LIVERPOOL'S COMMUNITY SAFETY PARTNERSHIP

LEARNING REVIEW

'SARAH' LDHR 9

DIED

2015

Prepared by David Hunter from the original document
March 2020 and revised July 2020.

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1. INTRODUCTION

1.1 This summary overview report was commissioned Citysafe, Liverpool's Community Safety Partnership in February 2020. In preparing it, the independent author read the original 2017 domestic homicide overview report and correspondence between the Home Office Domestic Violence Unit and Citysafe, and spoke with the review's commissioner.

1.2 This report is about the death of Sarah[1] who was murdered by her partner Adrian[2] in early 2015 at their home. This happened within a day of Adrian being released from prison for having breached a Domestic Violence Protection Order[3] following his abuse of her.

1.3 Later in 2015, Adrian pleaded guilty to murder and was sentenced to life imprisonment with a minimum tariff of 19 years.

1.4 All those involved in the review, offer their sincere condolences to Sarah's family and friends. Those condolences are extended to the family and friends of Sarah, whose child tragically took their life two months after Sarah's homicide.

1.5 Sarah's mother said, 'Sarah grew up in a happy loving family. She was clever, witty and fun to be around…her murder and subsequently the premature death of her beautiful child devastated our family beyond words. Forever missed'. Mother described Sarah as 'a much-loved mother to her…perfect children and a beloved…sister. Sarah's life has been cut dramatically short at the hands of Adrian. Earlier this year our family was left devastated again (referring to the suicide of her grandchild). The loss of people so close to us has caused our health to deteriorate. Sarah's surviving child has lost a mum and sibling...it is just devastating. That child must now face life without them. Although today's sentencing has given me some closure, the pain and loss will be with me forever. If I had a choice, I would want him to spend the rest of his life in jail'.

1.6 The sentencing judge is reported as saying: 'You brutally killed a defenceless and vulnerable woman in her own home. The assault was prolonged and vicious. The offence was committed while you were in a jealous rage in consequence of your misguided perception that she had been unfaithful to you' adding, that Adrian was 'controlling and dominant'.

[1] Sarah is a pseudonym chosen by her family with the aim of protecting her identity

[2] Adrian is a pseudonym chosen by the report's summariser in 2020. Sarah's parents were elderly and in poor health in 2015. It was thought disproportionate to approach them about the offender's pseudonym given the passage of time and the likely rekindling of the disturbing events.

[3] Domestic Violence Protection Order Sections 24-33 Crime and Security Act 2010

2. Establishing the Domestic Homicide Review

2.1 Merseyside Police notified Citysafe of Sarah's death. Citysafe's chair commissioned a review having determined the criteria[4] were met.

2.2 A review panel was established with an independent chair, who also wrote the original report. An Independent Domestic Violence Advocate from a Liverpool charity, which delivers domestic abuse services, provided additional objectivity.

2.3 Ten agencies, including three that can fairly be described as independent, provided written material[5] to the review; they were The Crown Prosecution Service, Basement[6] and Person Shaped Support UK[7].

2.4 Sarah's family contributed to the review and saw a draft of the original overview report before it was finalised. Sarah's mother provided some insight into Sarah's background. The family did not have an independent advocate nor did they meet the review panel.

2.5 The purpose[4] of a domestic homicide review is to:

a) 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:

b) 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

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

d) 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

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[4] Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[5] These reports are known as individual management reviews

[6] A homelessness Service http://www.the-basement.org.uk/

[7] PSS is a social enterprise who provide over 20 different services to support in whatever way is needed. https://psspeople.com/all-about-pss/what-we-do

domestic abuse is identified and responded to effectively at the earliest opportunity;

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

f) Highlight good practice.

3. Terms of Reference

3.1 The Terms of Reference for the review were set to determine whether:

1. The incident in which Sarah died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse

2. There were any barriers experienced by Sarah or her family/friends/colleagues in reporting any abuse in Liverpool or elsewhere, including whether they knew how to report domestic abuse, should they have wanted to

3. Sarah had experienced abuse in previous relationships in Liverpool or elsewhere, and whether the experience impacted on her likelihood of seeking support in the months before she died

4. There were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Sarah that were missed

5. Adrian had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies

6. There were opportunities for agency intervention in relation to domestic abuse regarding Sarah and Adrian or to dependent children that were missed

7. There are any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the city

8. There were any equality and diversity issues that were pertinent to Sarah and Adrian, for example, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

9. Abuse of alcohol or drugs was a significant issue in relation to the homicide and domestic abuse risks, and if so, how did each agency respond to the issue

10. There were any examples of outstanding or innovative practice arising from Sarah's case

11. There were any other issues which the panel should consider as important learning from the circumstances leading up to Sarah's homicide

4. BACKGROUND OF SARAH AND ADRIAN

Sarah

4.1 This is a summary of what Sarah's mother, father, sister and brother-in-law told the review chair. The following is a non-judgemental description of Sarah's life.

4.2 Sarah was the youngest of three siblings. They had a very happy, settled childhood living with both parents not far from Liverpool. Sarah went to the local grammar school where she did well, before going to secretarial college. Sarah had a strong personality and was bright, clever and quick-witted.

4.3 She travelled the world in her early 20's and when she returned to the Liverpool area, she secured a position as a legal secretary with a local law firm. They thought very highly of Sarah and encouraged her to gain professional qualifications so that they could employ her in a more senior role and to train her to become a solicitor.

4.4 Everything was going well for Sarah; she had a good job and lovely children. When she was around 35, everything changed. Sarah and her partner separated and almost immediately, her life changed. Her family noticed a rapid decline in her health and appearance and within a very short period of time, she was drinking excessively and associating with people she would not previously have been involved with.

4.5 Thereafter, Sarah was subjected to domestic abuse from several male partners and had periods of homelessness. Sarah became dependent on alcohol, fell-out with her parents and lost her job because of drug use. Her emotional well-being deteriorated and she lacked self-confidence, self-worth and self-esteem. Children's Services took steps to protect her children.

4.6 Sarah had to cope with domestic abuse and mental-health issues. Over the following four or five-years, she was offered wide-ranging help and support from professionals as well as from her family. They all knew how badly she wanted to change her life. Right up to her death Sarah continued to battle against her situation.

4.7 Her family desperately missed Sarah and she never gave up on her children. The surviving child misses her smile the most. The child also misses Sarah's weekly letters which always enclosed pocket money. Also missed are the 'normal' things she would do for the child, such as buying the latest Liverpool football shirt. Sarah would do similar things for the child who died. Sarah and her children were very close. The child added that their sibling just could not live without their mum.

4.8 Several of Sarah and Adrian's friends were written to by the chair, inviting them to contribute to this review; none responded. Adrian did not respond to an invitation to participate in the review.

