Domestic Homicide Review

Executive Summary

“Joan” who died in September 2018

LDHR 15 Final Report June 2021

Contents

1 Introduction and review process

1.1

This executive summary report of a Domestic Homicide Review (DHR) examines agency responses and support given to “Joan”[1], who died in hospital in September 2018, 12 days after sustaining head injuries caused by being punched in the face by her adult son “Ben”. At the time of the homicide incident Joan was 52 years old and Ben was 30. Both were of White British ethnicity. Following a police investigation, Ben was charged with and subsequently convicted for manslaughter. He had initially denied the charge but following a change of plea to guilty was sentenced to 54 months imprisonment, in January 2019.

1.2

The DHR process commenced with a meeting of with a meeting of the Liverpool Community Safety Partnership (CSP) DHR Standing Group on 21/09/18, when the decision to hold a DHR was agreed.

[1] To protect confidentiality of the victim and all family members, pseudonyms are used throughout this report.

2 Contributors to the review

2.1

The following table shows those services and organisations which contributed to the DHR. Panel members and the Independent Chair / report author were assured that those completing IMRs had had no operational or line management involvement with the homicide victim or perpetrator. All panel members were similarly independent from the case. The first Panel meeting was in March 2019. There were 5 Panel meetings in total.

Table 1 Services and organisations which contributed to the DHR

Organisation	Contribution
Liverpool City Council Adult Services	IMR and Panel membership
Mersey Care NHS Foundation Trust	IMR and Panel membership
Local Solutions: Independent Domestic Violence Advocate (IDVA) Service	IMR and Panel membership
Supported Housing Service (SHS) for Ben[2]	IMR
Merseyside Police	IMR and Panel membership
National Probation Service and Merseyside Community Rehabilitation Company (MMCRC)	IMR and Panel membership
Liverpool Clinical Commissioning Group (CCG) for GP Practice	IMR and Panel membership

[2] The Supported Housing Service is not identified in this report, to help protect the confidentiality of the victim and perpetrator.

Where panel members were from organisations which had been involved with Joan and Ben, the panel representatives had not had any direct contacts or management responsibilities for agency contacts with them.

2.2

In addition to information provided by IMRs, there was also a multi-agency learning day in November 2019. This included practitioners and operational managers who had had direct involvement and responsibility in relation to Joan and Ben. This event added significantly to the learning highlighted in this report.

3 Independent Chair / Author

3.1

Richard Corkhill[3] was appointed by LCSP to act as Independent Chair and Overview Author. Based in the North East of England, he has over 30 years operational and senior management experience in the social care and supported housing sectors. He has been a self-employed Consultant since 2004 and has successfully completed on-line Home Office training for DHR authors and Chairs. He has extensive experience in working on DHRs, Safeguarding Adults Reviews (SAR) and similar multi-agency review processes, including work on 15 DHRs in various English regions, since 2012. Mr Corkhill is fully independent and has never been employed by any of the organisations which were involved with the homicide victim or perpetrator.

[3] Further information about Mr Corkhill is available at: www.richardcorkhill.co.uk

4 Terms of Reference

4.1

The period under review is from 01/07/14 to the date of the homicide incident in 2018. There was a long history of police call outs to incidents involving Joan and Ben, prior to July 14 which the DHR has taken account of. However, the decision was taken to focus on the last 4 years of Joan's life as this was the period when there was evidence of escalation in frequency and nature of incidents. The terms of reference set out the following key areas for consideration, to be addressed in Individual Management Reviews (IMRs) and in this overview report:

4.2

What services did your agency offer to Joan and were they accessible, appropriate and sympathetic to her needs?

4.3

What services did your agency offer to Ben and were they accessible, appropriate and sympathetic to his needs?

4.4

How did your agency respond to issues of risk assessment and risk management relating to Joan and Ben, including:

- Risks posed by Ben as a perpetrator of domestic violence, and
- any evidence of adult safeguarding concerns where Ben may have been considered at risk of significant harm.

4.5

What information and/or concerns did family and friends have about domestic abuse and violence in the family and what did they do?

4.6

Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim or perpetrator, or on your agency's ability to work effectively with other agencies?

4.7

Issues of mental health and abuse of alcohol appear to have been significant factors. How did your agency respond to these issues?

4.8

Are there any examples of outstanding or innovative practice arising from this case?

4.9

Are there any other issues (not already covered in response to questions a - g) which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?

