St Helens Community Safety Partnership

Domestic Homicide Review

Overview Report

Report into the death of Emma (pseudonym)

March 2019

Author and Domestic Homicide Review Chair - Stephen McGilvray 2020

Contents

Glossary

CCG Clinical Commissioning Group.

CGL Change Grow Live (provider of substance misuse services).

CPA Care Program Approach. Support for patients who have a long enduring mental health condition or those who have a range of complex needs which require the support from secondary mental health services to support and co-ordinate their care.

DHR Domestic Homicide Review.

IDVA Independent Domestic Violence Advocate. Is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies.

IMR Independent Management Review

MARAC Multi Agency Risk Assessment Conference. This a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

MASH Multi Agency Safeguarding Hub. Co-located agencies formed to provide the highest level of knowledge and analysis of all known intelligence and information across the safeguarding partnership to ensure all safeguarding activity and intervention is timely, proportionate, and necessary.

MeRIT Merseyside Police domestic violence risk assessment tool

Non-CPA Utilised when a patient does not require a full CPA approach however continues to require support and monitoring from services for their treatment and recovery.

Risk Assessment Grades.

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

S.I.Review Serious Incident Reviews. Completed by National Health Service. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse. Investigations carried out under this Framework are conducted for the purposes of learning how to prevent a recurrence.

VPRF1 Vulnerable Person Referral Form.

Foreword

The Panel wish to express their deep condolences to Emma's son's, her sisters and her friends. The Panel also wish to thank them for their assistance in completing this Review which was so valuable and helped inform the work of the Panel. It was clear this support was provided by Emma's family in the hope that it could help prevent other families suffering a similar tragedy.

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Independent Author: Stephen McGilvray 2020

1. Introduction

1.1 This domestic homicide review examines agency responses and support given to Emma, a resident of St Helens prior to the point of her murder in 2019.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 In 2019, Merseyside Police received a telephone call from Dean's sister following an earlier call she had received from Dean who was in a distressed state advising her that something had happened to Emma who was in a bedroom at his home.

1.4 Police Officers attended Dean's home and found Emma dead in an upstairs bedroom. She had suffered multiple stab wounds. Dean was arrested at the scene and taken into Police custody. He was later charged with the murder of Emma.

1.5 Dean pleaded guilty to the murder of Emma when appearing at Liverpool Crown Court in June 2019 and was sentenced to life imprisonment with a minimum term of 18 years

1.6 The review will consider agencies involvement with Emma and Dean from the start of their relationship in 2018 until Emma's murder in 2019.

2. Timescales

2.1 In March 2019 Merseyside Police notified St Helens Community Safety Partnership of the fatal incident. Members of the Community Safety Partnership agreed that a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016 was required. The Home Office were notified of this decision.

2.2 As a result of the Community Safety Partnership decision the Chair of the DHR Panel was commissioned in March 2019. However, at the request of the Senior Investigating Officer commencement of the Independent Management Reviews was not undertaken until conclusion of the Criminal Justice process.

2.3 The DHR Overview Report was ready for submission to the Home Office for quality assurance purposes in November 2019 however the Panel were cognisant of the fact that a Serious Incident Review (S.I. Review) was being undertaken by the North West Boroughs Health Partnership (NWBH) the provider of mental health services in St Helens and that some key issues were common to both Reviews. Advice was sought in December 2019 from the DHR Enquiries Team at the Home Office on delaying submission of the DHR Report to await the S.I. Review publication so as to enable relevant findings from that Review to be incorporated into the DHR

Overview Report. Home Office advice was that the DHR Report should be delayed to facilitate this.

2.4 On 29th April 2020, permission was given by NWBH for the S.I. Review completed in respect of Emma to be released to the DHR Panel.

2.5 As anticipated elements of the S.I. report are relevant to the DHR and these have been included within this Overview Report. Following amendment to the DHR Overview Report Stephen McGilvray again contacted Emma's family and shared with them the amended copy of the completed Overview Report.

2.6 At the end of June 2020 details of the DHR Panels findings were shared with the St Helens People's Board which includes senior members of the CSP and Safeguarding Boards. The People's Board approved submission of the DHR Overview Report to the Home Office for quality assurance.

3. Confidentiality

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

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

Emma	Deceased	Aged 46 years
Dean	Perpetrator.	Aged 47 years

3.3 Emma and Dean were partners. Both are white British adults with English as their first language.

3.4 This Review does contain relevant sections from the S.I. Report completed in respect of Emma. However, Dean refused permission for the S.I. report exploring how he was managed by Health Services to be shared. Those wishes have been respected and Dean's S.I. review remains confidential and does not appear anywhere within this Review.

4. Terms of Reference

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

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

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

A. The extent of Control Dean imposed upon Emma within their relationship.
B. How effective in terms of communication and identifying risk in domestic abuse cases were the pathways between agencies.
C. The role of mental health services in responding to domestic abuse within Emma and Dean's relationship.

5. Methodology

5.1 Having received notification from Merseyside Police of the fatal incident. Members of the Community Safety Partnership agreed that a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016 was required. The Home Office were notified of this decision.

5.2 At the commencement of the Review the Chair met with and interviewed members of Emma's family, two sisters and one of her older children. At this time the family raised with Stephen McGilvray several issues and questions they had surrounding the murder of Emma and the support she received from agencies prior to the murder. These issues helped to inform the key lines of enquiry which the Panel reviewed.

5.3 Panel members were asked to provide chronological accounts of their agencies contact with Emma and Dean prior to the murder. Where there was no involvement or insignificant involvement, agencies advised accordingly.

5.4 Having reviewed the questions raised by Emma's family and the chronological accounts provided by Panel members agreed the key lines of enquiry the Review should focus upon.

5.5 Agencies completed Individual Management Reviews (IMR) and each IMR covered the following areas: A chronology of interaction with Emma and Dean, and their families; what was done or agreed; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view. Whilst completing the IMR Panel Members interviewed colleagues who had direct contact with Emma or Dean.

5.6 The Review also includes sections taken from the S.I. Review relating to Emma which had been completed by NWBH.

6. Involvement of Family and Friends, Work Colleagues, Neighbours, and Wider Community.

6.1 Before the first meeting of the DHR Panel a meeting was held between Stephen McGilvray and the family of Emma. A copy of the Home Office DHR leaflet for Family and Friends was given to each of the family members at this first meeting. It was established that the family were supported by Victim Support Homicide Service however, the family did not wish them to attend the meeting. The family did provide a file in which they had detailed key events in Emma's life and a series of questions they had of agencies surrounding the care and support Emma had received prior to her murder. The questions focussed upon the duty of care and a lack of action afforded to Emma when incidents had been disclosed by Emma to care agencies, and when matters were raised with those services by the family themselves.

6.2 Whilst the family did not attend the Panel meetings regular meetings and updates were held between the Chair of the Review and the family and issues the family raised at the first meeting as well as progress of the DHR Panels work formed the basis of each meeting.

6.3 Following meetings with the family the advocate from Victim Support Homicide Service was contacted and updates on the progress of the Review and meetings with the family were provided. However, the Victim Support Homicide Service did not provide advocacy for the family at Panel meetings nor at meetings between the Chair and the family.

6.4 NWBH undertook two S.I. Reviews, one for Emma and one for Dean, parallel to this DHR and there were several areas in which the key lines of enquiry for both reviews crossed over.

6.5 Advice was sought from the DHR Enquiries Team at the Home Office over the question of delaying submission of the DHR Overview Report to enable relevant

parts of the S.I. Review to be incorporated into it. Home Office advice was that it should. At this point Stephen McGilvray met the family of Emma and explained the Home Office decision and the delay to completion of the DHR. The outcome of the DHR Panel work so far was shared with the family and agreement reached that following publication of the S.I. Reports and any amendment to the DHR Overview Report Stephen McGilvray would again meet with Emma's family and share with them the final Overview Report prior to forwarding it to the Home Office.

6.6 The Serious Incident Review in respect of Emma was made available to the DHR Panel at the end of April 2020 who then agreed to incorporate relevant elements of the S.I. Review within the DHR Overview Report. Dean refused permission for the S.I. Review relating to him to be shared and none of its contents have therefore been incorporated within this Overview Report.