Adrian

4.9 He had a long history of offending, some of which emanated from relationships with previous female partners. He had been arrested for rape, but the allegation was retracted and the complainant felt unable to attend court. Between 2004 and 2007, the police attended 21 'domestic incidents' between Adrian and his partner. He was the perpetrator on 19 of those occasions. Some of the incidents continued after the relationship had ended. In April 2005, his then partner reported several incidents of domestic abuse and later that year, he was sentenced to 12-months custody for false imprisonment, assault, theft and harassment.

4.10 He was last supervised by the then Merseyside Probation Trust in May 2008. He was recalled to prison on a previous licence in respect of charges of wounding and criminal damage against an ex-partner and her friend, charges were withdrawn and he was released. He was later sentenced to a further term of imprisonment for assaulting the same former partner.

4.11 There are many reference in the original report to his significant abuse of alcohol and drugs. The above portrays a man who had no regard for females; who wanted his own way and was most likely engaged in what now is known as controlling and coercive behaviour. In short he was a dominant bully with the need to exercise power and control over females.

5. Analysis Against The Terms of Reference

5.1 Introduction

5.1.1 This analysis is taken from the original report and is based on the agencies' individual management reviews[8] and the domestic homicide review panel's discussions. That panel concluded: 'The individual management reviews produced during this review were quality assured by the original author, the respective agency and by the panel chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation. The standard of the individual management reviews was good'.

5.1.2 The domestic homicide review chair '…was particularly impressed by the air of openness and transparency that clearly existed among agencies that were involved in Sarah's case and the positive culture within Citysafe of a desire to work collaboratively and to learn from experience'.

5.1.3 Each term of reference appears in **bold** followed by the analysis as it largely appeared in the original report. Any additional commentary by the author of this summary overview report appears in italics.

5.2 Term 1

To determine whether the incident in which Sarah died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

5.2.1 Sarah had suffered abuse from at least six partners over a period of nearly ten-years. During that time, the police attended over 100 'domestic incident' calls, many of which had been made by Sarah. She was a victim of serial domestic abuse before she became involved with Adrian. A letter from a psychiatrist in 2013 mentioned that in three of the previous relationships, a partner had received a custodial sentence for assaulting Sarah.

5.2.2 Sarah was involved in a relationship with Adrian for about 12-months before the homicide. During that time, the police dealt with nine reported incidents of domestic abuse in which she was the victim. Five led to the arrest of Adrian. There were no prosecutions because Sarah felt unable to maintain her complaint. The reasons for this are explored later. Three separate Domestic Violence Protection Orders were granted against Adrian.

5.2.3 Adrian murdered Sarah after accusing her of spending his money and with being involved with another man while he was in prison. He assaulted her in the past during intoxicated disputes over money, so the incident that led to Sarah's death was not a 'one off' occurrence. Those incidents of reported

[8] An individual management review is a template report of an agency's involvement with the subjects of the review and answers the review's terms of reference.

violence and were a warning sign only because they were similar in circumstance. Sarah was risk-assessed as 'Gold'[9] after one of the assaults in 2014 and commented to the police officers that she believed that Adrian would kill her one day.

5.3 To determine whether there were any barriers experienced by Sarah or her family/friends/colleagues in reporting any abuse in Liverpool or elsewhere, including whether they knew how to report domestic abuse, should they have wanted to.

5.3.1 It is known that Adrian made a point of attending agency appointments with Sarah and that she was quick to emphasise that any visible injuries she had, had not been caused by him. It was documented in a letter from a psychiatrist in November 2014, that Sarah had attended a mental health assessment accompanied by Adrian. The referral had been made by Sarah's GP and mentioned domestic violence, because of Adrian's presence, Sarah, almost certainly felt compelled to say she had not been the victim of domestic abuse. The presence of domestic abuse offenders at medical and other 'official' meetings is seen in many domestic homicide reviews. It is controlling behaviour, designed to silence the victim.

5.3.2 The volume of 'domestic incidents' the police attended involving Sarah as the victim or perpetrator suggests that she had some confidence in contacting the police to make allegations, including those involving 'domestic abuse'.

5.3.3 Sarah knew through experience that the police would respond swiftly to such incidents and she may have used this tactic to stop the immediate violence or threat of it and keep herself safe. Like many victims of domestic abuse Sarah probably found it difficult to follow through with a complaint once the initial danger had passed.

5.3.4 Sarah and Adrian associated with people who relied heavily on alcohol and drugs and who lived in close proximity to one-another. They frequented each other's homes and congregated in the street drinking alcohol.

5.3.5 Many of their associates and friends had previous dealings with the police, having been offenders, victims and witnesses to a variety of offences. There have been incidents when these friends made reports to the police expressing concern for Sarah's safety, having witnessed the violence or the injuries she sustained at the hands of Adrian. However, for whatever reason, possibly through fear of retribution and Adrian's propensity for violence, the

[9] Merseyside Police use MeRIT (Merseyside Risk Identification Tool) to assess the risk to victims of domestic abuse. It uses Bronze, Silver and Gold to categorise risk; gold is the highest level. www.liverpool.gov.uk/referrals/professionals-refer-high-risk-victims-of-domestic-abuse/

person informing the police did not want to make a witness statement or in some cases did not want to identify themselves.

5.3.6 A very significant barrier to Sarah reporting abuse was her recurring fear of being made homeless. There has been ample evidence throughout this review of Sarah's ultimate desire to be re-united with her children, so the prospect of her being made homeless again would, probably in her eyes, have seriously damaged any possibility of that happening.

5.3.7 Sarah's parents contacted Wirral Children's Services following a disclosure by Sarah to them about her substance misuse and concerns she had about her children witnessing domestic abuse. Children's Services monitored the situation.

5.3.8 Refuge[10] list the following as barriers to leaving an abusive relationship.

It takes a great deal of courage to leave someone who controls and intimidates you. Women often attempt to leave several times before making the final break.

Remember, leaving an abusive partner can be very dangerous. Women are at the greatest risk of homicide at the point of separation or after leaving a violent partner.

It is important that you plan your departure safely. If you are planning to leave an abusive partner, read our planning to leave page.

'Why doesn't she just leave?'

The truth is that there are many practical and psychological barriers to ending a relationship with a violent partner. Here are just some:

Safety: the woman may be fearful of what the abuser will do to her and the children if they leave or attempt to leave

Lack of self-confidence: the woman may believe that it is her fault and that she deserves the abuse, and may fear she would never find anyone else if she left

Denial: she convinces herself that "it's not that bad"

Shame: she is embarrassed about people finding out

Guilt: the abuser makes her believe that she is to blame for his actions

Financial dependence: the woman may not be able to support herself and her children independently. See our page about financial abuse here

Loyalty: she may be loyal to the abuser regardless of his actions

[10] https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/domestic-violence/barriers-to-leaving/

Hope: she believes that things will improve with time. She believes she can make him change

Lack of support: she doesn't know to whom to turn

Pressure: family and friends pressurise her to stay and 'make it work'

Religious/community beliefs: she is under pressure not to break up the family

Love: despite the abuse, she still loves him

Jekyll and Hyde: the abuser switches between charm and rage; the woman thinks, 'He's not always like this'

Intimidation: the abuser threatens to take the children or pets away

Gender roles: she might normalise his behaviour because he's a man – 'that's how men are'. She may believe it's the woman's role to put the needs of others first

Immigration: if the woman has insecure immigration status, she may fear being deported

5.4 To determine whether Sarah had experienced abuse in previous relationships in Liverpool or elsewhere, and whether the experience impacted on her likelihood of seeking support in the months before she died.

