South Worcestershire Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Executive Summary Report

Ms L

Died October 2018

Case No DHR 16

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Independent Domestic Homicide Review
Chair and Report Author

March 2022

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1. Introduction

1.1 This is an overview report of a Domestic Homicide Review (DHR) under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004.

1.2 The subject of this Review is Ms L a white British female who was in her mid-40's at the time of her death. After consultation with Ms L's mother, it was agreed that the report would refer to her by a pseudonym.

Circumstances leading to this Review.

1.3 Ms L formed a relationship with a man who will be referred to as Mr P in the Report. Mr P was seven and a half years older than Ms L and the relationship commenced when they were both in-patients in the same mental health resource.

1.4 The precise circumstances of Ms L's death are not known; the only version of events available is that of Mr P who was with Ms L when she died. Mr P alleged that Ms L and he made a joint suicide pact. He says that they both injected themselves with heroin. While the dose proved fatal to Ms L it did not kill Mr P. There is evidence that the relationship between Ms L and Mr P was abusive; she was vulnerable due to her mental health difficulties and she had reported economic abuse and coercive control by Mr P on several occasions.

1.5 Mr P had a long history of mental health problems. He has had extensive contact with the Police because of stealing to fund his drug use and antisocial and violent behaviour.

1.6 A criminal investigation commenced following the discovery of Ms L's body. Initially, Mr P was arrested under suspicion of murder. The Crown Prosecution Service (CPS), decided that no further action would be taken as it would not be in the public interest. Ms L's family appealed that decision and the case was further reviewed by the CPS but they did not change their original decision. Ms L's family remain dissatisfied that Mr P has not been charged with any offence following Ms L's death.

1.7 The decision to undertake a Domestic Homicide Review was taken by South Worcestershire Community Safety Partnership following notification by West Mercia Police, regarding a death where domestic abuse had been identified between the victim and partner.

1.8 The guidance states that the purpose of a DHR is to:

a) Establish what lessons are to be learned from a 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 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.

2. The Review Process

2.1 The Domestic Homicide Review process commenced with an initial meeting of the South Worcestershire Safeguarding Partnership Board Domestic Homicide Subgroup. Nine agencies had significant contact with either Ms L or Mr P. Independent Management Reviews (IMR's) and chronologies of their contact with Ms L and Mr P were requested.

2.2 The timeline for the DHR was as follows:

21st January 2020 –	Mark Dalton appointed as Overview Author.
28th February 2020 –	Panel Meeting
6th March 2020 –	Home Visit to Ms L's mother by Overview Author.
16th March 2020 –	Terms of Reference agreed.
7th August –	Telephone meeting with Ms L's mother
14th August 2020 -	IMR's and chronologies submitted.
8th October 2020 –	Practitioner learning event.
27th October 2020 –	Panel Meeting
25th November 2020 –	Panel Meeting
8th December 2020 –	Panel Meeting

10th June 2021 –	Panel Meeting
11th March 2021 –	Final Overview presented to South Worcestershire Community Safety Partnership.
19th April 2021 –	Final Overview shared with Coroner.
13th May 2021–	online meeting with Head of Safeguarding Partnership and Mother to discuss the final report.
4th October 2021 –	Inquest

2.3 The progress of this Review was significantly affected by the lockdown in the summer of 2020. Firstly, it led to a delay in IMR's being completed because staff in Health and Social Care were called away for other duties. Secondly, the Overview Author because ill with Covid-19 in early 2021 which caused further delay.

3. Terms of Reference – see Appendix 1

4. The Domestic Homicide Review Panel

4.1 In accordance with the statutory guidance a DHR Panel was established to oversee the process of the Review. Members of the Panel and their professional responsibilities were as follows:

Mark Dalton,	Independent Chair and Author.
Tim Rice,	WCC Senior Public Health Practitioner, WCC Public Health.
Suzanne Hardy,	Safeguarding Services Manager, Herefordshire & Worcestershire Health and Care NHS Trust.
Caroline Mann,	DoLS Team Manager, WCC Adult Services.
Lloyd Griffiths,	Chairperson – SWCSP.
Louise Wall,	DCI, West Mercia Police.
Deborah Narburgh,	Head of Safeguarding, Worcestershire Acute Hospitals NHS Trust.
Jeremy Newell,	Deputy Designated Nurse, Adult Safeguarding Lead and PREVENT Lead, Herefordshire and Worcestershire Clinical Commissioning Group.