6.7 Following amendment, by including elements of the S.I. Review within the final version of the Overview Report, a further meeting did take place and the Overview Report was again shared and discussed with Emma's family prior to the submission of the Overview Report to the Home Office for quality assurance.

7. Contributors to the Review

7.1 The following agencies contributed to this Review through their presence at Panel meetings and by the completion of Independent Management Reviews (IMR).

- Merseyside Police
- North West Boroughs Healthcare (Mental Health Services)
- St Helens Clinical Commissioning Group
- Torus Housing
- Adult Safeguarding St Helens MBC.

7.2 All authors of the IMR's were independent and had played no part in the provision of services to either Emma or Dean or in the supervision of those providing services to them.

7.3 Making Space, the 3rd Sector providers of support to Emma, were present at the first meeting of the Panel and provided information regarding their processes and contact with Emma. Adult Safeguarding provided independent chronological information and IMR information on behalf of the 3rd Sector provider.

7.4 Following the initial meeting the Panel Members reviewed membership of the Panel but felt that there were no agencies absent from the group who could make a contribution to the work of the Panel.

8. Panel Members

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

- Stephen McGilvray. Independent Chair of DHR Panel and Author of the Overview Report.
- Beverley Hyland. Detective Chief Inspector, Merseyside Police.
- Neil Fairhurst. Manager Torus Group (Communities Housing).
- Jacquie Byrne. Manager Torus Group (St Helens IDVA Independent Domestic Violence Advocate Service provider).
- Jackie Hodgkinson. Northwest Boroughs Healthcare Mental Health Safeguarding Officer.
- Nina Ellament. Principal Solicitor Peoples Services St Helens MBC.
- Helen Newton. Safeguarding Officer, St Helens Clinical Commissioning Group.
- Dr. Michelle Loughlin. St Helens MBC, Assistant Director Public Health.

- Rachel Fance. Manager, Change Grow Live (Substance Misuse Service provider).
- Beverley Jonkers. St Helens MBC Community Safety Partnership.
- Simon Cousins. St Helens MBC Equalities Officer.

15. Chair of the Review Panel and Author of Review Report.

15.1 St Helens Community Safety Partnership commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in December 2019. Stephen McGilvray is also the author of this Overview Report.

15.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years but he has never been employed by St Helens MBC. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children. During the period this unit was under Stephen's management the team achieved CAADA Leading Lights accreditation for the quality of its systems and risk management processes.

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

15.4 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 16 years ago that Stephen

retired from Merseyside Police and it is 41 years since he worked as a Police officer in St Helens.

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

16. Parallel Reviews

16.1 Two reviews were held parallel to this Review.

16.2 A 72 Hour NHS Internal Review took place examining the treatment and care of both Emma and Dean. This has been shared with CCG and DHR Panel members.

16.3 The 72 Review Recommended that a S.I. Review be undertaken in respect of both Emma and Dean. The S.I. Review regarding Emma was completed and made available to the DHR Panel in late April 2020. That review contained the following terms of reference.

- To investigate gaps in care/service provision and/or policy which had causal effect or were contributory to this incident
- To identify any contributory factors using Trust policies and procedures, NICE guidance and/or best practice guidance, establishing any actions for lessons learned
- To liaise with the service and/or family to answer any questions they have in relation to care and treatment
- To consider system factors that could have been contributory or causal (for example workforce issues, capacity and demand, training, supervision, cultural issues in the team)
- To highlight areas of good practice

- To analyse findings and make recommendations for action to ensure learning is embedded
- To understand the scope of the service delivery for the Recovery team within the context of Emma's mental health presentation?
- To explore the decision-making process in the downgrading of Emma's CPA (Care Programme Approach) status from CPA to non-CPA and whether this was shared with the other organisations involved in supporting Emma?
- Was there any evidence to suggest that the clinical team were aware of Emma's risk of vulnerability and risk of domestic violence and was this appropriately managed?
- Were any other organisations involved with Emma's care aware of the risk of domestic abuse and if so was this appropriately escalated?
- To understand what escalation plans were in place in case of relapse with the organisations involved in Emma's care and identify if these were appropriate and followed

17. Equality and Diversity

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

17.2 During the work of the Panel no challenges had to be made by the Chair to agencies for a breach of equality standards.

17.3 All protected characteristics contained within the Equalities Act were considered throughout this review process including age, gender reassignment, being married or in a civil partnership, pregnancy or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex, sexual orientation. To ensure the review process considered issues around domestic abuse the panel included representatives specialising in domestic abuse.

17.4 The victim of this murder was female and it is clear that during the relationship Emma was subject to discrimination, as defined by The Equalities Act 2010 on the grounds of her gender and her disability by her male partner Dean.

17.5 Both Emma and Dean had mental illness diagnoses. Emma was diagnosed with Emotionally Unstable Personality Disorder and was subject to a Care Program Approach, outpatient's support. Dean has been diagnosed as suffering from Bipolar Affective Disorder which was managed by his G.P.

17.6 "*Women with mental health problems are more likely to be domestically abused with 30-60% of women with a mental health problem having experienced domestic violence*" (a). The Panel recognised the intersectionality barriers Emma faced in her life specifically the interaction of barriers relating to gender, domestic abuse and physical and mental health *"having mental health issues can render a person more vulnerable to abuse"* and people with mental health needs "*were more likely to have experienced different types of abuse*" (b). As the analysis section of this report will show Emma was the victim of physical abuse. Jealousy and controlling behaviour and sexual abuse at the hands of the perpetrator Dean.

18. Dissemination

18.1 In accordance with paragraph 79 of the Statutory Guidance for the conduct of Domestic Homicide Reviews following receipt of Home Office approval for publication the Overview Report, Executive Summary and Home Office letter will be provided to Emma's family and all other parties referenced in paragraph 79 of the Guidance who are listed within this report as Contributors to the Review.

19. Background Information (The Facts)

19.1 Emma and Dean were in a relationship between 2018 and her murder in 2019. After spending the evening at Dean's home Emma was murdered in the bedroom of the house. She died of multiple stab wounds inflicted by Dean who had been consuming alcohol prior to Emma's murder and Dean was currently on Police bail following a recent assault and unlawful imprisonment of Emma.

19.2 Dean was charged with the murder of Emma and later pleaded guilty to the murder of Emma when appearing at Liverpool Crown Court in June 2019 where he was sentenced to life imprisonment with a minimum term of 18 years

CHRONOLOGY

Background of Emma and Dean

19.3 Emma was a 46-year-old female with a diagnosis of Emotionally Unstable Personality Disorder who at the time of her murder was subject to a Care Program Approach (CPA) which describes the approach used in secondary care mental health services to assess, plan, deliver, review, and coordinate the range of treatments, care and support needs for people who have complex mental health issues.

19.4 Emma was the youngest of three sisters. She had been married twice and had five sons aged between 26 years and 9 years of age. Emma's youngest son died when he was a baby and whilst Emma maintained contact with her sons none of them lived with her in her supported living accommodation at the time of her murder. All had been cared for by family members since Emma's admission to hospital in 2010.

19.5 Between 2010 -2014 Emma was detained for treatment under Section 3 of the Mental Health Act 1983 being released from hospital in 2014. The treatment she received whilst in hospital included counselling for alcohol abuse.

19.6 Emma did return to hospital briefly as an inpatient in 2016 following the death of her mother.

19.7 Once released from hospital in 2014 Emma remained subject to a Section 117 Mental Health Act 1973, After Care Order. The After-Care Order remained in place at the time of her murder.

19.8 Section 117 Aftercare is a legal duty that can be placed on Health and Social Services once a person has been discharged from hospital to provide after care services for individuals who have been detained under various Sections including Section 3, of the Mental Health Act 1983.

19.9 A Section 117 Order will remain in place until it is decided by the Health and Social Service representatives in partnership with the service user, family, or carers that the person is in no longer need of such services at which point the Section 117 Order will be discharged.