5.4.1 As mentioned previously, Sarah had suffered abuse from at least six partners over a period of nearly ten-years; she had made most of the over 100 calls that the police received about it.

5.4.2 During earlier relationships, some of her victimisation resulted in the conviction of offenders. In other cases, she felt unable to follow through the report. There is absolutely no doubt that she feared Adrian, and was reliant on him for somewhere to live and probably as a means of funding her drug and alcohol use. The control Adrian had over Sarah is illustrated by the fact that not long before the homicide she gave evidence on his behalf at court. Again, this type of 'support' has been seen in other reviews.[11]

5.4.3 Sarah shared her history of physical and emotional abuse at the hands of former partners to whichever agency was trying to support her; this is not to imply that she was in any way complicit in the abuse; she was not. Adrian controlled Sarah and this would almost certainly have affected her decision-making, including her judgement on when it may be safe to leave the

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[11] https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C8024
This refers to child serious case review where domestic abuse kept mother from disclosing that her partner was injuring the children. Such was the offender's dominance over mother that she gave evidence at court in support of a bail application by the partner, knowing he would return to the home with her and the children.

relationship. Therefore, Adrian's controlling behaviour was very likely to be a barrier to her seeking support.

5.4.4 Paragraph 5.3.8 list some reasons why victims do not leave abusive relationships. There is extensive research on the subject. The British Medical Association [BMA] Board of Science publish a comprehensive report in June 2007 (Updated September 2014) titled, 'Domestic Abuse'. Section 3.4 deals with: 'Reasons why adults stay in abusive relationship.'[12] These include: Self-blame; Manifestation of love or affection; it's a one-off event; financial dependency and impact on children. Reading the narrative of the BMA report is recommended as it adds context to simple lists.

5.5 To determine whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Sarah that were missed.

5.5.1 The PSS (Person Shaped Support) Ruby Project[13] received a referral from the Royal Liverpool and Broadgreen University Hospitals in July 2014, that Sarah had attended the hospital with bruising to her left eye, her arms and back; she said she had been assaulted four-days earlier, although she had not said by whom.[14] The Project's understanding was that no MeRIT was completed at the hospital, because Sarah had not disclosed domestic abuse. Because Sarah had previously been known to the Women's Turnaround, where she had been subject to a Specific Issues Order[15] and had spoken about being the victim of domestic abuse, the Ruby Project accepted the referral on the basis that the assaults were likely to be domestic abuse related.

5.5.2 The Probation Service identified that their case records did not always indicate whether opportunities to 'routinely enquire' about domestic abuse experienced by Sarah had been seized upon, and that their staff should have adopted more of an investigative approach to their work.

5.5.3 There were opportunities missed by the GP to enquire about domestic abuse, but as mentioned above, other health professionals, such as nursing staff at the Royal Liverpool and Broadgreen University Hospitals regularly asked the appropriate questions.

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[12] https://www.bma.org.uk/media/1793/bma-domestic-abuse-report-2014.pdf

[13] This organisation provides over 20 different services to support you in whatever way you need us to. We have social care services and mental health services, through to services to support asylum seekers, families affected by addiction and female offenders.https://psspeople.com/whats-happening/news/ruby-goes-from-strength-to-strength

[14] Nursing staff at the Royal Liverpool and Broadgreen University Hospitals regularly sought disclosures from Sarah about domestic abuse. On this occasion, Sarah did not want to participate in the referral process, but nevertheless the hospital still made the referral.

[15] A Specific Issue Order is an order sought from the family court to determine a specific question which has, or may arise, in connection with any aspect of Parental Responsibility for a child.

5.6 To determine whether Adrian had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

5.6.1 Adrian had a long history of offending, some of which emanated from relationships with previous female partners. He had been arrested for rape, but the allegation was retracted and the complainant felt unable to attend court. Between 2004 and 2007, the police attended 21 'domestic incidents' between Adrian and his partner. He was the perpetrator on 19 of those occasions. Some of the incidents continued after the relationship had ended. In April 2005, his then partner made several allegations against him and later that year, he was sentenced to 12-months imprisonment for false imprisonment, assault, theft and harassment

5.6.2 Adrian was last supervised by Merseyside Probation Trust in May 2008. He was recalled to prison on a previous licence in respect of charges of wounding and criminal damage against an ex-partner and her friend, but when the charges were withdrawn, he was released again. Adrian was later sentenced to a further term of imprisonment for assaulting the same former partner.

5.7 To determine whether there were opportunities for agency intervention in relation to domestic abuse regarding Sarah and Adrian or to dependent children that were missed.

5.7.1 Agencies offered many services to Sarah in relation to domestic abuse. Her risk level was raised to 'Gold' in response to escalating incidents and information was shared with other agencies and managed jointly through the MARAC process.

5.7.2 Sarah was required to attend PSS Women's Turnaround Project as part of the Specific Issue Order, which expired in April 2013 and she attended three sessions of the Freedom Programme, a specific programme for victims of domestic abuse, which involved problem solving and understanding abuse.

5.7.3 She was also provided with contact details for the Women's Turnaround Project when Adrian was serving a short term of imprisonment for the breach of the third Domestic Violence Protection Order and was referred to PSS Ruby Project in July 2014. They were unable to contact her by phone or by visiting her address. The police encouraged Sarah to engage with PSS, but she did not want her details to be passed to them.

5.7.4 Regarding the two cases referred to the Crown Prosecution Service by the police, there was insufficient evidence upon which to base a prosecution. It was a finely balanced decision in respect of one of the incidents, which would probably have been tipped in favour of prosecution had witnesses been willing to come forward, even though Sarah felt unable to make a formal complaint.

5.7.5 The National Probation Service, having reviewed the Merseyside Probation documentation, feel they could have done more to verify with the police

what Sarah had told them - which could have led to consideration of protective measures being put in place and contact being made by the police with an Independent Domestic Violence Advocate.

5.7.6 A family decision was made for both children to be raised by their maternal grandparents. The children had been living with them for the eight-years up to Sarah's death. During that time, Sarah had contact with her children under the supervision of her parents and there was never any suggestion that they were ever at risk from their mother.

5.8 To determine whether there are any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the city.

5.8.1 The Crown Prosecution Service [CPS] has extensive and detailed guidance for prosecutors [and police] on how to pursue domestic abuse cases.[16]

5.8.2 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) published [23 January 2020] a joint report into the work of the police and the CPS in relation to Domestic Abuse Evidence Led Prosecutions (DA ELP).[17] The CPS said:

'We see responding to domestic abuse (DA) as a top priority.