5 Background and summary chronology

5.1

Joan's family background is complex, with a long history in which all members of the immediate family had witnessed or been involved in domestic abuse, as victims, perpetrators, or both. Alcohol misuse was a highly significant factor in most, if not all, instances. Joan suffered from mental health and alcohol dependency problems, in which her experiences (over many years) as a victim of domestic abuse were almost certainly a major factor. The homicide perpetrator had on previous occasions been a victim of various forms of domestic abuse, as well as a perpetrator. He also had very significant mental health problems, including a diagnosis of complex past trauma / Emotionally Unstable Personality Disorder (EUPD). These problems are highly likely to be a product of his complex and chaotic family background and early childhood traumas. From age 16, Ben had also suffered from very significant hearing loss, the cause of which is unknown.

5.2

Merseyside police records confirm a very long history of incidents involving Joan's previous partners. Although the timeframe for this DHR starts in 2014, it is significant to note that between 2004 and March 2014, Merseyside Police have records of 67 incidents involving Joan. This includes 38 occasions on which Joan contacted the police concerning verbal disputes with various family members including 2 previous partners, Ben, Ben's 2 brothers, her parents and her sister. The remaining 29 incidents were when other family members called the police to incidents of family conflict in which Joan was involved.

5.3

From 2006 onwards, Ben experienced serious mental health problems. Between 2006 and 2012 he had more than 30 contacts with the Accident and Emergency (A&E) Mental Health Liaison Team. His most recent Care programme Approach (CPA) review prior to the homicide was in May 2018, when the pre-existing

diagnoses were confirmed, including EUPD, obsessive compulsive disorder (OCD), and depressive episodes with anxiety. This review also recorded harmful use of alcohol as an additional diagnosis.

5.4

At the time of the homicide incident, Ben was resident at a support housing service for people with mental health problems, commissioned by Liverpool Adult Social Care (ASC) and delivered by a private sector provider. The service included a 24-hour staffed presence.

5.5

From July 2014 until the homicide in September 2018, there were around 60 police call outs to incidents in which both Joan and Ben were directly involved. On 41 of these occasions, it was Joan who made the request for police intervention. In most of these incidents, Joan called the police complaining that Ben was at her house creating some form of disturbance (either outside of the property trying to gain entry, or inside the property and becoming verbally aggressive and threatening.) On these occasions Joan made it clear that she wanted Ben removed from her home, but her consistent position was that she felt that his behaviours were due to his mental health problems, which she believed were not being properly recognised or responded to by mental health treatment and support services. On this basis, she would not support criminal charges. Police records of the large majority of these incidents do not suggest reports or direct evidence of physical violence between Ben and Joan, but there was frequently evidence that Joan was frightened and believed that without police intervention Ben would be very likely to become violent towards her. However, there were also a relatively small number of instances when Ben reported that Joan had been violent towards him. Where there were reported incidents of violence perpetrated by Ben, these included pushing, shoving, throwing furniture and single punches.

5.6

In addition to the approximately 60 police incidents involving Ben and Joan together, there were many other incidents which involved either Ben or Joan, with other family members or other third parties.

5.7

Following nearly all of the police attendances at incidents involving Ben and Joan, police records show that a Vulnerable Persons Referral Form (VPRF) was completed (in respect of Joan, Ben or both parties, depending on the incident and who was identified at the victim) and forwarded to Adult Social Care (ASC). This included 28 VPRFs completed where Joan was identified being at risk from Ben's behaviours.

5.8

ASC also received communications from other services, raising concerns about Joan's safety and wellbeing. This included a contact from North West Ambulance Service (NWAS), after Joan had sustained a suspected fractured jaw following an incident in April 2017 when she stated Ben had punched her in the face. ASC were also contacted on 3 occasions (July17, October 17, March 18) by an Independent Domestic Abuse Advocate, similarly expressing concerns for Joan as a domestic abuse victim of Ben. Despite these communications and the numerous VPRFs received from Merseyside Police, ASC did not carry out any formal assessment of Jean's potential care and support needs, or make any Safeguarding Adults enquiries, under Section 47 of the Care Act.

