Domestic Homicide Review

“Louise” who died in March 2020

LDHRMSAR20 Overview Report 9 February 2022

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Louise[1], a resident of Liverpool, prior to her death. The panel would like to offer their condolences to Louise's family on their tragic loss.

1.2 Louise's mum and a friend were invited by the panel to say what Louise had meant to them.

1.2.1 Louise's mum

Louise, my daughter was the funniest, kindest girl. She didn't have the best childhood and struggled a bit, but she grew into a strong, loving, caring person. Louise always felt the need to look out for the underdog. She stood strong on her beliefs. I was so proud of her.

Louise only had two serious relationships, tragically, one of which would change her completely. In her relationship, Louise went from being a strong, funny, and outgoing woman into a quiet, nervous person who sought approval from her partner before she made any decisions. Louise never had her own money as she was made to put it into her partners account who latterly we learnt was controlling her spending. My daughter and I used to speak every day but over time our chats became less and less frequent. I didn't like her partner because I'd seen the bruises, the loss of weight and how nervous Louise had become. Every decision was reliant on her partners say so.

Louise described her partner to me as 'her oxygen' and this worried me. Devastatingly, for the last two years of my daughter's life we didn't speak but I'd check her Facebook to make sure she was okay. I could see her life spiralling out of control and I was helpless. My life is empty without my Louise. She was trapped in a situation of control by someone who was never

[1] A pseudonym agreed with the victim's family.

going to let her go. I feel her decision to take her life was her only option as her cries for help were not heard.

1.2.2 Louise's friend

The last two years of her life I watched her decline so rapidly and to the point that I barely recognised her. She was an emotional wreck. I watched her be goaded into arguments that she never wanted to be in. I watched her lose weight and I mean drastic weight loss. She often spoke of her money being handled by Julie[2] and that she had no control of her money.

I would often receive random messages requesting money. The tone of these messages would indicate to me that it wasn't actually Louise sending these messages. She would also say when we did speak on Facebook call messenger that her Facebook would at times be used by Julie and this led me to be mindful of sending messages that would impact her wellbeing.

I didn't want her to be in trouble or danger. I would only inbox message her when I saw her appearing to not do so well on social media and she was online at that point and the same conversation would happen. She would speak of Julie having control of her money and that she never had any of her own.

The beatings that would happen when she confronted Julie over money and, also Julie messaging other females. Louise often spoke of being made to choose between her family and Julie and feeling that she had no choice but to choose Julie. Louise wasn't allowed friends, and this was apparent by her constant deactivating of multiple Facebook accounts.

I just want people to know that Louise was not manic on the day she took those tablets. When we spoke, she appeared fine she engaged in normal

[2] A pseudonym for Louise's partner, chosen by the panel from a list of names.

conversation was joking and, also had plans to send me some asthma pumps as my partner was struggling to get some sent to her due to Covid.

I truly believe that she wanted to get out of the relationship but didn't know how to, as all previous attempts had resulted in a barrage of abuse by her partner.

1.3 Louise was in a long-term relationship with her partner Julie, and there had been several domestic abuse incidents in the relationship over the preceding years. On the day Louise died, she had a number of communications with her sister who became concerned about her and contacted the ambulance service. When paramedics went to Louise's address, they found that she had passed away.

1.4 The coroner has already concluded the inquest into Louise's death. The circumstances of Louise's death, described in the record of inquest, are as follows:

"Louise was a 32-year-old lady with a medical history of self-harm, previous overdose, malnourishment and psychosis. On [time and date redacted], the North West Ambulance Service were contacted by Louise's sister advising of her concern that Louise had taken an overdose because of text messages and phone calls received in the early hours. When the ambulance service attended, Louise was found deceased, slumped against the couch in the living room. Empty blister packets of medication were close by. A Facebook post stated she had taken a combination of medication. Toxicological analysis revealed the presence of a large amount of alcohol, together with elevated concentrations of quetiapine and a fatal concentration of dihydrocodeine, neither of which were prescribed to Louise. The post mortem examination did not reveal any natural disease contributing to Louise's death. The toxic effects of quetiapine include drowsiness and cardiac arrhythmias. Dihydrocodeine is an opioid painkiller, and the concentration present was more than 12 times the fatal concentration. The main effect of opioid toxicity is respiratory depression, and this taken together with the alcohol which can also reduce

the level of consciousness and respiratory depression has resulted in a fatal outcome. It is unclear as to what Louise's intentions were when she consumed the medication and alcohol but taking account of the amount she consumed and in all the circumstances it is more likely than not she has taken them with the intention of taking her own life. The alcohol consumed would have impaired her state of mind when carrying out the act and therefore it is more likely than not Louise has taken her own life whilst the balance of her mind was impaired".

1.5 Decision to hold a Review

Following Louise's death, a referral was made to Merseyside Safeguarding Adult Board (April 2020) for consideration of a Safeguarding Adult Review.

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB[3] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) Condition 1 or 2 is met

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

[3] Safeguarding Adult Board

On 24 June 2020, the Independent Chair of the Merseyside Safeguarding Adult Board confirmed that the circumstances of the case met the criteria for a Safeguarding Adult Review.

1.6 The 2016 Domestic Homicide Review statutory guidance[4] says:

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

1.7 The Community Safety Partnership therefore took the decision at a meeting on 7 July 2020, that a Domestic Homicide Review should be conducted. Thereafter, the Safeguarding Adult Board and Community Safety Partnership agreed that a joint review would be commissioned.

1.8 In addition to agency involvement, the review will also examine: the past to identify any relevant background or trail of abuse before Louise's took her own life; whether support was accessed within the community; and, whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.9 The review considers agencies contact and involvement with Louise and Julie from 1 December 2017, until Louise's death in March 2020.

This time period was chosen because Louise took an overdose of medication in late December 2017: the panel wished to capture any available information in the lead up to that event.

In coming to this decision, the panel were aware that there may have been domestic abuse throughout Louise and Julie's relationship. The panel were

[4] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

also aware of significant changes to services in Liverpool and to partnership arrangements over the years and thought that the period chosen was proportionate and likely to produce relevant learning for contemporary services in Liverpool. Background information prior to 1 December 2017 is used in the report for context.

1.10 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.11 **Note:** *It is not the purpose of this DHR to enquire into how Louise died. That has already been examined during the coroner's inquest.*

2 Timescales

2.1 This review began on 23 September 2020 and was concluded on 22 October 2021 following consultation with Louise's family.

2.2 See further information at paragraph 5.2

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 Pseudonyms were agreed with the victim's family to protect her identity and the identity of others referred to in the report.

4 Terms of Reference

4.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.
  (Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe Under Review

4.2.1 The DHR covers the period 1 December 2017 to Louise's death in March 2020.

4.3 Case Specific Terms

4.3.1 Subjects of the DHR:

- Victim: Louise, aged 32 years
- Louise's partner: Julie, aged 41 years

4.3.2 Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[5] did your agency identify for Louise?

2. How did your agency assess the level of risk faced by Louise from the alleged perpetrator and which risk assessment model did you use?

3. What knowledge did your agency have that indicated Louise could be at risk of suicide as a result of any coercive and controlling behaviour?

4. Did your agency consider that Louise could be an adult at risk within the terms of the Care Act 2014?

5. What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around Louise?

6. What mental capacity assessment(s) were completed by your agency and what was the outcome?

7. Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?

8. What services did your agency provide for Louise and/or Julie; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

9. Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

10. How did your agency ascertain the wishes and feelings of Louise and Julie about Louise's victimisation and Julie's alleged offending, and were their views taken into account when providing services or support?

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

11. How effective was inter-agency information sharing and cooperation in response to Louise and Julie, and was information shared with those agencies who needed it?

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

13. What did your agency do to establish the reasons for Julie's alleged abusive behaviour, and how did it address them?

14. Was there sufficient focus on reducing the impact of Julie's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

15. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

16. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

17. What knowledge did family, friends and employers have that Louise was in an abusive relationship, and did they know what to do with that knowledge?

18. Were there any examples of outstanding or innovative practice?

19. What learning did your agency identify in this case?

5 Methodology

5.1 Following Louise's death in March 2020, a referral was made to Merseyside Safeguarding Adult Board for consideration of a Safeguarding Adult Review. This was agreed on 24 June 2020.

5.2 On 7 July 2020, Liverpool Community Safety Partnership agreed the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review (para 18 Statutory Home Office Guidance)[6]. The Home Office was informed on 22 July 2020.

5.3 The Safeguarding Adult Board and the Community Safety Partnership agreed that a joint review would be commissioned.

5.4 The start of the process was delayed as a result of agency work pressures in the Covid-19 pandemic and the need to source and commission an Independent Chair and Author. The first meeting of the DHR panel, which took place on 23 September 2020, determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews and the others, short reports. The Chair provided training to Individual Management Review (IMR)[7] authors to assist in the completion of the written reports.

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

[7] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

5.5 In April 2021, Louise's mum provided further information to the police: the police agreed to review and consider whether to reopen their investigation. As a result of this, a decision was made to suspend contact with the family as there was a risk of damaging any future prosecution. That decision was communicated to Louise's mum by her AAFDA advocate. This suspension of contact led to a delay in the DHR, as consultation with Louise's mum could not take place during this period. On 8 June 2021, the DHR chair was informed by the police that a review of evidence had taken place and that there would not be a new investigation**.**

5.6 Meetings took place using Microsoft Teams video conferencing and the panel met six times. In addition to panel meetings, an online practitioner event, utilising Microsoft Team breakout rooms, took place involving twenty practitioners and managers who had contact with Louise and Julie.

5.7 An advanced draft of the overview report was shared with Louise's mum via her AAFDA advocate in early July 2021. Earlier delays in the progress of the review and challenges in arranging meetings over the summer period meant that it was not possible to for Louise's mum to meet with the panel. Following an extensive period of consultation, as a result of which refinements were made to the report the process was concluded on 22 October 2021.

6 Involvement of Family, Friend, Work Colleagues, and Wider Community

6.1 Merseyside Police agreed to approach Louise's mum with information about the review. Following that, she agreed to an initial conversation with the Chair of the review. After a first conversation, which was followed up with written information on support services, Louise's mum chose to engage with AAFDA[8] as her advocacy service.

6.2 Thereafter, AAFDA provided an advocate to support Louise's mum in meetings, reviewing documents, and reviewing the overview report.

6.3 Information about Louise, provided by her mum, is used throughout the report and is attributed appropriately. Louise's siblings felt unable to contribute to the review.

6.4 The panel chair was also able to speak to a friend of Louise's who was supported by AAFDA. Louise's friend gave helpful background information and provided a tribute to Louise, which is at section 1 of the report.

6.5 The Community Safety Partnership wrote to Julie inviting her to contribute to the review. She did not reply.

6.6 Louise's mum was provided with a draft copy of the report which she was able to discuss with her AAFDA advocate over an extended. She provided feedback which resulted in refinements to the report.

[8] Advocacy After Fatal Domestic Abuse, a charity that supports the families of victims of fatal domestic abuse.

7 Contributors to the Review

Agency	Contribution
Merseyside Police	IMR
Liverpool Clinical Commissioning Group	IMR
Merseyside Community Rehabilitation Company	IMR
North West Ambulance Service	IMR
Liverpool Adult Social Care	IMR
Local Solutions (IDVA service)	IMR
PSS UK Women's Turnaround	IMR
We Are With You	Short report
Housing Options	Short report
Fylde Coast Women's Aid	Short report
Mersey Care NHS Foundation Trust	IMR
Liverpool University Hospitals NHS Foundation Trust	IMR

8 The Review Panel Members

Name	Organisation
Ged McManus	Chair and Author
Carol Ellwood Clarke	Support to Chair and Author
Angela Clarke	Domestic Abuse Lead, Liverpool City Council
Michelle Lesbirel-Jones	Merseyside Safeguarding Adult Board
Beverley Hyland	Chief Inspector, Merseyside Police
Esther Lucas	Careline Adult Services Manager, Liverpool Adult Social Care
Carmel Hale	Safeguarding Adult Nurse, Liverpool Clinical Commissioning Group
Karen Rooney	Community Director, Merseyside Community Rehabilitation Company
Susan Hewitt	Safeguarding Practitioner, North West Ambulance Service
Kate Scott	Public Mental Health / Suicide Prevention
Kerry Dowling	Local Solutions IDVA
Kari Rude	Support to Panel
Sharon Cooper	Service Manager, PSS UK

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

8.2 The Community Safety Partnership approached several LGBTQ+ agencies to see if they might be able to provide a representative on the panel given the victim and perpetrators sexual orientation. None were able to assist. At the conclusion of the process the report was shared with the chief executive of a charity providing services to the LGBTQ+ community who agreed to read the report and provide feedback.

9 Chair and Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, set out the requirements for review Chairs and Authors.