The inspection recognised that we have a clear focus on domestic abuse cases and that we understand the importance of achieving best possible outcomes for those impacted by domestic abuse.

We are pleased that Inspectors acknowledged that the application of the Code for Crown Prosecutors was excellent, having been applied correctly in 100% of the CPS charged cases examined, that we had good understanding of the risks posed to victims of domestic abuse, and understood the importance of managing those risks. We are happy that Inspectors recognised that our advocates are proactive, deal with cases efficiently, and are highly regarded by members of the judiciary.

However, this is a complex area of work and we are keen to continue to improve. We will work with our partners in the National Police Chiefs' Council and the College of Policing to ensure that evidence led prosecutions are considered for DA cases from the outset.

5.8.3 The internal investigation conducted by the police in respect of what went wrong after Sarah had telephoned to enquire about Adrian's release date from prison, identified a requirement for advice to be given to a police

[16] https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

[17] https://www.cps.gov.uk/publication/cps-response-hmicfrshmcpsi-joint-thematic-inspection-report-relation-domestic-abuse

officer about staff supervision, work allocation and monitoring procedures. Another officer also required to receive advice regarding prioritisation of work and time-management.

5.8.4 The police have also identified a need to prepare safety plans for victims when perpetrators are subject of a DVPO, or are due to be released from a term of imprisonment for breaching an order.

5.8.5 The National Probation Service has already updated its policies, procedures and training in respect of domestic abuse and is represented on the Liverpool MARAC and MASH. All staff are required to undertake mandatory e-learning and then progress to face-to-face training. In addition, senior and middle managers have designated lead roles in relation to domestic abuse on a local, national and regional level and ensure that operational staff are updated on relevant developments.

5.8.6 PSS UK is of the view that there needs to be an increase in awareness raising sessions/events of domestic abuse in Liverpool, including the process of how to refer victim's to MARAC (Multi Agency Risk Assessment Conference for victims of domestic abuse) and MASH (Multi Agency Safeguarding Hub). They add that the sessions should be ongoing throughout the year, to ensure they reach as wide a range of staffing levels as possible.

5.8.7 Sarah had complex needs and these made her vulnerable to victimisation. Professionals dealing with victims of domestic abuse who have complex needs have a responsibility to consider whether their standard domestic abuse responses are effective in complex cases. For example, professionals found it difficult to see Sarah alone thereby making it difficult for her to make disclosures, which were free from the intimidatory presence of a potential perpetrator. In complex cases, professionals should develop tactics that enables them to see victims by themselves. For example, professionals could establish the victim's routines and make discreet plans to meet victims when they are likely to be alone and with sufficient time to talk. An effective MARAC process should recognise complex cases and produce plans that provide the best opportunity of supporting victims to achieve their goals, including good safety planning. Multi agency planning is a necessity for victims with complex needs, such as housing, psychiatric support, substance misuse or dependency.

5.9 To determine whether there were any equality and diversity issues that were pertinent to Sarah and Adrian, for example age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

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

- age
- disability
- gender reassignment

- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

5.9.2 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[18]

5.9.3 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) specifically provide 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.

5.9.4 Therefore Sarah and Adrian's substance misuse is not within the scope of the legislation. Sarah might have been an adult with care and support needs which would recognise substance miscue.

5.9.5 Sarah's self-defined ethnicity was White British and Adrian defined himself as Black British. There has been nothing to suggest that any agency involved with Sarah or Adrian treated them unfairly or without proper consideration of their religious belief, ethnic background, nationality, sexual orientation, disability or social status.

5.9.6 In addition, there has been no evidence throughout this review to suggest there were any judgmental or discriminatory attitudes in relation to the lifestyles of Sarah or Adrian, by any agency or its members of staff.

5.9.7 There is clear evidence that potential diversity issues were properly considered, for example, on the two occasions that Adrian reported racial abuse, the police provided a swift response and arrested the offender. The joint re-housing application of Sarah and Adrian was entered onto the Liverpool Mutual Homes property pool plus system in 'Band B' following the verbal racial abuse of Adrian by a neighbour.

5.10 To determine whether abuse of alcohol or drugs was a significant issue in relation to the homicide and domestic abuse risks, and if so, how did each agency respond to the issue.

5.10.1 Sarah and Adrian misused alcohol and drugs; the evidence for this can be found in agency records. Here are some examples.

[18] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

- Alcohol was recorded as a contributory factor in the incidents the police attended during Sarah and Adrian's 12-month relationship and nearly in every engagement medical and housing organisations had with either of them.

- Sarah lost her employment and accommodation because of drug misuse.

- Sarah was placed on an Alcohol Treatment Requirement Order that was terminated for breaches of curfews.

- Adrian was warned by his landlord that alcohol related anti-social behaviour emanating from a social gathering at his flat was a breach of his tenancy obligations.

- Adrian did not attend detoxification appointments.

- Adrian was required to attend 'Addressing Substance Related Offending Programme' which he did not complete

- Sarah had many relapses. When under probation supervision, motivational work aimed at addressing and stabilising her substance and alcohol use was conducted and she was referred to several partner agencies for assessments regarding detoxification and rehabilitation.

5.10.2 Sarah and Adrian were offered significant support by many agencies in an effort to help them overcome their use of alcohol (in particular) and drugs. Sadly, for Sarah none of those interventions were successful and she found herself more or less constantly in the company of people with similar difficulties. Consequently she was vulnerable to the continuing domestic abuse by Adrian. He seemed unmotivated to change.

5.10.3 Sarah disclosed to her GP practice that she used drugs and alcohol and the latter was her major dependence. Like other agencies the GP practice providing support and encouragement to withdraw from alcohol.

5.10.4 'In general, women struggle with alcohol abuse and addiction at lower rates than men. The National Institute on Alcohol Abuse and Alcoholism publishes that nearly 10 million men in the US battled alcohol use disorder (AUD) in 2015 while just over 5 million women did. Women who suffer from intimate partner violence are more likely to abuse substances than those who don't. The National Council on alcoholism and Drug Dependence reports on a study that showed 33 percent of women who experienced physical violence also reported drug or alcohol problems as opposed to 16 percent of women who didn't experience physical violence. Alcohol played a role in 55 percent of domestic violence cases among these victims. Another study published by the Institute of alcohol Studies showed that victims of domestic abuse were

twice as likely to consume alcohol than their partner who perpetuate abuse'.[19]

5.10.5 In conclusion for this term it is fair to say that Sarah and Adrian had significant issues with alcohol and drug misuse. However, that is different from saying that Sarah's relationship with alcohol was the cause of her victimisation; it was not. Adrian was a violent man who wanted to control those females he was in a relationship with; his misuse of alcohol and drugs was a secondary factor.