19.10 Aftercare is defined as the help a person will receive in the community after they leave hospital. This can cover all kinds of things such as healthcare, social care, and supported accommodation. The services are intended to meet a need that arises from, or relates to a person's mental health problem and so reduce the risk of their mental condition getting worse, and them having to return to hospital.

19.11 In Emma's case the aftercare she received was in the form of, supported living accommodation and six hours support per week from a support worker. Emma received aftercare support from the same 3rd Sector support agency from the time of her discharge from hospital in 2014 until her murder in 2019. Emma had an Aftercare Plan review meeting held in December 2018 which recorded that she remained under the Section 117 Care Order.

19.12 Following Emma's discharge from hospital and the support she received from her family, sisters, sons' nephews and nieces, and her support worker Emma's confidence grew, progressing from a fear of leaving her home to playing an active

role in caring for her sick father several times a week. At no time during this very stressful period of her life was Emma seen to be consuming alcohol again.

19.13 At the beginning of 2018 Emma began her relationship with Dean. Emma knew Dean's sister via Facebook and following a period of communication via social media Emma and Dean began their relationship. In April 2018 Emma introduced Dean to her whole family.

19.14 Emma's family noted a change in her behaviour whilst she was in a relationship with Dean. "*She changed from being family orientated, never forgetting birthdays and anniversaries, and being in regular contact with her sons and sisters to having little contact with her family*".

19.15 In 2018 Emma increasingly spent time with Dean and had indicated to her family that she may give up her supported living accommodation and move into Dean's home with him. Emma also disclosed to her sister her intention that in 2020 she and Dean would be married.

19.16 During December 2018 and January 2019, Emma had limited contact with her support agency due to her spending more time at Dean's home, and when challenged by her care provider with the prospect of losing her tenancy, she informed the support worker that she was "*cooling*" the relationship, however, later suggesting that the relationship with Dean had improved.

19.17 There is no recorded history of domestic violence incidents with other partners for either Emma or Dean.

19.18 Dean was diagnosed with Bipolar Affective Disorder over 20 years ago and following this diagnosis had three short stays in hospital in the two years immediately following this diagnosis. He has not been admitted to hospital since that time and his condition has been managed in the community with support from his G.P.

19.19 Dean had been employment for five years since leaving school at 16, engaging in several different manual and service roles. He was not employed at the

time of this fatal incident and had not worked since the age of 21 due to his mental condition.

19.20 Dean was married for a short period during his early 20's and he is the father of one daughter from that marriage but contact between the two broke down a number of years ago.

19.21 Dean is the youngest of four children having two older brothers and a sister and he had lived in social housing accommodation for almost 20 years and for most of that time shared his home with his mother.

19.22 The Housing Association which owned the property described Dean as a model tenant during that time. The only involvement in terms of tenancy management was around the payment of rent which was always prompt and on time and repairs and maintenance reported by the tenant none were damage related. Their records indicate no evidence of domestic abuse being a concern.

19.23 Dean's mother moved out of the home she shared with Dean a short time before the fatal attack to live with her daughter. The reason for his mother moving out is believed to be the constant arguments which were taking place between Dean and Emma. The Panel did not engage with Dean's mother to explore this issue further.

19.24 Dean has a history of alcohol dependency and had received hospital treatment for detoxification from alcohol. Following treatment Dean relapsed and was consuming significant amounts of alcohol during the time of his relationship with Emma and at the time of her murder.

19.25 Dean was not subject to a Care Order however an appropriate adult was requested by Police Officers prior to interviewing Dean regarding the assault and detention of Emma in February. Adult Services Emergency Duty Team provided appropriate adult support, but Dean gave a no comment interview to Police.

20. Summary of key events.

20.1 Emma and Dean began their relationship in 2018. During the early months of that relationship Dean attended hospital for treatment having taken an overdose of prescribed medication. Whilst receiving treatment he disclosed to the Doctor treating him that had been arguing with his partner and the Doctor recorded that he was suffering from behaviour disturbances due to chronic alcohol use.

20.2 Emma was subject to a Section 117 Mental Health Act Aftercare Order from being discharged from hospital in 2014 until the time of her murder. Part of the aftercare package provided under this Order was that Emma would receive six hours per week carer support.

20.3 As part of the After Care Order requirements in July 2018 Emma was involved in the development of a relapse prevention plan, the latest version being added to her care records on 10 July 2018. This plan identified early warning symptoms of possible relapse in her mental health, alongside actions that she could potentially take if she became aware of these symptoms.

20.4 Within this plan, the early warning signs of Emma's relapse were identified as drinking alcohol, poor engagement with services, and neglecting herself or her surroundings. Actions identified within the plan to help Emma prevent a relapse included speaking with and accepting additional support from staff involved in her care from both mental health and the 3rd Sector care agency services, and seeking support from family members.

20.5 In November 2018 Emma had disclosed to her carer that she was being controlled by her partner Dean. He refused to allow her to speak to other men and made her remove all males out of her Facebook contacts as he believed she would sleep with them. Dean demanded sex all the time and refused to let her sleep in pyjamas he said "*its naked or not at all*." He was verbally abusive towards Emma and she was scared.

20.6 Carer records show that this disclosure by Emma was shared with the nominated Mental Health Practitioner who was the former Care Coordinator for Emma who advised the carer to report this information to the Safeguarding Team in Adult Services. Emma's carer states that as advised she made contact with Adult Services Safeguarding Team but was advised by them that no further action would be taken by Safeguarding because, based upon the information given Emma did not meet the safeguarding threshold. The carer states that the Safeguarding officer she spoke to advised her "*to keep an eye on the situation and go back to them if felt the situation had worsened*."

20.7 The Head of Adult Safeguarding, at St Helens Council described the process for callers wishing to pass concerns to the Safeguarding team as being directed to pass the information via the Council's Contact Cares facility and make a safeguarding referral. This will ensure that there is an audit trail and that enquires are completed under the relevant legislation. Contact by the carer with the Safeguarding Team did not follow the prescribed route and the Head of Safeguarding confirmed that there was no record of Emma's carer's contact with the Council on 19 November nor of the advice the carer was given.

20.8 This information regarding the control which Dean was imposing over Emma was not shared by either the 3rd Sector carer, Mental Health Services or Adult Services with any other agency and there is no information available to show that any further action was taken by any service in relation to this disclosure. There was no domestic abuse risk assessment completed or referral into MASH (Multi Agency Safeguarding Hub) which comprises co-located agencies formed to provide the highest level of knowledge and analysis of all known intelligence and information across the safeguarding partnership to ensure all safeguarding activity and intervention is timely, proportionate, and necessary, or MARAC (Multi Agency Risk Assessment Conference) made. The MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about

a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

20.9 At the same time as Emma disclosed that elements of her life were being controlled by Dean, Emma had begun missing pre-arranged Doctors' appointments. This was not a trait Emma had previously displayed and it is not clear the reason why she stopped attending. It may have been part of the control Emma was suffering at the hands of her partner Dean or it may have been an indication of Emma's worsening mental health condition.

20.10 In December 2018 following a referral made by his G.P. to Mental Health Services Dean was contacted by the Mental Health Team as part of a telephone triage assessment of his mental health. During this assessment Dean disclosed he was suffering from bouts of raging anger. He was becoming irritable with his partner and mother and had a belief that his partner was the Devil and he had thoughts at times that he was Jesus. An urgent medical appointment was arranged for Dean by the Mental Health Service following this triage assessment.

20.11 One month after the Mental Health Services triage assessment of Dean in December 2018 Dean, at the time accompanied by Emma, was seen by a Hospital Psychiatrist. During this hospital appointment Emma disclosed that she was concerned Dean had been getting more irritable with family members of late. The Psychiatrist concluded that Dean was presenting with mental and behavioural disturbances due to chronic alcohol misuse, but Dean assured the Doctor that he did not require any support to give up consuming alcohol which the Doctor accepted.

20.12 In mid-December Dean attended the Accident and Emergency Department of a local hospital after taking an overdose of his prescribed medication. Staff record that Dean was intoxicated and was aggressive requiring hospital security to assist in managing his behaviour. Dean then left the hospital before any referrals could be made to other services.

