WEST LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'ANNE' IN JANUARY 2021

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2018 to JANUARY 2021

OVERVIEW REPORT

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FINAL REPORT **October 2023**

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The Coronavirus-19 Pandemic

On the 31st of December 2019 the World Health Organisation (WHO) Office in the People's Republic of China picked up a media statement by the Wuhan Municipal Health Commission on cases of 'viral pneumonia' in Wuhan. The Country Office translated the media statement and passed it to the WHO Western Pacific Regional Office. At the same time, the WHO's Epidemic Intelligence Team picked up a media report about the same cluster of "pneumonia of unknown cause" in Wuhan.

On the 1st of January 2020 the WHO activated its Incident Management Support Team and on the 2nd of January informed the Global Outbreak Alert and Response Network (GOARN) about the cluster of pneumonia cases.

The UK Government issued a statement in Parliament on the 23rd of March 2020 stating that people 'must' stay at home, work from home, maintain social distance and that certain businesses must close. This has been described as the date when the first of a number 'lockdowns' and/or geographical tiered restrictions commenced in the UK.

The harm caused by the pandemic has been profound and distressing, and this has been exacerbated by the effect of the lockdown on usual social activity – socialising, schooling, shopping, going on holiday, and going to work. The effect on the public services has, at times, been almost overwhelming as the capacity to manage the impact of the pandemic has been tested to breaking point.

Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to Anne's family and friends for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work, particularly those agencies who contacted and spoke with Anne's friends and neighbours to gain a better picture of her personality and character.

Section 1. Background

1.1 This Domestic Homicide Review concerns the death of Anne, who died in January 2021. Anne died in Hospital following an overdose.

1.2 The Lancashire Constabulary have investigated the circumstances leading to the death of Anne and has concluded that there was no third party involvement in her death. Prior to her death, Anne made allegations of living with domestic violence and abuse for 20+ years, including incidents of abuse in 2019 and 2020. When asked by the Constabulary about these recent incidents, Anne denied making the allegations, stating that they were historical (and had been dealt with by the Constabulary in the early 2000's) and that she had been confused due to the impact of her medication.

1.3 Nevertheless, following the notification of her death, the Lancashire Constabulary referred the matter to the West Lancashire Borough Council to be considered as a domestic homicide review. The reason for this consideration is:

1.4 Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) states:
(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself,
held with a view to identifying the lessons to be learnt from the death.

1.5 Section 2 Para 18 of the DHR Guidance 2016 states:
Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

1.6 Anne died as a result of an overdose of medication. Whether taking her own life was deliberate or accidental is a matter for the Inquest to be held by the Office of His Majesty's Coroner.

1.1 Incident leading to the Domestic Homicide Review

1.1.1 In January 2021, the Southport and Ormskirk Hospital NHS Trust noted that Anne had been brought by ambulance to the A&E Department at the Southport and Formby District General Hospital. The Ambulance staff informed the Hospital that Anne had been found on the floor of her home by her Social Worker. Anne was extremely unwell on arrival at Hospital and a differential diagnosis was noted of mixed overdose and dehydration.

1.1.2 Later the same day, Lancashire Constabulary were informed that Anne was being transferred from Southport and Formby District General Hospital to the Royal Liverpool University Hospital for specialist intensive care.

1.1.3 On the following day, Lancashire Constabulary contacted the Royal Liverpool University Hospital and were informed that Anne's condition was deteriorating. Anne was recorded as having liver failure consistent with an overdose. Anne's home was preserved as a potential crime scene but later that day it was concluded that there were no suspicious circumstances.

1.1.4 At approximately five thirty PM Lancashire Constabulary were notified that Anne had died in the Royal Liverpool University Hospital

1.2 Significant people in this case

1.2.1 Both pseudonyms and the name for the subject in this case have been chosen by the DHR Panel. The significant people referred to within this Overview Report are described, in brief, below:

Name or pseudonym	Relationship to subject (if applicable)	Ethnicity
Anne	The victim in this Review. The name was chosen by the Panel	British/European heritage
M1	The Partner of Anne (until approximately November 2020). The Pseudonym was chosen by the Panel	British/European heritage
S1	Anne's sibling. The Pseudonym was chosen by the Panel	British/European heritage
S2	Anne's sibling. The Pseudonym was chosen by the Panel	Not confirmed
P1	The Panel was informed that Anne had a Husband – who died in 2007	Not confirmed

1.3 The use of pseudonyms

1.3.1 The Review Panel sought to involve Anne's Partner and her family (her Brother) in the Review. When the Review commenced in August 2021, the Commissioning Officer and the Author sent a letter of invitation to both Anne's Partner and her Brother (M1 and S1 respectively). The Lancashire Constabulary were also in contact with M1 and S1 and had shared relevant information with them. The letter to Anne's Partner expressed the condolences of the Panel, invited M1 to contribute to the Review. A number of weeks later, M1 responded and stated that they did not wish to contribute to the Review.

1.3.2 The Commissioning Officer contacted S1 and they were clear that they did not wish to be involved with the Review. However, as will be noted later in this Report, LC1 (a member of staff from the Lancashire Constabulary) did have a telephone conversation with S1 about the Review and about Anne.

1.3.3 S1 confirmed that Anne had another sibling, a Sister referred to in this Report as S2. LC1 liaised with the Office of the Coroner in order to co-ordinate their attempts to make contact with S2. LC1 – and the Office of the Coroner – were not successful in their attempts and replies were not received from the contact made.

1.3.4 Anne also had a Mother and a Father. S1 confirmed that he had informed Anne's Father of the death of Anne and on the advice of S1, the Panel did not attempt to make contact with them.

1.3.5 Nevertheless, In the absence of any direct contact between the Review and Anne's family or Next-of-Kin, the Panel decided to apply a pseudonym rather than use the real name of the subject of this case. The Panel chose the name 'Anne' as the name for the subject in this Review.

1.4 Purpose and conduct of the review

1.4.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

1.4.2 This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the latest revisions of the guidance issued by the Home Office in 2016 to support the implementation of the Act.

1.4.3 As described above, this particular case was referred by the Lancashire Constabulary for the consideration of a DHR in accordance with Section 2 Paragraph 18 of the DHR Guidance.

1.5 The time-period under review

1.5.1 At the initial meeting of the Domestic Homicide Review Panel, held virtually in August 2021, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2018 to the date of the incident in January 2021. The rationale for the parameters of the Review was that, in 2018 (after a period of 7 years), Anne once again came into contact with a service that escalated concerns regarding her welfare and safeguarding.

1.5.2 The agencies and services invited to participate and make submissions to the Review were reminded that if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, then such information should still be submitted in order to provide context for the case.

1.6 Proposed timescale

1.6.1 The first meeting of the DHR Panel was held on the 19th of August 2021. The Panel met again in November 2021, in December 2021, March 2022, April 2022, June 2022, July 2022 and in September 2022.

1.6.2 At the first meeting in August 2021, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

1.6.3 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies and the draft integrated chronology. Additionally, progress concerning the involvement of the family was considered.

1.6.4 At the third meeting, the Panel continued to scrutinise submissions from participating agencies, sought clarifications from previously submitted reports, and the emerging integrated chronology.

1.6.5 At the fourth meeting, the Panel continued to consider and scrutinise the submissions from participating agencies; the abridged chronology, narrative; responses to the key lines of enquiry and an update on the involvement of Anne's Partner and Sibling.

1.6.6 At the fifth meeting of the Panel, held in April 2022, the Panel considered the first draft of the Overview Report, including a draft of the key themes emerging from the Review, the draft single agency action plans and the draft recommendations for the multi-agency action plan.

1.6.7 The draft Overview Report, with recommendations, was considered by the Panel at its sixth meeting held on the 7th of June 2022.

1.6.8 At the seventh meeting of the Panel, held in July 2022, further amendments were made to the draft report.

1.6.9 At the eighth meeting of the Panel, held in early September 2022, the Panel approved the draft Overview Report and it was submitted to the West Lancashire Community Safety Partnership for approval and submission to the Home Office Quality Assurance procedure.

1.7 Statement of Confidentiality

1.7.1 The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals outside the DHR process.

1.8 The Conduct of the Review and methodology

1.8.1 At its first meeting, the DHR Panel approved the use of an Individual Management Review (IMR) and Chronology template. The Commissioning Officer from the West Lancashire Borough Council (WLBC), contacted each participating agency and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was, overall, excellent. The Panel, due to the COVID restrictions described earlier, made allowances for short delays in submission.

1.8.2 Together with the Commissioning Officer from WLBC, the Chair/Author provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office, December 2016). The IMR Authors were not directly involved with the subjects of this case. IMR reports were quality assured by a senior manager countersigning the report.

1.8.3 Copies of IMRs were circulated to all the DHR Panel members prior to the scheduled meetings. The IMRs were then discussed and scrutinised by the Panel and significant events were cross referenced and any clarifications that were considered necessary from the IMR author were invited via the independent author of the Overview Report.

1.8.4 The Panel agreed that a DHR should not simply examine the submissions received, but that the Review should be professionally curious, find any trail of abuse and in so doing identify which agencies had contact with Anne, and which agencies were in contact with each other.

1.8.5 As stated, the review panel sought to involve Anne's Partner and Sibling in the review and approached this with sensitivity and respect. Neither Anne's Partner nor her Sibling participated in the Review. However, in the meantime, Lancashire Constabulary contacted and spoke with friends and neighbours who lived near to Anne. The Author and the Panel are very grateful for their contribution to this Review.

1.9 The Conduct of the Review (contributors and Panel members)

1.9.1 Following the notification of Anne's death, the West Lancashire Community Safety Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of West Lancashire Borough Council.

1.9.2 The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

1.9.3 The Commissioning Authority (West Lancashire Borough Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

1.9.4 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to support the panel.

1.9.5 The views and conclusions contained within this overview report are based on findings from documentary submissions and interview transcripts and have been formed to the best of the Review Panel's knowledge and belief.

1.9.6 The members of the Panel are described in the table below:

Name	Organisation
Paul Charlson	Head of Planning and Regulatory Services, West Lancashire Borough Council
Cliff Owens	Community Safety Officer, West Lancashire Borough Council
Garry Fishwick	Review Officer, Lancashire Constabulary
Claire Powell	Area Manager, Lancashire Victim Support
Nicola Bradley	Tenancy Services Manager, West Lancashire Borough Council
Helene Cooper-Clark	Policy, Information and Commissioning Manager, Lancashire County Council
Bridget Welch	Specialist Safeguarding Practitioner for Adults and Children, Lancashire and South Cumbria Integrated Care Board
Bridget Cheyne	Domestic Abuse and Sexual Violence Lead, Wrightington, Wigan and Leigh NHS Trust
Deborah Norris	Safeguarding Manager, Wrightington, Wigan and Leigh NHS Trust
Kristy Atkinson	Designated Profession for Safeguarding Adults, Clinical Commissioning Group (subsequently the Lancashire and South Cumbria Integrated Care Board)
Sharon Seton	Assistant Director of Safeguarding, Southport and Ormskirk Hospital NHS Trust
Lisa Lloyd	Acting Operations Manager, Safeguarding Adults Service, Lancashire County Council
Susan Porter	Named Nurse for Safeguarding Adults and Children, Lancashire & South Cumbria NHS Foundation Trust
Amy Sharples	Clinical Lead, Intermediate Care Allocation Team
Mark Grimes	Development Manager/IDVA, The Liberty Centre
Sharon McQueen	Safeguarding Practitioner, North West Ambulance Service
Michelle Turner	Service Manager, Hospital Aftercare, Age UK
David Francis	Quality Assurance and Practice Improvement Lead, Quality Assurance and Adult Safeguarding, Lancashire County Council.
John Doyle	Independent Chair and Author

1.10 Contributors to the Review

Agency	Nature of Submission
The Liberty Centre	Short Report
Clinical Commissioning Group (GP for Anne)	Individual Management Review (IMR)
Age UK	Short Report
Lancashire Constabulary	IMR
Southport and Ormskirk Hospital NHS Trust	IMR
Lancashire County Council Safeguarding Service	IMR
Lancashire Victim Support	Short Report
Wrightington, Wigan and Leigh NHS Trust	IMR

West Lancashire Borough Council (Housing Services)	IMR
North West Ambulance Service	IMR
Lancashire and South Cumbria Foundation NHS Trust	Incident Investigation Review
Lancashire County Council Re-ablement and Occupation Therapy Service	IMR
Lancashire County Council - ICAT	IMR
Lancashire County Council – Adult Social Care (Community)	IMR

1.11 Parallel Reviews

1.11.1 There was one pertinent parallel process necessary for the Panel to consider. Following the death of Anne, the Lancashire and South Cumbria NHS Foundation Trust completed an incident investigation report.

1.11.2 The representative on the DHR Panel from L&SCFT shared the incident investigation report with the Author and the Panel. The incident investigation report was used to inform the Action Plan of the L&SCFT and it also informed the actions of other agencies.

1.12 Coronial Matters

1.12.1 As a matter of courtesy, the Office of the Coroner was informed that the Domestic Homicide Review was taking place and the expected time frame of the Review.

1.12.2 The Inquest into the death of Anne was scheduled for the 26th of October 2023. The outcome of the Inquest was not known at the date of publication of this Overview Report – though a copy of the Report was passed to the Coroner to assist them in their Inquest.

NOTE (Coroners Conclusion)

West Lancashire CSP was notified on the 25th of March 2024 of the conclusion from the coroner as to Anne's death. It was concluded that Anne died on the 5th of January 2021 at Royal Liverpool Hospital from the effects of ingesting an excess of medication, however, her intentions at the time could not be determined.

1.13 The Purpose of a Domestic Homicide Review

1.13.1 The Panel noted that the over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse 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; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

1.13.2 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

1.14 Specific Terms of Reference and Key Lines of Enquiry for this Domestic Homicide Review

a. To establish what contact agencies had with Anne.

This will require agencies to consider these issues:

1. To examine whether there were any previous concerns, incidents, or significant life events which may have indicated a risk of violence or suicide at any time during the period under review?
2. Had any mental health issues been self-disclosed by Anne or diagnosed by an agency for Anne?
3. Were there any complexities of care and support required by Anne and were these considered by the agencies in contact with her?
4. Were assessments of risk and, where necessary, referral of Anne to other appropriate care pathways considered by the agencies in contact with her?
5. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim?

b. To describe the way in which professionals and organisations carried out their duties and responsibilities for Anne.

This will require agencies to consider these issues:

6. What actions were taken to safeguard Anne and were these actions appropriate, timely and effective?
7. What were the key points or opportunities for assessment of risk and decision-making in this case?
8. Was Anne informed of options and choices in order to make informed decisions
9. What happened as a result?

c. To establish whether there were other risks or protective factors present in the life of Anne.

This will require agencies to consider these issues:

10. Were there any other issues that may have increased Anne's risks and vulnerabilities?
11. Were there any matters relating to safeguarding other vulnerable adults or children that the review should take account of?

12. Did Anne disclose domestic abuse to her family or friends? If so, what action did they take?
13. Did Anne's Partner make any disclosures regarding domestic abuse to his family or friends? If so, what action did they take?

NOTE

The following three key lines of enquiry concerned information about M1, Anne's long term partner. Consent to share personal healthcare information was sought from M1 and M1 declined to give consent. Agencies were advised that if they had relevant information, they should share only contact dates and non-specific details regarding M1

d. To establish what contact agencies had with M1, the Partner of Anne.

This will require agencies to consider these issues:

14. Was Anne's Partner known to any agency as a perpetrator of domestic abuse?
15. If so, what actions were taken to assess their risk to others?
16. Had any mental health issues been self-disclosed by Anne's Partner or diagnosed for them by an agency?
17. Was the mental capacity of Anne's Partner assessed by agencies?
18. Was Anne's Partner known to misuse drugs or alcohol, including misuse of prescription medication?
19. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the alleged perpetrator?

e. To describe the way in which professionals and organisations carried out their duties and responsibilities for M1, the Partner of Anne.

This will require agencies to consider these issues:

20. What actions were taken to reduce the risks presented to Anne (or others) and were these actions appropriate, timely and effective?
21. What happened as a result?

f. To establish whether there were other risks or protective factors present in the life of M1, Anne's Partner

This will require agencies to consider these issues:

22. Were there any other issues that may have increased Anne's risks and vulnerabilities?
23. Were there any matters relating to safeguarding other vulnerable adults or children that the review should take account of?
24. Did Anne disclose domestic abuse to her family or friends? If so, what action did they take?
25. Did Anne's Partner make any disclosures regarding domestic abuse to his family or friends? If so, what action did they take?

g. To establish whether agencies have policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

This will require agencies to consider these issues:

26. Were effective whistleblowing procedures in place to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures.
27. Was appropriate professional curiosity exercised by those Agencies working with Anne (and her Partner)

h. To analyse the communication which took place within and between agencies and to identify the degree of co-operation that occurred between different agencies involved with Anne (and her Partner).

i. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

1.14 Equality and Diversity

1.14.1 The review panel were committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to Anne, and her long term Partner, M1.

