when Amy went for a wee, Brain would follow her and stand outside the door, even if we were in my flat, he just didn't like Amy being out of his sight."*

13.52 Police statements taken during the murder investigation reveal that Amy sent a text message to her friend and told her not to phone her, unless Amy phoned her first and asked her to, or if Amy texted her asking the friend to phone her. Because Brian had made her change her phone number and had made her block the friend on all social media. In that friend's words Brian "*had made Amy isolated*"

13.53 Amy disclosed to a friend that she was making efforts to have the Guardianship Order placing her sons in the care of their grandparents revoked and to get her children back. Also that Brian used this fact to get his own way by threatening to cause her problems with the Authorities if she did not behave as he dictated. This included dressing as he dictated, and requiring Amy to give into his constant demands for attention both physically and sexually.

13.54 A further noteworthy observation illustrating the level of control Brian imposed upon Amy comes from a long standing friend of Amy's. This friend was in contact with Amy by telephone two days before her death. Amy told her friend about the assault which Brian inflicted upon her when she returned from her Grandmas funeral on 22nd November 2018 . (This was not reported to any Agency)

13.55 This friend later described to Police investigating the murder "*I believe that Amy was being abused mentally and physically by Brian and what happened to Amy was because she was trying to leave him and he was thinking if he couldn't have her, no one could*".

13.56 Indicators of the control and coercion Amy was facing and the pivotal risk factors from this relationship in the weeks leading up to her death include; Amy was trying to leave Brian. The belief Amy had about Brian that if he couldn't have her no one else could. Amy's concern that one day Brian would kill her and Brians text stating he was going "*to take Amy down and ruin her*." These factors were shared with the Police by Amy herself in the 999 phone call she made on 22nd September 2018.

13.57 Police Officers attending the incident on 22nd September 2018, when Amy disclosed that she was concerned one day Brian would kill her, did complete a MeRIT Risk Assessment form in respect of Amy but failed to include Amy's belief or concerns regarding Brian. Amy was assessed as being at a low risk of future harm (Bronze.)

13.58 Additionally, there are no records to indicate that Police Officers sought Amy's explanation of her beliefs and concerns. (The absence of Amy's concern that one day Brian would kill her from the VPRF1 is the subject of an Action by Merseyside Police included at Appendix A.)

13.59 The Police murder investigation in this case revealed the final evidence of Brian's controlling and coercive behaviour towards Amy which came two days before her death whilst she was attending her Grandmother's funeral.

13.60 Brian did not want Amy to attend the wake following the funeral and at the wake a family member saw that Amy was crying hysterically and went to comfort her and establish the reason for her distress. Amy told her, "*Brian keeps ringing me, he's going to go mad". "he just wants me to go home, cos he wanted me in now. He doesn't want me staying here. he wants me to get home and get a taxi*".

13.61 Whilst comforting Amy the relative could hear Brian shouting down the phone, *"f…..g come home, what the f..k are you doing"*

13.62 The opening paragraph of this section of the report makes it clear that no agency had any knowledge about the controlling and coercive behaviour of Brian towards Amy until after the murder. However, it is also clear from the Police murder investigation that some family and friends of Amy did possess such knowledge.

13.63 The Panel therefore commissioned further enquiry into why such information was not available to public bodies before. With assistance from AFFDA who were supporting Amy's family, Stephen McGilvray held a focus group with Amy's family and friends to establish why they felt unable to disclose information regarding control and coercion and what agencies could do in the future to make such disclosures more likely.

13.64 Amy's children had been removed from her care after Children's Services in Warrington were concerned with the levels of physical abuse being witnessed by them whilst Amy was in a relationship with Colin and took action to safeguard them.

13.65 The two children were made subject of a Guardianship Order and placed into the care of Amy's parents.

13.66 Amy had an overriding desire that one day her two children would be able to be safely returned to her care. To this end Amy had confided in friends that Brian was very controlling but she forbade them from telling anyone about the abusive relationship she was now in because she was afraid that to do so would jeopardise her ever seeing her children again.

13.67 Friends said that "*She (AMY) wouldn't reach out because of the kids".* Amy told them that "*If Social Services knows about this, I wouldn't see the kids*"

13.68 Amy's reluctance to reach out by reporting the abuse was extended to the Police for the same reason, (her desire to have her children back living with her). Amy had frequently reported incidents of abuse to Police when in a relationship with Colin. Family believe that it was via the Police that Children Services became involved with her which ultimately lead to the Guardianship Order being made. The family believe this was reflected in the significantly smaller number of calls Amy made to Police services during her relationship with Brian.