5.11 To determine whether there were any examples of outstanding or innovative practice arising from Sarah's case.

5.11.1 Sarah was offered a high volume of re-arranged initial assessment and clinic appointments at short notice by Mersey Care NHS Foundation Trust, due to assurances from herself and from Adrian that they would make attendance a priority. This was outside the Trust's normal appointments protocol.

5.11.2 PSS Women's Turnaround Service made a point of ensuring there was one consistent staff member working with Sarah and as a result, they built a good working relationship, which allowed for the worker to undertake direct and indirect work with her.

5.11.3 They also demonstrated practical and effective working practice when they liaised with the hospital after they had been unable to contact Sarah. It was agreed that if Sarah attended the hospital again, the PSS Ruby project would be contacted and would try to re-engage with her.

[19] https://www.alcohol.org/women/domestic-abuse-and-alcoholism/

6. LEARNING

6.1 Agencies

6.1.1 Merseyside Police

6.1.1.1 There was confusion within the Liverpool South Family Crime Unit[20] of the police about the ownership of the case, because of the involvement of other departments. Assumptions were made that matters were being progressed. This would have been avoided had there been in place a means of auditing work allocated to individual officers.

6.1.1.2 Merseyside Police have demonstrated that they are very good at identifying, highlighting and recording the fact that alcohol had been a contributing factor during a 'domestic incident', but are poor in responding to it. When alcohol abuse is a constant contributing factor in incidents of a 'domestic' nature, they should take a more robust approach to ensure that specific referrals are made to alcohol support teams, even for the low-level cases. They must also actively pursue the imposition of Alcohol Treatment Referral Order's through the courts when the opportunity arises, even in cases where there is a history of non-engagement and non-compliance.

6.1.1.3 The review highlighted the fact that the police were not updating MARAC with current contact details of victims that are held on their systems. For example, at a MARAC meeting on 9th August 2011, three actions were raised to obtain up-to-date telephone and address details for Sarah, so that she could be offered support. She was in fact serving a term of imprisonment at that time, which made her easily accessible and probably alcohol free. The information was on police systems, but the MARAC meeting was unaware of it. This is evidence of poor research and preparation for such meetings.

6.1.1.4 Merseyside Police utilised relatively new legislation by issuing Domestic Violence Protection Notices and applying for Domestic Violence Protection Orders. They have taken the safeguarding of victims a step further by managing the orders and securing terms of imprisonment for breaches.

6.1.1.5 This review has highlighted the need for the police to plan for the time when either a Domestic Violence Protection Order expires or when the perpetrator is released from prison having served a custodial sentence for breaching the order. Failing to ensure that an effective risk-plan is in place means that the long-term safeguarding of victims cannot be assured.

6.1.1.6 The homicide of Sarah happened in 2015. Five years later the police's experience of DVPN and DVPO has developed. However, the author of this 2020 summary knows of more recent and current domestic homicide reviews nationally where safety planning following the granting of DVPNs and DVPOs is not robust, including safety planning around prison releases for breaches of DVPOs. Therefore, it would be prudent for Citysafe to determine whether

[20] Following a Force restructure the department is now called Protecting Vulnerable Persons Unit - PVPU.

safety planning around DVPN and DVPO is effective in its area. See recommendation 25.

6.1.1.7 While the police are the decision makers on whether a disclosure is made under the Domestic Violence Disclosure Scheme [DVDS] [Clare's law], it is open to any agency to consider whether such a disclosure could be part of their safety planning. This was recognised by the National Probation Service [Merseyside] in this review who raised a recommendation for its service. That recommendation is now extended to Citysafe. See recommendations 10 and 25.

6.1.1.8 It might also be prudent to establish nationally whether the use of DVDS and DVPN/DVPO are being used effectively to support victims of domestic abuse. See recommendation 26.

6.1.2 The Royal Liverpool and Broadgreen University Hospitals NHS Trust

6.1.2.1 The Royal Liverpool and Broadgreen University Hospitals Trust engaged with the MeRIT/MARAC process well, and the Safeguarding Adult's lead ensured that the positive engagement enabled support to be offered to Sarah.

6.1.3 The National Probation Service

6.1.3.1 Case managers need a more investigative approach when dealing with offenders who are also domestic abuse victims, especially in establishing the identity of former and current partners and asking what happened and when. The information should be documented and risk-assessed, considering the outcomes of assessments undertaken by partner agencies.

6.1.3.2 There is the need for more regular liaison to be made with police intelligence operatives, especially in confirming what someone in Sarah's position has said about the prevalence of domestic abuse and the circumstances of it. As well as seeking corroboration of what had happened, the liaison is necessary to establish whether a MARAC referral has been made and an Independent Domestic Abuse Advocate is involved. It would also be useful to know what the outcome of any police investigation has been and to find out what protective measures (if any) have been initiated by the police, such as 'treat as urgent' markers, safety plans and target hardening. Safeguarding referrals/notification and liaison with Children's Services should always be undertaken at the commencement of an order and this information should always be included in the risk-assessment and management plan.

6.1.3.3 Offender Managers should discuss what services are available and understand that referrals can be made to domestic abuse services as part of their overall responsibility for supervision. There is also a need to make sure that accurate and full records are maintained of activity being undertaken by partner agencies.

6.1.3.4 When there is to be a change of Offender Manager, a documented handover meeting should take place between the incoming and outgoing Offender

Manager and the offender to ensure that continuity and clarity around the risk-management plan and the objectives of the sentence plan is maintained.

6.1.4 The Crown Prosecution Service

6.1.4.1 The Crown Prosecution Service identified the need to ensure that when making charging decisions, the lawyer responsible should articulate in writing the rationale behind the decision and should clearly identify all the issues raised.

6.1.5 Liverpool Mutual Homes

6.1.5.1 Liverpool Mutual Homes has questioned whether they could have been more proactive by attempting to speak with Sarah somewhere other than at the flat she shared with Adrian. It is difficult to determine how this could have been achieved though, without potentially compromising her safety.

6.1.6 PSS (Person Shaped Support) UK

6.1.6.1 The PSS Women's Turnaround Service has identified the need for all staff members, including those working outside of immediate domestic abuse support services, to undertake domestic abuse awareness training, MeRIT risk-assessment training and to learn about and understand the MARAC process. This is essential to enable them to identify potential domestic abuse victims and to work effectively with them.

6.1.6.2 The significant lesson learned through their involvement with Sarah, was in respect of the home visits that staff made after they had been unable to contact her by telephone. Although well intentioned, and preliminary checks were completed by staff with the police as to whether there were any domestic abuse incidents recorded (they were told there were none), they appreciated afterwards they could have placed Sarah at risk by making the visit. The organisation has now revised procedures to increase safety for clients and staff. New procedures are now in place.