1.14.2 There was no evidence that Anne was directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

1.14.3 The Panel noted that whilst none of the agencies contacted in relation to this Review identified any specific diversity issues concerning Anne, this did not mean to suggest that these agencies were unaware of Disability discrimination as it pertains to the Equality Act 2010. The Panel noted that Anne was not registered as a person with a disability.

1.14.4 The Panel considered the implementation of the Equalities Act and discussed the impact of the legislation on the services that were in contact with Anne. It was noted that equality law recognises that bringing about equality may mean changing the way in which services are delivered. This is the 'duty to make reasonable adjustments' to the way things are done and the way services are provided in order to make them useable by everyone eligible to use them.

1.14.5 The Panel noted the guidance from the UK Government, stating that if an organisation providing facilities or services to the public or a section of the public, finds there are barriers to people in the way it does things, then it must consider making adjustments (in other words, changes). If those adjustments are reasonable for that organisation to make, then it must make them.

1.14.6 The Panel also noted that this duty is 'anticipatory', meaning that an organisation cannot wait until a person with a disability wants to use its services, but must think in advance (and on an ongoing basis) about what disabled people with a range of impairments might reasonably need, such as people

who have a visual impairment, a hearing impairment, a mobility impairment or a learning disability.

1.14.7 The question posed by the Panel for those agencies in contact with Anne was whether:

- the way it operated
- the physical feature of its premises, or
- the absence of an auxiliary aid or service

created a barrier which would have placed Anne at a substantial disadvantage compared with other people using the service.

1.14.8 The Panel concluded that there were no barriers which prevented Anne from accessing and using the services available to her. The Panel noted that the Southport and Ormskirk Hospital NHS Trust, the Guardian Homecare Service, Age UK and others were particularly responsive to Anne's needs.

1.14.9 Indeed, the Panel noted that all of the agencies contacted in relation to this Review identified that Anne had specific needs concerning either her diagnoses regarding her physical health and/or the diagnosis of her Munchausen Syndrome (now properly referred to as Factitious Disorder) Anne received in 2006. However, it appeared that not all of the services were in receipt of the full picture of Anne's needs. Nevertheless, it was encouraging to note that the agencies involved in this Review were aware of the physical and mental illness that Anne endured and that discrimination, as it pertains to the Equality Act 2010, does not have to be direct or contemporaneous, and that efforts were made to support Anne to cope with the demands associated with her diagnoses.

1.14.10 The Panel noted that sex and gender are protected characteristic under the terms of the Act and were cognisant of the fact that there is a disproportionate prevalence of women as victims of domestic abuse, coercion, control and violence. Please refer to **Appendix 2** for further details concerning the prevalence of these incidents.

1.14.11 Taking account of Appendix 2, the Panel noted the analysis, by SafeLives, of the MARAC national dataset which facilitated a discussion concerning some of the key elements in this case:

- **Gender:** Women are much more likely than men to be the victims of severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- **Low income:** women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000
- **Separation:** Domestic violence is higher amongst those who have separated, followed by those who are divorced or single
- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction (whether or not it is related to domestic abuse)

- **Drug and alcohol abuse:** Victims of abuse have a higher rate of drug and/or alcohol misuse (whether it starts before or after the abuse): at least 20% of high-risk victims of abuse report using drugs and/or alcohol.

1.14.12 Setting aside the issue of gender, there had been allegations of domestic abuse by Anne's previous partner – though these allegations were not verified and Anne stated that the incidents occurred more than ten years prior to the scope of this Review and then referred to recent events, but retracted her statement. Nevertheless, it would have been naive for the Panel to assume that these allegations, though not substantiated, had no bearing on this Review.

1.14.13 The Panel also noted that Anne had received – some considerable time prior to the formal scope of this Review – a diagnosis of Munchausen's Syndrome (now referred to as Factitious Disorder). The Panel paid particular attention to this matter, considering whether it may have had an impact upon the response of professional towards Anne's presentation. The Lancashire and South Cumbria NHS Foundation Trust (the specialist mental health service for Lancashire and South Cumbria) were represented on the Panel and noted that the diagnosis had no impact upon Anne's contemporary presentations during the scope of the Review.

1.14.14 The Panel did not uncover any evidence to suggest any negative response by the services Anne was in contact with regarding her diagnosis.

1.15 Dissemination of the Overview Report

1.15.1 The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The West Lancashire Community Safety Partnership
- Anne's family will be contacted to seek approval to share a copy of the Report, prior to publication
- The Office of the Coroner
- The Lancashire Suicide Prevention and Bereavement Service
- The Office of the Police and Crime Commissioner for Lancashire
- All agencies involved in the review
- Office of the Domestic Abuse Commissioner

Section 2. Background information – the facts

2.1 A pen picture of Anne – the focus of this DHR

This information has been taken from a number of the agencies submitting reports to the Review. Particular thanks go to the Lancashire and South Cumbria NHS Foundation Trust (L&SCFT).

From the information Anne shared with a variety of agencies, the Panel was able to construct this brief 'pen-picture' of her life. The Panel noted that not all of this information could be verified.

Anne was born in Bootle, a town in the Borough of Sefton and was raised in Maghull, a small Parish in the Borough of Sefton. A number of agencies in contact with Anne noted that she stated that she is 1 of 3 children, though other agencies have recorded that Anne has only one sibling.

When, prior to the events in December 2020, Anne shared information with the agencies involved in this Review, she said that she was unsure if her parents were still alive because she had not had contact with them or her sibling(s) since the age of 22.

Anne reported a happy childhood, living with both parents. She said that school was fine, and there were no issues with bullying. Anne did well at school and obtained 9 GCSEs, 6 of which were graded as A. One problem identified by Anne during her school years was related to insomnia and feeling tired 'all the time'. Nevertheless, Anne maintained her education, entered sixth form, achieved her A levels and went to College.

After Anne left college, for a short time she worked in a post office and also as a carer. At the age of 18, she met her first husband (P1). Unfortunately, and unknown to Anne, P1 gave her heroin to handle and distribute in a nightclub. Anne was caught by the Police and sent to a young offender institution (YOI), having been given a sentence of 6 months to 2 years. She was released from prison at 6 months and 1 week and returned to live with her parents, who were supportive at this time. However, they realised that Anne had re-united with P1, at which point they stopped contact with Anne and they have ever since remained estranged.

Anne told the Lancashire and South Cumbria NHS Foundation Trust that she had contacted P1 when she was released from the YOI and married him when she was 19 and remained in a relationship with him until his death in 2007, or thereabouts. Anne said that P1 had been diagnosed with Myotonic Dystrophy (part of the group of conditions referred to as 'muscular dystrophy – leading to muscle deterioration) and that P1 died of a heart attack.

Anne described entering a new relationship fairly quickly after P1's death and this relationship was with M1. It was recorded that Anne has no children but she reported having had one miscarriage and one unsuccessful attempt of IVF. It was recorded that M1 has children and that Anne was good friends with the ex-partner of M1.

Following the death of P1 and the relationship she formed with M1, Anne continued to work in care. However, due to her physical and mental health conditions, she had been unemployed for the 10 years prior to the incidents in December 2020

2.3 The perspective of Anne's friends and neighbours

As noted earlier in this report, Anne's partner declined the invitation of the Panel to contribute their views and perspective and to share a clearer picture of Anne's life prior to the tragic incident in January 2021. Additionally, Anne's sibling did not respond to the efforts made by the commissioning authority to engage them in the Review and the suggestion made by the notes found in the GP record that Anne had another sibling living in the Lake District could not be verified.

This placed the Panel in the regrettable position of feeling that it did not have a clear picture of who Anne was.

Fortunately, the representative on the Panel from the Lancashire Constabulary (referred to here as LC1) offered to make a number of visits to the area where Anne lived and seek the views of her neighbours and people who lived nearby who may have known her. LC1 works for the Review Team at Lancashire Constabulary.

Anne lived in a ground floor flat in a two storey block of four flats. LC1 spoke to a neighbour of Anne who had moved into the block in January 2021 and did not know Anne. LC1 also spoke to another neighbour who was aware of Anne but, again, had only moved into the property after Anne's death. LC1 learnt that the former occupants of one neighbouring property (who LC1 was told knew Anne a little better) now lived a short distance away. Despite making a visit, there was no-one home. The Housing Service of the Commissioning Authority were asked if they had the details of the previous neighbour who had moved, but sadly, they didn't.

LC1 then spoke to a person (N1) who lived with her Mother at a nearby property. Both of them knew Anne and spoke about her as a good neighbour. They said that Anne would always stop and talk. N1 stated that they would have conversations with Anne, but said that quite often they could not fully understand her as Anne would often say one thing then change her story on the next occasion they saw her. N1 stated that Anne did not disclose any incidents of domestic abuse to them or to their Mother. N1 described Anne as a quietly spoken person with whom you really had to listen to hear what she was saying. N1 was aware that Anne's ex-partner (M1) left the address once they and Anne had separated. N1 had been told that M1 had secured another property elsewhere. N1 told LC1 that their bedroom wall adjoined Anne's property and they:

> "never heard anything untoward".

N1 stated that M1 and Anne had split up some time before Anne died, but could not be more specific. N1 stated that M1 and Anne seemed happy walking out together, but stated that M1 could have been "putting on a front". N1 could not expand further on that perspective.

Additionally, LC1 was told of another neighbour, N2, who had moved away from the area. LC1 recognised the name of the neighbour and referred to the notes from the Police investigation. LC1 found that N2 had reported to the Lancashire Constabulary the incident that occurred on the 18th of November 2020. N2 had discovered Anne collapsed on the floor of her property. LC1 made a number of attempts to contact N2 (there were a number of telephone numbers and, when LC1 visited their registered

address, they were not at home). Clearly N2 is known to Lancashire Constabulary because they stated to the investigation team that they would check up on Anne and sometimes run errands for her. LC1 considered that N2 may have some information that may be useful to the review and LC1 maintained their effort to contact them. Consequently, LC1 made contact with N2 in June 2022. N2 was in a relationship with the Son of N3 when they lived near to Anne, but they had since separated.

N2 (and the Son of N3) both befriended Anne and would shop for her and make sure that she was alright. N2 also knew her estranged husband, M1. N2 stated that M1 left Anne and moved out no later than September 2020. N2 said that M1 had two children who used to visit the property and "do the garden". N2 said that whilst Anne lived with M1 they regularly went away for a week or two weeks at a time, but N2 did not know where they went. N2 described the relationship between Anne and M1 as "not being close" towards the point when they separated.

N2 stated that Anne was struggling due to her illness and they found her collapsed on the floor on the 18th of November 2020 and had called an ambulance. N2 stated that Anne had said that she had been on the floor for a few days. N2 stated that Anne was also drinking whilst taking medication, which N2 and N3 tried to prevent her from doing and took the drink away from her. N2 said that Anne had made reference to her medical condition and indicated that she wanted to end her life as she was in pain. Anne had a Jack Russell Dog called Penny which she told N2 and N3 was "….worth a lot of money" and that she wanted them to look after Penny should something happen to her.

N2 stated that they were led to believe that Anne had been provided with Painkillers by someone else in the neighbourhood. N2 believed that this is what Anne used to take the overdose.

N2 described Anne as being a quiet lady and Motherly towards N2 and the Son of N3. N2 stated that Anne insisted on buying them gifts for looking after her and taking her shopping. Although N2 stated that both they and the Son of N3 declined the gifts, Anne was insistent and so they accepted some of them. N2 expressed concern that Anne would visit the ATM at a local supermarket and would not be concerned about her security and would openly display her card and numbers putting her at risk of being robbed.

LC1 managed to establish a conversation with N3 in July 2022. N3 was a neighbour of Anne and got to know her and her partner M1 following the death of N3's husband in 2017.

N3 has two sons S3 and S4. S3 lives with his mother and was present throughout the conversation. S3 was the partner to N2.

N3 described Anne as 'a bit of a loner' and did not see many people visit Anne's address. In 2017, M1 was living with Anne and following the death of N3's Husband, M1 helped the family by picking up the Sister of N3 in his car and transporting her to N3's home. N3 stated that M1 had not been living with Anne prior to her death, but, occasionally, he did visit. N3 said that M1 had his own house elsewhere. N3 described her relationship with Anne as friendly and they would occasionally chat. N3 said that

they did not visit each other's houses. N3 had only been into Anne's house on one occasion to check that everything was in order whilst Anne was away from home; she had told N3 that she staying with her son (*the Panel could not verify that Anne had a son).*

Following the death of Anne, N3 stated that M1 came to visit and asked her where Anne was, because M1 was unaware that Anne had died. M1 asked what had happened to Anne's dog; a Jack Russell Terrier called Penny. N3 was unaware of where the dog had been taken or who was looking after it.

N3 was aware that Anne had stayed' at the home of her son S3 and his former partner N2. Anne had intimated to S3 and N2 that she wanted to take an overdose as she had a lot of health problems. S3 stated that Anne told him that she had liver problems.

N3 said that Anne did not disclose private information and N3 did not know anything about Anne's family. S3 stated that he often helped Anne and M1.

N3 stated that they thought that Anne and M1 often visited a Static Caravan in the Lake District which Anne always described as 'their' caravan, giving the impression that they owned the caravan on a registered site. N3 did not know whereabouts the caravan was sited in the Lake District. N3 said that they did not go to the caravan very often but, when they did go, stayed over for a week at a time. (*The Panel could not verify the location or existence of the caravan).*

N3 was clear that she did not know if Anne has a sister or any other relative in the Lake District. N3 she stated that she was unaware of any relatives.

S3 said that they believed that Anne and M1 had split up as he had stopped visiting Anne shortly before she died. N3 last saw Anne two days before her death when she walked past her house with the dog, but they did not engage in conversation. Both N3 and her Son S3 both described Anne as a lovely and friendly person who was quietly spoken.

Section 3
Abridged chronology

Prior to the formal scope of the Review

Between **2003 and 2007**, there were fifteen Protecting Vulnerable People (PVP) submissions involving "standard risk" domestic abuse incidents between Anne and her Partner, M1. Most of these incidents involved verbal arguments (where alcohol use was a factor), and counter allegations being made by both parties.

The Panel was aware that at this time, Anne was – as she had disclosed to the Lancashire and South Cumbria Foundation NHS Trust – married to her first husband. Lancashire Constabulary re-checked their records and confirmed that between 2003 and 2007 incidents of alleged abuse involved M1 and not P1.

2011

Adult Social Care (ASC – Community) noted that on the 26th of September 2011 they received a Safeguarding Adults Enquiry. The detail recorded in the Safeguarding case notes states that Anne had made an allegation of Domestic Violence and identified her "ex-partner" as the perpetrator. There is no clear indication of who this was. When the Constabulary interviewed Anne, she said she didn't wish to take things any further. Anne informed the Social Care Support Officer (SCSO) that the Lancashire Constabulary had placed a marker on the address, that there was a vulnerable adult present there and that they would prioritise attending the address should they be alerted to any further incidents.

A record of these incidents was recorded by the Lancashire County Council Reablement Service. They noted:

> "….Anne has got bruising to arms, shoulder and face which has been done by ex-husband, he does not live at this address but has got a key to the home and comes when he likes. All information given to the safeguarding team and they have said that they will look into this".

Within the formal scope of the Review

2018

18/09/2018

A letter was received by Anne's GP regarding her sustaining soft tissue injury after a fall on the 16/9/18. There was no obvious comment on the nature of the fall or any safeguarding or domestic abuse concerns recorded. There was very little information in terms of the reason for this 'fall'. There doesn't seem to have been a task or note to see Anne following this which would have been expected.

08/11/18

A Safeguarding handover letter from North West Ambulance Service (NWAS) was received by Anne's GP. NWAS attended because Anne was having a seizure outside a local supermarket.

30/11/2018

Anne's GP requested a Specialist Triage, Assessment and Referral Team (START) assessment due to the safeguarding concerns shared by NWAS. The referral letter referred to chronic health conditions, anxiety, and panic attacks. There was no comment regarding domestic abuse, but it did mention social exclusion. There was no follow up made here based around the suspected seizure.