13.69 As described in paragraph 13.53 above friends believe that Brian used Amy's desire to have her children back to coercively control her and force her to submit to his physical and sexual demands. Failure to comply and he would cause her problems with the Authorities.

13.70 Amy believed she had only two choices and faced with the choice of hiding the abuse she was suffering or reporting matters to Agencies and therefore risking the likelihood of having her children returned to her care, family and friends were told and believe that she chose to suffer the abuse.

13.71 The Family Rights Group published a report in 2014 in which they cite the opinions of victims of domestic abuse who are also parents. "They often feel they are being doubly abused - first at the hands of the perpetrator and then by a child protection system that seems to lay the blame on them for inadequately protecting their child. If the mother experiences further domestic abuse, she often fears that reporting it could lead to the local authority using it as evidence to remove her child. In one case, a woman reported she was told by social workers that if there was another incident of domestic abuse the children would be removed. "What that tells the woman is you cannot report abuse to the Police, or you risk losing your children,".

13.72 There is no intention to reflect negatively upon the way in which agencies in Warrington carried out their duty to safeguard children by the inclusion of these extracts from the Family Rights Group.

13.73 However, from speaking to the family and friends of Amy these extracts mirror the thoughts and actions of Amy and explain why during abusive relationships some victims/survivors isolate themselves from agencies which could provide support.

13.74 When asked how, in the future, victims faced with the same "*choice*" as Amy may be able to overcome this and obtain support, Amy's parents suggested that future education campaigns should include the plea to victims that "*you can say anything to your parents*".

13.75 The risk assessment and referral to MARAC in St Helens where her case was considered on 18th October 2018 was based wholly upon Amy's ex-partner Colin's controlling and coercive behaviour.

D. The level of training given to staff within the agencies forming part of this Panel in regard to domestic abuse and risk assessment.

13.76 Details of the training currently delivered by organisations represented at this Review is as follows.

13.77 Cheshire Constabulary officers receive regular inputs regarding domestic abuse and the submission of Vulnerable Person forms and DASH risk assessments.

13.78 Domestic abuse training covers topics around Adverse Childhood Experiences (ACE's) breaches of bail, remand applications. Domestic Violence Protection Orders and Notices, the domestic violence disclosure scheme and serial domestic abuse perpetrators.

13.79 Merseyside Police student officers receive training in recognising the different types of domestic abuse, physical, psychological, emotional, sexual, and coercive and controlling behaviour. In addition, the importance of correctly completing the VPRF1 form is covered in detail.

13.80 Since April 2019 a two-day course at Merseyside Police Training Academy regarding controllin0g and coercive behaviour has been delivered to staff from Police Contact Centres, uniform patrols, and level one and two investigative staff. This training includes examining tactics used by perpetrators, victim blaming, and the importance of asking the right questions of both victim and perpetrator. Legislation and points to prove prior to charging are also explored.

13.81 The Domestic Abuse Team based within Torus Housing, who manage the IDVA Service on behalf of St Helens Community Safety Partnership acknowledged a gap in staff awareness on issues of coercion and control within intimate relationships and commissioned a Liverpool University Professor to provide input and training on these issues.

13.82 At North West Boroughs Health Partnership half day workshops have been held and more are planned. The workshops focussed upon risk assessment and recognition of control and coercion within an intimate relationship. Briefing sessions regarding domestic abuse are held at team meetings with a particular focus upon delivery to the Mental Health Teams.

13.83 What is clear from this analysis is that there is no multi-agency joint training on issues of Control and Coercion within an intimate relationship available to staff in St Helens.

14. Conclusions

14.1 Brian appeared to select vulnerable females to begin relationships with and evidence shows that Amy, who was suffering from PTSD at the time of meeting Brian, went from one physically abusive, coercive and controlling relationship into another. Such risks were not identified or acted upon by any agency involved in this Review.

14.2 The management of risk present within Brian and Amy's relationship does not appear to have been acted upon as swiftly and effectively as it may have been by organisations who engaged with Amy in St Helens.