20.13 The Panel have been unable to identify that this incident of an overdose and intoxication combined with aggressive behaviour was immediately followed up by any agency but it was referred to in Deans meeting with the Hospital Psychiatrist in January. There was no further action or support given to Dean in relation to this incident prior to the fatal attack on Emma nor any assessment of risk faced by Emma.

20.14 In December 2018 Emma's care plan was reassessed as part of the annual review process. Emma completed the assessment together with staff from the Integrated Continuing Health Care Team. During the assessment Emma answered No to a question asking if she or anyone else was concerned about excessive alcohol or drug use. The issue of the control that Dean was placing her under was not discussed during this assessment.

20.15 On 12th February 2019 one of Emma's sisters rang a Mental Health Practitioner and former Care Coordinator for Emma expressing her concerns that Emma's was "*currently consuming alcohol excessively*". The Mental Health Practitioner who had worked with Emma for a number of years agreed to respond to these concerns and the missed Doctors' appointments Emma had been making in recent months. The practitioner tried to contact Emma by telephone but was unsuccessful and this was followed by writing to Emma a letter which included details of a new Doctors appointment. The letter did not generate a response from Emma who missed the new appointment. No further attempts were made to contact Emma or changes made to the support she was receiving, and no further action was taken regarding Emma's sisters concerns.

20.16 Two days after the missed rescheduled Doctors appointment Merseyside Police responded to an emergency call which they traced to Dean's home address. During the call a female was heard crying and the voice of a male was heard saying *"Shut your f…..g mouth then"* followed *by "Shut your f…..g mouth now you don't need to speak do you".* The Police call handler endorsed the log to the effect that the male was not shouting but his tone was aggressive. The male was then heard to

say *“Shut up, you think I’m playing around, you’re playing around with my life here, next time I will f..k you up”.* The female, was heard in the background saying *“Dean I want to go home, let me go home, get off me, get off me.”* The male’s response was *“Are you going to shut up then”* to which she replied *“Please, oh please don’t”.*

20.17 Officers attending the incident arrested Dean for the assault of Emma, her unlawful imprisonment and making threats to kill her. A Vulnerable Persons form, VPRF 1, was completed by the Police Officers and the risk Emma faced was assessed as high or ‘gold’ and referrals were made to Adult Services. A high-risk Gold referral was made by MASH to the MARAC and to Mental Health Services in respect of both Emma and Dean.

20.18 Deans explanation for this action which led to his arrest was later given as caused by his fear that Emma would carry out her threat to leave him due to the constant arguing between the couple and he grabbed Emma by the throat to make her say that she would stay.

20.19 Speaking to Police Officers immediately after Dean had been arrested Emma disclosed that Dean had behaved in a controlling manner towards her since their relationship began, “*he controlled her phone contact with others and dictated when she could or could not leave the house*”. After the Police Officers had left, Emma disclosed to her carer additional information about the threats Dean had made towards her. The content of this conversation was sexually graphic and offensive. The carer believes that Emma had not disclosed this information when interviewed by Police Officers because she would not discuss matters in the presence of people she did not know or trust. She was therefore unable to share this additional information with the police officers who were both male and strangers to her.

20.20 Following the Police investigating officer’s consultation with the Crown Prosecution Service and with Emma’s carer, during which she expressed concern that the couple would resume their relationship, Dean was granted bail with conditions not to approach Emma by self, servant, or agent.

20.21 The day after the assault at Deans home, Emma's carer made a referral and telephone call to Safeguarding Adults at St Helens Council. Safeguarding case notes record that the carer after outlining details of the assault which had taken place then shared with them examples of the controlling behaviour Emma had been subjected to by Dean which Emma had disclosed to Police Officers immediately following his arrest. The carer also reported the concerns expressed earlier that month by Emma's sister regarding Emma's "*excessive consumption of alcohol and her increased isolation from the family"*.

20.22 Following receipt of this referral Adults Safeguarding held a strategy discussion which took place two days after the assault by Dean for which he had been arrested. It is recorded during this strategy discussion that Emma's carer believed that Emma and Dean had, despite the conditions imposed on Dean by Police Officers when granting him bail, been seeing each other again. The meeting noted that following this assault Emma had been referred to MARAC as a high risk/gold case, and that the carer would share with Emma details of domestic abuse support services for victims in their local area. The strategy discussion recorded that the Safeguarding intervention was to ensure Emma had access to an Independent Domestic Violence Advocate (IDVA) and domestic abuse support. An IDVA is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies. That being in place the referral was then closed by Adult Safeguarding.

20.23 Two days before the fatal attack the Police officer in charge of the assault case visited Emma in company with Emma's carer. Emma remained adamant that she would not provide evidence to support a prosecution of Dean, she also stressed her relationship with Dean was now over for good. Emma was advised about the option to apply for a non-molestation order, as was the procedure and the support available for seeking such an order should she choose to do so. There is no

evidence that the option of obtaining a Non-Molestation Order had been pursued prior to her murder.

20.24 After the fatal attack Merseyside Police received a telephone call from Dean's sister. She told Police that Dean had earlier called her in a distressed state advising that something had happened to Emma who was in a bedroom at his house.

20.25 Following receipt of the phone call Police Officers attended Dean's home and found Emma dead in an upstairs bedroom. She had suffered multiple stab wounds. Dean was still at the scene, he was arrested and taken into Police custody. The Coroner recorded the cause of Emma's death as being multiple stab wounds. Dean was later charged with the murder of Emma.

20.26 Dean admitted to having consumed a significant amount of alcohol on the night of the fatal attack.

20.27 After being charged with the offence of murder and whilst on remand awaiting trial Dean was examined by a Doctor who concluded that Deans actions on the night he murdered Emma were not the result of his mental disability impairing his judgement or self-control.

21. Overview.

21.1 There is no history of reported domestic violence incidents involving other partners for either Dean or Emma and prior to the fatal attack in March 2019 only one other domestic violence incident involving them had been reported to the Police which had taken place in February 2019 and for which Dean had been arrested and was on Police bail when he committed the murder.

21.2 Following that incident in February 2019, Dean had been arrested by Merseyside Police and had been released on bail with conditions not to approach Emma by self, servant, or agent. Dean remained on Police bail with those conditions up to the date of the fatal attack.

21.3 In November 2018 Emma had disclosed to her carer that during their relationship she was subjected to controlling behaviour from Dean. The carer shared this information with the Mental Health Team and on their advice with the Safeguarding Team within Adult Services who were contacted by telephone by the carer to report the disclosure. Whilst it is accepted that the call was made there is no record of the report made to Adult Services nor of any other action being taken to support Emma by the carer's organisation, Mental Health Services or Safeguarding teams within Adult Services following this disclosure of controlling and abusive behaviour. Neither is there any indication that this information regarding Dean's abusive controlling behaviour was shared outside of those three agencies.

21.4 Between November 2018 and the fatal attack there were several occasions when the negative impact upon the relationship of excessive alcohol consumption was highlighted and disclosed to services. No referrals were made during this time of either Emma or Dean into alcohol support services.

21.5 Throughout the relationship between Emma and Dean there is only one record of a domestic violence risk assessment being completed in respect of Emma. This was following the assault and unlawful imprisonment of Emma by Dean in February 2019 when Merseyside Police completed the assessment and judged Emma to be at a high risk of future serious assault or murder.

22. Analysis

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

The extent of Control within Emma and Dean's relationship.

22.2 On 19th November 2018 Emma had disclosed to her carer that she was being controlled by her partner Dean. Emma remained under a Section 117 Aftercare Order at the time of this disclosure. The information describing the elements of control used by Dean were shared by Emma's carer with the Mental Health Team.

On the advice of the Mental Health Services the carer also made a telephone call to the Safeguarding Team within Adult Services to report what Emma had disclosed. The carer was advised that Dean's actions did not meet the safeguarding thresholds. Safeguarding advised the carer "*to keep an eye on the situation and go back to them if they felt the situation had worsened*."

22.3 Clinical advice received from North West Boroughs Healthcare Mental Health Trust's Safeguarding Adults Professional Lead has identified that these disclosures from Emma "*should have triggered a safeguarding adult referral as she was an adult at risk as defined by the Care Act 2014 and was at risk of abuse and neglect. This refusal by Adult Services to accept Emma at this time as a safeguarding referral should have been challenged*".