6.2 Domestic Homicide Review Panel

6.2.1 The panel's learning centred on the challenges faced by agencies of how to effectively engage with victims of domestic abuse, particularly those victims who have other complex needs. Rather than saying, 'the victim declined/refused this or that service', agencies should approach future 'Sarah's' by reversing the premise and asking, 'how can we effectively engage with Sarah.'

6.2.2 Since Sarah's death in 2015, there have been advances in recognising the need to try different approaches to engage with domestic abuse victims. Nevertheless, working with victims of domestic abuse still remains a challenge and more so when they have complex needs. The Liverpool Domestic Violence and Abuse Strategy 2017-2020[21] has the following entry on page 13 under a sub-heading of 'Our Challenges'.

[21] https://liverpool.gov.uk/media/1357328/liverpool-da-strategy-final-web.pdf

6.2.3 ‘Local analysis shows gaps in services e.g. people suffering harmful practices relating to ethnicity and culture, men suffering abuse, LGBT communities, people with complex needs relating to substance misuse or mental illness, elderly victims or children who abuse parents. We need to widen our offer to increase access for all individuals who suffer domestic abuse.’

6.2.4 Given the passage of time since the homicide and the current The Liverpool Domestic Violence and Abuse Strategy 2017-2020, it was judged unnecessary to translate the review’s findings into a recommendation.

7. RECOMMENDATIONS

7.1 The recommendations appear below and their current status appears in action plan at Appendix A.

Merseyside Police

1. Merseyside Police should produce a documented 'working procedures', 'work allocation' and 'personal responsibility' procedure in relation to each role and working practice within the Protecting Vulnerable Persons Unit (PVPU). This should be published and appended to its 'Domestic Abuse (Policy and Procedure)' as a clear reference point, to avoid ambiguity. The procedures should be followed in every Protecting Vulnerable Persons Unit every within the force. (This is a recurring theme from a previous DHR).

2. When completing entries on PROtect logs/Niche, sufficient research should be carried out to identify the most up to date and correct information before it is documented. Doing so will prevent any misleading information being shared with other agencies. This should include current telephone and address details.

3. When seeking CPS advice in cases of 'domestic abuse', all available material pertinent to the investigation should be submitted. When reference is made to the 'mental health' of either victim or perpetrator, then the provenance/origins of the illness, as held on police systems, must be included.

4. When dealing with repeated low key 'domestic incidents' that involve alcohol abuse as a contributory factor, specific interventions and referrals to alcohol support groups must be considered, including referral to adult services.

5. When arrests and subsequent charges are made in relation to 'domestic incidents' and alcohol abuse is a contributory and continued factor, then officers dealing with the case must ensure the court is informed and consideration is given to applying for an Alcohol Treatment Referral Order as part of a community service order. This must be considered even if the subject has a history of non-compliance with such orders.

6. For the MARAC to produce meaningful actions, the panel must be provided with the most up to date information relating to the victim and the perpetrator and where that information identifies complex needs ensure they are catered for in the actions.

National Probation Service (Merseyside)

7. To encourage staff to approach domestic abuse with professional curiosity in each case and to ensure it is recorded on the case record. Risk registers should be flagged and reviewed at least every 16-weeks.

8. Offender Managers should undertake regular Protecting Vulnerable Person Unit checks with the police to verify information and confirm protective measures are in place for the victim and ensure it is documented on the case record.

9. Offender Managers should undertake safeguarding checks/referrals at the commencement of supervision and this information should be included in the risk-assessment and risk-management plan. This should be reviewed if a further domestic abuse or other significant incident takes place and consideration for a referral to MARAC should be made if the threshold is met.

10. In the event of a relationship with a new partner or known perpetrator of domestic abuse, consideration should be made, in consultation with the police, of a disclosure under the domestic violence disclosure scheme (Clare's Law).

11. Offender Managers should discuss what services are available and undertake referrals with victims of domestic abuse and ensure this is documented on the case record.

12. When there is a change of Offender Manager, a three-way handover meeting should take place between the offender and the outgoing and incoming Offender Manager and details of the meeting should be documented on the case record.

PPS (Person Shaped Support) UK

13. PSS Women's Turnaround staff should complete training on awareness of domestic abuse, MERIT risk-assessment and the MARAC process.

14. All staff employed on the PSS Ruby Project should complete the 'Safer Lives' IDVA training

Crown Prosecution Service

15. To ensure that CPS managers continue to use the quality assurance process (IQA) to maintain a high standard of advice and analysis in casework, particularly that relate to vulnerable people.

Mersey Care NHS Foundation Trust

16. To ensure that information sharing between the Trust and GPs is improved and that the exchange of information is properly documented.

General Practitioners

17. Patients attending with other people should have the name and relationship of that person recorded in the records.

18. Patients attending under the influence of drugs or alcohol should have their capacity to make decisions assessed and recorded.

19. Practitioners who see patients who are misusing alcohol and drugs should look beyond this for signs of abuse and record their presence or absence.

20. Practitioners should continue to offer support and signposting to victims of abuse, even if it has previously been declined.

21. The apparent lack of awareness, knowledge and understanding among GP's as to what range of domestic abuse services patients can be referred to should be addressed.

22. Consideration should be given to inviting domestic abuse agencies into surgeries.

Royal Liverpool and Broadgreen University Hospitals NHS Trust

23. To ensure that when checking a patient into the accident and emergency department, full identifying details of next-of-kin are always recorded. Where a patient indicates that they do not have a next-of-kin, this should be clearly documented.

24. To ensure that where there are cases of assault, the healthcare professional should document the name of the alleged perpetrator

End of report body
Next Appendix A

DHR OVERVIEW REPORT: ACTION PLAN

Action Plan for Community Safety Partnership	
DHR reference: LDHR9KD	Independent Chair / Overview Report Author:
Dates as given in Terms of Reference: 26th November 2015	Overview Report Completed: 22th April 2018
Name(s) (or initials) of Victim(s): KD	Ethnic Origin: While British

OVERVIEW RECOMMENDATIONS AND ACTIONS TO BE MONITORED BY THE CSP						
Nº:	**Recommendation** **Merseyside Police**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead agencies**	**Target date to complete**

1	Merseyside Police should produce a documented 'working procedures', 'work allocation' and 'personal responsibility' procedure in relation to each role and working practice within an intelligence unit. This should be published and appended to its 'Domestic Abuse (Policy and Procedure)' as a clear reference point, to avoid ambiguity. The procedures should be followed in every intelligence unit within the force. (This is a recurring theme from a previous DHR)	Review processes of allocation and responsibility and document.	Contained within the Policy. Fixed work procedures would not benefit the investigation within the area of PVP as abstractions, demands and individual circumstance dictate the response to do the right thing. Work Allocation is now addressed through the investigation allocation model (IAM). This model allocates crime based upon seriousness, complexity and THR.	All DA incidents are responded to according to threat, harm and risk and allocated for investigation to appropriate staff	Merseyside Police	Completed