Anne Steele,	Assistant Director of Services Swanswell Charitable Trust/Cranstoun.
Natalie Mathews	Senior Independent Domestic Violence Advisor, West Mercia Women's Aid.
Karen Sheldon (minutes)	WCC Public Health Administrator.

4.2 None of the Panel members had any direct involvement in the case or management responsibility for any of the practitioners involved.

4.3 The South Worcestershire Community Safety Partnership appointed Mark Dalton to chair the Review and to author the Overview Report. He is an independent registered social worker and an experienced SILP (Significant Incident Learning Process) reviewer. He is independent of all the agencies involved in this case and the South Worcestershire Community Safeguarding Partnership Board.

5. Scope of The Review

5.1 The period covered by this Review is from approximately one month before when Ms L and Mr P commenced their relationship (the Review seeks to understand how they were both placed in the same rehabilitation unit) until the date of Ms L's death in October 2018.

5.2 The agencies contributing to this Review were:

Worcester City Council (Housing)
Worcestershire County Council (Adult Services)
West Mercia Women's Aid
West Mercia Police
Herefordshire and Worcestershire Clinical
Commissioning Group (HWCCG) on behalf of the GP Surgery
Cranstoun Worcestershire -previously known as Swanswell (Alcohol and Drug Service)
National Probation Service
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust

5.3 All of the agencies contributing to this Review provided an Independent Management Review and an agency chronology by the Terms of Reference.

6. Family Involvement

6.1 Ms L's mother has been involved in the Review process from the outset; she met with the Overview Report author and had input to the Terms of Reference. She has provided a pen picture of her daughter and shared some of Ms L's reflections. Ms L's mother has discussed different aspects of her daughter's care with the Overview Report author and has read and commented on the final version.

6.2 An independent specialist advocate from AAFDA (Advocacy After Fatal Domestic Abuse) has provided support to Ms L's mother since December 2018 and throughout the Review process.

6.3 The South Worcestershire Community Safety Partnership wish to register its appreciation to Ms L's mother and extend its condolences for her loss.

7. Parallel Proceedings

7.1 There were no criminal proceedings following the death of Ms L. The Inquest into her death was postponed until October 2021 and the Individual Management Reviews and Overview Report of this Domestic Homicide Review were made available to the Inquest.

7.2 The Coroner returned a verdict of suicide but also recorded in his finding that Ms L was "found unconscious in her home address. [Mr P], who Ms L had formed a relationship with over the preceding months, was present when she died. Ms L had likely been subject to coercive and controlling behaviour. Ms L was pronounced deceased by paramedics."[1]

8. Equality and Diversity

8.1 The nine protected characteristics identified in the Equality Act 2010[2] were assessed for relevance to the DHR. The subjects of this review are both white British citizens.

8.2 The characteristics of disability and sex were discussed by the DHR Panel, and the potential vulnerabilities because of mental health issues and drug and alcohol abuse were recognised by Agencies working with Ms L and Mr P.

[1] This wording is taken from the Record of the Inquest.
[2] The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual orientation.

8.3 From the evidence available it would seem that mental health crises and criminal behaviour tended to obscure the signs that domestic abuse was taking place.

9. Summary Chronology.

9.1 Ms L became a voluntary in-patient in a community-based in-patient rehabilitation unit[3] in late April 2018.

9.2 Mr P was already an in-patient when Ms L became a service user. He had transferred 7 weeks earlier having previously spent 14 months in another rehabilitation facility. He was moved between establishments due to inappropriate behaviour towards female staff. Staff had questioned his suitability however a lack of alternative resources meant there was no other appropriate placement for him.

9.3 Following the commencement of her relationship with Mr P and discharge from The Unit in June 2018, patterns of behaviour emerge which have a bearing on Ms L's life with Mr P in the 4 months preceding her death. Firstly, her engagement with Health Services, and Mental Health Services in particular, becomes fragmented and sporadic.