9.2 Ged McManus was chosen as the DHR Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside) and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England (not Merseyside). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.3 The Chair was supported by another independent practitioner, Carol Ellwood Clarke. She retired from thirty years public service (British policing, not Merseyside) during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

9.4 Between them, they have undertaken over sixty reviews including the following: child serious case reviews; Safeguarding Adult Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA[9].

9.5 Neither of them has worked for any agency involved in this review.

10 Parallel Reviews

10.1 As set out at paragraph 1.3, the inquest into Louise's death has been concluded.

10.2 Conduct of the last contact was reviewed by Merseyside Police Professional Standards Department. It was established that the officer had recorded the matter correctly, appropriate referrals were made thereafter, and there were no lapses in safeguarding by Merseyside Police in that incident. The command team, therefore, concluded the matter did not require a referral to the Independent Office for Police Conduct (IOPC).

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

[9] Advocacy After Fatal Domestic Abuse.

11 Equality and Diversity

11.1 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine, or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.2 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed. Louise was referred to Adult Social Care (Careline) on a number of occasions during the review period. However, her case was not progressed for a care and support assessment as it was judged at that time that Louise did not meet the necessary criteria.

11.3 Louise sought support for her mental health and sometimes disclosed suicidal ideation, as well as domestic abuse. She was diagnosed with anxiety and depression, and Emotionally Unstable Personality Disorder (EUPD).

11.4 Louise and Julie were in a same sex relationship. They were not married or in a civil partnership.

11.5 All subjects of the review are white British. At the time of the review, they were living in an area which is predominantly of the same demographic and culture.

11.6 Taking into account the protected characteristics, there is no direct evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review. The panel considered whether there had been any unconscious bias based on Louise and Julie's sexuality. This is explored at paragraph 14.12

11.7 **Section 4 of the Equality Act 2010 defines protected characteristics as:**

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [10][for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian, or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could

[10] Section 6 of the Act defines ‘disability’ as:

(1) A person (P) has a disability if:

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

be “black Britons” which would encompass those people who are both black and who are British citizens].

- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

12 Dissemination

1. Louise’s family
2. Home Office
3. Liverpool CSP
4. All Agencies contributing to the Review

13 Background, Overview and Chronology

13.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies and material gathered by the police during their investigation following Louise's death. It is supplemented by information provided by Louise's mum. Events are reported here without commentary. Analysis of events during the time period of the review appears at section 14. Information prior to the review period is included for context and is not subject to detailed analysis.

13.2 Louise's mum provided information about Louise as a child and when she was growing up.

13.3 Louise was the middle child of five siblings. She was a shy child but also loyal and very caring. She was a joker and enjoyed playing practical jokes on her family and friends. Her mum said that Louise could be feisty and was not someone to cross lightly, as she would easily make her feelings known

13.4 Louise liked writing poetry as a teenager, and it was whilst reading Louise's work that her mum came across a letter that Louise had written which disclosed sexual abuse by her father. This ultimately led to a crown court case where Louise gave evidence. During the course of cross examination, Louise was questioned about things that she had said during counselling sessions. This caused her to leave the witness box and she did not continue with her evidence.

13.5 Louise's father was subsequently acquitted of the charges that had been brought. The case caused a split in the family and meant that Louise no longer saw her extended family on her father's side and did not see her father again.

13.6 Louise's mum said that it was after the court case that Louise started to self-harm. She was detained under a section of the mental health act on two occasions. She refused to have counselling because of her previous bad experience during the court case. During one of her hospital admissions, Louise asked her mum for permission to take her own life saying, "ten minutes pain for a lifetime of freedom".

13.7 Louise was active on social media and formed friendships online rather than in person. It was in 2013 that she met Julie online. Julie lived in the South-East of England and travelled to Liverpool to meet Louise in person. The couple formed a relationship and lived together in Liverpool for two years before moving to the South Coast, where they lived in a caravan on a holiday park.

13.8 Louise's mum related a number of incidents which had happened whilst the couple were living at the South Coast. Louise was on her own for much of the time, as she didn't like Julie's friends so didn't often go out with Julie, and Louise began to drink excessively. Louise's benefit money was paid into Julie's bank account and Louise had to ask for anything if she needed it. Louise's mum told her that this was wrong, and it was controlling behaviour by Julie, but Louise thought it was not a problem. For a few months, Louise arranged for her money to be paid into her mum's account. However, Louise found this difficult and went back to having her money paid into Julie's account, as she said it was easier.

13.9 After several months, the couple had to leave the caravan as rent had not been paid, for a while they were living in a car. On one occasion, Louise spoke to her mum on the phone, she said that she was in the car outside a house that Julie was visiting for a meal, but that she was not allowed inside.

13.10 On another occasion, Louise contacted her mum, sending pictures of her body with bite marks and bruising. Louise's mum went to visit her and confronted Julie about the injuries, but Julie denied any wrongdoing, stating that the injuries had been caused by the couple's dogs. Louise's mum did not think this was a plausible explanation given the severity of the injuries and the fact that Louise had no marks on her hands or face. After an episode of self-harm, Louise's mum picked her up and took her back to Liverpool, where Louise lived with her sister, Jade[11], for a while. During this time, Louise and Julie were reconciled and moved into their own property towards the end of 2017.

13.11 On 21 December 2017, Louise attended at a hospital Accident and Emergency department (Liverpool University Hospitals NHS Foundation Trust) following her taking an overdose of medication, which was said to belong to Julie. She was treated and seen by the Psychiatric Liaison Team (Mersey Care) before being discharged. Louise referred to Julie as her ex-partner and said that "*Julie puts her down and tells her how pathetic she is".*

13.12 On 22 February 2018, the police were called after Louise had left home (living with Julie) indicating that she was going to take her own life following an argument with Julie. Louise was found nearby and taken to hospital. A VPRF1 was submitted, and a referral was made to Adult Social Care. There is no record of her being seen by medical staff on this occasion. No action was taken by Adult Social Care.

[11] A pseudonym agreed with Louise's family

13.13 On 16 March 2018, the police were called to an incident at Louise and Julie's home. Julie, who was heard shouting "I'm going to have you", was arrested for threats to kill, Common Assault and possession of an offensive weapon against another family member at the scene. A VPRF1 was submitted by the officers and a Merseyside Risk Identification Toolkit, (MeRIT – see paragraph 14.2.1 for full details) risk assessment was completed, which was graded bronze. Louise made a written statement saying she had not been assaulted, and that her injury resulted from hitting her head on the wall. In her statement, she said that although her relationship with Julie had its ups and downs, Julie had never shown violence towards her or behaved in a controlling manner. Julie was seen in custody by the Criminal Justice Liaison Team (Mersey Care). The VPRF1 submitted to Adult Social Care was shared by them with Louise's GP practice.

13.14 On Friday 23 March 2018, Julie appeared at magistrates' court in relation to the incident of 16 March 2018. An incident occurred in the court building between Louise and her sister, Jade, following which Louise was asked to leave the building. Over the course of the next few months, whilst the occurrence of 16 March 2018 was investigated, a number of incidents of threats and damage were reported by Louise's family: they indicated that Louise and Julie were responsible for them.

13.15 On 15 April 2018, in the early hours of the morning, Louise phoned the police stating that Julie had set a dog on her and assaulted her. Officers quickly arrived but Louise then denied that she had been assaulted and said a bruise on her head had been caused by falling over. Louise did not make a statement and was taken to Aintree Hospital as she wanted to speak to the mental health team. However, she left before being seen. A MeRIT risk assessment was completed and graded as silver. A VPRF1 was submitted, Adult Social Care were notified and took no action.

13.16 On 16 April 2018, Louise returned home. Julie phoned the police claiming that Louise was assaulting her and had threatened to harm herself with a knife. When officers attended, Julie did not wish to pursue a prosecution. However, both Julie and Louise were arrested in connection with matters arising from the incident of 16 March 2018. A VPRF1 was completed for the domestic incident, recording Julie as the victim; she was signposted to the National Centre for Domestic Violence. Louise was seen in custody by the Criminal Justice Liaison Team. She reported having suicidal thoughts but no plans to act upon them and was given alcohol referral information. Adult Social Care received the VPRF1 and took no action.

13.17 On 11 May 2018, Julie was convicted of Common Assault on Louise's sister, Jade, following the incident of 16 March 2018. She received a suspended sentence order, and a restraining order was also imposed to prevent Julie approaching Jade and other family members. The case was transferred to Merseyside Community Rehabilitation Company (MCRC) and the case assigned to a case manager. Notes were added to the case management system denoting that Julie was diagnosed with bi-polar disorder and PTSD. Suicide and self-harm risk markers were applied to the case, as Julie reported a recent suicide attempt.

13.18 On 15 May 2018, Louise was admitted to hospital having taken an overdose of medication with alcohol. She had an existing mental health appointment the following week and after the liaison between the two services, Louise left hospital with the plan to keep the existing appointment. She kept the appointment for an assessment on 24 May and was referred to the early intervention team. Information was shared with Adult Social Care who shared it with Louise's GP practice.

13.19 On 21 May 2018, an initial assessment and sentence plan was completed with Julie by MCRC and shared with PSS UK Women's Turnaround. In working with women, MCRC contracts the PSS UK Women's Turnaround to deliver women-specific interventions in order to reduce reoffending. The teams are co-located, and all women subject to probation supervision are given a PSS UK Women's Turnaround keyworker. The risk management and sentence plans are routinely shared, which is considered good practice.

13.20 On 2 July 2018, Louise attended a hospital A&E department: she had a head injury following an alleged assault. She was treated and discharged. It is unknown how Louise came by this injury as she declined to discuss it.

13.21 On 11 July 2018, Louise's sister, Sarah[12], called the police to report that Louise had been assaulted by Julie. On arrival, officers found that both sisters had been drinking. Louise said that her injuries were from hitting herself on the head and falling over: she made a signed statement that she had not been assaulted. Louise was taken to hospital for treatment to her injuries. A MeRIT risk assessment was completed and graded as silver. A VPRF1 was submitted, Adult Social Care were notified and took no action.

13.22 On 25 July 2018, Louise's sister contacted the police. She was concerned for Louise's safety as Louise had telephoned her saying that she had taken an overdose of tablets. Police officers forced entry to Louise's home and found her awake and surrounded by tablets, although she denied taking any. She was taken to hospital by ambulance, a VPRF1 was completed and followed up with a referral to Mental Health Services. Louise was discharged from hospital following treatment. She did not give her consent for Adult Social Care to share information with her GP and there was no further action taken by Adult Social Care.

[12] A pseudonym agreed with Louise's family

13.23 On 8 August 2018, police officers were called to an incident involving Louise and Julie in Liverpool city centre. Both were very drunk, and Louise was arrested because of her behaviour. She later received a caution. A MeRIT risk assessment was completed and graded as bronze, showing Julie as the victim. A VPRF1 was submitted to Adult Social Care, they took no action.

13.24 On 9 September 2018, Louise contacted the police stating that she was on her way to the bus station to leave the city and thought that Julie was going to stop her. Officers found Louise in the street and took her to hospital after she stated she wanted to speak to the Crisis Team. Julie was not present. A VPRF1 was completed and a referral to Adult Social Care was made for Louise. Adult Social Care took no action.

13.25 In September 2018, members of Louise's family were arrested and questioned about serious criminal offences. They were released and no charges were ever brought. The family blamed Julie for providing what they consider to be malicious information to the police, which caused them to be arrested. Following this, Louise and her mum were not in contact with each other.

13.26 On 7 October 2018, Louise telephoned the police reporting that Julie had hit her with the Hoover. When officers attended, Louise was drunk and stated she had been watching a TV programme and became confused about what was happening due to her mental health issues: she denied Julie had assaulted her. Julie said that Louise had been drinking all day and there had been no domestic abuse incident. Louise was abusive and uncooperative and was arrested to prevent a breach of the peace. A MeRIT risk assessment was completed and graded as bronze. A VPRF1 was completed, and a referral sent to Adult Social Care for Louise. Adult Social Care took no action.

13.27 On Monday 8 October 2018, Louise's sister, Jade, contacted the police reporting malicious communications from Louise. Louise was arrested for this on 7 November 2018 and later convicted. A restraining order was issued.

13.28 Later in the day, on Monday 8 October 2018, the police received an anonymous 999 call to a disturbance at Louise and Julie's home. Louise was outside the flat with a minor cut to her arm, and the glass in the front door was broken. She was intoxicated. Julie said that she had just returned home to find Louise in that condition, and no domestic incident had occurred. Louise was taken to hospital to see the mental health Crisis Team, and have her wound dressed. She left before she could be seen by a mental health practitioner. A MeRIT risk assessment was completed and graded as silver, with Julie as the victim and Louise as the perpetrator. A VPRF1 was completed and referrals to Adult Social Care were made for both Louise and Julie. Adult Social Care sent a letter to Julie signposting her to support agencies.