Nº:	Recommendation Merseyside Police	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
2	When completing entries on PROtect logs/Niche, sufficient research should be carried out to identify the most up to date and correct information before it is documented. Doing so will prevent any misleading information being shared with other agencies. This should include current telephone and address details.	Development of new EVPRF process	The automated EVPRF has now been in place for over 12 months, also call assist within the control room. This provides the most up to date information re names, addresses and phone numbers to officers at the scene of an incident. This information automatically populates.	Introduction of EVPRF and call assist allows for effective and efficient sharing of information to patrol officers at scene and to partners.	Merseyside Police	This work is ongoing to continually improve the EVPRF to improve efficiency and effectiveness within the MASH

Nº:	Recommendation Merseyside Police	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
3	When seeking CPS advice in cases of 'domestic abuse', all available material pertinent to the investigation should be submitted. When reference is made to the 'mental health' of either victim or perpetrator, then the provenance/origins of the illness, as held on police systems, must be included.	Ensure appropriate disclosure of material when seeking a CPS decision	Merseyside Police have a Police Decision Makers (PDM's) role which is a qualified member of staff who quality assures all files prior to submission to CPS. The PDM's work closely with the CPS to ensure quality of submissions. The Niche Force system has a MH Flag. PDM and staff training re disclosure is continual. D/ Supt lead for disclosure within Force.	Quality assurance of files prior to submission to CPS.	Merseyside Police	Completed September 2018

Nº:	Recommendation Merseyside Police	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
4	When dealing with repeated low key 'domestic incidents' that involve alcohol abuse as a contributory factor, specific interventions and referrals to alcohol support groups must be considered, including referral to adult services.	Ensure appropriate referrals to support groups	Raised on a regular basis at Risk assessor meetings where staff are encouraged to use professional judgement for referrals to alcohol treatment programs etc. 7@7 training completed re 'supporting victims of DA. In addition Merseyside Police has implemented Early Help Hubs which support this recommendation.	Training completed. Introduction of Early Help Hubs	Merseyside Police	Completed

Nº:	Recommendation Merseyside Police	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
5	When arrests and subsequent charges are made in relation to 'domestic incidents' and alcohol abuse is a contributory and continued factor, then officers dealing with the case must ensure the court is informed and consideration is given to applying for an Alcohol Treatment Referral Order as part of a community service order. This must be considered even if the subject has a history of non-compliance with such orders.	Ensure appropriate referrals to support groups	As above	As Above	Merseyside Police	Completed

Nº:	Recommendation Merseyside Police	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
6	For the MARAC to produce meaningful actions, the panel must be provided with the most up to date information relating to the victim and the perpetrator and where that information identifies complex needs ensure they are catered for in the actions.	Review of MARAC processes and Action	The new EVPR assists with supplying of up to date information regarding victim and perpetrator. Preparation for MARAC is completed within the MASH and is current. A MASH review is currently taking place which incorporates MARAC	MASH review ongoing	Merseyside Police	March 2019 Complete

Nº:	Recommendation National Probation Service (Merseyside)	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
7	To encourage staff to approach domestic abuse with professional curiosity in each case and to ensure it is recorded on the case record. Risk registers should be flagged and reviewed at least every 16-weeks.	Process in place to ensure that registers are reviewed – officer diaries being embedded which will flag reminders to update registers. Mandatory training for all staff – log to ensure staff complete as this addresses the concern of professional curiosity.	Officer diaries in place Training records completed	Systems in place to address deficit. SPOs having ongoing discussions in management oversight re DA cases.	National Probation Service	Completed September 2018

Nº:	Recommendation National Probation Service (Merseyside)	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
8	Offender Managers should undertake regular Protecting Vulnerable Person Unit checks with the police to verify information and confirm protective measures are in place for the victim and ensure it is documented on the case record.	Court staff to complete pre-sentence. All Oms to complete post sentence and regularly throughout live of order	Management oversight process in place to ensure completed. Admin auto request info at Court and recording on case management system	All cases have FCIU checks completed as part of a checklist. Recording in place. Any gaps escalated.	National Probation Service	Completed September 2018

Nº:	Recommendation **National Probation Service (Merseyside)**	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
9	Offender Managers should undertake safeguarding checks/referrals at the commencement of supervision and this information should be included in the risk-assessment and risk-management plan. This should be reviewed if a further domestic abuse or other significant incident takes place and consideration for a referral to MARAC should be made if the threshold is met.	SG audit completed, training rolled out and ongoing monitoring of compliance via management oversight. SG sentence plan objective mandatory, where relevant.	QA tools in place to monitor compliance. All risk assessments and RMP are countersigned by SPO. Ongoing QA	All cases to have a SG check completed as mandatory when children are living with the service user or there is parental responsibility	National Probation Service	Completed September 2018 – though important that actions remain in place to ensure ongoing outcomes.

Nº	Recommendation National Probation Service (Merseyside)	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
10	In the event of a relationship with a new partner or known perpetrator of domestic abuse, consideration should be made, in consultation with the police, of a disclosure under the domestic violence disclosure scheme (Clare's law).	Disclosure to be considered in all cases. MAPPA referrals also to be considered	Examples of disclosure and professional discussions	All Offender Managers aware of the importance of discussing disclosure with their line manager and/or partner agencies	National Probation Service	Completed September 2018

Nº:	Recommendation **National Probation Service (Merseyside)**	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
11	Offender Managers should discuss what services are available and undertake referrals with victims of domestic abuse and ensure this is documented on the case record	Details of available services available to all Offender Managers	Details available in each office and Oms informed to record on case records	Improved access to services for victims	National Probation Service	
Nº:	**Recommendation** **National Probation Service (Merseyside)**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead agencies**	**Target date to complete**
12	When there is a change of Offender Manager, a three-way handover meeting should take place between the offender and the outgoing and incoming Offender Manager and details of the meeting should be documented on the case record.	Checklist in place for transfer of cases	To be used by all OMs when there is a change of officer	Embedded into practice with improved communication and information sharing	National Probation Service	Completed September 2018

Nº:	Recommendation PPS (Person Shaped Support) UK	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
13	PSS Women's Turnaround staff should complete training on awareness of domestic abuse, MERIT risk-assessment and the MARAC process	To arrange training for staff who have not completed training	Training records	All staff have an awareness of DA and process of MARAC and merit	PSS (Person Shaped Support) UK	Completed August 2018
Nº:	**Recommendation** **PPS (Person Shaped Support) UK**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead agencies**	**Target date to complete**
14	All staff employed on the PSS Ruby Project should complete the 'Safer Lives' IDVA training	3 staff on service, two have completed this and one staff member is currently on the IDVA course- Completion date	Certificates and confirmation of place	Staff are working to best practice and hold a recognized qualification	PSS (Person Shaped Support) UK	July 2018 On-going Feb 2019