9.4 Mr P. displayed behaviour that suggests he was both controlling and needy. The seriousness of his own mental health and addiction problems added to Ms L's stress levels through her attempts to accommodate his needs and support him. On one occasion Ms L had complained to a Substance Misuse Worker at an Alcohol and Drug Service (where Mr P had been referred) that supporting Mr P was "wearing her out". On several occasions, Ms L's possessions were taken and sold to buy alcohol or drugs for Mr P.

9.5 Mr P proved to be a malign influence leading to Ms L becoming involved in minor offending and causing problems with her relationships with her neighbours and with her family. In the period under review, Ms L came to the attention of the Police on 11 separate occasions for minor offences ranging from criminal damage and assault through to concerns about her being missing and her vulnerability.

9.6 Agencies had concerns about domestic abuse but these were never progressed and acted on. No agency was able to explore these concerns with Ms L. The reasons for this appear to be twofold; firstly because the evidence of domestic abuse was only noticed at the same time as other concerns about criminal behaviour or underlying mental health problems, and these took precedence. Secondly, there

[3] This Unit is a recovery unit for service users deemed to require a period of extended assessment and treatment as part of their recovery from an acute episode of illness. Referrals come from in-patient wards as well as from the community. It is a mixed sex facility, bedrooms for males and females are segregated on different floors. Service users could mix and socialise in communal areas but not in individual bedrooms.

were no multi-agency discussions about the concerns about domestic abuse. The appropriate multiagency forum would have allowed agencies to assemble the pieces of evidence about the risks inherent in the relationship with Mr P and consider the concerns Ms L's mother had expressed to The Unit and the GP's surgery.

10. Analysis.

10.1 The Recognition of Domestic Abuse.

10.2 While there may have been concerns about Mr P's presentation and demeanour when he had been engaged with rehabilitation services, staff at The Unit were only aware of the concerns about him and inappropriate behaviour towards a female member of staff. They were not aware of his history of domestic abuse offending towards his ex-partner and children. Therefore, concerns did not extend as far as considering the risk of mental or physical abuse.

10.3 A key question for this Review has been to understand the reasons why Ms L and Mr P were in The Unit at the same time. The Independent Management Review from the Mental Health Services makes the point that there was no clinical reason why either Mr P or Ms L should not be offered a place at The Unit, but it should have been known to them that Ms L had been described by one of their services as extremely vulnerable to exploitation from others.

10.4 Staff at the Unit had expressed concern about the decision to move Mr P to The Unit (because of complaints about his behaviour towards a female member of staff, lack of compliance with treatment and increasing disengagement). These concerns did not foresee the possibility of an inappropriate relationship forming with another patient.

10.5 Given Ms L's vulnerability this Review has carefully considered whether there were any opportunities for staff in The Unit to intervene to prevent the relationship from developing. However, it must be recognised that Ms L and Mr P had the right to form a relationship, and no one had the right to stop them.[4] They knew the staff at The Unit did not approve of the relationship; as they both denied its existence for a while and much of it was carried on away from The Unit itself.

10.6 Staff at The Unit recognised there was a risk that Ms L would become less engaged with her treatment as she spent more time with Mr P.

10.7 After they were both discharged from The Unit it was difficult to keep track of their whereabouts: Mr P should have been residing in a different town 30 miles from where Ms L lived, although he frequently

[4] The potential use of the Domestic Violence Disclosure Scheme and its use in this case is discussed below.

did not stay there and spent part of the time with Ms L. The fact that he would seemingly come and go at will, arrive uninvited and sell her possessions strongly suggests that she had no control over the relationship.

10.8 Reports of domestic abuse to the Police usually resulted in mutual allegations. There are five recorded incidents relating to a dispute between them; one of these related to an assault by Ms L on Mr P, one concerned an allegation that Ms L had Mr P's wallet, two concerned criminal damage caused by Mr P breaking into Ms L's home and one where Ms L complained that Mr P was making her sell her property and keeping the money to buy drink and drugs.

10.9 On every occasion it is clear from the reports that Ms L was extremely distressed and trying to calm her and alleviate her distress was the priority of the Police Officers who attended. On one occasion she was arrested for assault after pushing one of the Police Officers who attended an incident.