2019

20/04/2019

Anne called 111 and alleged that she was kicked by her husband 30 hours ago, resulting in flank injury and 2 black eyes. Anne also disclosed that her husband had taken her bag which contained some of her medication. The call handler asked Anne if she was safe and if the Lancashire Constabulary were aware of the situation. Anne answered yes to both questions.

23/04/2019

A letter from 111 was sent to Anne's GP. The letter stated Anne had been assaulted by her husband. The letter stated that Anne no longer lived with M1. Anne stated this had happened before. There was no entry in the GP notes or a follow up plan. There does not seem to have been an enquiry into this event.

24/04/19
The Safeguarding Service had a discussion with: Anne. Anne expressed that she was unaware that an alert or any concern had been raised. Anne expressed that she had refused to go to A&E and had a phone consultation with a GP who arranged for a prescription for her to collect. Anne expressed that she had not contacted the police and did not want them involved. Anne confirmed that she does not live with M1, he has a separate flat and was visiting her when the incident occurred. Anne expressed that she felt safe; this was the first time in about 8 years that something like this had happened and asked for no further action to be taken. The decision taken was to close this referral at stage 1 of a section 42 safeguarding enquiry. It was deemed to be an isolated incident. Anne requested that no further action should be taken

18/11/2020[1]
North West Ambulance Service (NWAS) and the Lancashire Constabulary received a 999-call from a neighbour (N2 and N3) reporting that a female was shouting for help from Anne's address. The service gained entry and found Anne in her bed with severe shoulder pain. She was found to have a dislocated shoulder and stated she had been drinking alcohol on Saturday night and fell into furniture whilst intoxicated. The crew assisted her to get dressed and she was transported to hospital. There was no other injury found and Anne stated she lived alone. The Police officer recorded that there may have been a domestic abuse element to the situation, although Anne stated that the injuries had not been caused by a domestic assault. The officer requested a re-visit by and Officer from the Lancashire Constabulary following treatment at Hospital.

18/11/20-25/11/20
Anne attended the A&E Department at Southport and Formby District General Hospital and was treated for a fractured right humerus following a reported fall 4 days previously after consuming alcohol. Records indicated Anne had a history of domestic abuse by M1. Anne reported no physical abuse from M1 on this occasion. Anne was referred to the Hospital Safeguarding Team. A domestic abuse risk assessment was completed by the Safeguarding Nurse, with a score of 15. Records indicated that Anne declined refuge accommodation due to her dog and wished to return to her home address. A referral was made to MARAC, the IDVA service, Trust-house (an in-house service for victims of sexual assault) and the Lancashire Constabulary were updated regarding the information shared. A 'consider domestic abuse' alert was added to Anne's electronic hospital records by the hospital safeguarding team. A referral was made to Age UK to support her with shopping. A food parcel was also arranged by the hospital on discharge. Anne was discharged home on the 25/11/20. A discharge letter was sent to the GP including details of domestic abuse concerns.

18/11/20
Southport and Ormskirk Hospital NHS Trust informed Lancashire Constabulary that Anne had reported domestic abuse by her partner whose identity was not disclosed to

[1] From the 5th of November, the UK was in its second national lockdown to help manage the COVID Pandemic.

staff. Anne stated that she did not want her partner to gain access to her house, although he had a key for the house. Anne stated that reports had been made to the police in the past. Anne was happy for the police to attend to speak to her but expressed concern about them speaking to M1

24/11/20
The Intermediate Care Allocation Team (ICAT) received their first referral. The referral was subject to triage and non-clinical home support was identified as appropriate in the first instance. Crisis care was commissioned for one visit to Anne per day – to take place in the morning.

24/11/20
Lancashire Victim Support received a high risk referral. Anne had disclosed 20+ years of abuse. Anne had lost contact with her family since being married. Triage contacted Anne via the hospital. She was unable to speak privately and so agreed to call LVS when she was home. Anne was given contact details for LVS.

25/11/20
Age UK received a request from Southport and Formby District General Hospital to 'Take Home and Settle (THAS)' Anne from Hospital. They had a food parcel for Anne. Anne was nervous about going home. Anne told Age UK about some of the abuse she had received from her husband. She stated that 4 years ago he broke her hip and it still bothers her now. Anne stated that she, in the past, has tried to take her life but didn't feel like that now. She stated she was terrified M1 would come back.

25/11/20
Lancashire Constabulary received a telephone call from a member of the safeguarding team at Southport and Formby District General Hospital reporting that Anne, was making an allegation of Rape. The incident was cross-referenced with the two earlier incidents. There were three elements to the log

- A high risk DV victim who has no mobile phone, no means of contacting the police and her ex-partner may be at the home address
- A report of historic rape that occurred two weeks ago, including many other incidents of sexual offences by the ex-partner including strangulation
- Theft of a dog

An officer attended Anne's home and reported as follows:
"Have spoken to Anne at length regarding the report which she was shocked about and said that it must have been an incident that happened years ago and has been dealt with by police. But, because she was on so many strong pain killers due to her injuries, she thinks she must have just got confused and doesn't even remember talking about the incident as she was quite "spaced out". There was nothing else to report other than what has already been reported and she was not prepared to go into any detail. Anne is safe and well in her flat and has been given a mobile phone and food parcel; she also has neighbours looking in on her. Anne's partner does not know she is back, and the locks have been changed. The officer pointed out that there was still damage to the front door and asked if we could contact the Council about getting the door replaced".

26/11/20

ASC (Community). A Senior Social Worker recorded that AGE UK was concerned about Anne's safety due to a violent husband (who no longer lived at the property). The Senior Social Worker advised the worker from Age UK to pursue a Domestic Violence Advocate. It is recorded that Age UK would continue trying to contact Anne by phone. The Senior Social Worker discussed with an SCSO and it was arranged to move the review forward to the 27/11/20.

26/11/20
Age UK contacted ICAT to raise concerns about domestic violence that had been disclosed on the first assessment. Advice was given to appoint a domestic violence advocate, with Anne's consent. A safeguarding alert was added to Anne's record (LAS). ICAT were not aware of domestic violence concerns prior to discharge from hospital. ICAT made a call to the Safeguarding Team at the Southport and Ormskirk Hospital NHS Trust for additional information.

26/11/20
Guardian Care (appointed to provide the care package) contacted ICAT and advised the Senior Social Worker that they were increasing their visits from once daily to four times a day as they were concerned that Anne appeared *'out of it'* due to her medication. Anne had been incapacitated to the extent she couldn't open the door and carers had climbed through the window.

26/11/20
A telephone call was received by the ISVA at the Southport and Ormskirk Hospital NHS Trust from the Lancashire Constabulary reporting that Anne had stated she was unsure about what had happened and cannot remember disclosing any incidents whilst in hospital due to the pain medication she was taking. The ISVA then contacted the Liberty Centre who stated that no disclosures had been made to them by Anne in relation to sexual abuse. Due to these discrepancies in information, and concerns regarding Anne's level of vulnerability, the matter was discussed with the Named Nurse for Safeguarding.

26/11/20
The Reablement Service contacted the Take Home and Settle service. Anne had consented to the provision of a Lifeline Service.

27/11/20
Anne's GP called her three times and a message was left to call the practice. The GP also called the social worker who had been in contact due to concerns they had about Anne's medication. A message was left. A later GP entry stated: 'withholding *certain medications (authors italics)* until further information is available as the patient is reported as 'groggy''. There does not seem to have been an attempt to re-contact the Social Worker or escalate to the Safeguarding service. The medication was stopped abruptly.

These medications were for the management of sleep, a treatment for depression and analgesia for chronic pain.

The Lancashire County Council Safeguarding service noted that Anne attended Southport and Formby District General Hospital and disclosed domestic abuse but disclosed slightly different incidents to different colleagues. Consent was given by Anne to raise concerns to the police. The police went out to see her and she said it was all historic and that she doesn't remember talking to anyone at the hospital. They are concerned that she is confused because there are gaps in the stories, she has told different accounts to different members of staff at the hospital.

The Lancashire County Council Safeguarding Service made a telephone call to Anne. She expressed some anxiety & asked if M1 would be contacted. She stated she doesn't want to make any statements or complaints about it because she will "pay for it". She said she just hopes he stays away. She thinks he is probably with his son. Anne confirmed she would like to consider what support was available with regard to risk planning. She consented to progressing this to the Enquiry Service for further discussions. Anne said she won't "turn anything down", as long as M1 won't be told.

30/11/20[2]
LVS spoke with the hospital ISVA who had gathered more background information from Anne. Anne had said that all incidents were historical. Hospital ISVA confirmed that a safeguarding referral had been made.

16/12/20
The MARAC meeting occurred. MARAC raised an action for a member of the safeguarding team to revisit Anne and make a full assessment to tie up all the information. However, this was not done. An officer from Lancashire Constabulary expressed that they had done all they could. There were no unreported matters and Anne had been advised to report any future incidents.

16/12/20
LCC Safeguarding service made a pre-arranged visit to Anne. Observations noted that Anne looked in pain when she was walking. The officer discussed with Anne why a safeguarding alert had been raised. The officer asked her what they could do to help her. The officer discussed getting a lifeline and a package of care, and Anne advised that this was already getting sorted out. The officer discussed with Anne that she had an advocate who had been trying to contact her. Anne advised that she did not want to speak with the advocate. Anne advised that she has good friends that were keeping their eye on her.

17/12/20
The safeguarding service also called Anne's GP and informed them about the domestic abuse and psychological support requested. The GP stated they would make a referral to the Mental Health Service for an assessment.

17/12/20
Anne's GP notes that they had spoken to the Safeguarding team regarding Anne. The report stated: 'she was beaten up by her husband and on floor for 3 days.' She still thinks 'he will come and get her'; she is not in state of mind to do self-referral to Minds-

[2] From the 2nd of December, England was divided into three tiers of regulation to help manage the COVID Pandemic

matter, agreed referral to MH for more support. ‘domestic abuse agency is involved as well’.

WLBC Housing Services contractor noted that there was a domestic violence incident and main communal door to the block where Anne lived had been breached and the door to her flat has been damaged (when the Fire Service forced entry). An emergency repair was requested.

23/12/20
LVS noted that the IDVA had received an email from the safeguarding hub stating they had spoken to Anne who was shocked about the DA report and doesn’t recall making it. Anne reported that it was something that happened a long time ago and had been dealt with by the police. Anne stated that she had been on strong painkillers at that time and ‘spaced out’ and didn’t want to discuss it further. She confirmed she was safe and well.

25/12/20
North West Ambulance Service received a 999 call from 2 people reporting a woman who had taken an overdose and wasn’t breathing. The caller identified the patient as Anne. As the call progressed, it was established that Anne was breathing and had regained consciousness. An ambulance was dispatched to the address. Anne was in an emotional state. Anne was reassured and calmed and she confirmed that she had taken the tablets with the intention to end her life.

This call was reviewed by NWAS and both people spoke to the call handler. NWAS noted that both displayed caring tendencies and both can be heard in the background talking with Anne. No aggression was heard in their tone and no other background noises which would suggest Anne was at risk of attack or assault. Anne was the only one that could be heard shouting in an agitated fashion.

A safeguarding referral to adult social care was discussed and Anne agreed to this.

25/12/20
Anne attended the A&E Department at Southport and Formby District General Hospital. The history at hand over from the paramedics was that Anne had been at another property where the two people who made the call lived. It was reported that Anne had taken an intentional overdose at 18:30 with the intention of ending her own life. At the time of medical review (a little while after arriving at A&E), Anne reported that she had not taken an intentional overdose, that she had taken her normal dose of medication, went to her neighbour’s house and was coerced into giving them money. Records indicated that Anne informed A&E that she had previously been a victim of domestic abuse by her husband and that she had had no contact with him for 20 weeks

26/12/20
Anne’s GP received a letter from the Mental Health team, after a review on the Hospital Ward. The letter stated a 20 – 25-year history of domestic violence from her husband. Letter stated that the husband had moved out. There was also a note in the letter that Anne ‘may’ have taken OD unintentionally, but was reportedly ‘down’. Possibly stated to her neighbours that she wanted to die and they called the police. There were details in this letter reporting physical, sexual, emotional abuse. It was noted in the letter that

Anne denied any truth in what she said and reported pain killers affecting her memory of events.

26/12/20
The plan of action documented by the Mental Health practitioner was to complete a safeguarding referral. A discrepancy in the information given by Anne to different professionals was noted in relation to the last contact with M1. On 25/12/21 Anne stated she had no contact with them for 20 weeks, then on 26/12/21 reported to Mental Health no contact with M1 for 4 weeks

29/12/20
The Safeguarding Service met with Anne in a private room at Southport and Formby District General Hospital. Anne agreed to proceed with the assessment.

Anne reported a 20-25-year history of experiencing domestic violence in her marriage. Anne stated that her injury on 18/11/20 had not been caused by M1 but stated that during a row, he had 'hit' her dog and this led had to her barricading her flat and M1 moving out. She reported that she had remained in the marital home and that she thinks that M1 is staying with his son.

Anne reported that she had become 'down' thinking about her marriage and voiced that she 'may' have taken an overdose unintentionally adding that she 'may' have also expressed that she 'wanted to die' to two 'friends' who reportedly live next door.

The safeguarding service noted a long history of contact with mental health services. Anne reported that she had previous psychiatric history and had been in services both in the community and as an inpatient approximately 15 years ago. She stated that she was an inpatient at Ormskirk hospital for approximately 9 weeks after taking an overdose. Anne reported that at the time of the overdose she was overwhelmed with a number of problems: including negative equity in the house causing bankruptcy, miscarriage and her (then) husband being diagnosed with Myotonic Dystrophy.

29/12/20
Age UK noted that Anne “didn't seem too good”. Anne was asked if carers were attending and she said that Age UK was the first that had attended recently. Age UK asked Anne if she would consent for them to call social services to ask about carers and she said that she did not mind and that she was struggling.

30/12/20
Anne gave consent to call Guardian Care, who were under the impression that Anne was still in hospital. Care Concern re-instated the care immediately.

The North West Ambulance Service received a 999 call reporting a 58yr woman was vomiting blood. She had self-discharged from hospital on the 25/12/2020 following an overdose. An ambulance attended. Anne described having a week long history of vomiting blood following a morphine overdose.

Anne was transported to the A&E Department at Southport and Formby District General Hospital.

- Anne was asked whether she felt safe at home, she answered yes;

- The medical assessment was completed.
- The Safeguarding proforma was completed by the hospital safeguarding team;
- Plan documented in notes to liaise with the allocated social worker regarding ongoing support;
- Discharge summary was sent to Anne's GP on the date of discharge.

01/01/21
Age UK made a welfare call. Anne called to give her new number and to let the service know she was home. Anne sounded better than last time she was visited. Anne stated that it was one crisis after another; the service acknowledged how much she had been through lately. Anne was asked if she would like a visit tomorrow, Anne asked the visit to remain as Tuesday, as planned.

02/01/21
North West Ambulance Service received a 999 call from Anne reporting she had tripped over a wire and fallen and was unable to get up off the floor. She stated she had hip and arm pain. She confirmed she was alone. She disclosed to the call handler she was a victim of domestic violence and the key was still in the door as she has someone to check on her each night to ensure she is ok and this may hinder access to her home. The Fire and Rescue Service were requested to assist (at 05:28hrs) to gain entry to the property. The ambulance arrived on scene and Anne was assessed and transported to hospital for further treatment. No safeguarding concerns were highlighted during the contact.

Anne was taken to Wrightington, Wigan and Leigh NHS Trust. Anne disclosed that she had pain in her hip and groin following a fall during the night. It was documented that Anne disclosed she had been suffering domestic violence from her husband for the past several years, and that today he kicked her in the abdomen. Anne was complaining of pain and tenderness. Anne stated that her husband had "put her on the floor". Anne was admitted as an inpatient and transferred to the Medical Assessment Unit (MAU). The Domestic Abuse Stalking & Harassment (DASH) tool was completed by staff in A&E.

At 13.30, Anne stated that she was going home and was unwilling to stay. Staff explained that if Anne did leave, she was going to be discharging against medical advice. Anne explained that she was having a panic attack. Staff advised that they could ask a doctor to come and see her, and get her regular medications prescribed. Anne's capacity was assessed by staff and she was found to be "orientated to time and place" and deemed to have capacity. Anne stated that her husband was no longer in her property and her locks have been changed.