13.29 On 2 February 2019, Louise attended a hospital A&E department with a foot injury.

13.30 On 6 February 2019, Julie told a MCRC case manager that Louise was not staying with her for the time being and was staying with her sister, as a result of Louise drinking again. Julie felt that she couldn't be around Louise when she was drinking.

13.31 On 4 March 2019, the ambulance service was called to a park in Liverpool where Louise had cut her wrists and taken an overdose. She was taken to hospital where she was admitted for treatment. Louise stayed in hospital until 8 March 2019, when she was discharged. A VPRF1 was completed, and Adult Services were notified of the incident. On her release from hospital, Louise was arrested for an outstanding court warrant: she had failed to appear at court in answer to the malicious communications charges (para no 13.27 – 8 October). Adult Social Care shared the information with Mersey Care.

13.32 On 15 March 2019, Louise appeared at North Liverpool Community Justice Court for an offence of Harassment (against her sister Jade). A Pre-Sentence Report, prepared by probation, noted that Louise described a good relationship with her partner, Julie, and denied that Julie was in any way abusive towards her: contrary to the beliefs of her family members. The report recommended that the domestic situation be monitored. The report noted that Louise had attempted to take her own life in recent weeks. The author proposed that Louise be made subject of a Community Order with an Alcohol Treatment Requirement and a Rehabilitation Activity Requirement (RAR). Louise received a Community Order of 12-months duration with a 15 days RAR and a 15-week curfew. A Restraining Order was also imposed, preventing contact with Louise's mother and sister. Furthermore, the court imposed a curfew requirement. This requirement necessitated Louise remaining in their home address, with Julie, during her curfew period.

13.33 On 27 March 2019, a MCRC offender manager completed a risk assessment and sentence plan for Louise. This was shared with PSS UK Women's Turnaround. The plan noted that Louise was engaging with Royal Liverpool University Hospital alcohol clinic and had been prescribed Librium. She was waiting to be prescribed mirtazapine. The assessment noted that there were no current concerns in Louise's relationship, that Louise denied Julie was in any way abusive towards her, and that concerns were fabricated by her family. She also stated that accommodation was not a problem. Louise was assessed as a suicide risk, and as such, a risk flag was applied to the case. She was not considered a risk to others, and as such, a Risk Management Plan was not completed. Her sentence plan included the improvement of thinking and problem-solving skills, enhanced emotional management, and continued abstinence from alcohol.

13.34 On Thursday 16 May 2019, Louise contacted the police via social media, reporting that Julie was threatening to throw her out of their home. Louise was concerned she would be in breach of her curfew as her residence there was a condition imposed by the court. She was reluctant for an officer to attend to ensure she was safe and well. There was no report of a domestic incident, and an officer spoke to her several times on the phone, indicating she was free to use her phone should she need to do so in an emergency. Louise agreed to an appointment at a police station on 22 May, and she was advised to contact her probation officer the following day regarding the accommodation issue.

13.35 On 20 May 2019, Louise told her offender manager that she and Julie had been arguing and were separating. She was remaining at the property for now as that was where she was required to live by the court order. She was advised that she should leave the property if she felt at risk.

13.36 On 20 May 2019, the ambulance service was called to Louise and Julie's home by Louise, who said that she had taken an overdose and stabbed herself. Julie told a police officer that Louise had self-harmed because she was distressed at being convicted of harassment and being on a tag. A VPRF1 was completed, and a referral was sent to Adult Social Care requesting support for Louise's alcohol abuse. Louise was taken to hospital by ambulance and admitted for treatment.

13.37 On 22 May 2019, a police officer contacted Louise as she did not attend a police station appointment. Louise asked for support for her alcohol abuse and mental health problems and stated she did not feel she was receiving either (Louise was in hospital at this time). A VPRF1 was completed with this information and a referral sent to Adult Social Care. No action was taken by Adult Social Care.

13.38 During this admission to hospital, discussions took place with Louise about moving into crisis accommodation, provided by Mersey Care, when she was medically fit for discharge. Louise discharged herself and left the hospital before this could be arranged.

13.39 On 19 June 2019, during an appointment with her offender manager, Louise said that she and Julie had been arguing lately, and she was keen to source her own independent accommodation. The offender manager advised that if the situation became volatile, she should leave the property and contact police (this in the context of a curfew order). Louise stated that her money was going into Julie's account and that she was applying for ID to enable her to set up her own. She claimed to have reduced her alcohol use, and whilst feeling low, she had not had any suicidal thoughts. The offender manager instructed Louise to attend Mersey Care's mental health drop-in to discuss how she could be medicated until she registered with a new GP. Louise was given money so that she could attend the Housing Options Service to complete a housing assessment. Louise did attend at the service but did not wait long enough for an assessment to be completed. There is no record of Louise attending the mental health drop-in.

13.40 On 17 July 2019, Louise attended at a hospital A&E department and stated that she had taken an accidental overdose. She left before receiving treatment.

13.41 On 9 August 2019, Louise appeared at Sefton Magistrates Court in relation to a Breach of Community Order. This followed warnings after failing to attend sessions (e.g., alcohol key worker). She was fined and the order was to continue.

13.42 On 3 September 2019, Louise telephoned a MCRC case manager. Louise sounded drunk and said that Julie had asked her to leave her home and she had slept in a 24-hour McDonalds. The case manager contacted MARS Riverside (a housing provider) who tried to contact Louise, without success.

13.43 On 5 September 2019, Louise saw a MCRC case manager after she had attended a group session (Understanding Your Emotions). She explained that Julie may be moving away the following day and was unsure if she could continue to stay in her flat. Louise was given practical advice on benefits and her health.

13.44 Later, on 5 September 2019, Louise texted a PSS UK Women's Turnaround worker to say that Julie had "battered her". This prompted a series of texts in which Louise said that she had left the house, was safe, and was staying with a friend. Louise would provide no further details. She was offered safety advice and support to link in with PSS UK domestic abuse services and other agencies. These offers were repeated over the following two weeks during appointments. Louise said that she had left the relationship and was fine. MARS Riverside and the Housing Options Service made a number of attempts to contact Louise, but all were unsuccessful.

13.45 On 19 September 2019, Louise attended to see her MCRC case manager. Louise looked much better and said that she felt more positive since Julie had gone, and said she was drinking less.

13.46 On 2 October 2019, following MCRC management oversight of the case, Louise's risk of harm level was increased to medium: this was a result of multiple domestic abuse incidents and alleged continued harassment.

13.47 Later in the day, an MCRC case manager received a text message from Louise informing that she had taken an overdose the day before, had called an ambulance, and had then discharged herself from hospital (Louise left before she could be treated). She said she was now back at Julie's house. The case manager called Louise and advised her that she must visit her GP urgently and re-engage mental health services. The case manager contacted Mersey Care to request an appointment and referred Louise to We Are With You. In addition, Louise was referred to the Rotunda College (with whom MCRC contracts) for counselling. Multiple attempts were made by Mersey Care to engage with Louise, but she did not engage with them and did not attend the appointments offered.

13.48 On 9 October 2019, Louise started a voluntary alcohol treatment programme with We are With You. Her attendance was sporadic, but she made progress and completed the course by January 2020. Louise had identified her triggers and, through this, had learned to control her drinking. It was noted that in the last meeting, Louise's personal presentation and mood was significantly improved.

13.49 On 7 January 2020, Louise contacted the police to report a dispute with Julie over ownership of a dog. Louise stated their relationship had ended some six months before and Julie was refusing to hand over the dog. An officer attended and advised that this was a civil matter. Julie alleged that Louise, who was intoxicated, had slapped her across the face. She was not in need of medical attention and declined to make a complaint of assault. Louise agreed to leave the premises and was transported to the YMCA in Liverpool. A VPRF1 was completed, with Julie as the victim. Also, a MeRIT risk assessment was graded as bronze.

13.50 On 13 January 2020, Louise contacted the GP practice where she had recently registered to ask for an appointment to discuss her mental health. She was seen by a doctor the same day.

13.51 On 1 March 2020, the police received a call from a member of the public reporting a disturbance when Louise was involved in a fracas with a number of people, including Julie's adult son, and Julie. Julie's son was arrested on an unconnected matter. A VPRF1 was completed, with Julie as the victim. Also, a MeRIT risk assessment was graded as bronze.

13.52 On 10 March 2020, Louise attended for her final appointment with her MCRC case manager. She said that she was taking sertraline and quetiapine daily and was feeling much better. She stated that she was grateful for all the support she had received and felt she was unlikely to offend again, given that she was no longer drinking. She was financially independent and stable, with her own bank account, and understood that she could maintain contact with her keyworkers if necessary.

13.53 On 12 March 2020, Louise contacted the police and an officer attended to speak to her. Louise said that Julie had subjected her to coercive and controlling behaviour during their 10-year relationship. Julie was, at this time, away in the South East. Louise was informed of her options and given reassurance about the support that could be provided. A MeRIT risk assessment was graded as gold and a VPRF1 was completed. Referrals to IDVA, MARAC and Adult Social Care were made.

13.54 On 13 March 2020 (Friday), the referral from the police to the IDVA service was actioned and Louise was contacted by telephone. The IDVA who spoke to Louise agreed to look into the possibility of hostel accommodation. No places were available in Liverpool and Louise was not considered suitable for the only refuge space available in the North West that day (Fylde Coast Women's Aid). Louise also had three dogs, which she was concerned about. It was agreed that Louise was safe where she was because Julie was away and not expected back for several days. Another refuge in the North West indicated that it may have space on Monday and would contact Louise then. Louise remained concerned and contacted Careline (Adult Social Care) to seek advice following her being declined accommodation by Fylde Coast Women's Aid. It was confirmed that she was currently safe, and she was asked to speak with the IDVA service again on Monday.

13.55 Louise was found deceased before the case could be followed up.

14 Analysis

14.1 **What indicators of domestic abuse, including coercive and controlling behaviour,[13] did your agency identify for Louise?**

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

14.1.1 Merseyside Police responded to a total of 33 incidents involving Louise during the time period of the review. Not all of these involved domestic abuse with Julie: some incidents involved others, for example, neighbours and Louise's family. Domestic incidents within the timescale of the review are comprised of those with Julie exclusively, and some disputes between the couple in which members of their families became involved. A number of incidents did not relate to domestic abuse and details of every incident are not included in the overview report.

14.1.2 A MeRIT domestic abuse risk assessment was completed by Merseyside Police on 10 occasions. On five occasions, Louise was recorded as the victim: Julie was recorded as the victim on five others. Louise made several allegations of assault against Julie, but on police attendance she denied that she had been assaulted and on occasions said that she had caused her own injuries. In all incidents, Louise and Julie were spoken to separately in line with Merseyside Police domestic abuse policy. No evidence of coercion and control was found or alleged until the last time Louise contacted the police, on 12 March 2020 (See paragraph 14.1.15).

14.1.3 Adult Social Care (Careline) received a total of 16 referrals, including 11 Vulnerable Persons Referral Forms (VPRFs) from Merseyside Police. These referrals referred to Louise's vulnerability due to mental health needs and domestic abuse incidents, whereby Louise had been identified as both the alleged perpetrator and victim.

14.1.4 Merseyside Community Rehabilitation Company (MCRC) supervised both Julie and Louise during part of the period of the review. Both were managed by different offender managers, and they were not involved in group work together.

14.1.5 Julie was made subject of a Suspended Sentence Order on 11 May 2018, having been convicted of an offence against Louise's sister, Jade. The circumstances were that Jade had become concerned for Louise's safety and she and a friend visited Julie and Louise's home. She was assaulted by Julie on her arrival. The offender manager's assessment identified Julie as being both a victim and perpetrator of domestic abuse and noted potential harm to Louise. Paragraph 14.15 highlights the challenges of identifying a primary perpetrator.

14.1.6 On 15 March 2019, Louise was made subject of a Community Order with a Rehabilitation Activity Requirement and a curfew. She had been convicted of harassment of her sister, Jade, (the victim of Julie's offence) and the court probation report author noted that whilst Louise had denied experiencing abuse in her relationship, it was an issue to be monitored. Post sentence, no mention was made about relationship difficulties within the OASys[14] risk assessment and the assessor noted that Louise's relationship was positive and supportive. The court imposed a curfew requirement, although the pre-sentence report recommended against this. This requirement necessitated Louise remaining in the address with Julie during her curfew period. Louise was told by her offender manager that if she needed to leave the home during the curfew period, as a result of domestic abuse, then she should do so. The panel noted that at this point, Louise had been the victim in four domestic abuse incidents. Whilst this information was not known to MCRC, the information would have been available if it had been requested. Had that information been known, it could have led to different offers of support, for example the Freedom programme.