22.4 The Trust's Safeguarding Adults Professional Lead has identified that this was a missed opportunity to share information. Following completion of a MeRIT domestic abuse risk assessment form based upon the information available this matter could have been referred to MARAC on the grounds of professional judgement due to the high level of control being exerted upon Emma by Dean and to the Local Authority as a safeguarding responsibility.

22.5 The Trusts Safeguarding Adults Professional Lead also believed that there was "*an over reliance on Emma's 3rd Sector carer in this situation*" and highlights a lack of action from the nominated contact/care coordinator within Mental Health Services over this matter.

22.6 The day after this disclosure to her carer regarding control, made in November 2018, Emma did not attend a scheduled Doctor's appointment. Previously Emma had engaged with services and attended all scheduled appointments.

22.7 On the 6th February 2019 Emma's carer carried out a home visit to Emma. Having been advised that Dean was inside the house, having stayed the night after drinking and therefore unable to drive the night before, Emma and her carer met and

spoke inside the carer's car. Emma described Dean as being "*a control freak*" and assured the carer that "*it's all over between them but she does feel sorry for him*"

22.8 In February 2019 Emma's sister raised concerns with the nominated contact within Mental Health Services believing that Emma's mental health was declining, she was consuming alcohol again, and that she was becoming withdrawn from her family. Researchers following a "*review of several officially reported 'intimate terrorism' cases illustrates, substance use can also be implicated in the perpetration of 'coercive control' and victims' responses to it. His analyses reveal that some victims do self-medicate to manage the depression the daily anticipation of violence engenders and that some perpetrators control victims by increasing their dependence on substances before restricting their access to them"*. (c)

22.9 Contextually since her discharge from hospital Emma had abstained from using alcohol even during the stressful period when she was caring for her father. Emma had made disclosure's that Dean was controlling her and Dean disclosed to Mental Health Services that he was being irritable with family members who he believed to be the Devil. Qualitative studies show that "*some perpetrators pose greater risks to their partners, not when they are high, but when they are irritable, withdrawing or are struggling to finance alcohol or drug purchases "* (d). Emma had a history of alcohol dependency, and these disclosures and behaviours were signs that Emma was in a controlling and physically abusive relationship. Despite these disclosures no domestic abuse risk assessment was ever completed nor any support for either partner for the impact alcohol was having within the relationship.

22.10 Mental Health Services within their Independent Management Review acknowledge that there are learning points to be found within actions surrounding Emma's withdrawn behaviour. In terms of professional curiosity, there could have been further probing with Emma to explore some of the potential reasons for Emma's reported isolation from her family. The Service acknowledge that the change in Emma's behaviour may have been related to her mental health declining or the impact of Dean's control on her level of independence.

22.11 A large study of females in America found that "*those who were victims of coercion had lower self-esteem, were more socially isolated and reported more depressed mood and social anxiety than did nonvictims*" (e) which describes behaviour being exhibited by Emma.

22.12 There are no records illustrating that contact was made by the Mental Health Practitioner with the 3rd Sector agency team to obtain their views/ understanding of why Emma's behaviour changed in this way.

22.13 Maintaining contact with her family was also one of the coping mechanisms identified in the relapse plan developed by Emma, her carer and Mental Health Services in July 2018. Adult Safeguarding within their IMR identified that *"isolation from family is a classic warning sign in domestic abuse cases and believe that there should have been a safeguarding referral to the Local Authority, which if it did not meet the criteria for MARAC, would have generated a professionals discussion/meeting".*

22.14 The Doctor's appointment Emma had previously not attended had been rearranged to take place on 20th February 2019. When Emma did not attend the rearranged appointment, the Panel believe that the developing situation surrounding Emma illustrated by the following points should have then been considered and acted upon.

- Emma had made a disclosure of coercion and control in Nov 2018 to her support worker which was shared with her previous named nurse in Mental Health Services.
- Emma had missed two Doctors' appointments. When she always had a history of good attendance and engagement with her Mental Health Team.
- None of the above was highlighted or included within the Easy Care Assessment completed with Emma by the Integrated Continuing Health Care Team during her annual assessment in late December 2018.

- On 6th February 2019 Emma had described Dean as being "*a control freak*" and assured the carer that "*it's all over between them but she does feel sorry for him*"
- On 12th February 2019, a concerned telephone call had been received by Mental Health Services from Emma's sister regarding her declining Mental Health and isolation from the family.

22.15 The S.I. Reviewer also acknowledged that some of the triggers in Emma's relapse care plan which had been developed by Emma and Services in July 2018 were missed, and that the breakdown in the support mechanisms contained within the Plan were not recognised.

22.16 All of this information should have been triangulated to provide a comprehensive assessment of risk in terms of Emma's mental health and concerns regarding coercive and controlling abuse taking place within her relationship. However, communication between the 3rd Sector Carer organisation and Mental Health Services had broken down. There is no evidence of contact being made by the Mental Health Practitioner with the 3rd Sector carer's organisation to obtain their views or understanding. Neither is there evidence of the carer's liaising with Mental Health Services in January – February and sharing any concerns they had.

22.17 Mental Health Services note that Emma was on a de-escalation plan so missing appointments would not normally have been an issue of concern. However, as there had been a disclosure regarding control within their relationship the missing of these appointments should have been investigated further and was not.

22.18 Clinical advice is that following Emma's failure to attend her rescheduled Doctors appointment this should have been discussed at the next MDT meeting given the concerns identified by her family.

22.19 The omission that during this period no one from the 3rd Sector agency providing mental health support for Emma, Mental Health Services, or the Adult Services Safeguarding Team completed a MeRIT domestic abuse risk assessment

of Emma once she had made these disclosures about control, she was suffering within the relationship compounds the failure to triangulate this information. MeRIT risk assessment forms are available to all agencies and service providers in St Helens and completion of the risk assessment form and submission to the MASH is the gateway to support for victims of domestic abuse at levels proportionate to the level of risk they face. This support may include one to one support from an IDVA. The process in St Helens and across Merseyside is that victims are unable to self-refer into the IDVA service, this service can only be accessed following the completion of a MeRIT form and a referral via the MASH to the MARAC. Policy across Merseyside also is that the victim does not attend MARAC meetings but is represented by an IDVA who speaks on their behalf.

How effective in terms of communication and identifying risk in domestic abuse cases was the pathways between agencies.

22.20 Placing the events of 2018 and 2019 in context; Emma and Dean both have a recorded history of alcohol abuse for which both have received hospital treatment and support. Emma had however successfully completed a period of abstinence from alcohol since her discharge from hospital.

22.21 Emma had been involved in the development of a relapse prevention plan, the latest version being added to her care records on 10 July 2018. This plan identified early warning symptoms of a possible relapse in her mental health, alongside actions that she could take if she noticed these signs. Within this plan, some of the early warning signs of relapse are identified as drinking alcohol, poor engagement with services, and neglecting herself/ surroundings.

22.22 In November 2018 Emma had disclosed that she was being controlled in her relationship with Dean. Following Emma's disclosure medical assessments of Dean were completed in December 2018 and a second assessment in January 2019. During those assessments' disclosures were made by Dean which included his

increasing anger, behaviour disturbances caused by alcohol abuse, and the aggression shown to Accident and Emergency Department staff whilst intoxicated in December 2018. These disclosures and incidents combine to illustrate the increasing risk of aggression being faced by Emma from Dean's abuse of alcohol. However, throughout this time no agency completed an assessment of risk being faced by Emma from domestic abuse.

22.23 In December 2018 a telephone triage assessment of Dean was completed by the Mental Health Team. During this assessment Dean disclosed he was suffering from bouts of raging anger. He was becoming irritable with partner and mother and had a belief that his partner was the Devil and he had thoughts at times that he was Jesus.

22.24 In mid-December Dean attended the Accident and Emergency Department of a local hospital after taking overdose of his prescribed medication. Staff record that Dean was intoxicated and was aggressive requiring hospital security to assist.