04/01/21
The senior Social Worker from the Lancashire County Safeguarding service made a home visit to return Anne's dog. The Social Worker knocked at the front door and shouted through the letter box for approximately 10 minutes; they then tried the front door and it unlocked and they shouted their arrival and attempted to go into the bedroom. The Social Worker couldn't open the door so they pushed the door and someone made a noise. The Social Worker popped their head around the door and saw Anne on the floor 'making strange noises.' The Social Worker called 999 for ambulance and police. The Lancashire Constabulary arrived first and then the

Paramedics. Anne was found lying on the floor with empty packets of Tramadol, Oramorph, Codeine and Paracetamol. The Paramedics undertook investigations and found Anne's blood sugars to be very low and suggested a possible overdose. One police officer remained at Anne's property. The Social Worker took Anne's dog for safe keeping. Anne was taken to hospital. No safeguarding concerns were highlighted during the contact.

Southport and Ormskirk Hospital NHS Trust noted that Anne had been brought to the A&E Department by ambulance. Anne was extremely unwell on arrival. Differential diagnosis of mixed overdose and dehydration. Anne was transferred to Liverpool Royal Hospital at 20:48 for further critical care input. A discharge summary was sent to Anne's GP.

Lancashire Constabulary noted a High Risk Vulnerable Adult concern through the MASH. At 21.39hrs Lancashire Constabulary were informed that Anne was being transferred from Southport and Formby District General Hospital to the Royal Liverpool Hospital.

Later in January, Lancashire Constabulary were notified that Anne had died in the Royal Liverpool Hospital.

Section 4. Over-view – what the services involved knew

Over-view – what the services involved knew about Anne

Hindsight bias

The Panel recognised that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do what we might consider – with hindsight – as "the correct thing". It would be unwise not to recognise that a Review of this type will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid this inherent bias and has, as best it can, viewed the case and its circumstances as it would have been seen by the individuals involved at the time.

A number of agencies that were involved with Anne (and M1) less frequently than others, have described their interactions in the form of a short-report narrative. Those agencies that had more frequent contact, for a longer period of time, have addressed each 'key line of enquiry' in turn as a part of their Individual Management Review. These are addressed under a different section of this Review.

All the agencies involved in this review provided candid accounts of their involvement in order to identify the lessons to be learned. The Panel analysed the involvement of each agency on a service-by-service basis. The involvement of each agency covered different periods of time and it is important to note that some of the contacts contained in the IMRs, and reflected here, hold more significance than others.

Service Narrative

4.1 Southport and Ormskirk Hospital NHS Trust

4.1.1 Within the timeline set out in the Domestic Homicide Review (DHR), Anne attended Southport and Formby District General Hospital on four separate occasions. On two of these occasions, Anne was admitted to hospital and on the last occasion was transferred to another Hospital. These attendances were in relation to acute medical care. The first occasion when domestic abuse was disclosed to staff by Anne, was in November 2020. At this time a domestic abuse risk assessment (commonly referred to as a DASH) was completed and Anne scored 15 – the threshold for referral to the local MARAC. Consequently, appropriate referrals were made to MARAC, the IDVA service and Trust House (a service that exists to support people who have endured sexual assault or abuse). The Lancashire Constabulary were also updated.

4.2 Lancashire Constabulary

4.2.1 There are fifteen historic Protecting Vulnerable People (PVP) submissions between 2003 and 2007 and as noted in the abridged chronology, these submissions involved "standard risk" domestic abuse between Anne and M1.

4.2.2 When the safeguarding officer at Southport and Ormskirk Hospital NHS Trust contacted Lancashire Constabulary to report that Anne had made allegations of Domestic Abuse and Rape against M1, the Lancashire Constabulary interviewed Anne and commenced enquiries. Anne denied that she had been

raped or assaulted, and she stated that the allegations she made at the hospital referred to incidents that had been reported to the police many years before.

4.2.3 Following the DASH – completed by staff at the Southport and Formby District General Hospital – Anne was referred to the MARAC and an action was raised for the Lancashire Constabulary to review the case, and complete a full assessment to tie up all information. There is no record of Anne being re-visited for an assessment to be carried out.

4.2.4 In the view of Lancashire Constabulary, there is clear evidence to suggest that this case was an apparent suicide. Anne had expressed suicidal ideation, and had taken an overdose in the previous month (December 2020). The Lancashire Constabulary believe that Anne was, at some points prior to her death, a victim of domestic abuse and this abuse was perpetrated by M1. Following investigation, Lancashire Constabulary has ruled out any third-party involvement in the death of Anne.

4.3 Lancashire County Council (LCC) Safeguarding Service

4.3.1 The Safeguarding Service recorded four (4) incidents whereby safeguarding alerts were raised with them concerning the safety of Anne. These alerts are described, in brief, below:

4.3.2 The first safeguarding alert was raised with Lancashire County Council on the 26th of September 2011. The alert concerned allegations of domestic abuse.

4.3.3 The second safeguarding alert was raised by NWAS on the 24th of April 2019. The alert concerned domestic, physical and emotional abuse. The Social Worker from the local MASH telephoned Anne to discuss the concerns raised. Anne confirmed that she had telephoned 111 because she had been hit by M1. Anne stated that she felt safe. Anne stated that it was the first time in about 8 years that something like this had happened. Anne asked for no further action to be taken and did not want the police involved or social care input. The safeguarding alert was closed at Anne's request.

4.3.4 The third safeguarding alert was raised on the 27th of November 2020 by the Southport and Ormskirk Hospital NHS Trust. The alert concerned allegations of domestic, physical, sexual and emotional abuse. It was noted that Anne offered slightly different versions of what abuse had occurred to different people. Crisis care was arranged for four (4) times a day and support from the re-ablement service was arranged. Anne agreed to the safeguarding enquiry being progressed to the Safeguarding Enquiry team for further support. Anne stated that she would not turn any support down, as long as M1 was not informed. The Senior Social Worker allocated to Anne (referred to here as 'SWS') visited Anne on the 16th of December. Anne disclosed that she had endured physical, sexual, and psychological abuse during the 20 years of her relationship with M1. Anne advised that she does not want the police to press charges, as this will make things worse for her in the long run. SWS agreed to liaise with the Lancashire Constabulary, the Housing Services Department, Adult Social Care and Re-ablement Services, etc. to determine what packages of care and support were being prepared and/or provided.

4.3.5 The fourth safeguarding alert was raised by the Southport and Ormskirk Hospital NHS Trust on the 29th of December 2020. The alert was raised and then shortly afterwards closed. Anne had stated that two neighbours had been spending some time in her home and 'doing her shopping' and using her bank card to buy some items for themselves. Anne stated that they had not been threatening her, but she had felt 'under pressure' to offer them money. Anne stated that she had reported this to the police who had attended her home.

4.4 Victim Support

4.4.1 Lancashire Victim Support received a referral for Anne following a disclosure of domestic and sexual abuse made by Anne whilst in Hospital. Initial contact was made with Anne whilst she was an in-patient. However, it wasn't suitable to speak as she was not in a private area.

4.4.2 Victim Support and Anne agreed to make contact again when Anne returned home. Despite many efforts to contact Anne, Victim Support were not able to re-establish the meeting commenced whilst Anne was in Hospital. Victim Support were informed by the Lancashire Constabulary that Anne didn't recall making the disclosure and the incidents were all historic and had been dealt with at the time.

4.4.3 On the 2nd of January 2021, Victim Support received another referral concerning Anne from the Wrightington, Wigan and Leigh NHS Trust. This referral noted domestic violence. The IDVA attempted to contact Anne but was told that unfortunately she had passed away.

4.5 Clinical Commissioning Group (GP for Anne)

4.5.1 Anne had periods of frequent contact with her GP surgery, but these tended to occur sporadically. There was evidence of annual reviews being undertaken by the Practice, particularly in terms of mental health and wellbeing. Additionally, medication reviews were completed annually, as would be expected.

4.5.2 There were a number of occasions when Anne attended a GP surgery in the Lake District to obtain medication when she stated she was visiting family. Anne had informed the GP in the Lake District that her medication had been lost or stolen and a replacement was required. From the documentation recorded by her GP, it appeared that Anne has a 'sister' in Ambleside and she occasionally helped with childcare. However, the 'sister' has not been located by any agency involved in this Review[3].

4.6 Wrightington, Wigan and Leigh NHS Trust (WWLFT)

4.6.1 Anne presented to the Trust in early January 2021 with hip and groin pain. During this presentation, Anne made a disclosure of domestic abuse. Staff attempted to address the issue with Anne, a DASH was completed and a

[3] The Panel worked closely with the Office of the Coroner to locate and contact Anne's next of kin. As noted, her Brother declined to become involved with the Review. The GP in Ambleside was also contacted to seek their record of the visits Anne made to their surgery. The GP confirmed that their record stated that Anne was "visiting her sister, who was getting married and Anne was to help with child-care". No address was recorded for the Sister. The Office of the Coroner held an address on record and wrote to the Sister, but receive no reply.

referral was made to the Independent Domestic and Sexual Violence Advocate (IDSVA) employed by WWLFT. Anne discharged herself from Hospital and this was against medical advice. However, a capacity assessment had been undertaken and Anne was capable of making this decision. Once the WWLFT IDSVA received the referral the domestic abuse disclosure was acted upon immediately, and the IDSVA attempted to contact Anne. Sadly, she had died before that contact could be made.

4.7 The Liberty Centre

4.7.1 The Liberty Centre had very limited contact with Anne. The Centre was contacted by the Safeguarding Nurse at the Southport and Ormskirk Hospital NHS Trust but was unable to establish contact with Anne.

4.8 West Lancashire Housing Services

4.8.1 The West Lancashire Borough Council Housing Services team had limited interaction with Anne and M1. Contacts related to the reporting of repairs and the recovery of rent arrears.

4.9 North West Ambulance Service (NWAS)

4.9.1 NWAS provided Anne (and M1) with face-to-face pre-hospital emergency care and treatment on eight occasions. Anne had also contacted NWAS 111 services on 3 occasions for medical support.

4.9.2 On the 20th of April 2019, Anne made contact requesting a GP appointment. She described having been assaulted by M1. The triage outcome was to attend the A&E service within the hour but Anne refused this. Attempts were made to ensure she was safe and that the Lancashire Constabulary had been informed which Anne confirmed they had been and she was safe. Anne did agree to a safeguarding concern being raised to social care for additional support. Details were passed to the out of hours GP service to facilitate an assessment.

4.9.3 On Christmas day 2020, NWAS attended Anne's home. She had taken an overdose of opiates and she had stated to her friend that she wanted to end her life. Anne stated she was "known" to mental health services but was not engaging with them. This was the first time she described any mental health issues to NWAS staff. Anne was taken to hospital.

4.9.4 Five days later, NWAS was called again because Anne was vomiting blood. Anne stated that she had self-discharged from hospital following an intentional overdose. Anne was taken to hospital.

4.9.5 The call on the 4th of January 2021 was the last call made to NWAS concerning Anne. Her social worker made contact stating that Anne had taken an intentional overdose of prescribed medication and she was in and out of consciousness. Anne was taken to hospital and her care handed over to the awaiting team.

4.10 Mental Health Liaison Team (MHLT) – Mersey Care NHS Foundation Trust

4.10.1 The MHLT, based at Southport and Formby District General Hospital, completed a mental health assessment for Anne on the 29th of December 2020.

4.10.2 The MHLT noted that Anne utilised the services within the community, particularly 'Making Space' and the Community Mental Health Team 'CMHT'. Anne stated that she received a prescription for appropriate medication but did not participate in psychological therapy because '…it did not work for her'

4.10.3 The MHLT also noted that a safeguarding specialist Social Worker (SWS) had been dealing with the matters concerning safeguarding and issues relating to actions from the West Lancashire MARAC. The Lancashire Constabulary had confirmed that there was a DA marker on Anne's property.

4.10.4 The MHLT risk management plan was described, briefly, as:

- Informal admission to Hospital was not indicated or requested;
- Anne agreed to support from the Home Treatment Team (HTT) in West Lancashire. Contact was made with the HTT at LSCFT and they agreed to contact Anne to arrange support;
- MHLT noted that there was a plan in place with regard to the management of domestic violence and that the specialist Social Worker (SWS) would be updated;
- MHLT were informed by the staff at Southport and Ormskirk Hospital NHS Trust that Anne had taken her own discharge from Hospital before they could speak with her concerning her safeguarding needs.

4.11 Lancashire and South Cumbria NHS Foundation Trust

4.11.1 Prior to the incidents in December 2020, Anne had sporadic contact with the mental health services provided by L&SCFT. These contacts dated back to 2007. The notes recorded during these contacts did not describe a history of reported suicidal thoughts or plans. L&SCFT informed the Panel that Anne had a diagnosis of Munchausen's Syndrome (now referred to as 'Factitious Disorder'). However, L&SCFT were clear that this diagnosis did not appear to be specifically relevant to the most recent phases of care.

4.11.2 Anne was referred to a Specialist Triage, Assessment, Referral and Treatment Team (START) on the 17th of December 2020 by her GP. This followed an episode of alleged domestic violence. It became apparent that Anne was unaware of the referral.

4.11.3 L&SCFT attended the Multi Agency Risk Assessment Conference (MARAC) held on the 16th of December 2020 and the details of the triage completed by START were shared within the MARAC by the Safeguarding Team. The START referral was closed on the 21st of December 2020.

4.11.4 Following a referral by the MHLT, the saw Anne on the 27th of December 2020. They concluded that Anne had no further mental health needs and Anne stated that she did not require any additional support from the HTT. The HTT

confirmed, for their own assurance, that Anne's care package had been re-instated by the care agency.

4.12 Lancashire County Council – Adult Social Care (Community)

4.12.1 From the case records, Anne lived alone, had no children and there were no other people living at the same address at the time of the contact. Anne had been in a relationship with M1 and they had previously lived together at M1's only recorded Primary Address. ASC records indicated that they shared the same address between the 9th of October 2020 and the 14th of December 2020. However, on the 25th of February 2019, M1 advised a Social Care Support Officer that he had lived with Anne for a period of ten years but that he now lived alone and they had remained good friends.

4.13 Intermediate Care Allocation Team (ICAT)

4.13.1 ICAT received their first referral on the 24th of November 2020. As noted in the chronology, non-clinical home support was identified as appropriate in the first instance.

4.13.2 Anne was also allocated to a Social Care Support Officer on the 11th of December 2020, who contacted Anne on the same day. The SCSO was advised by Anne that she was busy and asked for a call back. This was arranged for the following week. The SCSO had a case discussion with SWS and agreed to discuss the case with the Reablement Team Manager. The following is documented on the case note:

'Plan moving forward confirmed. Ideal outcome for Anne will be to have doors fixed and secure, telecare, emotional support therapies and POC (package of care) to ensure Anne feels safe. Multidisciplinary approach being taken'

4.13.3 On the 17th of December, the SCSO spoke with Anne over the telephone and gathered information so that an overview assessment and a package of care referral could be made. The SCSO also identified referrals were required to Telecare and Age UK. All referrals were processed on the 18th of December 2020.

4.13.4 The SCSO contacted Anne, and a face to face assessment was completed on 27th November. The SCSO contacted Anne's GP for an urgent medication review. The GP confirmed that a medical review would take place on 27th November. The SCSO also contacted West Lancashire house repairs service to repair the front door.[4]

4.13.5 Age UK conducted a home visit on the 26th of November 2020. At this visit Anne agreed to a lifeline being installed at her property and the SCSO made the appropriate referral. Age UK noted that Anne stated that she felt safe at home.

4.13.6 In summary, the SCSO made the following recommendations:

- Medication review organised by GP;

[4] A contractor from the West Lancashire Borough Council visited to resolve matters concerning Anne's door and the communal door to the block on the 22nd of December 2020

- New front door waiting to be fitted;
- Re-ablement, four visits per day;
- Lifeline referral;
- Age UK to support with cleaning and shopping;
- Continued support from the pain clinic; and
- Support from the Liberty Centre.

4.14 Lancashire County Council Reablement Service

4.14.1 The reablement service provided crisis support to facilitate Anne's discharge from hospital. This was provided from the 25th of November 2020.

4.14.2 The overall purpose of the Reablement provision was to support Anne to return to her previous level of independence. The provision covered the period from the 26th of November 2020 to the 22nd of December 2020. Guardian Care Concern provided a package of care from the 23rd of December 2020 to the 28th of December 2020 as Anne was not making optimum progress on the Re-ablement Service provision.

4.14.3 On the 30th of December 2020 the Hospital Aftercare Service made a referral noting that Anne had discharged herself from hospital and was without care for 4 days. The reports noted that Anne was not coping, was isolated, and estranged from her family.