- Opportunities to complete risk assessment's including the responsibility of contacting agencies in a neighbouring area where earlier incidents of abuse had been delt with and sharing that knowledge with MARAC or other safeguarding bodies were not taken.
- At key points there was a lack of professional curiosity shown by those engaging with Amy. In the few weeks prior to her death Amy disclosed Brian's controlling and coercive behaviour but no one investigated these elements sufficiently to afford her the protection she required.
- The focus upon ex-partner Colin appeared to overshadow agencies actions and hid the abuse inflicted by Brian.
- Agencies in St Helens when assessing the level of risk within the relationship appear to have dealt with incidents involving Brian and Amy in isolation and took no account of the context within which that incident was taking place.

- The MARAC which considered the risk faced by Amy in October 2018 was poorly informed which hampered its decision making.

14.3 The very strong desire that Amy had to have her two children back in her care overrode her family and friends' power and willingness to report the physical abuse, controlling and coercive behaviour Brian subjected Amy to.

14.4 One element in resolving this issue is for front line service providers to victims of abuse go beyond satisfying themselves on issues of physical abuse alone and make investigation of control and coercion as much of a priority issue as physical abuse. To assist this, raising levels of knowledge and education on the issue of control and coercion within an intimate relationship needs to take place publicly and amongst agencies.

15. Recommendations

15.1 Following completion of the IMR's some have made their own single agency recommendations. These together with the following recommendations which have been made by and agreed by this Panel are included at Appendix A of this report.

15.2 All organisations represented at this Review inform and educate staff about the need to recognise and actively investigate the level of control and coercion present within an intimate relationship.

15.3 Education and marketing must take place both nationally and locally. To raise awareness about control and coercion within an abusive intimate relationship and when people choose to avoid reporting incidents to Authorities, to inform them about the wide range of other bodies and pathways which remain open to report incidents of domestic abuse.

15.4 When assessing the level of risk that a domestic abuse incident presents do not view the incident in isolation consider instead the context in which that incident and the victim exists. Whilst it is vital that this consideration is made at a local level the Panel believe that the importance of assessing contextual risk would also benefit from future reinforcement by Central bodies.

15.5 The Panel acknowledged that within some pockets of the CCG change to deliver a greater level of engagement from G.P. and other Health professionals in taking positive action in risk assessment and information sharing when a patient discloses domestic abuse is required.

15.6 In order to facilitate effective risk assessment organisations must acknowledge that staff representing them at MARAC meetings require sufficient time to adequately research cases and individuals before attending the MARAC and afford them that resource.

Appendix A

Action Plan

Action Plan

Recommendation	Scope	Action to Take	Lead Agency	Key milestone	Target date	Outcome
All agencies inform and educate staff about the need to recognise and actively investigate the level of control and coercion present within an intimate relationship.	**Local**	Contact all local agencies and stakeholders represented at the St Helens People's Board with information about Coercive Control	**Peoples Board**	Raising awareness of Coercive Control included in the St Helens Domestic Abuse Strategy which is being revised. Training package in Coercive Control Domestic Abuse identified and cascaded to agencies/stakeholder s represented at St	**30.06.20**	**Greater accuracy in assessment of risk.** **Greater protection from further abuse for survivors and their families.**

		Domestic Abuse and signs to be aware of and ask that this be cascaded within their organisations along with details of help available. Identify available training on Coercive Control and		Helens People's Board. OPCC workplace Domestic Abuse Awareness Raising Programme in place across S Helens public sector organisations and other agencies who work with people.		

		request local agencies/ stakeholders complete this.				
Education and marketing must take place both nationally and locally. To raise awareness about control and coercion within an abusive intimate relationship and when people choose to avoid reporting incidents to Authorities, to inform them about the wide range of other bodies and pathways which	**Local and National**	Develop borough-wide awareness raising campaign that includes Coercive Control and which identifies how people can report	**Peoples Board and Home Office**	Raising awareness of Coercive Control included in the St Helens Domestic Abuse Strategy which is being revised. Borough-wide awareness campaign implemented.	**30.06.20**	**Greater awareness amongst public of control and coercion within intimate relationship.** **Higher levels of**

remain open to report incidents of domestic abuse.		domestic abuse and where they can go for help.				**reporting in all aspects of domestic abuse.**
When assessing the level of risk that a domestic abuse incident presents do not view the incident in isolation consider instead the context in which that incident and the victim exists. Whilst it is vital that this consideration is made at a local level the Panel believe that the importance of assessing contextual	**Local and Home Office**	**Identify available training on Coercive Control and request local agencies and stakeholder**	**Peoples Board and Home Office**	Training package on Coercive Control Domestic Abuse identified and cascaded to agencies/stakeholders represented at St Helens People's Board.	**30.06.20**	**Higher quality assessments of risk.** **More effective action plans to prevent repeat domestic abuse**