22.25 In January 2019 following the triage assessment by Mental Health Services a month earlier Dean, at the time accompanied by Emma, was seen by a Hospital Psychiatrist. During this hospital appointment Emma had disclosed that she was concerned Dean had been getting more irritable with family members of late. It was concluded that Dean was presenting with mental and behavioural disturbances due to chronic alcohol misuse, but Dean assured the Doctor that he did not require any support in order to give up consuming alcohol. No referral to alcohol support services of any kind was made at this time.

22.26 On review of patients held records it has been agreed, by Mental Health Services that in hindsight Dean should have been assessed within 24 hours of his disclosing anger towards his partner and his mother during the telephone triage and not have waited until January for further assessment.

22.27 There are no records to show that any risk assessments were completed in respect of Dean's partner Emma, or Dean's mother, who were identified within his

triage consultation as the Devil. Nor is there evidence to show that Emma's earlier disclosure to her carer later, shared with Mental Health Services and Adult Services, that she was being controlled by Dean was assessed alongside his triage disclosure. It is now acknowledged by Mental Health Services that a further detailed risk assessment should have taken place to establish the impact these thoughts were having on his relationship.

22.28 Emma had accompanied Dean during his hospital appointment in January following his triage assessment a month earlier. Despite the fact that Emma was under a Section 117 Aftercare Order thus escalating the safeguarding risk, unless Doctors had questioned Emma herself it would not have been known to clinicians treating Dean that Emma was a patient of the Recovery Team. This was because unless disclosed by Emma or Dean during the consultation information systems are not in place to alert Doctors treating Dean of this fact.

22.29 There is no information available to show that Emma had been questioned about Dean's belief that she was the Devil or that her personal health was enquired into. The reason that patient record systems did not show that Emma was a vulnerable person is because NWBH Mental Health Assessment and Recovery teams are co-located within the same building as each other however, they are separate teams managed by two different managers with separate databases for each. Both teams would not routinely cross reference case files to establish further details regarding a patient's partner. This would only happen if the patient stated their partner was known to services and any risks were shared or if concerns arose within the consultation.

22.30 Mental Health Services believe it would be deemed a disproportionate response and a breach of a person's right to privacy to cross reference patient's files unless any concerns were noted, or this was shared by the patient directly.

22.31 At the end of the consultation it was concluded that Dean was presenting with mental and behavioural disturbances due to chronic alcohol misuse. Mental Health Services acknowledge that "*with hindsight it is acknowledged that Dean's previous*

thoughts to harm his partner and mother should have been discussed and explored further within this face-to-face meeting".

22.32 Home Office research revealed that "*Alcohol use was a feature in a majority of domestic abuse offences (62%) and almost half the sample (48%) were alcohol dependent. Alcohol may be a distinguishing factor in domestic violence offenders. Problems of alcohol use should therefore be addressed where identified as a criminogenic need and consideration given to its potential impact on interventions and other needs".* (f) Research into the link between alcohol abuse and domestic abuse shows that it is "*closer to the truth to say that domestic abusers like to also abuse alcohol. Where the (domestic) abuser is also an alcoholic, it is usually necessary for them to get treatment for both conditions*." (g). The failure to act upon the information that both Emma and Dean gave to Mental Health professionals and provide treatment and support to Dean for his alcohol misuse during this period ignores these links and placed Emma at greater risk.

22.33 In February 2019 her carer had met Emma whilst Dean waited for her in his car nearby. The carer queried Emma and Dean's relationship status and was told that Emma "*feels sorry for him and that he has agreed to see a doctor in respect of his mental health/anger issues, and that she believed that if he got himself sorted they could make a go of relationship*".

22.34 Safeguarding advice obtained as part of the S.I. Review suggests that this *"was a Safeguarding warning sign that should have been acted upon, but it was not."*

22.35 Taking all these factors together had the sum of these warning signs and concerns been noted it may not have been held a routine enquiry to cross reference Emma and Deans files and an assessment of risk faced by Emma deemed appropriate and necessary at several points during this period.

The role of services in responding to domestic abuse within Emma and Dean's relationship.

22.36 Following Emma's disclosure that she was being controlled by Dean the 3rd Sector provider of mental health services to Emma report that they contacted Mental Health Services and alerted them to this fact. The 3rd Sector carer followed the advice of Mental Health Services and alerted Safeguarding Teams within Adult Services of this disclosure of domestic abuse but was advised that Emma did not meet safeguarding thresholds. Emma at this time remained under a Section 117 Aftercare Order.

22.37 Reflecting upon this the S.I. Report includes clinical advice received from the Trust's Safeguarding Adults Professional Lead which identified that "*these disclosures from Emma should have triggered a safeguarding adult referral as she was an adult at risk as defined by the Care Act 2014 and was at risk of abuse and neglect. This refusal by Adult Services to take this safeguarding notification further at this time should have been challenged".*

22.38 The Trust's Safeguarding Adults Professional Lead has identified that this was a missed opportunity to share information. Following completion of a MeRIT risk assessment based upon the information available this matter could have been referred to MARAC on the grounds of professional judgement due to the high level of control being exerted upon Emma by Dean and to the Local Authority as a safeguarding responsibility.

22.39 The Panel felt it important to note at this point that staff employed by the 3rd Sector provider of care to Emma had not received any training to help them recognise the signs and symptoms of domestic abuse within their clients. They have not received any training in completion of the MeRIT risk assessment forms and were unaware of the gateways into domestic abuse support services which exist in St Helens.

22.40 The day after Emma's disclosure she did not attend a pre-planned appointment with the Mental Health Recovery Team. Emma received a phone call from her named contact within Mental Health Services who was also her previous named nurse, the primary purpose of which appears to be establishing why Emma had not gone to appointment. During the phone call "*Emma was asked about the incident yesterday that was reported re issues with boyfriend, she reassured the named contact everything was fine now*." No further probing was made of Emma about the abuse within the relationship she was in with Dean and why there had been such a change of mind in Emma over the space of 24 hours.

22.41 In December 2018 the caretaker of the supported living accommodation where Emma lived reported to the 3rd Sector Care Providers that he had witnessed Emma and Dean arguing between themselves in a communal corridor of the property. The decision of the 3rd Sector provider was that there being no other underlying aspects of domestic abuse impacting upon Emma at this time they would take no further action regarding this report. Clearly the disclosure made by Emma one month prior to this regarding the controlling abuse she was suffering was not considered at this time. Had the two incidents been considered together this may have prompted the Care Provider into taking further action.

22.42 Following the serious assault Dean inflicted upon Emma in February 2019 the 3rd Sector provider alerted Adult Safeguarding Services to the incident.

22.43 Records of a Safeguarding Adults Initial Strategy Discussion, held on receipt of this referral to their service, show that Emma was *"being clearly coerced*". That the Police have placed restrictions on Dean so that he cannot make contact with Emma, but that Emma did not intend to make a statement of complaint to the Police regarding the incident. The carer "*believes that they, (Emma and Dean), had seen each other again"* since his arrest and release on conditional bail. The Safeguarding intervention had been to ensure Emma's access to an IDVA and her carer had been sent details of domestic abuse support services in that area. Due to the fact that the case had been referred as a gold case to MARAC, and because Emma had said she

did not wish to speak to partner agencies Adult Safeguarding where in agreement that they would now close the safeguarding enquiry.

22.44 A VPRF1 submitted by Merseyside Police was received by the IDVA Service two days after the assault of Emma by Dean at his home in February 2019. The case was placed on the pending list. Cases were prioritised for contact by the IDVA based on when they were due to be heard at MARAC and this case was scheduled to be heard by MARAC on 14th March 2019.

22.45 Attempts would always be made by the IDVA Service to contact victims in cases listed for MARAC to ensure that the voice of the victim is heard at the MARAC meeting. The length of time between the referral being received by the IDVA and the date of the MARAC and the lack of capacity within the IDVA Service at that time prevented an immediate contacting of Emma by the IDVA. Emma was murdered before the IDVA was able to contact her and before the case was considered at MARAC.