Section 5. Analysis

5.1 Responses to the Key Lines of Enquiry

It is important to note that the responses set out below are determined by the line of enquiry and the agencies that were able to respond to the enquiry. If an agency (listed elsewhere in this report) had no pertinent or noteworthy comment to make, then no response is offered in this section.

It is important to note that the information contained within the previous section ('what the services in contact with Anne knew') is not repeated here. This is purely for ease of reading and the avoidance of repetition.

The DHR Panel approved the inclusion of eight (8) 'headline' key lines of enquiry (KLOE) for this Review and a number of supplementary questions to help direct the responses to the key lines of enquiry. For the ease of reading, the lines of enquiry have been repeated within this section of the Report and the responses to them wrest under each headline KLOE.

A. To establish what contact agencies had with Anne.

1. **To examine whether there were any previous concerns, incidents, or significant life events which may have indicated a risk of violence or suicide at any time during the period under review?**

The Panel noted that when Anne visited Southport and Formby District General Hospital in December 2020, she disclosed domestic abuse and these allegations were investigated by the Lancashire Constabulary. Anne denied that the incidents were recent and that she had been confused due to the medication she was taking.

Nevertheless, the Lancashire Constabulary believed that a safeguarding interest should have been shared with the local MASH, so that this could have been shared with partner agencies.

Anne's visit to Wrightington, Wigan and Leigh NHS Trust in January 2021 assumed a slightly different tone. Anne disclosed allegations of domestic abuse but then self-discharged and requested that the Constabulary must not be informed. The Trust respected Anne's wishes and referred the case to their on-site Independent Domestic and Sexual Violence Advocate.

The Lancashire Constabulary were informed of potential financial exploitation by two neighbours (referred to in the 'pen-picture' as N2 and S3). The Constabulary investigated and found no evidence of any criminal offences. There was no suggestion of domestic abuse. The officers raised a Vulnerable Adult Report through the MASH at Standard Risk. The referral was also 'stepped-up' to Adult Social Care. The referral led to a Vulnerable Marker being placed on Anne's address.

The attendance at Hospital – and transport there by the North West Ambulance Service (NWAS) – led to the Lancashire County Council Safeguarding Service recording four (4) safeguarding alerts concerning Anne.

Anne's attendance at Hospital were triggered by her taking an overdose. When the Mental Health Liaison Team (MHLT) assessed Anne in December, they noted that Anne reported that she had become 'down' thinking about her relationship with M1 and voiced that she 'may' have taken an overdose unintentionally, adding that she 'may' have also expressed that she 'wanted to die' to two friends who live nearby.

The MHLT service worked with Anne to develop a risk management plan, as described in the narrative.

According to the submission from the Clinical Commissioning Group (now referred to as the Integrated Care Board) Anne had long-standing mental health problems and lived with chronic pain.

The CCG/ICB noted that in April 2019 there was a letter from 111 stating that Anne had been 'physically kicked by her husband'. In the letter it was mentioned that the husband no longer lived with Anne. There does not seem to have been any action taken at this point. The content of the letter raised significant concerns about domestic abuse, and this was not coded in the notes. Consequently, when Anne had a general review in May 2019, there was no mention of any enquiry about domestic abuse.

The Panel noted that this matter recurred in Anne's General Practice. In August, NWAS 111 submitted a discharge letter to Anne's GP and referred to Anne's 'husband taking her medication' and Anne being 'hit by her husband', but the Practice only recorded the issue of the missing medication.

Furthermore, in November 2020, Anne's GP practice was contacted by a Social Worker with concerns over the side effects of Anne's medication. The Social Worker was worried about 'over sedation' and the effects of Anne's prescribed medication. There was an attempt by the GP to contact Anne on three occasions. The GP left Anne a message to call back. Anne's medications were stopped abruptly until further information became available.

During the scrutiny of the submission from the CCG/ICB, the Panel noted that the author recorded that it was not clear if there was any handover to the GP regarding the safeguarding and domestic violence concerns that other agencies on the MARAC were aware of, as demonstrated at the meeting held on the 16th of December.

However, on the 17th of December 2020, considering the notes held by the Practice, it would appear the Practice was contacted by a member of the Safeguarding Team to hand over concerns regarding a physical assault.

As time moved on, the Panel noted that the GP engaged positively, proactively and quickly – particularly when liaising with the MHLT. The IMR author did note that best practice would have been to contact Anne and arrange a review (face to face preferably, unless COVID restrictions prevented this) to assess her mental health, suicide risk and any ongoing physical problems from the previous assault. It was noted that the GP did speak directly with the mental health team and they did agree to contact Anne. There was no indication in the notes as to whether this was chased up to ensure it happened.

NWAS had 4 key contacts with Anne – in April 2019, December 2020 and January 2021. In the last week of contact with Anne, NWAS noted that Anne presented in mental health crisis and had an episode of suicidal ideation. She had taken an opiate overdose. Attending crews documented all the details that were given and they shared information with staff at the receiving hospital and with social care services. Anne was in a highly agitated and anxious state, and her health was, due to the effects of the opiates, a priority at that time.

The Lancashire and South Cumbria NHS Foundation Trust (L&SCFT**)** reported to the Panel that Anne had been referred to START in September 2017 (by her GP). START saw Anne and referred her back to the care of her GP. START saw Anne again in November 2018 and referred her to Minds Matter and 'Re-Start'. The L&SCFT service became aware of Anne again in December 2020, the details of which are described below:

- Anne was referred to START by her GP. The referral stated that Anne was not in a "state of mind" where she could self-refer to Minds-matter. No concerns were raised in the referral regarding risk to self. During triage, it was identified that Anne may be involved in a longstanding domestic violence relationship. The START Practitioner liaised with the Safeguarding Practitioner. They discussed the recent information provided by Anne's GP. The START Practitioner was informed of the MARAC actions, and that the police would follow-up and check on Anne's welfare.
- The START Practitioner contacted Lancashire police and they confirmed that all actions from the MARAC were completed[5]. It was not possible to clarify if the perpetrator remained at the home address. There was a 'Domestic Abuse' marker on the property. Under these circumstances, the START Practitioner advised that START were not in a position to actively engage with Anne and the case was closed on the 21st of December.
- On the 26th of December, Anne was referred to and assessed by the Mental Health Liaison Team (MHLT) and as noted, they referred her to the West Lancashire Home Treatment Team (HTT).
- The HTT assessment was conducted at Anne's home. The records indicated that Anne was warm in manner and described getting out and about with no problems. Her mental state examination elicited no concerns, except that she "appeared more anxious". It was documented that Anne had separated from her partner in November after a long history of domestic violence[6]. It was identified that there was no need for HTT input. It was planned that the HTT would liaise with the care agency.

Lancashire County Council – Adult Social Care (Community)

Between the 23rd and 24th of April 2019 there was an active Safeguarding Adults Enquiry. The record contains a copy of a letter sent out by a Social Worker from the Multi Agency Safeguarding Hub (MASH) that advised a referral was made following Anne contacting 111 on the 19th of April 2019. The letter also acknowledged that Anne

[5] As previously noted, the Panel were informed that this was not accurate

[6] As described later in this section, the Risk assessment and management plan lacked detail and there was little evidence of the interviewer questioning the previous alleged overdose or assessment of ongoing risk. Documentation regarding the Service User`s safety and potential risk from her partner was also lacking.

had said that she felt safe and did not wish the Lancashire Constabulary to be contacted and that the case would be closed.

Anne confirmed to the SCSO that she did not live with her husband but he had been visiting when the incident occurred. Anne stated that she felt safe and that there hadn't been an incident like this for a period of 8 years and requested that there be no further action. Anne stated that she did not want any further input from Adult Social Care at that time.

2. Had any mental health issues been self-disclosed by Anne or diagnosed by an agency for Anne?

NWAS noted that at their attendance at the incident in December 2020, Anne reported feeling depressed and wished to end her life. She gave no confirmed diagnosis of a mental health condition during the contact with the NWAS service, but stated that she was "known" to mental health services and but was not actively engaging with them.

When Anne arrived at Southport and Formby District General Hospital in November 2020, as a part of the risk assessment, she stated that she felt depressed. The MHLT also noted that, following her first overdose, Anne reported a history of depression and anxiety, but no suicidal intent.

Prior to this, in 2019, when discussing the second safeguarding alert, Anne told the Social Worker that she had been referred to the Mental Health service and 'Minds Matter'. Later on, when discussing the third safeguarding alert, Anne disclosed a history of anxiety and depression and also flashbacks of 20 years of abuse. This led the Social Worker to ask Anne's GP to refer her for a mental health assessment.

There was a record that Anne suggested suicidal thoughts in November 2011 and a referral was made to START for further assessment. After the assessment, Anne was discharged back to her GP and a referral was made to Minds-matter for psychological support.

Wrightington Wigan and Leigh Foundation Trust drew the attention of the Panel to a key consideration, noting that Anne presented to WWLFT during the COVID 19 Pandemic and referred the Panel to the recent instructive publication from the Home Office, and others, concerning homicides and suicides during the initial phase of the management of the COVID-19 Pandemic.[7]

Lancashire & South Cumbria NHS Foundation Trust (L&SCFT)
The majority of the contact Anne had with L&SCFT was outside the scope of this Review. The information was shared and it is reflected throughout this Report because it provides useful context, thus:

[7] *Vulnerability Knowledge and Practice Programme. Domestic Homicides and suspected Victim Suicides During Covid 19 Pandemic 2020-2021 (2021) Bates, Hoeger, Stonemand and Whitaker. Home Office* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf*

Addiction and substance misuse
Anne reported to staff that she had a history of addiction and was dependent on codeine.

Mental Health History.
Anne was initially referred into the mental health services by her GP due to symptoms of anxiety and insomnia. There followed, between October 2007 and 2009, several appointments with the same consultant psychiatrist attached to the Single Point of Access (SPoA) team. These sessions focussed on the prescription of medication for sleep, anxiety and pain relief.

A chronology of events was completed by L&SCFT and included in this chronology , there was reference to: in November 2007 an admission to A&E listing a variety of illnesses, including a fictitious pregnancy; Anne had also 'pretended' to be a registered nurse, and said that she had had 3 children who had died of carbon monoxide poisoning. The summary made mention of a Munchausen syndrome whilst Anne was in her 20s

A referral was received from Anne's GP in September 2017. This was a referral to the Specialist Triage, Assessment, Referral and Treatment (START) Team. The referring GP requested a review of Anne's mood which was reported as being low, but that she had no suicidal thoughts. When assessed, Anne requested medication to manage her anxiety as she felt psychological therapy did not help at all. She was reviewed by a Consultant Psychiatrist who found her main problem to be panic attacks, which appeared to have increased. Anne was not found to be depressed or experiencing suicidal thoughts. Advice and information were provided but no adjustments to medication were made and she was discharged back to her GP.

In November 2018, Anne was referred back to mental health services and was reviewed by the START Team. When seen by the START Team, Anne spoke further about her panic attacks. It was documented that Anne was to be referred to Minds-matter, for assessment and therapy, and to Restart for issues related to social inclusion.

3. Were there any complexities of care and support required by Anne and were these considered by the agencies in contact with her?

The Panel noted a number of incidents and accounts describing Anne's complex life.

When Anne was admitted to Hospital, the ISVA identified concerns regarding the discrepancies in the information and narrative reported by Anne to the Lancashire Constabulary and to staff in the hospital.

The Safeguarding Service also noted that Anne would, at times, tell different people a different version of events in relation to the abuse that she alleged. Additionally, they noted that Anne, from time to time, would appear reluctant to engage with professionals offering help and support.

Lancashire Victim Support (LVS)
LVS noted that Anne clearly had health needs since both referrals they received were from the hospital and LVS knew that Anne had a social worker. However, the details of Anne's specific needs were not known to the LVS service. A problem compounded by the fact that LVS was unable to undertake a risk and needs assessment.

Clinical Commissioning Group (CCG) – GP for Anne
The author of the IMR noted some evidence of a chaotic lifestyle. On a number of occasions Anne had lost her prescribed medications, had them taken or been away 'visiting family' and had to obtain urgent prescriptions. Looking at the information available, there was evidence that Anne was socially isolated and the involvement of some degree of social prescribing may have been useful. Anne, at times, missed appointments for significant medical problems, including liver function abnormalities and an undiagnosed seizure disorder.

Lancashire County Council Safeguarding Service
The Adult Social Care service arranged for Anne to have a 'Lifeline' fitted in her home. There were difficulties in arranging for this to be fitted by the Life-Line provider because when they telephoned Anne to arrange for the work to be undertaken, Anne did not answer the telephone (due to the poor telephone reception). Life Line advised Adult Social Care that if a customer does not answer the telephone when they are arranging for a Life Line to be fitted, they would usually cancel the order. The Panel considered this to be a paradox of mutually conflicting but dependent conditions.

4. Were assessments of risk and, where necessary, referral of Anne to other appropriate care pathways considered by the agencies in contact with her?

When Anne made disclosures of domestic abuse to Hospital staff at Southport and Formby District General Hospital and Wrightington, Wigan and Leigh Hospitals NHS Trust, a risk assessment and/or DASH was completed and appropriate referrals were made to the West Lancashire MARAC, the IDVA service, IDSVA service, Trust-house and the Lancashire Constabulary.

The Lancashire & South Cumbria NHS Foundation Trust were aware of and involved in two separate safeguarding alerts and investigations, as described by the Lancashire County Council Safeguarding Service.

L&SCFT were also present at the MARAC meeting held on the 16th of December and the Home Treatment Team made concerted efforts to ensure LCC were providing ongoing physical health care and following up the safeguarding concerns.

The author of the Clinical Commissioning Group (CCG) IMR identified that this matter was an ongoing issue. Whilst on occasion the author identified good practice in the escalation of concerns to various teams, including START and Safeguarding, there was little evidence of a risk assessment being undertaken by the Practice. When relevant forms were completed, urgency was frequently noted as 'within 5 days' and on at least two occasions, no formal assessment of risk was made. The author did note that it is possible that, after discussion with other agencies, it was felt that no

further assessment was necessary, but the Author noted that best practice would have been to assess risk at the time.

Mental Health Liaison Team (MHLT)
The records of risk assessments, from both MHLT and the HTT, are consistent and they show that there was no clear evidence of suicidal intent, no suicide note, or evidence of Anne planning to end her own life.

5. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim?

The services in contact with Anne during the scope of this Review noted – either as a part of their initial assessment or during case notes – that she was a white British, heterosexual woman who spoke English as a first language. Anne was not recorded as having any registered physical disabilities.

There were no issues reported by the services involved in this case that prevented them from offering appropriate and consistent support during the consultations they had with Anne.

The Panel noted that whilst none of the agencies contacted in relation to this Review identified any diversity issues concerning Anne – or M1 – that impeded their access to, or use of, available services. The agencies and services involved in this Review are aware of Disability discrimination as it pertains to the Equality Act 2010.

As noted, Anne (and M1, within the parameters of the limited extent of the information shared with the Panel) lived with a number of physical and mental health difficulties. Under the terms of the Equality Act[8], a disability means a physical or a mental condition which has a substantial and long-term impact on a person's ability to do normal day to day activities. A person is covered by the terms of the Equality Act if they have a progressive condition and/or if they have had a disability in the past. For example, if a person had a mental health condition in the past, which lasted for over 12 months, they are still protected from discrimination because of that disability.

The DHR Panel recognised that it is important to note that discrimination does not have to be intentional to be unlawful.

It is perfectly plausible that the safeguards contained within the Equality Act and the Care Act should have applied to Anne, because of the conditions she was living with – her diagnosis of Factitious Disorder, her seizures, her mobility issues, her chronic anxiety and physical pain.

The Panel did not identify that Anne was discriminated against by any of the services in contact with her. In reaching this conclusion, the Panel noted that Anne, though intermittently, had good engagement with, amongst others, her GP, to some extent the IDVA Service, the Lancashire Constabulary, NWAS 111, and particularly the Southport and Ormskirk Hospital NHS Trust and her specialist Social Worker (who cared for Anne's dog when she was in Hospital.

[8] https://www.equalityhumanrights.com/en/equality-act/equality-act-2010

B. To describe the way in which professionals and organisations carried out their duties and responsibilities for Anne.

6. What actions were taken to safeguard Anne and were these actions appropriate, timely and effective?

When Anne disclosed domestic abuse, Southport and Formby District General Hospital and Wrightington, Wigan and Leigh NHS Trust completed an assessment, and/or a DASH and made appropriate referrals.

At Southport and Formby District General Hospital, due to the concerns regarding discrepancies in the information shared with professionals by Anne, a safeguarding referral was made to the Lancashire County Council Safeguarding service. Hospital records demonstrated that relevant alerts and proformas were added to Anne's hospital record by the safeguarding team to inform community staff of concerns and the package of care currently in place for Anne.