[14] The probation service nationally accredited offender assessment system

14.1.7 MCRC records indicate that Julie and Louise's relationship was turbulent and there is little evidence that relationships and risks were explored. At one point during the course of supervision, Louise disclosed that her money was deposited into Julie's bank account. The panel thought that this may have been an indicator of economic or financial abuse. This was addressed and Louise did manage to open her own bank account. There were several notes made of Louise's perceived insecurity in relation to how permanent her accommodation was with Julie, and her awareness of the fact that she could have been asked to leave at any time. Louise disclosed that she had overdosed on Julie's prescribed medication and on one occasion she had spent the night in a 24-hour McDonald's after Julie had asked her to leave. On occasions, Louise discussed her housing situation and was given advice. In June 2019, she was given money so that she could attend the Housing Options Service to complete a housing assessment. Louise did attend at the service but did not wait long enough for an assessment to be completed. In September 2019, MARS Riverside (a housing provider) and the Housing Options service made a number of attempts to contact Louise, but all were unsuccessful.

14.1.8 Between 3 April 2019 and 18 November 2019, Louise completed work with PSS UK Women's Turnaround as part of her Rehabilitation Activity Requirement. She did not disclose domestic abuse within her initial Turnaround assessment. In September 2019, Louise texted a member of PSS UK Women's Turnaround staff alleging that Julie had "battered her". Staff followed this up by enquiring if she was safe. Louise informed staff that she was staying with friends and the relationship with Julie was over. Additional domestic abuse support was offered to Louise through the PSS UK domestic abuse service – RUBY@Turnaround – but she did not engage with the support offered. On 19 September 2019, when Louise attended to see her MCRC case manager, the records indicate Louise looked much better and said that she felt more positive since Julie had gone, and said she was drinking less. The panel thought it was interesting that Louise seemed to feel better when Julie was not around and thought that this could be a further indicator of domestic abuse.

14.1.9 Louise attended hospitals managed by Liverpool University Hospitals NHS Foundation Trust on 13 occasions during the review period. On five occasions, she left prior to being assessed. There is no evidence that Louise was considered as a victim of domestic abuse or of coercive and controlling behaviour during these attendances. Whilst Julie was identified as a partner, there was nothing documented to suggest she was responsible for the attendances or of being a potential perpetrator. She was referred to on one occasion as only being there to take Louise home. In 2018, Louise attended hospital twice with alleged assault. She did not disclose details of a perpetrator and did not want to discuss any aspect of the injuries, or who was involved. The panel heard that routine enquiry into the possibility of domestic abuse has now been introduced in the emergency departments managed by Liverpool University Hospitals NHS Foundation Trust.

14.1.10 Louise was seen on a number of occasions, when attending hospital, by the Psychiatric Liaison Team (Mersey Care). On their first contact with her on 21 December 2017, Louise said:

"She had been seeing her ex-partner Julie in Essex who she met on Facebook, and that Julie puts her down and tells her how pathetic she is."

Louise said that she had a maladaptive coping mechanism (Louise's words).

14.1.11 While in custody on 17 April 2018, Louise spoke to a mental health practitioner about her mental health and described her dogs and Julie as protective factors. She reported a good four-year relationship until problems with her family made things difficult.

14.1.12 On 5 March 2019, when admitted to hospital after an overdose, she was seen by the Psychiatric Liaison Team. She again reported the dogs and Julie as protective factors. Her stress factor was reported as the court case, which was due to be finalised on 15 March 2019.

14.1.13 On 23 May 2019, following an admission to an Intensive Care Unit as a result of an overdose, Louise was again seen by the Psychiatric Liaison Team and said that she would like a short period of respite in crisis accommodation. Her rationale was that she needed to “build bridges” with Julie. The IMR author spoke with the practitioner involved. They remembered the incident and said that the manner in which Louise was talking was in keeping with someone who had gone through a traumatic overdose, was embarrassed, and realised the impact on others afterwards. While waiting for crisis accommodation, Louise decided she was not willing to stay and self-discharged.

14.1.14 Professionals did not always find it easy to identify domestic abuse. Louise’s drinking problem and Emotional Unstable Personality Disorder meant that the presenting issues were often unclear. The panel discussed what could have been done to help bring clarity and thought that one option would have been a professionals’ meeting. This is further discussed at paragraph 14.11.4. When Louise made a clear disclosure of domestic abuse to PSS UK Women’s Turnaround, she was offered extensive domestic abuse support and counselling, but did not take this up. This may have been impacted by Louise’s previous adverse experience of counselling, which was not known to PSS Women’s Turnaround.

14.1.15 There was no confusion on 12 March 2020, when Louise reported to a police officer that Julie had subjected her to coercive and controlling behaviour during their 10-year relationship: this included preventing her from having her own bank account until recently and forcing her to engage in sexual activity with men for money. She stated that one of the men had gone 'too far' on the last occasion, raping her anally. The officer was with Louise for almost two and a half hours during which Louise said that she was unable to progress the allegations until she felt stronger. Julie was, at this time, away in the South East and not due to return for five days. Louise did not want to make a statement saying that she had rung the police to get help. She was given reassurance about the support that could be provided. A MeRIT risk assessment was graded as gold and a VPRF1 was completed. Referrals to the IDVA service, MARAC and Adult Social Care were made. This was the first time that there was a referral to MARAC by any agency.

Note: Louise's mum has read the report and feels that the full detail contained in this paragraph, whilst unpleasant and graphic, is important as it highlights Louise's bravery in reporting the attack.

14.1.16 Louise repeated the allegations to an IDVA the following day and indicated that she was happy to go to a domestic abuse refuge. Although nothing could be found in the North West that day (Friday), it was thought that Louise was safe as Julie was away: arrangements were made to follow up after the weekend. Sadly, Louise died before other arrangements could be made. Panel members questioned whether the changes in Louise's circumstances had made her more vulnerable to taking her own life. The panel member representing Public Health, who has expertise in this area, advised the panel that isolation and a lack of mitigation of risks, i.e., not being suitable for the refuge place, would have increased the risks. The panel also noted that when Louise contacted Adult Social Care after being declined for the refuge place, an opportunity existed to link Louise with mental health support. The panel agreed that raising awareness of suicide risk, staff training, and access to advice may be important in reducing such risks in future.

This is a learning point (Panel learning 1) and leads to panel recommendation 1.

14.1.17 The Serious Crime Act 2015, received royal assent on 3 March 2015. The Act created the offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine, or both. The offence, which does not have retrospective effect, came into force on 29 December 2015. The legislation was therefore effective for the whole of the period under review.

14.1.18 The panel considered whether there was evidence that Julie had subjected Louise to coercion and control and in doing so referred to the Crown Prosecution Service's policy guidance.

14.1.19 The Crown Prosecution Service's policy guidance on coercive control states:

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless

- Enforcing rules and activity which humiliate, degrade, or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits, or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g., threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college, or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation

- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends, and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

The panel also saw that Louise complained that on 12 March 2020 a few days before her death that she had been subject to sexual coercion.

Examples of sexual coercion[15]

A person may try to sexually coerce someone through:

- **Harassment:** Repeatedly asking someone for sex when they have expressed disinterest is coercive behaviour especially if it intends to wear someone down until they give in.
- **Guilt:** A person may try to make someone feel guilty for saying no to sex. For example, they may emphasize how long it has been since they last had sex, say that the person owes them sex, or that it is their obligation as their partner.
- **Lies:** A person may use misinformation to coax someone to have sex with them. They may use myths about consent to convince someone they have no right to say no, make false promises, or tell them their demands or coercive behaviours are normal.
- **Threats to the relationship:** A person may threaten to leave a relationship if someone does not consent to sex. Alternatively, they may play on their partner's insecurities, such as by suggesting they are boring or unattractive if they say no, or that they will start being unfaithful.
- **Blackmail:** This is when someone weaponizes secret information about a person to force them into having sex. For example, the perpetrator might

[15] https://www.medicalnewstoday.com/articles/sexual-coercion#examples

threaten to release nude photographs online if someone does not consent to sex.

- **Fear and intimidation:** A person may behave in a scary or intimidating manner when they do not get their way to pressure someone into sex.
- **Power imbalance:** A person may use the power they get from their job, status, or wealth to coerce someone. They may threaten someone with job loss, lower grades, a tarnished reputation, or other negative consequences if they do not agree. Alternatively, they may promise rewards and opportunities.
- **Using substances:** A person may encourage someone to use drugs or alcohol to make them more compliant and therefore easier to coerce into sex. If a person has sex with someone while inebriated or unconscious, this is rape.

The panel did not have information on what method had been used in order to coerce Louise.

14.1.20 In coming to a view, the panel were aware that they now had information from Louise's mum that agencies did not have at the relevant time. The panel thought that there was clear evidence that Louise had been subjected to coercion and control.

14.1.21 The panel saw that Louise had:

- complained of "being put down and told how pathetic she is"
- had her money paid into Julie's bank account
- alleged assaults by Julie
- complained that Julie forced her to engage in sexual activity with men for money

14.1.22 The panel thought that the Julie's report to the police on 12 March 2020 that she had been forced to have sex with men amounted to sexual coercion

14.1.23 The panel also felt that there may have been an imbalance of power in the relationship based on age and experience, as Julie was nine years older than Louise. The imbalance of power in relationships and its consequences are explored in a series of articles published on www.marriage.com

An extract is reproduced below:

How does imbalance in power dynamics affect the relationship?

In relationships that are strong and healthy, the influence both partners have is (almost) equal. One might have more financial power, the other more social connections, but ultimately, they are respectful of one another and make decisions together.

When there is an imbalance of power in relationships, there are several adverse effects:

- Damaged intimacy and connection
- The demand – withdrawal dynamic (one partner seeks change while the other withdrawals)
- Frustration, anger, and depression that is also linked to the demand-withdraw dynamic
- Feelings of anxiety, fear, and shame
- Impaired self-esteem, self-image, and sense of personal value
- Isolation, threats, and abuse as a means of maintaining the power imbalance
- Lack of trust in the partner and endurance of the relationship
- Decreased overall satisfaction of the relationship

- End of relationship or marriage

The panel thought that a number of the adverse effects were apparent in the relationship between Louise and Julie.

14.1.24 The panel thought that there was now clear evidence of controlling and coercive behaviour. The panel also reflected that until Louise's very clear disclosure of 12 March, no one agency had sufficient information to come to that conclusion.

14.1.25 The panel discussed the impact of financial and economic abuse in this case. Surviving Economic Abuse[16] provides the following definitions:

- Financial abuse
- Controlling finances, stealing money, or coercing someone into debt.
- Economic abuse
- Financial abuse plus restricting, exploiting, or sabotaging other resources such as housing, food, property, transportation, and employment.

The panel were clear that during the period that Louise's money was being paid into Julie's account, she was vulnerable to financial abuse. Louise's mum said that Louise had to ask Julie for money if she needed anything. Although Louise was assisted to open a bank account and her money was then paid into her account, the panel thought that the financial abuse had placed her at a significant disadvantage.

[16] Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

14.1.26 The tenancy of the privately rented property that the couple lived in was in Julie's name. This presented difficulties for Louise when she wanted to leave the relationship as she did not have anywhere else to go or the financial resources to find anywhere. Paragraph 14.10 includes information in relation to Louise's attempts to find a refuge space.

14.1.27 The Women's Aid report, "The Economics of Abuse"[17] provides the following information:

"The majority of women admitted to refuge have financial needs, whether they are working, had to leave their employment, already in receipt of benefit or having to make a new claim for benefit. There will be a period of time when they have nil income." (Service responding to the Women's Aid Annual Survey 2018).

[17] https://www.womensaid.org.uk/wp-content/uploads/2019/12/Economics-of-Abuse-Report-2019.pdf

14.2 **How did your agency assess the level of risk faced by Louise from the alleged perpetrator, and which risk assessment model did you use?**

14.2.1 Merseyside Police assessed each incident using the Merseyside Risk Identification Toolkit, or (MeRIT) on the VPRF1. It consists of 40 questions designed to assess the extent to which the relationship has broken down, a brief social assessment, and a violence assessment. The answers inform a score which is graded bronze, silver, or gold accordingly. The results are conveyed to the MASH (Multi Agency Safeguarding Hub) via the VPRF1, and to the custody officer in cases where there has been an arrest. If urgent measures are needed, the matter is escalated to the senior officer on duty. In every case, a secondary risk assessment is undertaken at the police Vulnerable Persons Referral Unit, where assessors correct any obvious errors and gather additional information; thus, providing an opportunity for the grade to be adjusted, according to professional judgement. The final grade informs the appropriate level of intervention and determines the necessary referrals.

14.2.2 The 10 MeRIT risk assessments involving Louise and Julie were each viewed independently. There is no evidence that the accumulation of incidents caused any of the risk assessments to be adjusted or additional measures taken at the second risk assessment. The final MeRIT assessment of 12 March 2020, which was graded as gold, ensured that immediate IDVA support was provided to Louise and the case was referred to MARAC.