10.10 Ms L did not herself recognise that she was the victim of domestic abuse, and there was little evidence to suggest that Mr P had been physically violent to Ms L although there was evidence to show that he was exerting coercive control over her and subjecting her to economic abuse. At various times she complained to the Police and her GP that Mr P was taking her possessions and was "pestering" her. Similar complaints were made to other services on different occasions. Equally, she would report that he was "sick" and needed help.

10.11 The abusive behaviour towards Ms L included controlling her use of her phone, selling her possessions, threatening violence towards her and her family and taking her money.

10.12 The degree of Coercive Control was concealed by several factors; the mental health issues which often presented as crises when the Police were involved (other agencies were only partially aware of the incidents when they were reported by Ms L after the event had taken place).

10.15 The Relevance of the Domestic Violence Disclosure Scheme (Clare's Law).

10.16 The Domestic Violence Disclosure Scheme – commonly known as Clare's Law, is a process which allows the Police to share information about the background of a potentially violent partner with a person they are in a relationship with. The usual route for sharing information would be following a request from an individual to the Police to disclose information about the offending history of the person they were in a relationship with, this is known as the "right to ask."

10.17 There is also a second pathway known as the "right to know" where the Police can take the initiative to disclose information to warn an individual about a potential threat.

10.18 The provision of information does not in itself provide protection; however, it may prompt the potential victim to seek additional help and support. The Police have confirmed that concerning Mr P they held relevant information which they would have disclosed if they had received a request. Ms L was not encouraged by the Police or any other Agency to make an application.

10.19 The information that Ms L had about Mr P's past offending came from him and did not include any information about the convictions for violence against his previous partner. However, had the Police informed Ms L of Mr P's past offending she may have made efforts to end the relationship and seek a place of safety.

10.20 Although the Police had identified that Ms L and Mr P were in a relationship as early as 13th July (when the Police were called to a disturbance in a pub) she would often deny the fact and refer to Mr P as her "friend", and at no time did they ever officially share the same address. Also, the Police had no records of violence by Mr P towards Ms L, although Ms L's mother had seen evidence of this and Ms L had admitted to her that Mr P had assaulted her by strangling and causing bruising to her neck. He had damaged her property and they were aware that she had disclosed to medical staff that he had made her sell most of her property and then stolen the money from her.

10.21 Effectiveness of DASH Risk Assessments.

10.22 The DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) Assessment Tool is a standardised risk assessment questionnaire used by all UK Police forces and other agencies who work with victims of domestic abuse. The questions are used to identify, assess and manage risk. Depending on the number of risk indicators identified, the level of risk is assessed as standard, medium or high. There is also scope for those undertaking a DASH risk assessment to use their professional judgement to determine the level of risk. All high-risk DASH assessments are reviewed by the Domestic Abuse Risk Officer (DARO) who has the discretion to amend the initial designation of the level of risk.

10.23 All incidents assessed as high risk are automatically referred to the MARAC (Multiagency Risk Assessment Conference), this is where local agencies meet to discuss the highest-risk victims of domestic abuse in their area. Referrals to MARAC can also be made where there are several lower-risk assessments made in a short period. People discussed at the MARAC would usually have an action plan developed to offer

them protection from their abuser and be contacted by organisations that could offer further support and help in keeping them safe.

10.24 Ms L was the subject of four DASH risk assessments in a relatively short period between mid-July and mid-August, including two high-risk referrals made within 48 hours of each other. However, none of these referrals resulted in a referral to the MARAC. The DARO reduced the risk assessment to medium for several reasons; Ms L stated that she had separated from Mr P, Ms L's previous arrest for assault on Mr P and her further assault on her mother which occurred whilst the DARO was attempting to find a place in a refuge for Ms L.

10.25 The reassessment of risk by the DARO was a missed opportunity to consider the ongoing risks of domestic abuse in the context of mental health problems. The initial Police response was crucial in determining how Ms L would be treated; if she was recognised as the victim of domestic abuse, then there would be a referral to the MARAC and probable referral to agencies who could support her in separating from Mr P. However, if she were considered mentally ill, the issue would be whether she had the mental capacity to be held responsible for her actions. On several occasions, the Police faced this dichotomy and concluded that Ms L's mental health issues took precedence over the consideration of domestic abuse.