NWAS shared their concerns with relevant agencies, including referrals to the Lancashire County Council Safeguarding Service. In turn, the safeguarding service, via their Social Work team, communicated regularly with other agencies to share information and agree actions, and these agencies included Anne's GP, Age UK, the Liberty Centre, Guardian Home Care (the care agency), hospital staff, the IDVA service, Telecare, Lancashire Constabulary, West Lancashire Borough Council Housing Service and internal teams within Lancashire County Council.

Information concerning available support services was shared with Anne and also posted out for her to read. Three home visits were undertaken by the allocated social worker (SWS) to support the routes of communication, check on welfare, develop trust and reduce risk.

During 2018 and 2019, in response to existing diagnoses of depression and anxiety, Anne's GP completed annual face-to-face reviews and enquiries were made regarding home life, alcohol use, and medication.

The author of the CCG/ICB submission noted that the management of COVID-19 and the application of standard operating procedures clearly created difficulties in the routine monitoring of all patients. Given Anne was socially isolated, not working, had a history of high use of opioid analgesia and sedating drugs, it should have been encouraged to highlight Anne as a vulnerable person. This may have enhanced her visibility within the 'system' and encouraged more regular assessment.

The overall quality of care provided by the Lancashire & South Cumbria NHS Foundation Trust (L&SCFT) appeared to be good, particularly so with regard to timely responses to referrals and inter-agency working. Clinical practice was carried out in a safe and conscientious manner, and placed the needs of Anne at the forefront of decision making.

The author of the submission noted that the assessments undertaken by the Home Treatment Team (HTT), including the risk assessment, were not of a particularly high standard. There was an absence of detail regarding the circumstances leading to the

overdose in December 2020. There was also little mention of an assessment of potential future risk to self. The risk management plan was sparse in terms of clinical detail and the articulation of its findings. The risk of future overdose, given Anne's history of medication misuse, availability and access to her own prescribed medication (including morphine) was not fully explored and potentially mitigated. There was no clear summary or risk formulation or clear rationale explaining why Home Treatment was not deemed necessary. However, expert opinion has been provided that agrees with the decision to discharge from the HTT. It was noted that usual operational policy was compromised due to the absence of input from the Consultant Psychiatrist during the discharge decision making process – this was due to unavoidable staff absence due to sickness. These matters are addressed in the Single Agency Action Plan.

7. What were the key points or opportunities for assessment of risk and decision-making in this case?

Taking account of the chronology, we can see that:

- When Anne reported an assault to the NWAS Health Advisor, the advisor utilised their professional curiosity to establish whether appropriate agencies were aware of the situation and that Anne was safe. Information was shared, with Anne's consent, with social care and GP services to provide further support in her social setting. All relevant information was shared with the receiving hospital staff (including Anne's care package from Guardian Care);
- The ISVA from the Southport and Ormskirk Hospital NHS Trust made a timely safeguarding referral was made to Lancashire County Council, following additional concerns raised by the Lancashire Constabulary;
- The Lancashire County Council Safeguarding Service Social Worker assessed risks and promptly considered appropriate actions following all the four safeguarding alerts that were raised with Lancashire County Council. The risks were regularly reviewed, particularly during the three home visits that were undertaken by Anne's allocated social worker (SWS).

8. Was Anne informed of the options and choices available to her to make an informed decision?

The services in contact with Anne during the scope of the Review – including Southport and Formby District General Hospital, Wrightington, Wigand and Leigh NHS Trust, the LCC Safeguarding Service, NWAS, Victim Support and others – confirmed that when meeting with and speaking with Anne, she was engaged with the decisions being made concerning her care and the information shared with others about her presenting condition. One notable example was with the LCC Safeguarding Service:

Anne was clear that she did not want to move to a refuge, preferring to remain living in her home with her dog, Penny. She was aware that she would not have been able to take her dog to a refuge.

The author of the Clinical Commissioning Group submission noted that it appeared that there was limited discussion with Anne about her treatment options, though there was no obvious disagreement with the plans made with clinicians at the Practice. The treatment and referral plans were appropriate, particularly in terms of the management

of Anne's liver function abnormalities and seizure events. It was noted, however, that often there was a lack of follow up.

9. What happened as a result?

The Panel noted that, both within and outside the formal scope of this Review, Anne appeared to engage well with a number of services and clearly articulated her thoughts and feelings during her contact with them. This was clear from her interactions with her Social Worker (SWS), the Southport and Formby District General Hospital, the Lancashire Constabulary, and others.

However, the Panel were cognisant of the discrepancies identified by a number of services concerning the information Anne provided to different professionals regarding the alleged incidents of assault. It was possible, then, that risk assessments may not have captured the full picture of risk.

However, despite this, it appeared to the Panel that Anne had access to and frequently used the service pathways made available to her by the agencies that were responding to her expressed needs.

C. To establish whether there were other risks or protective factors present in the life of Anne.

10. Were there any other issues that may have increased Anne's risks and vulnerabilities?

A number of services reported to the Panel that Anne was estranged from her family and had been for approximately 20 years. It was not clear to the Panel if this distance was made by Anne or by her family. However, the Panel did conclude that the effect was magnified during the management of the COVID Pandemic and also because it appeared that Anne did not have many friends.

11. Were there any matters relating to safeguarding other vulnerable adults or children that the Review should take account of?

The agencies in contact with Anne during the scope of this Review did not report knowing of any other vulnerable adults or children.

12. Did Anne disclose domestic abuse to her family or friends? If so, what action did they take?

The Panel knew, as already described, that Anne had no contact with her family and hence, no disclosures of domestic abuse were ever made to her relatives. However, as noted in the pen-picture (on page 15) Anne did talk to her neighbours and did allude to an incident of domestic abuse to one of them. The neighbour did subsequently discuss this with the Social Worker from the MASH and this information was shared with relevant partners.

13. Did Anne's Partner make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

None of the agencies involved in this Review recorded any information concerning this particular line of enquiry.

NOTE

The Panel took the decision to remove the three key lines of enquiry concerning information about M1, Anne's long term partner. Consent to share personal healthcare information was sought from M1 and M1 declined to give consent. Agencies were advised that if they had relevant information, they should share only contact dates and non-specific details regarding M1. Upon considering the information submitted, the Panel concluded that it did not add significantly to the purpose of the Review.

G. To establish whether agencies have policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

26. Were effective whistleblowing procedures in place to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures

All of the services making submission to the Review confirmed that they had mechanisms in place to escalate concerns to enable staff to report concerns and "speak-up". A number of services – in the NHS, for example – referred to practice reviews whereby learning from 'whistle-blowing' is shared across the service.

27. Was appropriate professional curiosity exercised by those Agencies working with Anne (and her Partner)

The Panel noted that all of the agencies made attempts to make necessary inquiries concerning Anne's circumstances, how incidents had occurred and how to manage risk in the future. The Panel drew attention to three examples – two where professional curiosity was exercised and one where such curiosity was not exercised as forthrightly as it could have been:

Southport and Ormskirk Hospital NHS Trust

There was evidence of professional curiosity being exercised by Hospital staff, particularly the Independent Sexual Violence Advocate (ISVA) who noted discrepancies in the history given by Anne to different professionals.

NWAS

NWAS informed the Panel that it is important to note that the same Clinicians do not attend each incident. Though this means there was no continuity of care by the same Paramedic, each incident is managed in accordance with the same criteria and process. It was also noted by NWAS that when concerns were identified, these were discussed with Anne and shared in a timely and appropriate manner with partner agencies. As has been described elsewhere, the Health Advisor from 111 did exercise

a high degree of professional curiosity during a call with Anne regarding an incident of alleged domestic abuse (please see page 22).

Lancashire & South Cumbria NHS Foundation Trust (L&SCFT)
The Panel noted the incident inquiry undertaken by the Trust and noted the comment that several matters relating to risk were not sufficiently explored/documented during the face to face assessment on the 27th of December 2020. These risks included the recent separation from her partner, M1. Whilst M1 was the alleged perpetrator of domestic abuse, they were also someone whom Anne had spent a considerable amount of time living with, and potentially depending upon. Given the overdose that occurred, it was noted that the means, and the access to prescribed analgesic medication and the history of misuse and overdose were not mentioned in the face-to-face assessment. The potential risk of accidental death via overdose was not documented.

The Review undertaken by L&SCFT informed the Panel that one HTT Practitioner had not completed the relevant Clinical Risk Assessment training at the time when this assessment was completed. The relevant Team Leader has subsequently confirmed that Level 2 risk training for the HTT staff involved in the L&SCFT Review has since been completed.

H. To analyse the communication which took place within and between agencies and to identify the degree of co-operation that occurred between different agencies involved with Anne (and her Partner).

Southport and Ormskirk Hospital NHS Trust
The records held by Southport and Formby District General Hospital indicate that there was effective and timely communication by hospital staff and appropriate referrals made to other agencies concerning the domestic abuse disclosed by Anne.

Lancashire Constabulary
Lancashire Constabulary also sustained this view, confirming that information was shared by Southport and Formby District General Hospital with Lancashire Constabulary, specifically on the 18th of November and again on the 25th of November 2020. The information was detailed and contained a completed DASH risk assessment by the hospital which described the abuse reported by Anne. The Constabulary also noted good information sharing with the MARAC Team and the Liberty Centre.

Following the death of Anne, Lancashire Constabulary received two new pieces of information. One suggested that Anne had attempted to take her own life on Christmas Day 2020. This incident was not reported to Lancashire Constabulary and there was no record of such an incident having occurred.

The second, on the 5th of January 2021, involved a Social Worker contacting Lancashire Constabulary to inform them that they had been contacted by staff at Wigan Wrightington and Leigh NHS Trust informing them that Anne had attended the Royal Albert Edward Infirmary on the 2nd of January 2021. Anne had disclosed to hospital staff that she had been ‘beaten up’ by her husband. Lancashire Constabulary had not been notified of this assault or that Anne had attended the hospital. This was

a missed opportunity for police to investigate the criminal assault and ensure that Anne was effectively safeguarded. M1 has not been subject to a formal police investigation in respect of this incident.

An action raised by MARAC on 16th December 2020 was not followed up. This was a missed opportunity to re-visit Anne to assess all available information, especially considering the suspicion that Anne was at risk of financial exploitation by two male neighbours. There is also a lack of clarity around the precise nature of the relationship between Anne and M1 in the weeks prior to her death.

Lancashire Victim support (LVS)
There is evidence that multiple agencies worked with LVS to provide information about Anne and to get her independent support. This included Anne's case being discussed at the local MARAC. It was noted that the IDVA service liaised with the Lancashire police and Anne's social worker to try to connect with Anne to offer support.

I. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

The agencies in contact with Anne concluded that, broadly, all necessary safeguarding procedures were adhered to and were in accordance with expected practice. There were a number of exceptions to this conclusion, specifically:

- The coding exercised by Anne's GP should have been better; as should the procedures operating within the Practice for risk assessment and follow-up. The Panel were, of course, cognisant of the pressures caused by the management of the initial phase of the COVID Pandemic.
- The delivery of the MARAC actions from the meeting held on the 16th of December 2020, as described by the Lancashire Constabulary;
- The Constabulary also noted a possible missed opportunity for a Police Officer to attend the Hospital following the disclosures made by Anne on the 18th of November 2020;
- The assessments undertaken by the Home Treatment Team were noted by the Lancashire and South Cumbria NHS Foundation Trust as being sub-optimal and the opportunity for Anne to benefit from the START service, was truncated by the belief that Anne still lived with a violent offender;
- GP recommendations for others: The author of the IMR from the CCG took the time to consider the matter regarding discharge letters from the NWAS 111 service. On one occasion, a 111 letter was reviewed and only the symptoms and medications were recorded by the Practice. The IMR Author suggested that they may not necessarily expect the GP surgery to pursue and clarify other elements contained within the letter (such as allegations of abuse) and that this point should be noted by the 111 service.

Section 5.2.
Scrutinising events and incidents from participating agencies.

This section of the Overview Report is a consideration of the responses to a number of key incidents described by what the services knew about Anne, the responses to the key lines of enquiry, coupled with observations from the Panel.

The Panel considered the key elements from the aforementioned sections of the Report for some time in order to distil the information shared by the agencies during and prior to the formal scope of the Review.

This consideration illuminated a number of complex points upon which the circumstances that led to Anne's death seem to turn. These points are not in any order of priority.

Point 1

5.2.1 As the Panel noted, Anne was referred to the local MARAC and her situation was discussed on the 16th of December 2020. One action recommended was that the Lancashire Constabulary should contact Anne and undertake an assessment in order to "tie together the loose ends". This assessment was not undertaken by the Constabulary and whilst the Panel considered this to be a missed opportunity to arrange further support for her, the Panel also noted that the Constabulary had spoken to Anne and had shared with her the contact details for the services that could support her.

5.2.2 The Panel noted that the Author of the CCG (now the ICB) IMR recorded that it was not evident if there was any formal 'handover' to the GP concerning the safeguarding and domestic violence matters that other agencies were aware of and had recorded during the meeting of the MARAC held on the 16th of December 2020.

Point 2

5.2.3 Anne attended the Wrightington, Wigan and Leigh NHS Trust on the 2nd of January 2021 stating that she had tripped and fallen and was enduring pain to her hip. During the consultation, however, Anne disclosed that she had been suffering domestic abuse from M1 for several years. A DASH was then undertaken. The Panel noted that on this occasion, Anne requested that this disclosure should not be shared with the Lancashire Constabulary. The Panel acknowledged that this can be perplexing for any Police service. However, specialist domestic abuse services noted that the result of this is that the client is often – though not always – acutely attuned to the management of risk in their own circumstances and professional discretion should apply. The Panel discussed this matter and noted that the Lancashire Constabulary will always consider such circumstances as a missed opportunity to intervene and support the victim.

Point 3

5.2.4 On the 23rd of April 2019 there was a letter from 111 stating that Anne had been 'physically kicked by her husband', suffering pain in her left side and back. There does not appear to have been any action taken by the General Practice

at this point. The content of the letter raised significant concerns about domestic abuse, and this was not coded in the note as a previous problem.

5.2.5 Then, on the 19th of November 2020, a letter was received by the General Practice from the local A&E service. In this letter, a discharge summary, there was a clear reference to a history of domestic abuse. There was no history of this being coded in the GP notes at this time.

Point 4

5.2.6 On the 26th of November 2020 Anne's GP practice was contacted by a Social Worker with concerns over the side effects of Anne's medication. The Social Worker was worried about 'over sedation'. The Author of the CCG IMR noted that whilst attempts were made to contact Anne, they were minimal, and her long-term medication was stopped abruptly (though for arguably reasonable safety concerns). The view of the IMR author was that expected practice would be to contact Anne, involve other teams and escalate the concern before ceasing Anne's prescribed medications.

5.2.7 On the 27th of December 2020, the Practice received a letter from A&E and it was added to Anne's notes on the same day. The letter concerned an admission following an overdose on the 25th of December 2020. The letter mentioned domestic abuse and referred to an 'overdose with secondary vomiting'. This letter was coded by the Practice as 'vomiting' with a free text note of 'haematemesis' (vomiting blood). In the view of the Author of the CCG IMR, this was significant letter – in the view of the Panel, more significant than a code of haematemesis.

5.2.8 As described elsewhere, Anne took an overdose on the 4th of January 2021. Taking account of the events in late December, the letter from A&E was clearly a significant event and it appears that concerns of domestic violence and overdose were overlooked. Had these concerns, coupled with the issues raised by the Safeguarding Service, been added to the record before the 29th of December, it may have prompted a review of Anne from a wellbeing, safety and mental health point of view.

5.2.9 The handover of information between agencies, such as mental health, safeguarding and social care was at times passed on without direct review or consideration of the patient or assessment. There were attempts made which was positive but frequently not followed up.

Point 5

5.2.10 The Safeguarding Service recorded four (4) incidents whereby safeguarding alerts were raised with them concerning the safety of Anne. The first safeguarding alert was raised with Lancashire County Council on the 26th of September 2011. The alert concerned allegations of domestic abuse. The second safeguarding alert was raised by NWAS on the 24th of April 2019. The alert concerned domestic, physical and emotional abuse. The Panel acknowledged that there were a number of occasions when Anne denied the allegations that she had made, or offered slightly different accounts to different professionals concerning allegations. However, the information shared by the

Safeguarding Service demonstrates that Anne was aware that the allegation made in April 2019 occurred 8 years after the allegation described in the first safeguarding alert. This demonstrated to the Panel that Anne had sufficient capacity to recall critical incidents in order to offer this context to the Practitioner.