Nº:	Recommendation Crown Prosecution Service	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete
15	To ensure that CPS managers continue to use the quality assurance process (IQA) to maintain a high standard of advice and analysis in casework, particularly that relate to vulnerable people.	To use the IQA as set out in the CPS IQA guidance and ensure management oversight.	IQA compliance is monitored as part of the CPS APR process.	The quality assurance of casework decisions	The Crown Prosecution Service	March 2018 Completed November 2018

Nº:	Recommendation Mersey Care NHS Foundation Trust	Key Actions	Evidence	Key Outcomes	Lead agencies	Target date to complete

16	Patients attending with other people should have the name and relationship of that person recorded in the records.	To disseminate and advertise codes to Primary care providers via training sessions	Usage of codes of other people present in consultations seen in records Behaviour has changed – audit of usage of code seen. Future practice training will reiterate specific codes (e.g. Mother present, relative present)	Quality assurance of record keeping	General Practitioners	Completed November 2018
Nº:	**Recommendation** **GPs**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead agencies**	**Target date to complete**

17	Patients attending under the influence of drugs or alcohol should have their capacity to make decisions assessed and recorded.	To disseminate tools to assess and record capacity and encourage usage in Primary care via training and feedback sessions	Usage of template forms in consultations seen in records Mostly free text in notes. Consistent coded recording recommended and BK will send across example of assessment tool. Future practice educational meeting will reference this.	Quality assurance of record keeping Knowledge of Mental capacity and how it relates to primary care	General Practitioners	Completed Nov 2018

Nº:	Recommendation GPs	Key Actions	Evidence	Key Outcomes		Target date to complete
18	Practitioners who see patients who are misusing alcohol and drugs should look beyond this for signs of abuse, and record their presence or absence.	To disseminate and advertise codes to Primary care providers via training sessions	Usage of codes seen in records High usage of alcohol screening tools. Wider social prescribing awareness and usage including Citizens Advice and LDAS via verbal advice to patients. Suggestion of usage of "informal referral to another agency" as Read code. Attendance at LCCG training on domestic abuse 26.07.17 noted.	Quality assurance of record keeping Knowledge of ways that abuse can present	General Practitioners	Completed March 2018

Nº:	Recommendation GPs	Key Actions	Evidence	Key Outcomes		Target date to complete
19	Practitioners should continue to offer support and signposting to victims of abuse, even if it has previously been declined.	Training in association with LDAS to GPs to highlight need for continued support	Training session held at Liverpool Clinical Commissioning Group	Quality assurance of record keeping Increased awareness of domestic abuse and its impact as seen in primary care Recognition that recording of ongoing support could be better. Practice will arrange training from LDAS. Discussion around links with mental health and social prescribing. Awareness to think of men, same sex couples, older people, (grand) parents and children. i.e. anyone can be a victim of domestic abuse.	General Practitioners	Completed March 2018

Nº:	Recommendation GPs	Key Actions	Evidence	Key Outcomes		Target date to complete
20	Consideration to develop awareness, knowledge and understanding among GP's of domestic abuse services for patients to be referred to	Training in association with LDAS to GPs to highlight local signposting and support	Training session held at Liverpool Clinical Commissioning Group LCCG provided to safeguarding leads 26.07.17 which was attended. Practice will look to training from LDAS.	Increased awareness of domestic abuse and its impact as seen in primary care	General Practitioners	Completed March 2018

Nº:	Recommendation GPs	Key Actions	Evidence	Key Outcomes		Target date to complete
21	Consideration should be given to inviting domestic abuse agencies into surgeries.	Usage of information from other agencies to inform discussions with GPs in area	Continued discussions with primary care providers in targeted areas LDAS poster in surgery as well as leaflets. Safeguarding poster in every room with appropriate contact phone numbers including LDAS. Training considered with LDAS as above	Increased awareness of domestic abuse and its impact as seen in primary care	General Practitioners	Completed Nov 2018

Nº:	Recommendation GPs	Key Actions	Evidence	Key Outcomes		Target date to complete
22	To ensure that information sharing between the Trust and GPs is improved and that the exchange of information is properly documented.	Record keeping policy already in place. To be reinforced via training.	GP letters are sent following every service user contact or inpatient stay. Documentation within the Trust is in accordance with the trust record keeping policy which is audited. This will be reinforced via safeguarding training and information governance training. https://www.merseycare.nhs.uk/media/5457/it04-corporate-records-v5-upload-30-aug-18-rev-apr-19.pdf https://www.merseycare.nhs.uk/media/5405/it06-health-records-policy-up-8-august-2018-rev-jul-20.pdf	Improved standard of documentation and information sharing.	Mersey Care NHS Trust	Completed Nov 2018

Nº:	Recommendation Royal Liverpool and Broadgreen University Hospitals NHS Trust	Key Actions	Evidence	Key Outcomes		Target date to complete
23	To ensure that where there are cases of assault, the healthcare professional should document the name of the alleged perpetrator.	To discuss with A & E leads actions taken when documenting assault cases and identifying wither by initial or name the alleged perpetrator	Discussed with the ED team regarding information pertaining to perpetrators and documenting within health records	Assurance that the appropriate information requested and recorded.	Royal Liverpool and Broadgreen University Hospital NHS Trust	Completed October 2016

Nº:	Recommendation Royal Liverpool and Broadgreen University Hospitals NHS Trust	Key Actions	Evidence	Key Outcomes		Target date to complete
24	To ensure that information sharing between the Trust and GPs is improved and that the exchange of information is properly documented.	Record keeping policy already in place. To be reinforced via training.	GP letters are sent following every service user contact or inpatient stay. Documentation within the Trust is in accordance with the trust record keeping policy which is audited. This will be reinforced via safeguarding training and information governance training. https://www.merseycare.nhs.uk/media/5457/it04-corporate-records-v5-upload-30-aug-18-rev-apr-19.pdf https://www.merseycare.nhs.uk/media/5405/it06-health-records-policy-up-8-august-2018-rev-jul-20.pdf	Improved standard of documentation and information sharing.	Mersey Care NHS Trust	Completed Nov 2018

No	Recommendation Domestic Homicide Review Panel	Key Actions	Evidence	Key Outcomes		Target date to complete
25	That Citysafe determine whether the DVDS and DVPNs and DVPOs are being used effectively in its area to support safety planning for victims of domestic abuse, including safety planning in advance of offenders being released from prison for breaching DVPO.	MARAC Steering Group to review information from Police about the use of DVDS, DVPO,DVPN and their effectiveness	Information from Police MARAC Steering Group notes	Reassurance that these Police operations are effective	AC/MARAC Steering Group	November 2020 Completed – MARAC Steering Group reassured that these processes are working

No	Recommendation National Recommendation	Key Actions	Evidence	Key Outcomes		Target date to complete
26	That the Home Office establish nationally whether the use of DVDS and DVPN/DVPO are being used effectively to support victims of domestic abuse.	Home Office to review the use of DVDS/ DVPO/DVPN nationally	Home Office Report	Reassurance that these Police operations are effective	Home Office	March 2021

End