22.46 The Panel did question the failure of Adult Safeguarding to take positive action in response to an alleged breach of Dean's Police bail conditions. Emma was subject to a Section 117 Aftercare Order and Adult Safeguarding record in their strategy discussion that she was now in a coercive relationship. The same strategy discussion records that Emma's carer believes Emma and Dean had seen each other again following his arrest and release on bail thus breaching Dean's bail conditions of which they were also aware. The Panel question was it reflective of their duty of care towards Emma to take no further safeguarding action or notify Police of the breach of Dean's bail conditions?

22.47 It is also worthy of noting that following Emma's disclosure that she was in a controlling relationship, November 2018, and following the serious assault which took place only days before her murder, February 2019, the Panel were unable to find records that show any extra mental health support or additional support of any kind was provided to Emma by any of the services legally obliged or commissioned to support her mental health.

23. Conclusions.

23.1 Emma and Dean had a relatively short relationship towards the end of which the risks Emma faced from domestic abuse escalated very quickly and disastrously.

23.2 None of the agencies charged with supporting Emma or Dean's mental health recovery appeared to show any signs of professional curiosity about the risks from domestic abuse being faced by Emma.

23.3 There were several disclosures which should have raised alarm about the increasing risks from domestic abuse being faced by Emma. However, no domestic abuse risk assessment was completed until in the days before her murder Emma suffered a serious assault at Deans home. This risk assessment was completed by Merseyside Police.

23.4 Risks were also increased due to different parts of systems being unable to talk to each other and important information therefore was hidden to professionals.

23.5 Following the serious assault by Dean in February this was also the first time that the domestic abuse suffered by Emma was enquired into further by any agency. Here Merseyside Police worked with the Crown Prosecution Services and engaged the help of Emma's carer in an effort to have Emma reconsider her decision and to cooperate with the criminal prosecution of Dean.

23.6 The S.I. Report concluded that based on the clinical and professional advice received, the actions taken by the mental health practitioner after receiving information from Emma's carer regarding Control and following the serious assault committed by Dean in February 2019 were not robust. The reviewer concluded that there was an over reliance by the mental health practitioner on the unqualified staff member from the 3rd Sector organisation to follow this through and provide an appropriate level of support to Emma.

23.7 Advice received from the Trust's named Safeguarding Adults Professional Lead confirmed that the mental health practitioner should have escalated actions through the Trust's internal Safeguarding Adults team. As such there was a missed opportunity for possible consideration by MARAC.

24. Lessons Learnt

24.1 In October 2019, St Helens Council reviewed their existing Domestic Abuse Strategy by holding a Domestic Abuse Summit, bringing together partners across the borough to commence a discussion about how organisations can work together to tackle the issue of domestic abuse in St Helens communities. A key objective of the summit was how to "Stop the Silence" which the partnership believed surrounded domestic abuse within St Helens communities and to create responsive services to meet those needs.

24.2 In order to ensure that the Strategy was inclusive of the aims and objectives across the partnership, consultation took place with a number of fora and a multi-agency group, led by the Director of Public Health, then built upon the findings from the Summit and developed the priorities contained within the new Domestic Violence Strategy 2020 – 2022. Accountability for the delivery of the Strategy's Action Plan is now managed through a dedicated subgroup of the Community Safety Partnership and new governance structures have been developed to facilitate this work.

24.3 The Actions contained within the Strategy seek to challenge perceptions of abuse, highlighting issues such as coercive control, child to parent abuse and domestic abuse experienced by older people. The Strategy also recognises the need to safeguard children and vulnerable adults from the impact of domestic abuse and to work within communities to raise awareness of this issue, end the silence that still exists and to ensure that timely and effective support is available for victims and their families. The Strategy also highlights the need to address the perpetrators of abuse, considering both the provision of support for those who acknowledge their behaviour

and to agreeing a way forward across the partnership to effectively hold to account serial perpetrators of abuse.

24.4 Following this Review several new practices and procedures have already been implemented.

24.5 A review of capacity within the IDVA service has resulted in the provision of four new posts within the IDVA Service funded by St Helens Council. These include additional IDVA's and Domestic Abuse Outreach workers.

24.6 Further changes have been implemented by Mental Health Services in St. Helens.

- The Mental Health Assessment team have a new process for screening a Patient who is telephone triaged. If there are any Safeguarding concerns, if the patient is pregnant, psychotic, or suicide ideation they will have a face to face assessment and will be seen within 24 hours up to a maximum 10 days.
- Mental Health Assessment Team will now follow up those patients who haven't responded or do not attend (DNA) their allocated appointment. There will be an emphasis on proactive engagement and staff will do home visits if contact has not been established.
- New patients to Mental Health Services will be discussed daily at a 3pm Multi-Disciplinary meeting. The sharing of information and assessment of risk will be part of this discussion.
- Nomination will be made of domestic abuse champions within both Mental Health Recovery and Mental Health Assessment Teams were previously none existed. This will take place once the full complement of staff is appointed. These champions will work closer with adult safeguarding team to support the teams.
- Closer working relationship has been established with Change Grow and Live (CGL) which includes joint home visits between Mental Health Services and CGL and the appointment of a drugs link worker within the Mental Health

team. (CGL is the specialist drug and alcohol support provider within the Borough.)

- Development of a closer working relationship with IDVA service. The IDVA team manager is now attending both Mental Health Recovery and Mental Health Assessment Teams to share knowledge regarding domestic abuse services within St Helens.
- There has been a higher take up of NWBH internal domestic abuse training across both Recovery and Assessment Teams. This training which is delivered by the Adult Safeguarding team includes recognising coercion and control within an intimate relationship and how to complete the Merit risk assessment and make referrals to MARAC.
- A “safety huddle” meeting has been introduced for Mental Health assessment team and recovery teams which includes raising safeguarding concerns about clients.
- The Mental Health Assessment Team have freed up a daily appointment slot each day to enable one urgent appointment to be accommodated. Once screened the person will either be graded as emergency or downgraded to routine. If it is an emergency grading, they will be seen within 24 hours

24.7 Changes have also been made within the Safeguarding Adult’s Team following this Review.

- On receipt of a referral to the Safeguarding Adults Team which discloses domestic abuse taking place. Even if it is identified that this person is not already in service or does not have any other identified care or support needs the Safeguarding Adults Team will make contact with the person making the referral, appropriate professionals, and the victim of abuse (if safe to do so).
- The Safeguarding Adults Team will ascertain what support the client requires, and whether all relevant professionals are aware of this abuse taking place. They will take action to minimise risk faced by the client and ensure that a MeRIT risk assessment form is completed.

25. Recommendations

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

25.2 In the area of mental health care and safeguarding, professional curiosity at the initial screening and throughout patient contact to be developed through further domestic abuse training and supervision.

25.3 Recognition of the need to complete domestic abuse risk assessments within G.P. practices.

25.4 Staff from 3rd Sector agencies engaged in front line service provision to people with mental health conditions are provided with multi-agency training on the signs and symptoms of domestic abuse and the pathways into the reporting of and support for these victims and the completion of risk assessments. This should be an ongoing program to capture new entrants into the services.

25.5 The Mental Health Service will continue working with staff from within mental health care providers, mental health services, and Adult Safeguarding to provide ongoing safeguarding supervision thereby ensuring that the need for domestic abuse risk assessment is recognised and provided.

25.6 The current practice of telephone triage for patients with complex needs to cease and those identified patients be offered face to face appointments.

25.7 Development of a system of referral to Adult Safeguarding which is open, transparent and auditable between mental health care providers, mental health services and the Adult Safeguarding team

25.8 Following the S.I. report into the care Emma had received from NHS Services seven recommendations have been made to Mental Health Services and Adult

Services Safeguarding Team and these have been included within Appendix A following the DHR Panel recommendations.