Point 6

5.2.11 The Panel considered the matter of the veracity of Anne's accounts of domestic abuse. Having considered allegations of historic abuse and acknowledging that the Lancashire Constabulary presume – on the balance of probability – that these allegations are true, the Panel focused attention upon more recent allegations of abuse.

5.2.12 NWAS informed the Panel that each contact is triaged as an individual incident therefore no history is known to attending Clinicians about the patient unless alerts (such as special medical needs/conditions or violence/aggression that could compromise staff safety) are applied to the patient's address. On the 2 occasions where injuries were present during contact with Anne, these were described as a result of falls. The injuries were isolated and no other bruising/marks were documented during assessment. By way of example, one contact described the situation as:
"She (Anne) was alone in the home and there were no signs of disturbance at the address. She was not frightened and openly disclosed during one contact that she had been the victim of domestic violence in the past and she had safety mechanisms in place to protect her from harm. Partner agencies also attended on these occasions to assist with entry to the property, allowing for any professional discussions around probable cause."

5.2.13 As already discussed, a Multi Agency Risk Assessment Conference (MARAC) had been held on the 16th of December 2020 (and as the Panel noted, an action for the Lancashire Constabulary to visit Anne to undertake an assessment "and tie everything together" was not undertaken). The Panel also noted that, at this time, Anne was referred to a Specialist Triage, Assessment, Referral and Treatment Team (START) by her GP. This followed an episode of alleged domestic violence. START was aware of the MARAC meeting and the involvement of the Safeguarding Team. M1 was discussed at the MARAC and, taking account of the allegations made, they considered M1 to be a 'high risk'. The START service were cognisant of a high risk abuse environment being discussed at the MARAC and assumed that M1 still lived at the property and, hence, did not feel safe. Consequently, the referral was closed on the 21st of December 2020.

Point 7

5.2.14 Setting aside the difficulties that statutory services encountered when trying to engage with Anne, a number of independent services also had difficulties making contact with and maintaining contact with Anne.

5.2.15 The Liberty Centre had very limited contact with Anne. They were contacted by the Safeguarding Nurse at the Southport and Ormskirk Hospital NHS Trust but were unable to establish contact with Anne.

5.2.16 A similar situation faced Lancashire Victim Support (LVS). LVS received a referral for Anne following a disclosure of domestic and sexual abuse made by Anne whilst she was in Hospital. Initial contact was made but a full conversation was not possible because Anne was not in a private area. Both parties agreed to make contact again when Anne returned home. Despite many efforts to contact Anne, Victim Support were not able to re-establish the meeting commenced whilst Anne was in Hospital.

Section 6. Elements of good practice.

Throughout the Overview Report, reference is made to examples of good practice exercised by the services in contact with the subjects of this case. The Panel wishes to focus upon a number of these examples – set out below – to underline the learning that has been generated by this Review.

6.1 Southport and Ormskirk Hospital NHS Trust

6.1.1 There are many examples of good practice highlighted in this case, both in the hospital's recognition and response to the initial disclosure of domestic abuse made by Anne in November 2020. There have been appropriate and timely referrals to other agencies made by the hospital safeguarding Team and effective communication with other professionals involved with Anne from the time of the initial disclosure. In addition to this there is evidence of making safeguarding personal, with Anne's wishes clearly documented in health records. There is evidence of safeguarding alerts and proforma's being added to Anne's records that informed staff directly involved in Anne's care of the safeguarding concerns in the community. Furthermore, the referral made to the Local Authority following recognition of discrepancies in the information provided by Anne to different professionals, demonstrates both professional curiosity and recognition of Anne's complex care and support needs.

6.2 Lancashire Safeguarding Service

6.2.1 The general, case notes were checked by the MASH social worker and the adult social care support officer was swiftly informed about the concerns. Additionally, the MASH social worker consulted with the adult social care support officer who undertook a face to face visit with Anne and discussed some of the safeguarding concerns and took actions to swiftly reduce risks.

6.2.2 On the 24th of April 2019, the MASH Social Worker checked the details of a reported incident with the Lancashire Constabulary and spoke with Anne regarding the 'alert' that had been raised in order to share information with her and with other care services.

6.2.3 On the 27th of November 2020, the service requested an update from the police. The MASH Social Worker once again discussed the concerns with Anne and confirmed the actions already agreed, the support options available and gained consent to progress to a full safeguarding investigation by the safeguarding Enquiry Team.

6.2.4 On the 30th of November 2020 there was swift contact by the County duty social worker concerning an unanswered call. The safeguarding social worker (SWS) requested support from the care agency to consult with Anne as they had not managed to speak to her after ringing several times and leaving messages.

6.2.5 On the 14th of December 2020 SWS arranged a face to face visit with Anne following poor reception over the telephone. SWS demonstrated accordance with the policy of Making Safeguarding Personal and had discussions with Anne, listened to her views and considered her capacity around undertaking the safeguarding enquiry and agreeing and reviewing the safeguarding plan.

6.2.6 On the 16th of December 2020, SWS sought to develop a trusting relationship with Anne. They explored with Anne her risks and how to reduce them, passed on messages from the advocate and agreed to request additional support from the police and Anne's GP regarding mental health support.

6.2.7 On the 4th of January 2021, SWS forced entry into Anne's property due to there being no response and requested support from the police and the ambulance service.

6.3 NWAS

6.3.1 NWAS reviewed their notes associated with this case – for both Anne and M1 – and concluded that each contact had been assessed correctly and the actions taken were appropriate and followed current clinical and safeguarding policies and procedures.

6.3.2 NWAS noted that information was shared directly with health colleagues at the time of contact and that the information was clarified by accompanying patient report forms.

6.3.3 Communication with partner agencies in both electronic reports and verbal face-to-face was assessed as being good and information was shared in a timely and detailed fashion.

6.3.4 NWAS informed the Panel that frontline clinicians do not have caseloads. This can be viewed as both positive – in that each contact has a "fresh eyes" approach – or negatively, in that all background information is not readily available.

6.4 CCG – GP for Anne

6.4.1 The Author of the CCG submission noted that Anne's Practice undertook regular medication reviews (which, prior to the management of the COVID Pandemic, were face-to-face).

6.4.2 The author also noted that the referral to the appointment with the START service demonstrated good practice.

6.4.3 On the 16th of December 2019, Anne was seen by a GP surgery in Ambleside whilst visiting her sister and helping with childcare[9]. This letter demonstrated good practice from both GP practices. The GP in Ambleside performed a risk assessment and, due to the nature of the medication involved (amitriptyline, zolpidem), ensured they contacted Anne's own GP the same day to ensure this was safe to prescribe. Confirmation was made and Anne's own GP ensured a copy of the GP summary was sent over and saved into her notes.

6.4.4 On the 26th of December 2020, a letter was received from the Mental Health Team with a detailed assessment. The letter contained detailed information regarding domestic violence of a physical, sexual and controlling type. This was

[9] As noted elsewhere, it has not been possible for the Panel to confirm that a sister exists

a very significant letter. It was noted that the letter was added onto DOCMAN on the 29th of December 2020. Codes were also added noting 'Victim of Domestic Violence' and 'Overdose of Drug'.

6.5 Lancashire Constabulary

6.5.1 The Constabulary undertook thorough investigations into the allegations made by Anne – both historical and during the scope of this Review. The Constabulary managed the consideration of Anne's referral to the MARAC, placed a vulnerability marker on Anne's address and worked well with the Southport and Ormskirk Hospital NHS Trust concerning the sharing of the safeguarding alert.

6.6 The Liberty Centre

6.6.1 The Liberty Centre noted that the service exercises close working relationships with other partners in order to offer long term support to clients who have experienced trauma. It is noteworthy that this support is not time limited and places the client at the centre of the decision-making process.

6.6.2 Additionally, it was recognised by the Panel that the Liberty Centre is a specialised service that supports male victims of abuse and is recognised as a leader in this sector.

6.7 Lancashire Victim Support (LVS)

6.7.1 LVS noted a number of examples of good practice, in particular with regard to the partnership working that occurred in an effort to get Anne the help and support of an experienced IDVA. The initial referral came from the Southport and Ormskirk Hospital NHS Trust and contact was made with Anne whilst she was still an inpatient at the Southport and Formby District General Hospital. Arrangements were made to contact her on her return home and to complete a full assessment. When this was unsuccessful there was a considerable amount of liaison with the hospital and the safeguarding social worker (SWS), who was involved with the case, in an attempt to gather more information and to establish a contact with Anne so that a full risk and needs assessment could be completed.

6.8 Wrightington, Wigan and Leigh NHS Trust (WWL)

6.8.1 The Panel noted that the WWL NHS Trust is fortunate to have an independent domestic and sexual violence advocate (IDSVA) on-site.

6.8.2 The IDSVA service was contacted when Anne attended the Trust in January 2021. Anne had requested that the Constabulary were not informed of her visit nor of the allegation of abuse Anne had made. The Trust respected Anne's request and referred her to the in-house IDSVA. The IDSVA made vigorous attempts to make contact with Anne, but they were unsuccessful.

6.8.3 The Panel noted the work undertaken by the University of Manchester to evaluate the effectiveness of the on-site IDSVA service[10]

[10] https://www.arc-gm.nihr.ac.uk/media/Resources/ARC/Organising%20Care/HIDVA%20Report%20Executive%20Summary-FINAL.pdf

Section 7.
Lessons learnt from this case by the agencies submitting information.

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are some of the lessons learnt that have been identified by the agencies that had contact with Anne and/or M1.

These lessons and the points raised by the scrutiny of the Panel referred to in the previous section will help to refine the action plan agencies will be expected to address at the end of this Review. The lessons learnt and any opportunities perceived to have been missed are set out agency by agency:

Safeguarding

7.1 There was some concern regarding the increased risk due to Anne's reluctance or difficulty to engage with professionals. This was discussed in Safeguarding Manager team meeting on the 26th of October 2021 and it was requested that team managers discuss such matters in team meetings, with the option that Social Workers/SCSO's place a risk marker on the record. The County Safeguarding Operational Manager discussed this recommendation with the Lancashire County Council Principle Social Worker and they approved this action and also recommended that if required a summary case note be added to the client information system.

7.2 As noted previously, there was concern expressed by the Panel that Telecare referrals would be closed down if the service user did not answer a phone call, when telephone poor connection was the reason for the referral in the first place. The Safeguarding Team Manager and the Safeguarding Social Worker will consider working with the Telecare manager to request that cases are not just closed if a service user does not answer telephone calls, and that Telecare discuss the case with the social worker involved so that they can aim to resolve the matter.

7.3 There was some concern that the Safeguarding Service was not aware of the MARAC meeting held to discuss Anne's case on 16th of December. Relevant Safeguarding and Social Work managers will consider contacting the MARAC manager to discuss the importance of the Safeguarding Service being invited and/or updated regarding MARAC meetings.

The GP for Anne (known as the CCG during the scope of this Review)

7.4 Anne had a long history of depression, anxiety and chronic pain conditions. The Author of the CCG IMR noted good practice in the planning of annual reviews, and medication reviews although the depth of questioning during these assessments may not have given Anne the opportunity to disclose to Practitioners her experience of domestic abuse, which from the later letters seems to been extremely significant and complex. At times cues were overlooked in letters, for example reports of physical assault from husband not

highlighted as a potential indication of domestic abuse. These events could have given opportunities for the practice to signpost and safeguard Anne.

7.5 The GP Practice used by Anne has standard safeguarding policies in place and staff have completed mandatory training. The Author of the IMR has spoken to the Practice Business Manager and they were very open to further training and acknowledged that specific Domestic Abuse training, outside of standard safeguarding update, may be useful.

7.6 Document management was often an issue with narrative content of letters not highlighted to the Safeguarding Lead. On certain occasions, letters with significant content could have been processed more quickly, for example with the detailed letter processed on 29 December 2020, and this may have triggered a Practice response to support this patient. Coding at times also could have been clearer, particularly with regards to overdose and codes regarding domestic abuse.

7.7 On the 19th of November 2020, a letter was received from A&E (a discharge summary) and there is clear reference to a history of domestic abuse. There is no history of this coded in the GP notes at this time. There is a note regarding shoulder injury and ongoing pain. This letter was recorded and a comment was added 'no action required'. It would have been useful for the GP to arrange a patient review, either by phone, video or face to face. This would appear to be a missed opportunity given the patient contact on the 27 December 2020. There are codes added to this letter in the form of 'fracture of humerus' and 'accidental falls'

7.8 With regard to the abrupt cessation of Anne's medications (on the 27th of November 2020), the IMR author noted that whilst attempts were made to contact Anne, they were minimal, and her long-term medication was stopped abruptly (though for arguably reasonable safety concerns). After the attempts to contact Anne had failed, there did not appear to have been any follow up actions or escalation to safeguarding, social services or the Lancashire Constabulary. The view of the IMR author was that expected practice would be to contact Anne, given the concern over medication side effects, involve other teams and escalate the concern. However, it was noted that by stopping the medication, a response was triggered and a review appointment was made. The GP did attempt to risk access for suicide and there was a comment that Anne denied low mood or thoughts of self-harm. The author concluded that, given the suspicion of physical assault from her husband, further enquiry could have been made and escalated. It may also have been useful, at this point, to code for potential domestic abuse.

7.9 On the 26th of December 2020, a letter was received from the Mental Health Team with a detailed assessment. The letter contained detailed information regarding domestic violence of a physical, sexual and controlling type. This was a very significant letter. It was noted that the letter was added onto "DOCMAN" on the 29th of December 2020. Codes were also added noting 'Victim of Domestic Violence' and 'Overdose of Drug'. Whilst this was recognised as good practice, the author of the IMR did share with the Panel that it was, in their view,

unfortunate that the significant nature of this letter did not trigger an urgent assessment by the GP or any follow up at the time. This view was magnified by the fact that a GP reviewed the letter after Anne had died. An earlier review of this letter may have triggered a response from a member of the Practice to assess Anne and feedback to the various teams around the patient. There was a clear indication of escalating mental health problems at this time.

7.10 On the 27th of December 2020, the Practice received a letter from A&E. This letter was an A&E attendance report and was added to Anne's notes on the same day. It mentioned domestic abuse and 'overdose with secondary vomiting'. This letter was coded by the Practice as 'vomiting'. In the view of the IMR author, this was significant letter. Although codes were added, incidents shared with the Practice by the Safeguarding Team in November would not have been in the notes at this time because they were added on the 29th of December 2020. There was also no code of 'overdose' added. It did not appear to the IMR author that this letter was sent for review by a GP in the Practice.

7.11 Given the subsequent overdose in January 2021, this was clearly a significant event, that did not trigger a review by a GP, and concerns of Domestic Violence and Overdose appear to have been overlooked.

7.12 The difficulties or working during the COVID-19 pandemic should also be acknowledged. The standard operating procedure of 'telephone first' and cessation of some routine monitoring work may have exacerbated a situation where Anne was increasingly vulnerable but also less visible. Identifying Anne as vulnerable is likely to have increased the possibility that appointments were carried out face to face where additional cues can often be picked up allowing for signposting and safeguarding checks to be made.

Southport and Ormskirk Hospital NHS Trust

7.13 The emotional impact of the alleged financial exploitation by two males on Anne remains unclear as does the impact of domestic abuse on Anne's decision to end her life.

7.14 This case highlights the importance of professional curiosity in identifying safeguarding concerns and demonstrates the need to be holistic in considering individual's care and support needs.

Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT)

7.15 The impact of the Covid 19 Pandemic is difficult to assess. It is important to note that Anne's presentation was over the Christmas and New Year period when lock down restrictions were still in place.

7.16 Whilst WWLFT staff did offer and complete referrals for Anne to other services, this case has illuminated that WWLFT staff could be reminded to be acutely aware of circumstances such as those faced by Anne and consider carefully involving the Constabulary and Social Care services.

7.17 The issue concerning the sharing of information about domestic abuse with the Lancashire Constabulary is, as already discussed, a complex one. Consequently, WWLFT will ensure that all WWLFT staff carefully consider the

reporting of a crime to both the Constabulary and Social Care services following a patient's disclosure of vulnerability and risk.

The Liberty Centre

The Liberty Centre noted two key lessons, thus:

7.18 The need to engage with a client before they leave the hospital setting. This could potentially be beneficial in maintaining contact with the client and in offering continuity of support when the client returns home.