14.2.3 Probation staff use the Offender Assessment System (OASys) to assess the risks and needs of all offenders. The assessor for Julie noted, on 21 May 2018, that she was considered both a victim and perpetrator of domestic abuse. She had suffered significant problems in her own childhood, both before and after the murder of her mother through domestic abuse. The assessment recorded that Julie and Louise had been in a relationship for approximately four years, and that Julie had been married previously and had a 20-year-old son. Julie had significant mental health issues. Areas of concern within the assessment were: relationships; emotional wellbeing and thinking and, behaviour. She was assessed as posing a medium risk of serious harm to two named people, and with the potential for serious harm noted to Louise. The Risk Management Plan (RMP) noted the need to request police checks on a regular basis. Interventions during the Suspended Sentence Order included the objective to work on her emotional management. The information was shared with PSS Women's Turnaround.

14.2.4 The panel heard that the well-established Spousal Assault Risk Assessment, used by probation services, was not used at the relevant time for same sex relationships. Policy has now been changed and the circumstances of Julie and Louise's relationship would now result in a SARA being completed.

14.2.5 The OASys for Louise was completed on 27 March 2019. The assessment noted that there were no current concerns in Louise's relationship, and she denied that Julie was in any way abusive towards her – stating that any concerns were fabricated by her family. The assessment linked relationships to offending, not harm. Louise also stated that accommodation was not a problem. She was assessed as a suicide risk, and as such, a risk flag was applied to the case. Louise was not considered a risk to others and therefore a risk management plan was not completed. Her sentence plan included the improvement of thinking and problem-solving skills, enhanced emotional management, and continued abstinence from alcohol. The information was shared with PSS Women's Turnaround.

14.2.6 There is no documented evidence that the offender managers for both women discussed their cases together, although the MCRC IMR author stated an opinion that “this no doubt happened informally”. Links were not drawn between the two assessments, for example, Julie was perceived as both a victim and perpetrator of domestic abuse, but Louise was not considered a risk to others. Given that the two were in a long-standing relationship, it would have been helpful for Louise’s OASys assessment to be informed by the previous assessment for Julie. The OASys assessments for both women were not reviewed effectively when new information came to light. The content of the termination assessments for both women, completed on 10 December 2019 (Julie) and 10 March 2020 (Louise), remained unchanged from that completed at the commencement of their supervision. A termination assessment should document progress, or change, throughout the period of supervision.

The panel thought that it would be helpful, where two clients are in a relationship, to hold a documented meeting between the workers involved in order to ensure that information on risk was formally shared. This is a learning point and leads to a recommendation for MCRC and PSS Women’s Turnaround.

14.2.7 Although PSS Women's Turnaround worked with both women, there is no documented evidence that the relevant workers discussed their cases together. Louise denied that there was any abuse in her relationship with Julie at her initial assessment with them and no further risk assessments were done. Louise's disclosure to Women's Turnaround on 5 September 2019, that Julie had "battered her", prompted supportive action by an experienced domestic abuse worker, but a formal risk assessment was not undertaken. The staff member who received Louise's text is an experienced domestic abuse worker so is able to assess safety and risk via communication. The worker did a verbal risk assessment with Louise via text and given the limited information she had available, ensured Louise was safe, practical support and advice was given and offered domestic abuse follow-up support. Louise would not share further information on the incident. The DHR panel had an extensive discussion on this point and felt that although the actions of the PSS Women's Turnaround worker were outside existing guidance, which suggests a formal risk assessment, they were reasonable and proportionate in the circumstances.

14.2.8 Adult Social Care (Careline) did not undertake any formal risk assessments following the referrals from Merseyside Police and North West Ambulance Service. There is evidence of social worker oversight and advice being offered to staff in relation to how the referrals should be actioned. However, this largely focussed on the sharing of information with appropriate agencies and not around ascertaining the level of risk or how identified risks should be addressed or managed. Each referral was dealt with in isolation and the opportunity to review information from previous referrals was not taken. The practitioner event heard that, although Careline is a 24-hour service, the processing of referrals can be time sensitive and reviewing previous information is not always possible. As the number of referrals accumulated, reviewing all of the information together would have increased concerns around the risk to Louise from domestic abuse and self-harm. A review of all the information held would also have helped to determine whether the threshold for a safeguarding adult enquiry (Section 42 Care Act 2014) had been met. The professional opinion of the panel member representing Adult Social Care is that the case did, on reviewing all of the information, meet the threshold for a safeguarding adult enquiry. The panels attention was drawn to new multi-agency guidance issued to all agencies in Liverpool in May 2021[18]. Part of the guidance states:

In addition, the following cases that do not meet the criteria for a S42 should also be considered for a non-statutory/other enquiry and/or a professionals' meeting

- *Modern slavery.*
- *Domestic abuse gold status.*
- *Cases where there have been numerous domestic abuse incidents.*
- *Domestic violence protection orders.*

The panel thought that the guidance was helpful in pointing professionals towards holding a multi-agency meeting in cases such as Louise's.

[18] https://liverpool.gov.uk/media/1360353/lcc-domestic-abuse-guidance-v3-120521.pdf

14.2.9 Other agencies did not have information that Julie presented a domestic abuse risk to Louise, and risk assessments were not undertaken.

14.3 **What knowledge did your agency have that indicated Louise could be at risk of suicide as a result of any coercive and controlling behaviour?**

14.3.1 Throughout the period under review, records on police systems show the risk of suicide was considered every time Louise came into contact with police. This was due to the automatic appearance of warning signals and information markers against her name whenever police were informed of an incident involving her. She did tell officers and call handlers the reasons for her thoughts of self-harm on some occasions, which included problems in her relationship with Julie including domestic abuse. There was, however, no clear indication to the police that coercion and control contributed to her low mood, or that it even existed in her relationship with Julie until the disclosure on 12 March 2020. This was reflected in the referrals that were made to other agencies.

14.3.2 Louise was treated in hospital on a number of occasions following episodes of self-harm. She discussed difficulties in her relationship with Julie but did not disclose information which would have led practitioners to suspect coercive control. One comment made by Julie to the Psychiatric Liaison Team in December 2017 that “Julie puts her down and tells her how pathetic she is”, can now, with the benefit of hindsight, be seen as part of a pattern: at the time, however, this was seen as a one-off comment and did not prompt further action. Greater professional curiosity could have led to more information being disclosed.

14.3.3 MCRC knew that Louise was at risk of taking her own life and had documented previous attempts. Initially, Louise told her offender manager that her relationship with Julie was positive and supportive. During the course of supervision, Louise disclosed that her money was deposited into Julie's bank account and there were several notes made of Louise's perceived insecurity in relation to how permanent her accommodation was with Julie, and her awareness of the fact that she could have been asked to leave at any time. Louise was given advice and assistance with her practical issues, for example, obtaining appropriate identification to open a bank account. She was also referred appropriately to other organisations, for example, Mersey Care and We Are With You.

14.3.4 We Are With You saw Louise twice in October 2019. Louise cancelled her third appointment by phone. She was noticeably upset on the call but did not want to discuss why. The case manager updated Louise's offender manager (MCRC) and agreed a contact support package. Contact was made with Louise later that day, she disclosed suicidal feelings and crisis support was put in place. Louise's mood was notedly improved at the end of the call, support information was provided by text, and it was decided that no further welfare checks were required. The We Are With You case manager followed up with Louise the next day. Louise confirmed she was well and arranged forthcoming sessions. Her attendance from this point was intermittent, though she did complete the course. The panel thought that the actions of We Are With You were appropriate in providing immediate support to Louise when she was feeling particularly low**.**

14.3.5 Whilst the risk of Louise taking her own life was known to many agencies, the presence of coercive control in her relationship with Julie was not recognised by any agency until her clear disclosure in March 2020.

14.3.6 The panel were made aware of research indicating a significant number of domestic abuse victims suffer from suicidal ideation. A study[19] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. Although this research does not relate specifically to coercion and control, the panel thought that it was relevant in the context of the risks that Louise presented, and that practitioners should be aware of the link between domestic abuse and suicidal ideation. This is a learning point (panel learning 2) and leads to panel recommendation 2.

[19] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse[19] [*Vanessa E. Munro & Ruth Aitken]*

14.4 **Did your agency consider that Louise could be an adult at risk within the terms of the Care Act 2014?**

14.4.1 Section 42 of the Care Act 2014 states:

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3) "Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

(a) having money or other property stolen,

(b) being defrauded

(c) being put under pressure in relation to money or other property, and

(d) having money or other property misused.

14.4.2 Merseyside Police and North West Ambulance Service (NWAS) made appropriate referrals to Adult Social Care highlighting Louise's vulnerability. It was then for Adult Social Care to assess that information and decide on an appropriate course of action.

14.4.3 The Adult Social Care IMR author concluded that:

"Louise was considered to be a vulnerable person at risk within the terms of the Care Act 2014 due to her regularly presenting in mental health crises. However, as Louise appeared to be able to identify when she needed support for her mental health and regularly contacted the police to gain support it was determined that she was able to contact services in times of need".

Adult Social Care could have offered a Care Act assessment as there was sufficient information to believe that Louise had care and support needs.

14.4.4 Concerns raised by the police and NWAS were shared with Adult Social Care who decided that there was no direct role for them. As outlined at paragraph 14.2.7, referrals were dealt with in isolation.

14.4.5 When Adult Social Care received the final referral from the police in relation to Louise's report of 12 March 2020, the information generated a safeguarding enquiry. This was passed to an area team for action but by the time it was received, Louise was sadly deceased. An option would have been to pass the enquiry to Liverpool Adult Social Care's 24-hour duty team. The panel heard that this is a small team which is focussed on helping people in immediate crisis. The team could potentially have carried out a welfare check on Louise, subject to capacity at that time, but was not asked to do so.

14.5 **What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around Louise?**

14.5.1 Previous paragraphs have outlined the response of Merseyside Police and North West Ambulance Service in making appropriate referrals following contact with Louise. On four occasions, police officers took Louise to hospital as she had asked to speak to a mental health professional.

14.5.2 Throughout the review period, Criminal Justice Liaison Teams (Mental Health) were in place; they provide advice and guidance to Merseyside Police officers and assess individuals in custody. Louise was assessed on each occasion she was arrested. In addition, the Mental Health Triage Care, staffed by a police officer and a mental health professional, is a resource available to provide assistance at any policing incident with a mental health component. It was deployed to the incident on 23 February 2018.

14.5.3 The Force operates a policy, 'Responding to People with Mental Ill Health or Learning Disability', last reviewed in April 2019, which informs the police response to such individuals, whatever the reason for police contact. Louise was dealt with by the police as a victim, witness, and suspect, as well as a vulnerable individual. The recorded incidents show the relevant part of the policy was implemented in relation to Louise, examples of this are an application for early special measures when she was a potential witness to an assault on Julie, and the use of an appropriate adult during her police interviews.

14.5.4 MCRC were aware of Louise's mental health issues and that she had drinking problems. Appropriate referrals and signposting were completed regarding her mental health. Some of the work that Women's Turnaround completed with Louise, as a result of their partnership with the MCRC, was focussed on reducing her use of alcohol. Also, at the end of her supervision period, Louise was referred to We Are With You, where she completed a voluntary alcohol treatment programme.

14.5.5 All specialist mental health services were provided by Mersey Care. Louise was seen in police custody and in court by the Criminal Justice Liaison Team (CJLT). She was also seen by Liaison Psychiatry Services on admission to hospital for each of her three overdoses.

14.5.6 Prior to the timescale of the review, Louise was known to Mersey Care to use alcohol as a coping mechanism. On 5 June 2018, she was assessed using the PANSS[20] assessment: it was identified psychotic blips were linked to ceasing cannabis use six weeks earlier. It was agreed with Louise that an antidepressant would be prescribed through her GP.

14.5.7 On 8 October 2018, Louise was seen in custody by the Criminal Justice Liaison Team. She said that she did not have current self-harming or suicidal thoughts. She reported drinking every day but declined a referral for support. Information on services relating to alcohol was provided to Louise, but there is no record of her seeking help until she was supervised by MCRC and referred to We Are With You.

14.5.8 After admission to hospital on 4 March 2019 due to an overdose, Louise agreed that she would stop drinking. A referral to a Mersey Care counselling service was made to support this, but it was later found that Louise was ineligible for the service.

14.5.9 On 15 March 2019, when seen at court by a CJLT practitioner who assessed her mental health and asked about her current mood, thoughts of self-harm and suicide, Louise reported no concerns. A referral was made to Single Point of Access due to low mood. Louise did not attend the appointment and was discharged on 23 April 2019.

[20] The PANSS is a standardised, clinical interview that rates the presence and severity of positive and negative symptoms, as well as general psychopathology for people with schizophrenia within the past week.