5.9

Ben had ASC involvement and was subject to the Care Programme Approach, due to his mental health problems. The private sector supported housing service was aware of conflicts between Ben and his mother, as a there were a number of incidents which occurred at the supported housing premises where Joan would visit Ben, even though she had been barred from the premises by the supported housing

provider. However, the focus of the supported housing service was very much on Ben as a victim of abuse, which they witnessed as being perpetrated by Joan. This provider has advised that their staff at no point received information that Ben had been identified as a high-risk perpetrator, with his mother as the victim. This service also confirmed that staff had had no knowledge about the MARAC process (i.e. general knowledge or awareness of what MARAC was, or any specific information that Ben had been identified as a high-risk perpetrator resulting in his mother's referral into MARAC)

5.10

In September 2016 Joan was identified as a high-risk victim, after being punched in the face by Ben and suffering a bleed to her head and an ear injury. This resulted in referral into the MARAC process. Between May 2017 and Jan 2018, there were a further 5 incidents where Joan was recorded as a gold victim of Ben. However, the recording of gold in these incidents was based on the original gold incident in September 2016, as the individual incidents were relatively low level with no reported physical violence.

5.11

The large majority of the approximately 60 police call outs to incidents involving Ben did not lead to any formal warnings or criminal proceedings. Those that did are summarised below:

NOVEMBER 2014:

Police issued warning under 1994 Protection from Harassment Act, after a series of incidents when he had gone to his natural father's house, behaving aggressively and asking for money.

NOVEMBER 2014:

Following another incident at his father's house Ben was charged with offence of harassment and placed on bail with conditions to stay away from his father's house.

NOVEMBER 2014:

Sentenced at Magistrates Court for the harassment offences against his father. Made subject to 12 months Supervision under a Community Order. (Supervision provided by Merseyside MCRC) Indefinite Restraining order also imposed, barring future contact with his father.

JANUARY 2015:

Sentenced at Magistrates Court for the harassment offences against his father. Made subject to 12 months Supervision under a Community Order. (Supervision provided by Merseyside MCRC) Indefinite Restraining order also imposed, barring future contact with his father.

FEBRUARY 2016:

Following breach of the Restraining Order, a 1-month Curfew was imposed.

MARCH 2016:

Following an offence (Feb 16) of criminal damage to a window at his supported housing project, he was charged with criminal damage.

At the same hearing, Ben was also convicted for an offence Section 39 assault (common assault) against his mother, following an incident (Feb 16) at Ben's supported housing premises. The support worker had witnessed Ben kicking and stamping on Joan, on the floor. Both Ben and Joan were reported to have been under influence of alcohol. Joan had denied that this assault had taken place.

Ben was convicted of both offences. He was placed on a further Community Oder and a 6-week Curfew Order.

JULY 2016:

Domestic Violence Protection Notice (DVPN) issued after incident where Joan had called police to have Ben removed from her home. There was evidence (bruising) indicating that Joan had been physically assaulted, but she would not support any

criminal charges. A Domestic Violence Protection Order (DVPO - expired Aug 2016) was subsequently granted.

SEPTEMBER 2016:

Further DVPN issued after incident when Joan's ex-partner called police reporting that Ben had punched Joan in the face. Joan had refused to support any criminal charges, citing Ben's mental health problems. However, Ben was charged with section 39 assault.

DECEMBER 2016:

Ben convicted for above offence of section 39 assault and placed on a 12-month Community Order with 20 days Rehabilitation Activity Requirement and a Curfew.

6 Key issues arising from the review

6.1

The DHR identified a number of key issues, including:

6.1.1

There were occasions when Joan refused to support criminal charges against Ben, but Evidence Led Prosecutions (ELPs) may have been possible. There is no record to indicate ELPs were considered by the Police or CPS as a potential option.

6.1.2

Whilst ASC records (relating to both the victim and the perpetrator) provided clear and repeated evidence that Joan was an adult with care and support needs and that she was at high risk of domestic abuse from Ben, at no point was a decision made to carry out adult safeguarding enquiries, or to assess Joan's social care needs, or risks.

6.1.3

Part of the rationale for ASC not to take the actions outlined above appears to have been Joan's refusals to support criminal charges against Ben. However, the DHR Panel concluded that Joan's refusals to support criminal charges should have been a strong rationale *for* ASC to instigate adult safeguarding procedures, *not* a rationale for no further action.

6.1.4

Whist NWAS believed they had made a "safeguarding referral" following the incident in April 2017 when Joan suffered a possible fractured jaw after being punched in the face, this was not regarded by ASC as requiring a Section 42 enquiry, and therefore did not register on ASC records as a "safeguarding referral". This further highlights an issue which has been raised in previous DHRs (in Liverpool and elsewhere) around inconsistent use and understanding of terminologies.

6.1.5

However, the above point is not only an issue of professional terminology, as the information shared with ASC by NWAS (regardless of terminologies such as “referral”, “alert” “notification”) should have been recognised as requiring a safeguarding response under the section 47 of the Care Act.