Appendix A

Action Plan

Action Plan

Action Number	Recommendation	Scope	Action to Take	Lead Agency	Outcome
1	In the area of mental health care and safeguarding professional curiosity at the initial screening and throughout patient contact to be developed through further domestic abuse training and supervision.	Local	Development of assertive outreach program	NWBH	Each of CGL's staff have received an intensive training day on domestic abuse, coercive control and all aspects of the recommendations in this plan. All staff have monthly to bi-monthly supervision. Domestic abuse training has taken place across both Recovery and Assessment Teams within Mental Health Services. This training which is delivered by the Adult Safeguarding team includes recognising coercion and control within an intimate relationship and how to complete the

					MeRIT risk assessment and make referrals to MARAC. New patients to Mental Health Services will be discussed daily at a 3pm Multi-Disciplinary meeting. The sharing of information and assessment of risk including in domestic abuse cases will be part of this discussion. A blended approach to assessment is provided. Telephone triage has continued due to the restrictions imposed by the current Covid pandemic; however, this is a more detailed triage and includes Bio/psycho/social model. This including questions about risk and safety at home and relationship questions and

					safeguarding questions about domestic abuse included at the point of triage. If any concerns are raised at this point it will be escalated further. If a person does not seem able to engage, they will be asked to attend for a face to face comprehensive assessment this would be a full detailed assessment including historical details including previous trauma and current risks to self or others.
2	Continue working with staff from within mental health care providers, mental health services, and Adult Safeguarding to provide ongoing safeguarding supervision thereby	Local	Partnership working between agencies in all areas of risk assessment	NWBH	Mid Mersey Safeguarding team provide a daily duty system and this is available to all staff from 9am till 5pm. Evidence of appropriate referrals from St Helens Mental Health Teams.

	ensuring that the need for domestic abuse risk assessment is recognised and provided.				MERIT & MARAC Training delivered to team via multiagency training lead by the IDVA Service. Daily Safety Huddle to discuss levels of risk in cases including from domestic abuse. There is now evidence of increased number of referrals to Safeguarding and MARAC.
3	The current practice of telephone triage for patients with complex needs to cease and those identified patients be offered face to face appointments.	Local	Creation of system which identifies clients with complex needs and responds to them.	NWBH	The changes within this action have been made and this is now embedded in practice

4	Recognition of the need to complete domestic abuse risk assessments within G.P. practices.	Local	Reinforce the need to complete risk assessment and pathways to MARAC through training.	CCG	The IDVA Service now provide MeRIT risk assessment/MARAC Awareness/and Local domestic abuse referral pathways training, and Domestic Abuse – Impact on the Child Training to local partner agencies and professionals. The IDVA Service are now providing bespoke training support to several Primary Care services, including tailored MeRIT and MARAC Training to the Think Wellbeing Improving Access to Psychological Therapies, (IAPT) practitioners, and working with the Clinical Commissioning Group (CCG) to provide bespoke MeRIT and MARAC training to local GP's. This training has also been extended to trainee GP's.

5	Staff from 3rd Sector agencies engaged in front line service provision to people with mental health conditions are provided with multi agency training on the signs and symptoms of domestic abuse and the pathways into reporting and support for these victims and completion of risk assessments.	Local	Establishment of ongoing system of training for all 3rd Sector providers	High Risk Steering Group	Following a refresher training course for all Adult Safeguarding staff the Merit/ MARAC training has now been made mandatory for all new staff joining Safeguarding Services and is part of the induction program. This commitment has been included within the revised Domestic Abuse Strategy for St Helens. Training has taken place for 3rd Sector providers of service. This is ongoing and not a one off event. IDVA service have a rolling programme of training for MERIT/MARAC and it was made mandatory for social care staff to attend.
6	Development of a system of referral to Adult Safeguarding which is open, transparent and auditable	Local	Creation of process and education of organisations	Adult Safeguarding Board	The process for callers wishing to pass concerns regarding domestic abuse to the Safeguarding team is that callers/agencies are directed to pass

	between mental health care providers, mental health services and the Adult Safeguarding team		and Departments in its use.		the information via the Council's Contact Cares facility and make a safeguarding referral. This will ensure that there is an audit trail, and that enquires are completed under the relevant legislation. Evidence from Key Performance indicators that Mental Health teams within St Helens do make safeguarding referrals to St Helens Local Authority. However not all these referrals are accepted as meeting the threshold for safeguarding (section 42 Care Act 2014) relationship. Recent safeguarding audit of cases (not specific to Domestic abuse) which have been referred to St Helens LA has taken place.

Safeguarding Adults action plan

	Recommendation	Scope	Action to Take	Lead Agency	Action complete Outcome
7	In the area of mental health care and safeguarding professional curiosity at the initial screening and throughout patient contact to be developed through further domestic abuse training and supervision.	Local	Assessment team and Home Treatment team and Recovery Team have all had domestic abuse training and additional safeguarding supervision.	NWBH See additional information below.	The increased knowledge is evident in terms of the increase in both Merseycare MARAC referrals and merit risk assessment forms.

S.I. Review - Recommendations/Lessons learned actions:

NWBH

	Gaps Identified	Expected Outcome	Action to address	By who	Action complete Outcome
8	Lack of Clarity around the formal CPA process as opposed to the New Ways of Working 'Care Coordinator Assessment and	There will be a clear consistent process based on NWBH Policy & Procedure that can be appropriately bench marked and which will; provide clear direction to staff around the regrading of CPA and the involvement of service users and other agencies	Report to be shared with CT Head of Quality Knowsley Borough who is undertaking a review of current CPA Policy & Procedure guidance. CPA Policy & Procedure is	Head of Quality St Helens Head of Quality Knowsley	Review of CPA completed. St Helens Recovery Team piloted the use of the CPA Quality Assurance Framework tool during quarter 4 2020/21. The tool has been further developed in response to the pilot feedback (I have attached a copy of the latest tool for information). Work is ongoing in effort to embed this on a sustainable IT platform in order to support the analysis of agreed quality measures, we are also trying to align the CPA work stream with Mersey Cares quality initiatives around CPA whilst considering the

	Review Process' (Nurse lead MDT Reviews)	involved in care and support of patients.	currently being reviewed.		commitment to the new Community Mental Health Framework. In the interim and in order to maintain some traction we have asked teams to commit to the completion of a CPA QAF audit on 10% of their CPA caseload and matrons to provide an assurance report back to the working group at the end of Q2 to summarise their findings and associated actions. Review of CPA completed.
9	The sharing and acting on information between	Care records will clearly document sharing of information alongside evidence of staff escalating concerns	Introduction of Daily Team Huddle.	Team Manager	Introduced Daily Safety Huddles (Minuted) Trust Managerial Supervision as per Trust Policy. My Supervision introduced.

	the two practitioners in Making Space and Recovery team.	and acting on concerns where it is appropriate to do so.	Invitation to be offered to Making Space Team to attend Recovery Team meeting and for Recovery team management to attend Making Space Team meeting to establish better communication links and foster a more appreciative understanding of	Managerial Supervision Clinical Supervision CCC/ MH Deputy Team Manager/ Team Manager	Improved level of communication between individual practitioners and wider teams. Making Space Manager has met with Team manager and Head of Quality at the to discuss the case in particular and to firm up assurances that her staff had the relevant contact details for the Recovery Team and to discuss both their and our expectations of collaborative working. Making Space Manager has attended NWBH team meetings to promote their service this was a good opportunity for making Space to showcase their service and meet our team colleagues.

			any barriers to closer working.		
10	Escalation through internal safeguarding pathways.	Staff to complete an Internal Referral to NWBH Safeguarding Team with a communication form highlighting concerns.	NWBH Safeguarding Team NW attend Team Meeting MERIT & MARAC Training.	NW NWBH Safeguarding Lead	NWBH Safeguarding Lead attends Team Meeting. The safeguarding lead bases himself in the Recovery Team weekly to provide advice and support. MERIT & MARAC Training delivered to team with Interagency training delivered by the IDVA Service. Daily Safety Huddle where domestic abuse risk levels are discussed and acted upon. Evidence of system improvements are the increased number of referrals to Safeguarding and MARAC.

11	Completion of risk documentation The Risk Assessment was not updated following information received by Making Space staff.	Staff to update the Risk Assessment upon receipt of any information considered to be a risk.	Individual Managerial Supervisions. Sharing SI Report with team at Team Meeting	Team Manager/ Deputy Manager	Team Meeting minutes 1-1 Supervision Notes. Case Note Audits.

Appendix B

References

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