10.26 The operating protocol for the MARAC allows agencies to identify relevant cases in several ways. While the DASH assessment is the standard screening tool used by the Police and other agencies, it is also possible to make a referral based on the professional judgement of the person in contact with the victim, combined with this it is possible to escalate a referral because of the number of callouts to a victim. However, while the police officer (in this case) believed that discussion at MARAC would be helpful once these decisions were reassessed by the Domestic Abuse Risk Officer (DARO) there was no further questioning of this decision.

10.27 The advice from the Vulnerability and Safeguarding Team within the Police is that there should always be a referral to the Adult Safeguarding Team where the Police feel there is a significant risk of domestic abuse even in cases where the threshold criteria for discussion at MARAC are not met.

10.28 In Ms L's specific case a multiagency discussion could potentially have looked at barriers to her engagement; such as her relationship with mental health workers, her attitude towards the Police and the influence of Mr P and considered other ways of reaching out to her to offer support.

10.29 An important caveat to this is that under the Care Act 2014, Ms L would have been assessed as having the capacity to make decisions about

herself, and at this particular time in her life (August 2018) she did not recognise the relationship with Mr P as abusive.

10.30 Suicide and Self-Harm.

10.31 Before the fatal overdose that ended her life, Ms L had taken an overdose of prescribed medication approximately 18 months previously. This was a serious attempt at a time when Ms L was extremely depressed and unhappy about the effects of the prescribed drugs she was taking and she did not feel she was being listened to by the doctors treating her.

10.32 Ms L was not a user of illicit drugs and except for the one attempt 18 months previously, she had never attempted self-harm or suicide. She was not considered a suicide risk by mental health professionals.

10.33 Missing appointments, loss of contact with services and failing to take medication regularly are significant causal factors that contribute to suicide and self-harm. There is a risk that vulnerable service users like Ms L will fall through the net when they transfer to the care of Community Mental Health Teams.

10.34 Mr P's history of suicidal thoughts and actions was significantly different to Ms L's; he had a more extensive history of suicide attempts and self-harming episodes. In addition to taking overdoses of medication, he had also cut himself, refused medical treatment and threatened to jump into the river and in front of a train. In contrast, Ms L was not an illicit drug taker and she did not regularly attempt suicide as Mr P did.

10.35 Ms L's family discounted the idea of a suicide pact between her and Mr P. Recent conversations had suggested that she was in a positive frame of mind. They believe that it is more likely that Mr P coerced Ms L to take the drugs and to write suicide notes. In the family's opinion, they believe that the language used in the notes suggests that they were dictated by him to Ms L. The family are also aware that Ms L had a morbid fear of needles they believe that it is unlikely that she would have injected herself, but would have been assisted by Mr P.

10.36 Working with people who struggle to engage.

10.37 Ms L's discharge from The Unit and transfer to the Community Mental Health Team was a strategy that inevitably increased the degree of risk. Due to her history of taking medication erratically because of the side effects that she experienced from taking these drugs and the relationship with Mr P, difficulties in engaging with Ms L were to be expected. Difficulties emerged almost immediately when she complained about the lack of support the day after her discharge.

10.38 Ms L was assumed to have the capacity to make decisions about her care, further treatments or therapy could only be delivered with her cooperation. In this case, it was suggested to Ms L that she take - a

further period of home leave from The Unit rather than discharge herself. This strategy would have kept her "in the system" and may have been beneficial if it had been combined with an active strategy to reengage her with community services and address problems as she saw them.

10.39 In the context of supporting Ms L the negative influence of the relationship with Mr P was key. His personal history with services shows that he was generally non-cooperative and anti-authority. His attitude supported Ms L's reluctance to engage, and it is difficult to see how her suspicions and reluctance to engage with services could be overcome while the relationship with Mr P endured.