6.1.6

The absence of any care needs assessments or adult safeguarding enquiries in relation to Joan was a critical missed opportunity.

6.1.7

The DHR process has highlighted a range of discrepancies between ASC records and those of partner agencies, regarding communications and referrals concerning Joan. If ASC staff are making decisions (e.g. whether or not to implement adult safeguarding procedures) but are not informed by highly significant past incidents and referrals, it is very probable that decision making will continue to be flawed.

6.1.8

Mersey Care NHS Foundation Trust’s (MCNHSFT) community mental health services had sporadic contact with Joan, and she had on a number of occasions disclosed that she was a victim of domestic abuse, both historical and current. However, there is no record to indicate that any MeRIT assessments were carried out by MCNHSFT, or that they considered the need to refer Joan into the MARAC process, or any other form of multi-agency planning.

6.1.9

MCNHSFT had more intensive and consistent contacts with Ben. However, their response to Ben as a perpetrator of abuse against Joan appears to have been limited to establishing that his mental health problems were not such that he could not be held criminally responsible for his actions. As the vast majority of Ben’s physical assaults of Joan resulted in no criminal charges, the fact of his criminal responsibility provided Joan with no real protection. Despite this, there was still no

consideration of the need for a planned or multi-agency response to clear evidence that Joan was at significant and ongoing risk from Ben.

6.1.10

The supported housing service (SHS) has acknowledged that the apparent lack of staff with any knowledge of MARAC as a process, highlights an urgent and fundamental staff training need.

6.1.11

There are inconsistencies between SHS's' records / staff recollections and the records of other services involved in in this case. These relate to what (if anything) was communicated to SHS by other agencies in relation to Ben being a high-risk perpetrator of domestic abuse against his mother. The outcome is that the one service which was in daily contact with a high-risk perpetrator was focussing on managing risks of the perpetrator being a domestic abuse *victim*. The reality was that the level of risk to Ben from Joan had been assessed at the lowest level, whilst Joan had accurately been identified as being at the highest (Gold) level of risk from Ben. The outcome was that there was no effective work being carried out by supported housing staff to challenge or otherwise address Ben's behaviours as a perpetrator. This was a major missed opportunity.

6.1.12

The SHS service was working very much as a stand-alone service, with very poor levels of communication *to or from* key partner agencies. The weaknesses inherent in this type of "silo working" have been a repeated theme of many DHRs.

6.1.13

There is no record of SHS being informed about MARAC meetings, or of the MARAC process resulting in SHS being asked to become actively involved in managing the very clear risks that Joan faced as a high-risk victim of Ben. SHS may be criticised for the fact that staff had not received training about MARAC. But the reality was that if staff had no information that Joan was a high-risk MARAC case, then it cannot be assumed that staff training alone would have made a significant difference.

6.1.14

The DHR Panel is of the view that there were significant opportunities when GPs could have proactively engaged Joan in discussions about her experiences and needs as a domestic abuse victim and explored probable links between this abuse and her ongoing problems with depression, anxiety and alcohol dependency issues. As the internal review carried out by the GP practice has already acknowledged, there was a significant lack of professional curiosity in this respect.

6.1.15

Although Joan had been assessed at gold level risk and discussed at MARAC (September 2016) there is no record of the GP practice having had any knowledge of, or involvement with, the MARAC process. This is another example of services working in “silos”.

6.1.16

Following an internal review of the circumstances leading to Joan’s death, her GP practice has identified changes in local practice which are supported by the findings from this DHR. These changes include:

- Mandatory safeguarding competences for all practice staff, relevant to their job description.
- Practice safeguarding lead to manage a “vulnerable patient” patient list and initiate searches and patient reviews on a quarterly basis.
- Safeguarding lead to ensure that domestic violence is appropriately coded and reviewed on a quarterly basis.

6.1.17

Ben was subject to a Community Supervision Order which was overseen by Merseyside Community Rehabilitation Company (MCRC). There is evidence that MCRC correctly identified risks, including potential risks to Joan as a result of ongoing incidents when Ben and his mother had alcohol fuelled arguments resulting in the need for police interventions. There is also evidence of good communication and information sharing between the police and MCRC, and that this information was

utilised correctly to inform risk assessments. Whilst these risks were correctly identified, this was not followed up with any focused work to try and challenge the repeated behaviour pattern of Ben and his mother drinking excessively together, leading to verbal conflicts and / or physical violence perpetrated variously by Ben, Joan or both of them. In summary, risks were identified, but not managed.