14.5.10 After an overdose on 22 May 2019, Louise was admitted to hospital and assessed by the Psychiatric Liaison Team but self-discharged the following day. During this hospital admission, Louise was also spoken to by an Approved Mental Health Practitioner. The IMR author for Adult Social Care concluded that this triage of Louise's case focussed on her diagnosis of Emotionally Unstable Personality Disorder, which does not generally benefit from a hospital admission. The risks to Louise and the reasons for taking the overdose were not fully considered. More professional curiosity was needed in order see beyond Louise's diagnosis of EUPD.

This this a learning point for Adult Social Care and links to a single-agency recommendation.

14.5.11 Louise's appearance at court on 9 August 2019, in relation to a Breach of Community Order, should have prompted a review of OASys. This would have given the opportunity to consider risk management in relation to self-harm, and a review of the risks within her personal relationships. Louise could have been considered for a Mental Health Treatment Requirement (MHTR)[21] at court. This is learning for both court staff, and offender managers when making proposals in Breach cases. The panel thought that a MHTR may have been helpful to Louise in that there is some evidence that she complied with the instructions of MCRC staff when she was under their supervision: this may have enhanced the possibility of her engaging effectively with mental health practitioners. The panel were told that consideration of the usefulness of a Mental Health Treatment Requirement is now embedded practice and therefore no recommendation is made on this point.

14.5.12 On 4 October 2019, a referral was received by Mersey Care from Women's Turnaround. This prompted a series of contacts and appointments which Louise did not attend, all of which were followed up with further contacts and appointments.

[21] Piloted from 2017 at Sefton magistrates' court.

14.5.13 Mersey Care did take into account Louise's use of alcohol and other substances during their assessments with her. Louise's engagement with the organisation during the review period was in response to crisis: she did not attend follow-up appointments.

14.5.14 As a younger woman, Louise had been detained in hospital for treatment under the Mental Health Act. Panel members thought that her experiences could have been a negative influence on her ability to engage with mental health services.

14.5.15 The panel also reflected that Louise's documented Adverse Childhood Experiences and trauma may have affected how she reacted to situations and engaged with others. The traumatic experiences in Louise's early life continued into her relationship with Julie and the panel thought that Louise's experiences with Julie may have been an example of traumatic bonding. The term traumatic bonding was developed by Patrick Carnes[22]. It is said to occur as a result of ongoing cycles of abuse in which the intermittent reinforcement of reward and punishment creates powerful emotional bonds that are resistant to change. A simpler definition is that traumatic bonding is a strong emotional attachment between an abused person and their abuser, formed as a result of the cycle of violence.

[22] https://healingtreenonprofit.org/wp-content/uploads/2016/01/Trauma-Bonds-by-Patrick-Carnes-1.pdf

14.5.16 A generally accepted definition of *trauma* is:

An *event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being*.

Domestic abuse is clearly a form of trauma, made all the more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship.

http://www.safelives.org.uk/practice_blog/trauma-informed-work-key-supporting-women

14.5.17 The panel thought that the trauma Louise experienced during her life may have had a significant effect on her and how she related to others. This is a learning point (panel learning 3) and leads to panel recommendation 3.

14.6 **What mental capacity assessment(s) were completed by your agency and what was the outcome?**

14.6.1 There is limited evidence of mental capacity assessments being completed in this case.

14.6.2 The absence of capacity assessments may have been as a result of professional's understanding and application of The Mental Capacity Act 2005 principles, which they felt did not require them to complete a mental capacity assessment.

Principle 1 (A presumption of capacity) states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 (Individuals being supported to make their own decisions) "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3 (Unwise decisions) "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 (Best Interest) "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 (Less Restrictive Option) "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in the particular circumstances of the case".

(Mental Capacity Act Guidance, Social Care Institute for Excellence)

14.6.3 North West Ambulance Service documented mental capacity assessments with Louise in their interactions with her on 13 May 2018, 8 October 2018, 20 May 2019, and 17 July 2019. On all occasions, Louise was assessed to have capacity to make decisions on her treatment by NWAS. On 22 May 2019, a doctor recorded that Louise had capacity to make the decision to discharge herself from hospital.

14.6.4 The panel discussed whether the impact of domestic abuse and coercion and control could have affected Louise's ability to make decisions. The panel thought it possible that Louise's previous traumatic experiences from domestic abuse may have affected her decision making on occasion, but also felt that there was insufficient information on which, to come to a conclusion given that the two capacity assessments recorded related to relatively isolated decisions regarding medical treatment.

14.7 Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?

14.7.1 Both Merseyside Police and North West Ambulance Service made a number of referrals to Adult Social Care. Having reflected, both organisations do not think that the information in the referrals merited a safeguarding concern or strategy meeting. The information contained in a safeguarding adult concern, had one been thought appropriate, would be little different to that in the referrals that were made.

14.7.2 No other organisation contributing to the review made referrals to Adult Social Care or thought that there was a need for a safeguarding adult concern or strategy meeting. This is further commented on at paragraph 14.11.14.

14.7.3 Having received the referrals, Adult Social Care (Careline) were in possession of information which, taken together, presented a picture of the risks to Louise through her mental health and substance use, as well as allegations of domestic abuse. Careline makes a decision what action to take on each referral. On reflection, Adult Social Care feels that there were missed opportunities to make a safeguarding adult referral from Careline to the Safeguarding section of Adult Social Care. This may then have generated further action, for example, a safeguarding enquiry under section 42 of the Care Act 2010. This is a learning point and leads to a single-agency recommendation made by Adult Social Care.

14.7.4 Louise met the criteria to be offered a Care Act assessment as part of a safeguarding response. This would have enabled information to be gathered to assess whether a safeguarding enquiry was appropriate, or whether risk could be managed by undertaking an assessment under the Care Act or signposting onto another agency. Louise's ability to contact services, particularly police and ambulance when she was in crisis, appears to have led to Careline overestimating her ability to protect herself and engage with support.

14.8 **What services did your agency provide for Louise and/or Julie; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?**

14.8.1 The services provided by agencies have largely been covered in previous elements of analysis. Louise was seen and assessed by the Mersey Care Psychiatric Liaison Team on each occasion that she was admitted to hospital following her self-harm. The assessments were considered to be appropriate by the Mersey Care IMR author. On leaving hospital, Louise did not then engage with the services that were available to support her.

14.8.2 Both women were referred to PSS UK Women's Turnaround as part of their probation orders. There was an overlap of three months when both were open to the service. Both had separate keyworkers and counsellors and did not attend the same interventions.

14.8.3 Julie was open to PSS UK Women's Turnaround between 21 May 2018 and 12 July 2019, as part of her probation order. Between 21 May 2018 and 12 July 2019, Julie attended an assessment, a one-to-one and 11 counselling sessions (different counsellor than one allocated to Louise). Her case was closed in July 2019, due to ill health.

14.8.4 Louise was open to PSS UK Women's Turnaround between 3 April 2019 and 18 November 2019, as part of her probation order. During assessment, and from referral information, issues around alcohol misuse and mental health were identified. Louise attended an assessment and one session of ARC (Drug & Alcohol recovery group). Her intervention was changed to Understanding Your Emotions. This intervention was around mental health and wellbeing. Louise attended six Understanding Your Emotions sessions. She engaged well in the sessions and within the group, provided examples and contributed to group discussions. There were no concerns around Louise within group sessions. She was referred for counselling intervention on 22 August 2019 and was offered numerous appointments for counselling between then and November 2019, which she did not attend.

14.8.5 Adult Social Care did not provide Louise or Julie with any services. Louise was contacted by telephone in August 2018 and declined support, whilst Julie was sent a letter in October 2018, offering support, and signposting her to substance misuse and mental health services. The nature and number of referrals received into Careline meant that there were opportunities to review all of the information received in order to determine an appropriate response given the risks identified and allegations made.

14.8.6 The panel recognised the efforts of some agencies (for example MCRC and PSS UK Women's Turnaround) in providing training for staff in suicide awareness and prevention but thought that more could be done across the partnership. The panel were made aware of a number of free training resources available to all agencies across the health and social care sector. For example

https://www.zerosuicidealliance.com/training

The panel was also told that other resources are now available to support mental health and well-being, for example

https://www.qwell.io/

This is a learning point linked to panel learning and recommendation 1.

14.9 **Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?**

14.9.1 All events in this review predated the first Covid-19 lockdown of 21 March 2020, and services to Louise and Julie were not affected by the pandemic.

14.9.2 There is good evidence that both Louise and Julie were referred and signposted to appropriate services. The police signposted them both to domestic abuse support agencies and the Merseyside Police website which provides advice.

14.9.3 Louise was signposted to alcohol services by Mersey Care on a number of occasions. When Louise was told that she should attend at the Housing Options service by MCRC, she said she was unable to do so as she had no money. MCRC provided her with the money for transport and she did attend, although she did not wait for an assessment.

14.9.4 When Louise disclosed domestic abuse to PSS UK Women's Turnaround, she was offered specialist domestic abuse support and counselling, but did not engage. Julie was provided with housing support letters and a referral to services in Liverpool that help by providing furniture and white goods.

14.9.5 Both Louise and Julie were mobile and accessed different areas of the city. They had smart phones and were active on social media, indicating an ability to do at least limited research on services that may be able to help them.

14.9.6 The panel were satisfied that Louise and Julie had access to information and were signposted to services where appropriate. Louise did not typically access those services until she was in crisis and did not access the follow-up appointments offered.

14.9.7 Louise's mum told the Author of the report that Louise was good at hiding her past trauma and telling professionals "what they wanted to hear". She also said that Louise would not engage in counselling following her bad experience at court as a teenager, when she was questioned in court using records of her counselling sessions. There is nothing in agency records to suggest that professionals were aware of this, and Louise was offered counselling on multiple occasions, but did not take it up. The panel thought that more professional curiosity about this may have enabled professionals to understand Louise's position.

14.10 **How did your agency ascertain the wishes and feelings of Louise and Julie about Louise's victimisation and Julie's alleged offending, and were their views taken into account when providing services or support?**

14.10.1 Louise was contacted, via telephone, by Adult Social Care in August 2018, following a referral raising concerns around her mental health; however, she declined support at this time. Adult Social Care did not pursue opportunities they had to make contact with Louise to discuss the allegations of domestic abuse she had made. This could have considered what support was available to her or whether she would be willing to agree to an assessment of her care and support needs.

14.10.2 In all of the incidents in which Louise made allegations of abuse to the police against Julie, she retracted the allegations and did not cooperate with an investigation. When Julie made allegations of assault against Louise, she declined to assist a prosecution. Both women were, on occasions, quite hostile in their dealings with police officers, which hindered the opportunity for discussion. The police IMR did not identify any of the incidents as being capable of prosecution within the limits of the evidence gathered. Merseyside Police provided information to the review about developments since these events in relation to 'evidence led prosecution', which make it much more likely that a prosecution will be pursued.

14.10.3 However, when Louise made disclosures about her treatment by Julie and others on 12 March 2020, she was provided with information on her options and the support available to her. She said that she did not feel strong enough at that time to pursue the allegations, but the disclosures were recorded appropriately, and it was planned to follow up with her later. Louise did engage with the IDVA, who contacted her following these allegations, but was fearful of repercussions should Julie become aware that she had spoken to the police. She was fearful of repeat victimisation and wanted to get away before Julie returned. The IDVA service offers options and choices to support victims to reduce risk and increase safety. The IDVA ascertained Louise's wishes, safety was discussed, and options were provided: Louise decided that she wanted to access a refuge. The only refuge space available in the North West that day was considered unsuitable for Louise, given her recent self-harm and the fact that it was only staffed during core hours.

14.10.4 The panel thought it was unfortunate that, whilst Louise was considered unsuitable for the refuge as it was felt there was not enough support available, she was then left without any support at all. Paragraph 14.1.16 outlines an opinion that the rejection from the refuge may have increased the risk of Louise taking her own life. This was not recognised by Adult Social Care or the IDVA service, who were aware of the rejection because Louise told them when she spoke to them on the telephone after the rejection. Both services assessed that Louise was safe based on the absence of physical risk from Julie at that time. This is a learning point linked to panel learning and recommendation 1.

14.10.5 The panel heard that there is a national shortage of refuge spaces which can offer 24-hour on-site supervision for clients who may have suicidal ideation. This is a learning point (panel learning 4) which leads to panel recommendation 4.

14.11 **How effective was inter-agency information sharing and cooperation in response to Louise and Julie, and was information shared with those agencies who needed it?**

14.11.1 Information and referrals were shared frequently and appropriately between agencies involved in the review. This is evidenced in the number of referrals by the police and NWAS to Adult Social Care.

14.11.2 Adult Social Care sought information from Mersey Care to establish whether Louise was open to services and receiving support for her mental health. This information was occasionally delayed as at the time this could only be completed during core hours Monday to Friday. The panel heard, however, that plans are being implemented for a selection of Careline, adult services staff members and social workers to have access to the Mersey Care NHS system at any time of the day and night.