10.40 Mental Health and Crime.

10.41 The Police have documented that during the period under review, they were involved with Mr P on 16 separate occasions, with Ms L on 11 separate occasions and jointly on 5 occasions.[5] While this volume of contact was not unusual for Mr P, it was significantly higher for Ms L and was undoubtedly due to her relationship with Mr P. Before this relationship, Ms L had only come to the attention of the Police when she was mentally unwell and she did not have a criminal record.

10.42 Ms L's behaviour continued to pose a dilemma for the Police, arresting her and processing her as a criminal seems heavy-handed and disproportionate when she was unwell. Although on one occasion Ms L behaved in a way where it seemed that she intended to provoke the Police Officers into arresting her. The possibility of detaining Ms L under section 136 of the Mental Health Act[6] could have been considered.

10.43 It would seem that no consideration was given to the fact that the domestic abuse that Ms L was suffering from Mr P was possibly affecting her mental health. This may also have been exacerbated when she felt she was receiving no support from agencies including the Police which resulted in aggressive behaviour borne out of frustration rather than aggression towards anyone else.

10.44 Mr P also posed complex problems for the Police. On one occasion he broke into Ms L's bungalow, injuring himself on a broken window in the process. When the Police attended, he injured himself further with

[5] Mr P was reported for incidents which included offences of damage, public order, theft, vulnerable adult incidents (where he attempted to or stated he wanted to end his life) and missing episodes.
Ms L was reported for offences of criminal damage, assault, disorder missing episodes, vulnerable adult incidents and concerns for her welfare.
The five recorded joint incidents involve disputes over property, one alleged assault by Ms L on Mr P, to incidents of criminal damage caused by Mr P on Ms L's property and Ms L disclosing coercion and economic abuse.

[6] S136 of the Mental Health Act 1983 allows the Police to remove a person to a place of safety if they appear to be suffering from a mental disorder.

broken glass and was taken to hospital for treatment. Ms L was not home at the time of the incident the Police Officers in attendance recognised the potential link to domestic abuse and recorded it as such, although they did not contact Ms L at the time.

10.45 However, the Harm Assessment Unit (HAU) considered that the incident related to Mental Health rather than Domestic Abuse. Ms L declined to pursue a complaint concerning the damage at that time and no further action was taken. However, it would seem that her decision was made initially before she had seen the damage to her property and she subsequently contacted the Police, complaining that she was having issues with Mr P. She recognised Mr P needed help and that he needed to be in hospital. The Police advice on this occasion was that she could make a complaint about the damage, but Mr P's mental health issues would make a successful prosecution unlikely.

10.46 Further indications of domestic abuse would become known following a disturbance at the offices of the Community Mental Health Team. Having been removed from the premises Ms L informed the Police Officers she was having issues with Mr P and that he was forcing her to sell her property and kept the money for himself. The Officers attending identified the potential for domestic abuse and completed a DASH risk assessment and graded this as high risk[7].

10.47 Further incidents would occur at her home address involving arguments between Ms L and Mr P. Ms L was consistent in saying that she wanted the relationship to end, that Mr P was not well and needed to be in hospital and that he would not leave her alone. Ms L had now repeated that she wished Mr P would leave her alone on at least 3 occasions. She had also stated she was afraid of what he would do after she had kicked him out. A further DASH assessment was undertaken which assessed the risk as high, but the assessment was changed after review by the DARO. Ms L also consented for information to be shared with partner agencies.

10.48 Within a few days Ms L would again be arrested for a minor assault on her mother when she pulled a necklace from her neck. Ms L was staying with her mother after the damage caused to her property by Mr P and she felt unsafe staying at her property alone.

10.49 The records show an escalation in Ms L's distress which sometimes manifested itself in aggressive behaviour when she became frustrated because she felt she wasn't being listened to. There are several contributory factors to this that should have been considered, she was no longer taking her medication, she was upset and frightened by Mr

[7] A high risk designation would automatically lead to a referral to MARAC (Multiagency Risk Assessment Conference) a meeting where information is shared on the highest risk domestic abuse cases between relevant agencies.

P's behaviour, she had fallen out with her mother, the plans to move her to a refuge had fallen through and she was feeling unsupported. Her distress and mental health needs were obvious, they subsumed all consideration of domestic abuse and safeguarding.