6.1.18

MCRC staff were not confident in working with Ben's emotional and mental health needs and presentations. Guidance could have been taken from his CMHN and other professionals involved in his care, but there is no evidence of any discussions of this nature having taken place, nor any professionals meetings to co-ordinate his progress through his Community Orders." This is further example where "silo working" was a significant factor.

7 Summary of key conclusions

7.1

In situations of multiple and of complex needs where domestic abuse victims may not actively support prosecutions, the police and CPS should consider the merits of Evidence Led Prosecutions. There was at least one instance in this case where an ELP should have been considered, but no indication that any Police / CPS discussion of this option took place.

7.2

The absence of any active responses under Safeguarding Adults procedures, was a major missed opportunity for developing a cohesive multi-agency risk management strategy. This missed opportunity was one of many examples where agencies were working silos.

7.3

The absence of cohesive and planned multi-agency responses represented a major barrier to Joan and Ben being able to access services which could have helped to address their multiple / complex needs, and the associated risks of violence and abuse within their relationship.

7.4

Joan's reluctance to support criminal proceedings against Ben should have been recognised as an additional reason to urgently establish a multi-agency safeguarding approach. That it was highlighted as a reason not to implement adult safeguarding procedures demonstrates a lack of understanding of the nature of domestic abuse and the needs of victims with multiple and complex needs.

7.5

The large volume of VPNs generated by Merseyside Police should have resulted in a much more proactive Adult Safeguarding response from ASC. That it did not, highlights a need to review policy and procedure to address this issue.

7.6

Supported housing staff reportedly had no knowledge of the MARAC process, indicating a serious deficit in training on domestic abuse. Given that they were working with residents who were likely to be domestic victims and / or perpetrators, this is a matter of serious concern.

7.7

The DHR has highlighted numerous examples of agencies working in “silos”, resulting in a lack of effective multi-agency working. Perhaps the starkest illustration of this is that the supported housing provider’s focus on Ben in relation to domestic abuse was in managing the risks to him as a *victim*, when all of the evidence held by partner agencies was that the risks he posed as *perpetrator* of violence against Joan were far greater than any risks in the opposite direction. A result of this silo working was that the service which had intensive daily contact with Ben, did no work with him to try and address his abusive behaviours.

7.8

The DHR has highlighted a lack of clarity in respect of the MARAC process, including a need for clear operational guidance and procedures which recognise thresholds for instigating multi-agency strategy meetings and action plans.

7.9

The use and meaning of terminologies such as *Referral, Notification, Vulnerable Person Notification, Safeguarding Referral, Safeguarding Alert* continues to be a source of confusion between agencies in Liverpool. As a result, different agencies

have different understandings and expectations of what actions (if any) will result from these types of inter-agency communications.

8 Individual recommendations from agency IMRS

8.1 Merseyside Police

8.1.1

Officers and staff involved in dealing with domestic abuse should be reminded of the need for adherence to the positive action approach towards domestic abuse and the need to consider Evidence Led Prosecutions in cases where victims do not support a prosecution. Consideration of such prosecutions should become standard Police and CPS practice for cases of repeat incidents where the victim refuses to support prosecution.

8.2 Adult Social Care

8.2.1

There should be a mandatory process to ensure that further action is taken in cases where there have been numerous VPNs received from the police. This process should be supported by policy, procedure and guidance which actively promotes professional challenge of any tendency towards tolerating domestic abuse within families and relationships where there are complex and multiple needs, such as misuse of alcohol and mental health problems.

8.2.2

Adult Social Care should explore ways in which case record systems and processes could provide better linking and tracking of information between the case records of high-risk domestic abuse perpetrators and those of their victims.

8.2.3

Staff should be reminded that all information pertaining to adult safeguarding enquiries - including decisions to trigger or not to trigger a Section 42 enquiry - must be recorded on the enquiry document on Liquid Logic. ASC decision makers should be made aware that a decision by the domestic abuse victim not to support criminal

action is **not** a valid rationale for not triggering Section 42 enquiries. On the contrary, it may well be an indicating factor that Section 42 enquiries should take place.

8.3 Liverpool Domestic Abuse Service

8.3.1

No recommendations

8.4 Local Solutions

8.4.1

No recommendations

8.5 Royal Liverpool and Broadgreen University Hospitals NHS Trust[4]

8.5.1

Improve actions following parental / adult child assessment.