14.11.3 The panel also heard that information is routinely shared by Merseyside Police with MCRC relating to MCRC new clients. However, during the review period, specific information requests had to be made on other cases. An enhanced system of information sharing to routinely share updated information on all clients under MCRC management has now been agreed.

14.11.4 Whilst the panel agreed that information had been shared appropriately between agencies, they reflected that this did not result in robust action to protect Louise. There is no evidence that a multi-agency meeting was considered prior to March 2020 in order to discuss Louise's case and develop a multi-agency action plan.

Given the number of agencies involved, the DHR panel thought that this would have been appropriate and helpful. This is discussed further at paragraph 14.15.9.

14.12 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Louise and Julie?**

14.12.1 Diversity issues are discussed at section 11. The panel, however, wished to reflect on the potential impact of Louise and Julie's sexuality on the services provided to them. For example, members of the panel asked:

"What would have happened if Louise had been in a relationship with a man and reported the same issues"?

14.12.2 Whilst it is impossible to evidence what theoretically would have happened in such circumstances, the panel felt that agencies would have taken a more protective and proactive approach towards Louise had she been in an abusive relationship with a man. It is possible that unconscious bias affected the considerations of agencies in this case.

14.12.3 In coming to a view, the panel took into account available research, for example the Galop[23] report, 'LGBTQ+ people's experiences of domestic abuse[24]'. The key findings of the report were:

- LGBT+ victims/survivors share similar types of domestic abuse as their heterosexual/cisgender peers, but their experiences often differ because their sexuality and gender identity.
- LGBT+ victims/survivors disclosing domestic abuse often report multiple vulnerabilities as a result of their sexual orientation, gender identity, physical/mental ill health, or substance abuse.
- The majority of LGBT+ victims/survivors disclosed domestic abuse from intimate 'same-sex' partners, though a significant proportion reported abuse from family members, particularly younger victims/survivors, those from black and minority ethnic communities and trans men.

[23] https://www.galop.org.uk – an LGBT+ and anti-violence charity

[24] https://www.galop.org.uk/lgbt-peoples-experiences-of-domestic-abuse/

- Nearly two-thirds of victims/survivors identified as a gay, bisexual and/or transgender male and the majority were abused by a male perpetrator.
- Over four-fifths of lesbian women disclosed abuse from a female perpetrator

14.12.4 The panel heard that MCRC has now commissioned specialist training for its staff in dealing with abuse in same sex relationships. This is a learning point (panel learning 5) and leads to panel recommendation 5.

14.12.5 Louise's mum thought that this was an important area of learning due to general perceptions of domestic abuse in the community. For example, she had comments from people that had said 'at least you don't have to worry about being beaten up by a fella' when she had disclosed that Louise was in a same sex relationship.

14.13 What did your agency do to establish the reasons for Julie's alleged abusive behaviour and how did it address them?

14.13.1 There was no engagement by any agency with Julie that explored her alleged behaviour towards Louise. On the first four occasions that Louise made allegations, they were quickly withdrawn or denied by her, and police officers felt that there was insufficient evidence to arrest and question Julie. Although every effort was made to provide Louise with support to enable her to follow up the allegations, this was not successful. The police also considered whether a Domestic Violence Prevention Notice[25] could have been applied for, but there were no occasions on which it was felt the necessary criteria were met.

[25] Sections 24 -33 Crime and Security Act 2010

14.14 **Was there sufficient focus on reducing the impact of Julie's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**

14.14.1 Louise was judged to be the victim of domestic abuse in five reports to the police. They are briefly summarised in the below table:

Incident and Date	Outcome
16 March 2018 - Police were called to an incident at Louise and Julie's home. Julie was arrested for assault on Louise's sister, Jade. Louise made a written statement saying she had not been assaulted, and that her injury resulted from hitting her head on the wall. In her statement, she said that although her relationship with Julie had its ups and downs, Julie had never shown violence towards her or behaved in a controlling manner.	Julie was later convicted of the assault. A MeRIT risk assessment was graded as bronze, with Louise recorded as the victim.
15 April 2018 - Louise phoned the police stating that Julie had set a dog on her and assaulted her. Louise then denied that she had been assaulted and said a bruise on her head had been caused by falling over. Louise did not make a statement.	A MeRIT risk assessment was completed and graded as silver.
11 July 2018 - Louise's sister, Sarah, called the police to report that Louise had been assaulted by Julie. On arrival, officers found that both sisters had been drinking. Louise said that her injuries were from hitting herself on the head and falling over: she made a signed statement that she had not been assaulted. Louise was taken to hospital for treatment to her injuries.	A MeRIT risk assessment was completed and graded as silver.
7 October 2018 - Louise telephoned the police reporting that Julie had hit her with the Hoover. When officers attended, Louise was drunk and stated she had been watching a TV programme and became confused about what was happening due to her mental health issues: she denied that Julie had assaulted her. Julie said that Louise had been drinking all day and there had been no domestic abuse incident.	Louise was abusive and uncooperative and was arrested to prevent a breach of the peace. A MeRIT risk assessment was completed and graded as bronze.
12 March 2020 - Louise contacted the police and an officer attended to speak to her. Louise said that Julie had subjected her to coercive and controlling behaviour during their 10-year relationship. Louise was informed of her options and given reassurance about the support that could be provided.	A MeRIT risk assessment was graded as gold. A referral to MARAC was made.

14.14.2 In each incident, the attending officers judged that there was insufficient evidence to arrest Julie. This was in part influenced by Louise's reluctance to provide evidence against her. An option open to the police is to consider a prosecution without the victim's consent. In the four earliest incidents, Louise denied that she had been assaulted and provided an alternative explanation for any injuries. The police review of the case has not identified any of the incidents as being capable of being prosecuted without the victim's consent. The panel noted that there were four incidents where Louise was a victim in 2018, and this did not result in a referral to MARAC or professionals' meeting. This is further discussed at paragraph 14.15.

14.14.3 It is possible that the final report from Louise could have resulted in police action to arrest and interview Julie if Louise had gone on to provide further evidence. The report was filed by the police after Louise's death and has resulted in no action.

14.14.4 Julie's MRCR offender manager recognised her as both a perpetrator and victim of domestic abuse. Work was planned with Julie regarding her emotional management, and there is evidence that she engaged with Women's Turnaround and with counselling. Her compliance was relatively good.

14.15 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?**

14.15.1 No agency involved in the review has highlighted significant breaches of its own policies and procedures.

14.15.2 Based on their previous convictions or the risk that they presented, neither Louise nor Julie fitted the criteria for referral to MAPPA.

14.15.3 The panel heard that none of the first nine domestic abuse incidents, involving Louise and Julie, were graded at the gold level which automatically generates a referral to MARAC. Only the 10th report, immediately prior to Louise's death, would have done so. The 10 incidents are briefly summarised in the below table for ease of reference.

Incident and Date	Outcome
16 March 2018 - Police were called to an incident at Louise and Julie's home. Julie was arrested for assault on Louise's sister, Jade. Louise made a written statement saying she had not been assaulted, and that her injury resulted from hitting her head on the wall. In her statement, she said that although her relationship with Julie had its ups and downs, Julie had never shown violence towards her or behaved in a controlling manner.	Julie was later convicted of the assault. A MeRIT risk assessment was graded as bronze, with Louise recorded as the victim.
15 April 2018 - Louise phoned the police stating that Julie had set a dog on her and assaulted her. Louise then denied that she had been assaulted and said a bruise on her head had been caused by falling over. Louise did not make a statement.	A MeRIT risk assessment was completed and graded as silver, with Louise recorded as the victim
16 April 2018 - Louise returned home. Julie phoned the police claiming that Louise was assaulting her and had threatened to harm herself with a knife. When officers attended, Julie did not wish to pursue a prosecution.	A MeRIT assessment was completed for the domestic incident, recording Julie as the victim
11 July 2018 - Louise's sister, Sarah, called the police to report that Louise had been assaulted by Julie. On arrival, officers found that both sisters had been drinking. Louise said that her injuries were from hitting herself on the	A MeRIT risk assessment was completed and graded as

Incident and Date	Outcome
head and falling over: she made a signed statement that she had not been assaulted. Louise was taken to hospital for treatment to her injuries.	silver, with Louise recorded as the victim
8 August 2018 - Police officers were called to an incident involving Louise and Julie in Liverpool city centre. Both were very drunk, and Louise was arrested because of her behaviour. She later received a caution.	A MeRIT risk assessment was completed and graded as bronze, with Julie recorded as the victim.
7 October 2018 - Louise telephoned the police reporting that Julie had hit her with the Hoover. When officers attended, Louise was drunk and stated she had been watching a TV programme and became confused about what was happening due to her mental health issues: she denied Julie had assaulted her. Julie said that Louise had been drinking all day and there had been no domestic abuse incident.	Louise was abusive and uncooperative and was arrested to prevent a breach of the peace. A MeRIT risk assessment was completed and graded as bronze, with Louise recorded as the victim.
8 October 2018 - Police received an anonymous 999 call to a disturbance at Louise and Julie's home. Louise was outside with a minor cut to her arm and the glass in the front door was broken. She was intoxicated. Julie said that she had just returned home to find Louise in that condition and no domestic incident had occurred.	A MeRIT risk assessment was completed and graded as silver, with Julie recorded as the victim.
7 January 2020 - Louise contacted the police to report a dispute with Julie over ownership of a dog. Louise stated their relationship had ended some six months before and Julie was refusing to hand over the dog. An officer attended and advised that this was a civil matter. Julie alleged that Louise, who was intoxicated, had slapped her across the face. She was not in need of medical attention and declined to make a complaint of assault.	A MeRIT risk assessment was completed and graded as bronze, with Julie recorded as the victim.
1 March 2020 - The police received a call from a member of the public reporting a disturbance when Louise was involved in a fracas with Julie's adult son. Julie's son was arrested on an unconnected matter.	A MeRIT risk assessment was completed and graded as bronze, with Julie recorded as the victim.
12 March 2020 - Louise contacted the police and an officer attended to speak to her. Louise said that Julie had subjected her to coercive and controlling behaviour during their 10-year relationship. Louise was informed of her options and given reassurance about the support that could be provided.	A MeRIT risk assessment was graded as gold. A referral to MARAC was made.

14.15.4 Safelives[26] guidance on MARAC referral is that following three standard (bronze MeRIT) risk assessments in twelve months, a referral should be made to MARAC. This guidance is not followed in Liverpool due to the high volume of high-risk cases, and there is no number of assessments which triggers a referral to MARAC.

14.15.5 In Liverpool, rather than the number of times a case has come to the notice of police or partners being a criterion, professionals are able to refer cases to MARAC based on their professional judgement. In this case, there were seven assessments at either bronze or silver level in 2018, and a further two in 2020, before the last incident in March 2020. All assessments are reviewed a second time and can be regraded by an assessor who has access to all background information: this may not have been available to an officer at the time of the incident. The panel heard that around 50% of cases that are discussed at Liverpool MARAC are referred using professional judgement. Those cases are subject to a further quality assurance before being scheduled for MARAC. The panel acknowledged the high level of professional judgement referrals and discussed whether guidance on what should be taken into account using professional judgement, including repeat incidents, should be developed. The panel thought that this would be helpful. This is a learning point (panel learning 6) and leads to panel recommendation 6.

14.15.6 Had the case been heard at MARAC, it would have brought together a myriad of information from agencies about the couple, which was not immediately apparent to single agencies.

[26] A national charity dedicated to ending domestic abuse. www.**safelives**.org.uk

14.15.7 Whilst MARAC was one option which could have helped to bring together all the information and manage the risks that the couple presented to each other, it was not the only option. Adult Social Care had many referrals from the police and NWAS and could have chosen to call a multi-agency meeting or strategy discussion. As each referral was treated in isolation, it seems that although information was available, it was not brought together to give a clear picture of the risks involved. This is a learning point and leads to a single-agency recommendation by Adult Social Care.The table at 14.15.4, shows the challenge to an individual practitioner dealing with a single incident in identifying who is the primary perpetrator in a relationship where allegations are made by both parties. Louise's mum commented on reading the report that sometimes a perpetrator might make themselves look like a victim. A multi-agency meeting with appropriate agency representation may have been able to identify a primary perpetrator and set actions accordingly.

14.15.8 The panel were made aware of the Multi Agency Risk Assessment and Management (MARAM) process which was implemented across the four areas covered by the Merseyside Safeguarding Adult Board in April 2020 (Liverpool, Knowsley, Sefton, and Wirral). This process, which is intended to be used in cases where there are issues relating to mental capacity, vulnerability, and risk-taking behaviour in respect of adults with care and support needs, was not in place at the time of the events being reviewed. The panel did, however, think it was appropriate to link MARAM to this case as the issues presented are within the scope of the MARAM process and the process could potentially be used for similar cases in future. The panel reflected that even if the MARAM process had been in place, it would only have been instigated if the risks had been recognised by bringing all the available information together.