10.50 Domestic Abuse, Mental Illness and Substance Misuse.

10.51 Ms L was assessed as either mentally ill or the victim of domestic abuse there was a failure to recognise that she could be both at the same time. In addition, there is a cumulative risk of harm when these factors coexist. In Ms L's case, there were additional factors recorded in her medical records such as adverse childhood experiences and social isolation which were also relevant. Ms L's presentation when she was ill made her difficult to engage and work with her. Equally, it was difficult for her to approach services of her own volition when she was ill.

10.52 On one occasion the Police explicitly described Ms L's status as changing from victim to offender after she pushed a Police officer and was arrested for common assault, which took the focus away from the reason the Police had been called in the first place and her needs as a possible victim not properly established at the time or subsequently.

11. Conclusion.

11.1 The fundamental issue in considering the circumstances leading to the death of Ms L Is the process whereby responding to her mental health needs inadvertently prevented the recognition that she was the victim of domestic abuse perpetrated by Mr P. The relationship was a cause of concern to professionals when they became aware of it.

11.2 Mr P needed support from Mental Health Services in his own right and was unwell for significant periods. He did not engage well with Health agencies or other services who attempted to help him. At times, his behaviour was recognised as manipulative; on several occasions he seemed to be using his knowledge of the mental health services to avoid the consequences of his criminal behaviour.

11.3 Ms L's family consider the decision to place her in the same unit as Mr P was unsafe and given the evidence of his recent inappropriate behaviour towards a female member of staff, his criminal record including offences of domestic violence and rape and the previously expressed concern about Ms L's vulnerability to exploitation the potential for an abusive relationship to develop should have been considered.

11.4 Given Ms L's history and diagnosis, the lack of engagement with services was an additional risk factor. Agencies need to collaborate in

cases of domestic abuse to better understand the specific risks and indicators. There had been no attempt to identify a primary perpetrator and the response to Ms L and Mr P did not recognise that their relationship was continuing.

11.5 There were missed opportunities to raise and share concerns about the ongoing risks to Ms L of being in a relationship with Mr P.

12. Lessons learned.

12.1 Where there are multiple referrals for a person with known mental health problems to the Police there should be earlier consultation between Police and Mental Health Services before deciding the most appropriate way to respond. The current guidance is not conducive to a holistic assessment as it deals with specific incidents and therefore views incidents in isolation rather than as a pattern of behaviour.

12.2 Non-specialist agencies need the training and support to be able to recognise conditions and be able to access information and guidance on the most appropriate way to speak to and engage people who have problems with mental health. For example, as a person who may have had Asperger's Syndrome, Ms L may have experienced difficulty in showing empathy or insight as to the consequences of her behaviour. She may also have struggled with speculative questions asking her what she thought should happen.

12.3 Complaints of coercive control and economic abuse should always be thoroughly investigated and recognised as aspects of domestic abuse.

12.4 Remaining in contact with vulnerable service users who are reluctant to engage has serious resource implications and it must be recognised that resources are not infinite. However, there is a recognised increased risk of self-harm when a person loses contact with services and does not comply with their medication[8]. The Unit did attempt to stay in contact with Ms L but she would not engage with them.

12.5 There were some missed opportunities to identify that Mr P and Ms L were in a relationship. Given the historical concerns about his behaviour and her vulnerability, it was important to share this information between Agencies, in this case, the Police and mental health services.

[8] Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide

12.6 Agencies should consider supporting the service user to access the Domestic Violence Disclosure Scheme where there are concerns about a vulnerable service user entering into an inappropriate relationship.

13. Cross-reference with other DHR's

13.1 At the same time as this review was undertaken a second DHR in Worcestershire was being completed. They share similar lessons; in both cases, one of the conclusions reached was that the presence of mental illness masked the evidence that domestic abuse was taking place. A second common theme was the reassessment and effective down-grading of the risk analysis of DASH assessments.

13.2 The two DHR's took place in different parts of the County and involved different professionals, the events leading to the commissioning of the DHR's also took place 12 months apart. The fact that the same issues arose reinforces the recommendations for raising awareness of the complexities and different approaches which are needed when people with mental illnesses suffer domestic abuse.