8.5.2

To review the process in place for patients who are repeat attenders with mental health issues.

8.6 Merseycare NHSF Trust

8.6.1

Clinical records to be reviewed regarding domestic violence alerts and a system to be introduced to trigger further action in domestic abuse cases.

Review organisational training needs, to identify targeted training for domestic abuse where required.

[4] LUFHT have provided an action plan associated with these recommendations and confirm that these actions were completed by 30/09/2019.

8.7 SHS

8.7.1

No local recommendations (see Overview Recommendation 1).

8.8 GP Practice

8.8.1

Highlighting of known domestic abuse within GP records

8.8.2

Emphasizing the importance of professional curiosity.

8.8.3

Record keeping

8.9 Merseyside Community Rehabilitation Company

8.9.1

All staff to complete Safeguarding Adults training

8.9.2

All frontline staff to understand neurodiversity and develop strategies to work with difference.

8.9.3

Risk Assessment and sentence planning to involve all relevant agencies and workers.

8.10 North West Ambulance Service

8.10.1

No recommendations

9 Overview Recommendations

9.1 Overview recommendation 1

9.1.1

Commissioners of housing support services should ensure that all service contracts include a requirement for staff and managers to receive regularly updated training on domestic abuse. This training should include work on risk assessment and risk management approaches with perpetrators and with victims of abuse. It should also include raising awareness and understanding of local multi-agency policy and procedure and the role and function of MARAC. This recommendation should be particularly highlighted and followed up for action, with the specific supported housing provider which featured in this DHR.

9.2 Overview recommendation 2

9.2.1

The CitySafe Board should arrange a review of MARAC processes, and related multi-agency procedures and guidance on domestic abuse, with the aim of:

- Establishing clear operational guidance and procedures which recognise thresholds for instigating multi-agency strategy meetings and action plans. Thresholds to include specifying of the number of repeat incidents which should trigger a strategy meeting.
- Updating all partners on multi-agency policy and procedure and guidance on domestic abuse
- Increasing awareness and understanding of common themes and practices in relation to domestic abuse, safeguarding adults and working with people who are vulnerable and have complex and multiple needs.
- Highlighting that agencies working in silos represents a major barrier to services, for people with multiple and complex needs who are victims and / or perpetrators of domestic abuse.

- Supporting all agencies to review their training needs and plan future training programmes.

9.3 Overview recommendation 3

9.3.1

There should be a multi-agency review of terminologies used in policies, procedure, notification and referral systems around adult safeguarding and domestic abuse. The aim should be to ensure that all partners work to common definitions and expectations of actions to follow, in relation of terms such as:

- Referral
- Notification
- Vulnerable Person Notification
- Safeguarding Referral
- Safeguarding Alert

9.4 Overview recommendation 4

9.4.1

There should be a one-day multi-agency Learning Event to share all of the learning from LDHR 15.

10 Appendix 1 Glossary

A&E – Accident and Emergency

ASC – Adult Social Care

CCG – Clinical Commissioning Group

CPA – Care Programme Approach

CPS – Crown Prosecution Service

DHR – Domestic Homicide Review

DNA – Did Not Attend

DVLO – Domestic Violence Liaison Officer (Police)

DVPN – Domestic Violence Protection Notice

DVPO – Domestic Violence Protection Order

ELP – Evidence Led Prosecution

EUPD – Emotionally Unstable Personality Disorder

FLO – Family Liaison Officer

HDG – High Demand Generator

IDVA – Independent Domestic Violence Advocate

IMR – Individual Management Review

LCAS – Liverpool Community Alcohol Service

LCSP – Liverpool Community Safety Partnership

LDAS – Liverpool Drug and Alcohol Service

LS – Local Solutions

LUFHT – Liverpool University NHS Foundation Trust (Royal Liverpool Hospital)

MARAC – Multi Agency Risk Assessment Conference

MCNHSFT – Mersey Care NHS Foundation Trust

MeRIT – Merseyside Risk Identification Tool

MHA – Mental Health Act

MHHR – Mental Health Homicide Review

MHL – Mental Health Liaison Team

MPEHT – Merseyside Police Early Help Team

NPS – National Probation Service

NWAS – North West Ambulance Service

OCT – Obsessive Compulsive Disorder

RASA – Rape and Sexual Abuse Service

RCA – Root Cause Analysis

SAR – Safeguarding Adults Review

SHS – Supported Housing Service

VPRF – Vulnerable Persons Referral Form