14.15.9 The panel heard about a further type of multi-agency meeting called 'Complex lives Multi-Disciplinary Team meeting'. These meetings, chaired by Mersey Care, were also developed in 2020 and involve a range of services, including IDVAs, who can bring cases to the meeting for discussion.

14.16 **Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?**

14.16.1 There are two previous Liverpool DHRs which are considered to have similarities to this DHR. Liverpool DHRs 11 and 15 both featured complex needs with a number of referrals to Adult Social Care. DHR11 has been published, DHR15 has not. The recommendations from both those reviews have been considered and drawn through into a single action plan shown at Appendix A, which will now be taken forward by Adult Social Care.

14.17 **What knowledge did family, friends and employers have that Louise was in an abusive relationship, and did they know what to do with that knowledge?**

14.17.1 As set out earlier in the report, Louise's mum had long-standing concerns about the relationship and had tried to talk to Louise about some of the issues. For example, Louise's money being paid into Julie's bank account. Louise did not easily take advice and shrugged off her mum's concerns. Her mum says that Louise was deeply affected by her treatment and the outcome of the court case as a teenager and was unlikely to trust the criminal justice system. The panel also saw that this was reflected in Louise not taking up the many opportunities for counselling that she was offered.

14.17.2 Following incidents in 2018, Louise's mum and sister, Jade, became estranged from her, whilst her sister, Sarah, continued to support her. It was to Sarah whom Louise sent her last text messages, which caused Sarah to call an ambulance.

14.17.3 Two of Louise's friend's made statements to the police after her death which became part of the evidence presented to the coroner at Louise's inquest. Louise met both people on the internet, formed a friendship, and went on to meet them in person. Both friends gave a similar account of contact with Louise being dominated by talk of the abuse she received from Julie, including receiving photographs of Louise's injuries on occasions. Both friends counselled her to seek support locally, but thought that she did not do so, and could see that there was a pattern of domestic abuse followed by reconciliation.

14.18 **Were there any examples of outstanding or innovative practice?**

There were no examples of outstanding or innovative practice identified during the review.

14.19 **What learning did your agency identify in this case?**

This single-agency learning is taken directly from agency IMRs.

Liverpool University Hospitals NHS Foundation Trust

Recognition and use of routine enquiry for all ED attendances, ensuring that the questions are asked when the person is on their own. This has now been implemented.

Merseyside Community Rehabilitation Company

When several professionals are involved in the care and management of service users, professionals' meetings should take place at the commencement of statutory supervision, and regularly thereafter, to co-ordinate activity and generate understanding of needs. This includes the care and management of individuals within relationships.

PSS UK Women's Turnaround

If two service users are in a relationship, ensure that all contacts that reference them both are shared fully within the team and follow up any

alleged incidents of domestic abuse with MeRIT risk assessment and other agencies who may have further information. (A centralised management system for clients has now been introduced).

Adult Social Care

If all referrals had been followed up by way of contact, an offer of assessment, or a Safeguarding concern being raised and reviewed, then these allegations could have been monitored and reviewed to determine the most appropriate response and the best placed agency to be identified.

Care Act Assessments are not being routinely utilised as a way of responding to vulnerable individuals where there is a reason to believe that they may have care and support needs, and where there is possible a risk of abuse or neglect.
There is a need for further training, briefings and learning and development opportunities within Careline to support understanding and decision-making in cases where there are allegations of domestic abuse. Opportunities to understand the nature of coercion and control and how this can impact upon the capacity of an individual to make decision to protect themselves and inconsistency in allegations would also be of benefit.

In circumstances whereby Careline received multiple referrals of a domestic abuse nature, consideration should be given to the level of risk, evidence of abuse or self-harm and suicide ideation. Also, how engagement of the vulnerable can be maximised and whether a multi-agency meeting or strategy discussion/meeting would be beneficial.
If a case is open to one of ASC's area teams, there is an opportunity for an allocated worker to engage with an individual to complete a risk assessment and consider whether a referral to MARAC is warranted, either by score or professional opinion. If the case is not open to a team and a referral to MARAC is considered warranted, Careline should discuss this with the referring agency. In Louise's case, a discussion could have been had about ensuring this case was referred to MARAC.

At the point of referral to Careline, opportunities exist to contact the service user directly to ascertain their view and wishes in relation to a safeguarding concern. This would provide an opportunity to explore whether a Care Act Assessment would be beneficial and if the service user consents. Although there are considerations in relation to creating unnecessary risks to the service user, these should be weighed up in relation to the risk already present. There is an opportunity for Careline to be creative when contacting individuals who allege domestic abuse by partners whom they reside with.

15 Conclusions

15.1 Louise and Julie had been in a relationship since 2013. Louise's family say that she had suffered abuse for much of the relationship. In 2017, after a period living in the South East, the couple returned to Liverpool.

15.2 Over the following years until her sad death in March 2020, many incidents involving the couple were reported to agencies. Whilst information was shared between agencies, little was done to pull together an overall picture of the relationship and the risks to both Louise and Julie. If all the available information had been drawn together, opportunities existed for a multi-agency meeting to be convened to consider if a safeguarding enquiry or a referral to MARAC would have been appropriate. This would have allowed for multi-agency information gathering and sharing, and oversight and action planning to reduce the risk. Those opportunities were not grasped.

15.3 Louise did not easily accept help. A bad experience in court as a teenager made her reluctant to engage with the criminal justice system and counselling. This was not known by professionals who dealt with Louise during the timeframe of the review. On the occasions that Louise reported domestic abuse to the police, she withdrew her allegations and there was insufficient evidence for the police to act. Other than engagement with Merseyside Community Rehabilitation Company and their partner Women's Turnaround, which Louise had to engage with, she typically only engaged with services when she was in crisis, and then quickly withdrew. She often did not attend follow-up appointments. Louise's reasons for non-engagement were never fully understood by professionals.

15.4 The nature of Louise and Julie's relationship was not easily understood by agencies. Both were recorded as victims and perpetrators of domestic abuse to each other, although this was not known to all agencies.

15.5 The panel discussed the couple's relationship in the context of Johnson's[27] typology of intimate partner violence. This divides domestic abuse (intimate partner violence) into four categories:

Intimate terrorism, or coercive controlling violence, occurs when one partner in a relationship, typically a man, uses coercive control and power over the other partner, using threats, intimidation, and isolation. Coercive Controlling Violence relies on severe psychological abuse for controlling purposes; when physical abuse occurs, it too is severe. In such cases, one partner, usually a man, controls virtually every aspect of the victim's, usually a woman's, life. Johnson reported in 2001 that 97% of the perpetrators of intimate terrorism were men.

Violent resistance, a form of self-defence is violence perpetrated by victims against their partners who have exerted intimate terrorism against them. Within relationships of intimate terrorism and violent resistance, 96% of the violent resisters are women.

Situational couple violence, also called common couple violence, is not connected to general control behaviour, but arises in a single argument where one or both partners physically lash out at the other. This is the most common form of intimate partner violence, particularly in the western world and among young couples, and involves members of both sexes nearly equally. Among college students, Johnson found it to be perpetrated about 44% of the time by women and 56% of the time by men.

Mutual violent control, is a rare type of intimate partner violence occurring when both partners act in a violent manner, battling for control.

[27] Michael Paul Johnson is emeritus professor of sociology, women's studies and African and African American studies at Penn State university, USA, having taught there for over thirty years.

15.6 The panel also considered whether there had been bi-directional violence. The term has been generated to capture relationships in which both parties use violence and/or abusive behaviour. The term suggests that a single primary aggressor cannot be identified.

15.7 The panel thought that on the balance of information available, it was likely that Louise had suffered intimate terrorism and had responded on occasions by violent resistance. The panel acknowledged that whilst it is possible to categorise the abuse Louise suffered in hindsight, it was difficult for individual practitioners dealing with single occurrences to do so.

15.8 The 2018 Changing Lives report 'Too complex for complex needs', focusses on the successes of assertive outreach work for victims of domestic abuse who have needs such as substance misuse, poor mental health and domestic abuse combined. The panel thought that Louise could be seen as part of that group. The report asks, and answers the question:

Where might we have intervened earlier?

It is difficult, with such a small sample, to identify definitively any obvious opportunities for early intervention with these women. However, the women's stories suggest it would be helpful to refer women for more intensive support:

- at the second or third referral to MARAC
- on eviction from a refuge
- on refusal of a refuge space on the grounds to 'complex needs'

15.9 Louise was refused refuge space because the only space available was unsupervised outside core hours and it was thought unsuitable for her given her recent history of self-harm. She had drinking problems and a history of overdose and self-harm. It is possible that Louise may have been helped by consistent supportive outreach if it had been available. The existing services in Liverpool were unable to consistently engage with her.

15.10 Louise was judged to have capacity to make decisions in relation to accessing services and whether to accept offers of help. The panel recognised the challenges that professionals can face when there is a known risk to individuals, whether through self-harm or suicidal ideation; however, there was no evidence available that would have justified implementing sections of the Mental Health Act to safeguard Louise and remove her liberty.

15.11 On the day prior to her death, Louise had been in contact with professionals and disclosed a 10-year history of coercive control from Julie. Louise was deemed to have been safe, given that Julie was living outside of the area and was not anticipated to return. The panel acknowledged that this distance was not necessarily a safety barrier as coercive control within the Serious Crime Act 2015 (Section 76), states that victim's only need to 'fear' that violence will be used. With no available refuge accommodation that was accessible to Louise, due to her risk of suicide, the panel acknowledged that there were no alternative options but for Louise to remain at home, with planned further agency engagement after the weekend. The potential for Louise's risk of self-harm to increase at this point was not understood or recognised by those who had contact with her.

15.12 The inquest did not establish any third-party involvement in Louise's death. The panel acknowledged the tragic circumstances of this case and again offer their condolences to Louise's family.

16 Learning

This learning arises following debate within the DHR panel.

16.1 **Narrative**

Training for staff on suicide awareness and prevention is inconsistent across the partnership.

Learning

The availability of free training resources to agencies should enable them to provide information and advice to staff on suicide prevention.

Panel recommendation 1 applies.

16.2 **Narrative**

The link between domestic abuse and suicide is not well known or understood.

Learning

Knowledge of the link between domestic abuse and suicide will enable professionals to formulate appropriate risk assessments and risk management plans.

Panel Recommendation 2 applies.

16.3 **Narrative**

Case illustrates the challenges faced by professionals in achieving effective engagement with victims of domestic abuse. As stated earlier in the report, there are multiple reasons why victims feel unable to engage.

Learning

Some victims of domestic abuse find engagement with agencies especially difficult. This may be particularly the case when a victim such as Louise has suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma-informed way.

16.4 **Narrative**

There is a shortage of refuge accommodation for people who have complex needs.

Learning

The absence of safe accommodation can lead to further risk.

16.5 **Narrative**

The panel felt it possible that unconscious bias affected the considerations of agencies in this case.

Learning

Improved awareness of abuse in same sex relationships may help to eliminate unconscious bias.

16.6 **Narrative**

Louise and Julie's circumstances were not referred to MARAC as incidents were not assessed as Gold. The high volume of incidents did not generate a referral on professional judgement.

Learning

Cases where there is a high volume of repeat domestic abuse incidents, combined with other risk factors, should be recognised as high risk and generate a MARAC referral.

17 Recommendations

DHR Panel

17.1 Agencies involved in the review should provide Liverpool Community Safety Partnership with evidence of the training and information provided to staff on suicide prevention. The Community Safety Partnership should assess the information received and consider whether a multi-agency training package for Liverpool is required.

17.2 Agencies involved in the review should provide Liverpool Community Safety Partnership with evidence that information has been provided to staff on the links between domestic abuse and suicide. The learning from this review should be used to assess whether a city-wide multi-agency package, to inform practitioners of the links between domestic abuse and suicide, is required.

17.3 Agencies involved in the review should provide Liverpool Community Safety Partnership with assurance that their training plans take into account the need to train staff in trauma-informed practice. The Community Safety Partnership should assess whether a city-wide multi-agency approach to trauma-informed practice is required.

17.4 The Domestic Abuse Act 2021 (section 57) requires all Local Authorities to:

(a) assess, or make arrangements for the assessment of, the need for accommodation-based support in its area,

(b) prepare and publish a strategy for the provision of such support in its area, and

(c) monitor and evaluate the effectiveness of the strategy.

The assessment and strategy for Liverpool should take into account the learning from this case.

The panel further recommends that the Home Office encourage all local Authorities to ensure that their assessment and strategy for accommodation-based support takes into account people with complex needs, including the risk of suicide.

17.5 Agencies involved in the review should provide Liverpool Community Safety Partnership with assurance that staff are trained in relation to the possibility of unconscious bias and domestic abuse in same sex relationships.

17.6 Guidance for professionals on what factors should be taken into account in making a professional judgement referral to MARAC should be developed.