14. Recommendations.

14.1 The Review Panel has noted that several of the issues raised by this Review including the Domestic Violence Disclosure Scheme, Domestic Abuse Protection Notices[9] and issues of economic abuse will be affected by the passing into law of the Domestic Abuse Act 2020. A wider and more encompassing definition of Domestic Abuse may assist Agencies in recognising and responding to cases such as Ms L in the future.

14.2 The recommendations made by this Review reflect the legislation and statutory responsibilities in place in November 2020. They should be reviewed in light of the new legislation when it becomes law.

14.3 In particular agencies are ensuring that their internal policies and procedures reflect the updated comprehensive statutory definition of domestic abuse. Agencies will also need to have training strategies in place to disseminate these changes to their staff.

14.4 Of particular relevance to this Review will be the revisions to the definition of economic abuse and coercive control. Economic abuse will include damage to the victim's property as well as control of the

[9] The Bill will repeal the current Domestic Violence Protection Notices (DVPN's) and Domestic Violence Protection Orders (DVPO's) and introduce a new civil Domestic Abuse Protection Notice (DAPN) to provide immediate protection following a domestic abuse incident, and a new civil Domestic Abuse Protection Order (DAPO) to provide longer-term protection for victims.

victim's mobile phone. Coercive control is now defined as existing between people who are "personally connected;" there is no requirement for the individuals to be living together.

14.5 The guidance on the Domestic Violence Disclosure Scheme (Clare's Law) will also become statutory guidance, in Ms L's case this may not materially have changed the Police action, and there is no evidence to suggest that she was aware of her "Right to Ask". However, the "Right to Know" enables the Police to make a disclosure on their own initiative and with the additional clarity provided by the changes to the Domestic Violence Disclosure Scheme there is a clear framework for how this is done and under what circumstances.

Recommendations for all Agencies.

14.6 The constituent partner Agencies of the South Worcestershire Community Safety Partnership should review the advice given to:

a) Agencies when responding to domestic abuse concerns where there are known risks of mental illness and substance misuse.

b) The public through online communication and links placed on Agency websites and elsewhere. The South Worcestershire Community Safety Partnership should review its use of social media and print media and seek to identify opportunities of raising the level of public awareness about domestic abuse.

14.7 The impact of the current training regarding the Domestic Violence Disclosure Scheme should be audited to ensure that the learning is embedded in practice.

14.8 The South Worcestershire Community Safety Partnership should review the information available about the Domestic Violence Disclosure Scheme and ensure that guidance for professionals and leaflets to raise awareness generally are available.

14.9 All Agencies and commissioners of services should review existing Re-Engagement Policies with the aim of identifying and reaching out to service users who have found it hard to engage for whatever reason.

Agency-Specific Recommendations.

Police.

14.10 Modifications to DASH risk assessments made by Domestic Abuse Risk Officers (DARO's) should be referred back to the Officers responsible for the original assessment to explain why the change was made and to ensure that this is a safe decision. Frontline officers should be made

aware of the mechanisms for escalating concerns to the MARAC if this is warranted in their professional judgement.

14.11 Training on the impact of domestic abuse, substance misuse and mental health should be provided for frontline Officers to raise awareness of these complex issues.

Cranstoun Worcestershire.

14.13 Share learning regarding the importance of recording a service user's partner's name in sessions for future identification and support purposes.

14.14 Share learning regarding the importance of having a clear re-engagement plan for service users who are NFA (No Fixed Abode) or rough sleeping, as per Service Engagement Policy. Identify any training requirements for staff on this issue.

14.15 Ensure that all staff are aware of the importance of sharing and corroborating information provided by service users where there is an indication of domestic abuse.

Clinical Commissioning Group.

14.16 Surgeries should consider adding an alert to patient records when a trusted agency reports the potential risk of abuse/violence to either staff or other service users.

14.17 The GP practice to consider reviewing their protocol in respect of relatives phoning on behalf of patients concerning the potential risk of coercion and control.

14.18 All staff who have face-to-face contact with patients and service users should undertake learning activities connected to domestic abuse training.

Appendix 1

Terms of Reference

Terms of Reference
Case 16 – March 202