risk would also benefit from future reinforcement by Central bodies		**s complete this.**				**incidents by inclusion of causal and contributor y factors in the abuse.**
In order to facilitate effective risk assessment organisations must acknowledge that staff representing them at MARAC meetings require sufficient time to adequately research cases and individuals before attending the	**Local**	Implement a system to ensure a minimum of one week's advance notice of cases prior to MARAC meeting via issue of the	**Peoples Board**	System implemented that ensures a minimum of one week's advance notice of cases prior to MARAC. Chair has confirmed representatives attending MARAC have been allowed sufficient time to	**31.12.19**	**Risk Assessmen t Plans based upon more comprehen sive information.**

MARAC and afford them that resource.		Agenda. MARAC Chair to ask agency representatives if they have been allowed enough time to research MARAC cases and issue an instruction to employing organisation as necessary.		research cases prior to the MARAC meeting and any issue raised with employing organisation.		

Refuge's Casework management policy and effective casework training should be reviewed to ensure that all staff understand the requirement to contact clients following a new referral by another agency.	**Local**	**Request casework manageme nt training and risk assessmen t training includes information about review of risk assessmen ts following a new referral by another agency**	**Refuge, Warringto n**	**Inclusion of training program.**	**December 2019**	**Accurate risk assessment .**

Refuge to develop a process to effectively identify clients who have not had risk assessment reviewed at least every four weeks.	**Local**	**Automatic reminder displays when casework manageme nt system is entered by a caseworker .** **This reminder can be seen by the**	**Refuge Warringto n**		**Completed November 2019**	**Up to date risk assessment .**

		caseworker’s manager.				
People being rehoused into St Helens from a neighbouring borough due to Domestic Abuse should be referred direct to the new tenancy officer within the complex needs team at signup.	**Local**	**Appointment of a member of staff to this new post.**	**Torus Housing**	**Creation of new post.** **Recruitment and selection of suitable candidate to this post.**	**Since the start of this Review a member of staff has been appointed and is now in post**	**Referral of new tenants directly to this post are now being made.**
Staff at MASH should be reminded of the importance of researching the history of parties involved in domestic abuse. In	**Local**	**Learning from this Review to be shared with all**	**Merseyside Police**	**Learning points to be developed into an information and education package.**	**Information and education packages have been**	**Every Merseyside Police staff member working in**

particular ensuring previous addresses are taken into consideration during the risk assessment process.		**MASH Teams on Merseyside .**		**Circulation of learning package to all MASH Teams on Merseyside.**	**produced and circulated to all MASH Teams and personally to every MASH Team member.**	**a MASH Team has received this package.** **Learning has also been shared at the Merseyside Police Protecting Vulnerable Person's meeting.**

Consideration should be given to adopting measures to ensure that whenever a victim states they think the perpetrator will kill them one day the comment is recorded on the VPRF1 and its context explored with the victim at the earliest safe opportunity.	**Local**	**Reinforcement of learning and training already provided in completion of Form VPRF1.**	**Merseyside Police**	**Inclusion of lessons from this Review in the extensive training at all levels of Merseyside Police which takes place on protecting vulnerable people and completion of VPRF1 forms.**	**Already underway and action is ongoing.**	**Outcome sought is greater level of protection and support for vulnerable victims of domestic abuse.**
Make more use of completing MeRIT forms to determine whether referral to MARAC is needed.	**Local**	**MeRIT completion to form Key Performance Indicator within**	**CCG**	**Increase in MeRIT completion by G.P. practices.**	**December 2020**	**Greater level of support and action for victims following**

		Commissioning Standards. **Support for G.P. practices giving training and time to complete MeRIT forms.** **Amendment of patient registration forms to include**				**disclosure of domestic abuse.**

		domestic abuse question. **Alert added to patient records in cases of domestic abuse disclosure.**				
The Panel acknowledged that within some pockets of the CCG change to deliver a greater level of engagement from G.P. and other Health professionals in taking	**Local**	**Maintain current level of support to G.P. practices.**	**CCG**	**Inclusion of IDVA at training days.** **MARAC Steering Group directed support to G.P. practices.**	**December 2020**	**High level of engagemen t across all CCG practices.**

positive action in risk assessment and information sharing when a patient discloses domestic abuse is required.		**Involvement of IDVA at bi-annual G.P. safeguarding training days.** **Close working with MARAC Steering Group to achieve support for G.P. practices.**				