7.19 The need to be 'professionally curious' and to ask questions and work in partnership to safeguard clients

Lancashire Victim Support (LVS)

7.20 LVS made strenuous efforts to support Anne – taking account of the scope of the service and its limitations on capacity. The LVS noted that the service would never visit the home address of a client unannounced (due to the potential risk to the client and the staff). The service did acknowledge that they could have visited Anne whilst she was in hospital (recognising that, depending upon the circumstances, they may do), however, of course, when LVS received the referral, efforts were being made to manage the initial phase of the COVID Pandemic and so this was not an option that was considered safe.

Lancashire Constabulary

7.21 An action raised by MARAC on 16th December 2020 was not followed up. This was a missed opportunity to re-visit Anne to assess all available information, especially considering the suspicion that Anne was at risk of financial exploitation by two male neighbours

Section 8
Key themes Emerging from the Review

These emerging themes are not in order of priority

8.1 Anne's health, vulnerability and engagement with services

8.1.1 The Panel recognised that evidence clearly suggests that poor physical health can have a significant and negative impact on mental health and poor mental health can either effect domestic abuse or be a significant risk factor for victimisation[11]. Anne had a long history of mental health difficulties, including low mood and depression and at least one episode of suicidal ideation.

8.1.2 The Panel considered that a key characteristic of Anne's engagement with some services was contact with a service during a period of crisis, then a period of some complexity that may have led to missed appointments. Coupled with this was the fact that events appeared to have turned very quickly from November/December 2020 when the Panel assumed that M1 had left the relationship and there was an intense period of planning, assessing and co-ordinating of services.

8.1.3 This period of time coincided with a point when Anne's vulnerability became magnified, she became more isolated and became lonely. This is the point where Anne would have reached the threshold for a full assessment under the terms of the Care Act.

8.2 Assessing risk and safeguarding alerts

8.2.1 Anne made numerous allegations of domestic abuse, and violence against M1. From the submissions received, it appeared that Anne had been alleging and referring to living with domestic violence and abuse for two decades.

8.2.2 The Panel noted that, following allegations of assault either in 2018-19, late 2020 or historically, Anne would often be reluctant to provide a statement in order to support the process of prosecution and would not encourage the Lancashire Constabulary to be involved or arrest the alleged perpetrator. The Panel also noted that, in 2020, Anne shared slightly different accounts with different agencies and this included telling the Lancashire Constabulary that the allegations she shared with staff at Southport and Formby District General Hospital in December 2020 referred to events in the past.

8.2.3 However, the Panel were aware of evidence to suggest that trauma in childhood and adolescence can have an effect on a person such that they exercise a high level of emotional dissonance.

8.2.4 The majority, if not all, of the services Anne was in contact with knew that she had made allegations that she was a victim of domestic abuse – either in the past and/or during the formal scope of this Review.

[11] See Trevillion, et al, 2012, published by Safe Lives in 2015

8.2.5 It should be noted that the GP did not undertake an assessment of Anne's risk of domestic abuse, whilst during this period she was subject to a DASH by the Southport and Ormskirk Hospital NHS Trust, and she was assessed as reaching the threshold to be considered by the MARAC.

8.2.6 It was clear to the Panel that Anne was attempting to tell a story of the domestic abuse she had endured and this story was also about abuse loneliness, and about trauma and she tried to tell this story to the services she was in contact with. However, as noted throughout this Report, when invited to expand on these matters and provide assistance to the Police to pursue them, these accounts were occasionally inconsistent, and often denied. However, the Panel did note that Anne did tell a consistent story to healthcare professionals and a Senior Social Worker. It may be the case that Anne felt safer in these conversations than she did when speaking to other agencies.

8.3 The offer of Refuge

8.3.1 Outside the scope of this Review, the Panel noted that Anne was offered refuge on at least one occasion. However, she declined this offer because she knew that she would not be able to take her dog. The Panel noted that this was not the first Review to record that having a pet often precludes support from a Refuge. The Panel observed that there are services available for women with pets who need refuge[12].

8.4 Professional curiosity, liaison and sharing information

8.4.1 The Panel recognised that this theme arises in a number of Homicide Reviews, Safeguarding Reviews, and Serious Case Reviews. The Panel was cognisant of the NICE Domestic abuse quality standard (QS116). There were numerous examples of agencies sharing information in a prompt and timely manner, the 111 advisor, and others, exercised a high degree of professional curiosity.

8.4.2 The services contributing to this Review worked well together. However, a number of services – Lifeline, the Liberty Centre, and Victim Support – could not, for different reasons, establish meaningful contact with Anne during the period covered by this Review.

8.5 Supporting victims with complex needs

8.5.1 Anne had complex physical health needs, complex mental health needs and, allegedly, had lived with domestic violence for many years.

8.5.2 A successful care pathway for a client such as Anne is dependent on the willingness of the client to follow through on agreed actions. Difficulties may be encountered when a client is highly motivated one day but fragile and changes perspective the next.

8.5.3 In turn, this may lead to certain services (for example, the MASH Social Worker or Age UK, amongst others) being in the position of supporting a client with multiple complex needs for a period of time when the client's primary need is to manage their pain. Then, the service they are currently in contact with does not

[12] For example, see the Freedom Project (a dog fostering support service) provided by the Dogs Trust https://www.dogstrust.org.uk/how-we-help/freedom-project

have the specialist expertise to provide this support. The consequence is that those services who manage to maintain regular and frequent contact with a client become, on behalf of specialist services, a 'quasi-triage service'

8.5.4 Generally, having a better multi-agency response to complexity would potentially improve outcomes for clients who live with domestic abuse. There may be scope to consider initiatives such as 'Team Around Me' and/or a 'Multiple Disadvantage Outreach Services'.

8.6 Trauma in adolescence and early adulthood

8.6.1 Anne spent time in a Young Offender Institution (YOI); her first husband died at a relatively young age and Anne received a diagnosis of Factitious Disorder.

8.6.2 The Panel recognised that trauma is described by MIND as:

"….going through very stressful, frightening or distressing events".

8.6.3 The national charity NAPAC (National Association for People Abused in Childhood) recognises that childhood trauma, in all forms, has a significant impact on the lives of victims, as children and into adulthood.[13]

8.6.4 The Lancashire Violence Reduction Network (VRN) have an ambition for the public services across Lancashire to become "trauma informed" in their day-to-day practice and develop a knowledge base and best practice procedures concerning the impact of Adverse Childhood Experiences on child and adult clients. The Panel were encouraged to note the developments regarding this ambition, and the resources associated with it, described in the Lancashire VRN website[14].

8.7 Services were offered in the period of the Pandemic. Social isolation and loneliness

8.7.1 According to the submissions made by a number of agencies, Anne was estranged from her family and had been for the majority of her adult life. Anne's GP (and Adult Social Care) noted that she had few friends, but noted that her neighbours would 'look out for her'.

8.7.2 There is also published research – from the Home Office and others – concerning the incidence of suicide during periods of COVID lockdown.

8.8 Anne's account of her lived experience

8.8.1 As noted earlier in this Report, the Lancashire Constabulary – on the balance of probabilities – presumed that a number of allegations of abuse made during the period 2003-2020 were accurate and true.

8.8.2 The Panel had to acknowledge that some accounts, made in late 2020, did contain some discrepancies and the Panel considered this matter in context and at length. The Panel noted that a number of agencies and one or two of Anne's neighbours held information about Anne that couldn't be verified. For example:

[13] www.napac.org.uk
[14] https://www.lancsvrn.co.uk/resources/

- Anne told one service that she had a Son and this was not true;
- The Panel was informed by a number of services that Anne's Sister lived in the Lake District (*the Panel believe Anne's sister lives in Lancashire or Merseyside)*
- Anne told one service that she had a diagnosis of cancer that was terminal;
- A number of services believed that Anne was married in the early 2000s and that her husband had died;
- Anne told a number of agencies that her family had instigated her estrangement from them, but following a conversation with S1, the Panel considered that this may not be entirely accurate.

8.8.3 However, when it comes to the central issue of abuse, the Panel noted that Anne was very precise in 2019 when she told the Safeguarding Service that it had been 8 years since any such incident had occurred. In this specific respect, Anne was entirely accurate.

8.8.4 During this period of consideration, the attention of the Panel was drawn to research concerning the impact of adverse experiences in childhood and early adulthood – including the possibility of a manifestation of dissonance.[15]

[15] PART III – How Trauma Affects Memory and Recall - The Impact of Trauma on Adult Sexual Assault Victims (justice.gc.ca)

Section 9
Conclusion

The Panel noted that it is apparent that Anne took her own life. Whether this was deliberate or accidental will be determined by the Inquest held by the Office of HM Coroner.

This is undoubtedly a tragic case – a woman who endured chronic physical pain, trauma in adolescence and early adulthood, and – the Panel presumes – an unclear duration of domestic abuse and violence, controlling behaviour and emotional trauma

The Panel noted that a number of agencies referred to Anne being isolated and had been estranged from her family for many years and had few friends. The Panel also noted that Anne was socially isolated and – toward the end of the scope of this Review – alone and lonely. This situation will have been exacerbated by the management of the COVID Pandemic and also when her long term relationship ended.

A number of services involved in this Review noted that Anne and M1 were 'struggling to cope'. When staff exercised professional curiosity, it seems that Anne had mentioned to Wrightington, Wigan and Leigh NHS Trust that she was struggling to cope with M1's declining mobility. The Panel acknowledged that M1 was a constant presence in Anne's life for many years and noted that a number of agencies had recorded that he had left the relationship in September or October 2020. Giving up a relationship can have a significant impact on a person's wellbeing. Leaving the home – to go shopping, to attend a hospital appointment, etc – means facing the prospect of returning home and being alone and lonely.

The Panel recognised that Anne engaged with some agencies and not others, shared a particular account of events with one agency and a slightly different account with other agencies and the Panel can understand why Anne may have done this. It is clear that Anne had a story to tell about the abuse she endured and she tried to tell that story as well as she could.

The services in contact with her – for varying lengths of time – were confident that they always left an opportunity for Anne to contact them (and she would); confident that they believed what Anne said and responded to the account properly and professionally and confident that they did not abandon or give up hope that Anne would engage with their service and benefit from the support they could offer.

Anne shared stories about the domestic abuse she suffered – she would say that they were historical and also contemporary; she would assert accounts of domestic abuse to one agency and then deny them to another. The Panel noted that Anne was relatively consistent in her accounts with the Health Services she came into contact with, but less so with agencies who have safeguarding responsibilities and with the Constabulary

Anne was attempting to tell a story and this story was about abuse, about loneliness, about trauma and she tried to tell this story to the services she was in contact with. However, as noted above, when probed on these matters, these accounts were occasionally inconsistent, and then often denied.

NOTE (Coroners Conclusion)

West Lancashire CSP was notified on the 25th of March 2024 of the conclusion from the coroner as to Anne's death. Concluding Anne died on the 5th of January 2021 at Royal Liverpool Hospital from the effects of ingesting an excess of medication however her intentions at the time could not be determined.

Section 10
Recommendations for Action approved by the Panel

Set out below are the Recommendations made by the Panel, accompanied by the rationale for each Recommendation.

These Recommendations are **NOT** in any order of priority.

	Rationale	**Intended outcome**	**Recommendation for action**
1	The Panel noted, from the submissions received, that Anne did endure a number of 'adverse experiences' during her adolescence and early adulthood. These traumas will have had an effect on Anne during her adult life. The Panel was informed that the Lancashire Violence Reduction Network (LVRN) have an ambition for the public services across Lancashire to become "trauma informed" in their day-to-day practice and develop a knowledge base and best practice procedures concerning the impact of Adverse Experiences on adult clients. The Panel learned that the CCG also has an ambition to support the development of trauma informed practice.	The outcome here concerns public service organisations generating an ambition to become "trauma informed" in their day-to-day practice and develop a knowledge base and best practice procedures concerning the impact of Adverse Experiences on adult clients. Additionally, it is about how to make enquiries concerning the impact of adverse events in a 'professionally curious' way. Ultimately the intended outcome is to develop services that are 'trauma competent and trauma confident'. Building a solid base of knowledge and practice is the primary goal.	The Panel recommends that the West Lancashire Community Safety Partnership • Encourages all agencies that have formed a part of this Panel to seek out training and education opportunities to become 'trauma informed' in their day-to-day practice and to develop a knowledge base and best practice procedures concerning the impact of Adverse Experiences in Childhood on adult clients. • Encourages services that have formed a part of this Panel to consider developing policies and practices to achieve a standard of 'Trauma Informed Practice' in the delivery of their service to reflect the ambition of the LVRN. • Encourages services that have formed a part of this Panel to examine published and peer reviewed examples of good practice and, where feasible, to replicate them. • Encourages services that have formed a part of this Panel to appoint a specific point of contact to report back to WLCSP on progress against the

			implementation of the above 'trauma informed recommendations.
2	The Panel learned that service intelligence from specialist mental health teams is suggesting that there are a number of clients who experience suicidal ideation and have a background of living with Domestic Abuse. Additionally, the Panel heard of an example of client engagement whereby people who have considered suicide or have attempted suicide and who are, or have been, living with domestic abuse/violence, coercion, or control are being given space and time to share their experiences with relevant professionals. This work is coupled with the use of 'real time surveillance data' to determine the scale of the response to these services users will require.	It is intended that vital intelligence can be shared across the service landscape within Lancashire to identify people who are experiencing thoughts of suicide or harm to themselves and who are living with domestic abuse. All services that work in the domestic abuse or mental health area are aware and responsive to the significant links between experiencing domestic abuse or similar traumas and the impact this has on suicide ideations.	The Panel recommends the West Lancashire Community Safety Partnership: • Shares the 'suicidal ideation' learning opportunity with the Lancashire and South Cumbria Integrated Care Board (ICB) and other lead officers for suicide prevention in the Local Authorities to enable a shared and co-ordinated work plan that will allow this learning opportunity to be shared with health professionals across Lancashire. Lancashire and South Cumbria Health and Care Partnership :: Start the conversation (healthierlsc.co.uk) • To share this learning opportunity with the pan-Lancashire DHR Task and Finish Group. In order to encourage services to consider the possible links between 'suicidal ideation' and Domestic Abuse as part of the intelligence gathering process to identify "victim suicides" who should be considered for the DHR process. Lancashire and South Cumbria Health and Care Partnership :: Suicide prevention (healthierlsc.co.uk)
3	This Review is about an apparent victim suicide. The Panel considered the Report published by the Home Office concerning Domestic Homicides and Victim Suicides during 2020-21 (i.e., during the initial phase of the management of the COVID Pandemic) and noted the conclusion and	The intended outcome is to establish a process that ensures that 'victim suicides' are identified and considered for a domestic homicide review and that this process is applied uniformly across Lancashire.	The Panel recommends that the West Lancashire Community Safety Partnership: • Encourage all agencies that have formed part of this Panel to ensure a process is in place to identify victim suicides and ensure they are considered for a DHR • WLCSP to share this learning opportunity with the MARAC and other safeguarding responses,

	recommendation that people who have taken their own life and had a history of domestic abuse should be eligible for and referred to the DHR screening process. The Panel also noted – from the same report – the specific risk factors associated with victim suicides.		and requests they consider the findings of the Home Office Report with the aim of developing an assessment process that identifies any risk of victim suicide, i.e., where coercion and control (and according to the evidence – non-fatal strangulation) are present in the case they are reviewing.
4	The Panel considered the Report published by the Home Office concerning Domestic Homicides and Victim Suicides during 2020-21 (i.e., during the initial phase of the management of the COVID Pandemic) and noted the research suggesting that the DARA tool (Domestic Abuse Risk Assessment) better identifies coercive and controlling behaviour (which can lead to homicide or victim suicide)	The intended outcome is to demonstrate improved risk identification amongst all agencies that support victims of abuse.	The Panel recommends that the West Lancashire Community Safety Partnership: Shares the learning from this review with Lancashire Constabulary and the Office of the Police and Crime Commissioner so that they may jointly consider the most appropriate Domestic Abuse Risk Assessment tool for improved risk identification.
5	A number of services involved in this Review reported that they had difficulty engaging with Anne. The Panel also noted that Anne appeared to engage well with staff when she was in NHS settings (a General Hospital in particular). The Panel considered that, from the submissions made, Anne did disclose information to Hospital staff and did consent to the completion of a DASH RIC.	The outcome here is about improving the ability of services to engage with vulnerable and/or complex clients and to embed additional IDVA/ISVA capacity in acute hospital settings and in mental health settings. It is about enhancing capacity and about further improving performance and sharing best practice on how to engage with a 'complex client'.	The Panel recommends that the West Lancashire Community Safety Partnership: • Encourage all agencies that have formed part of this Panel to consider the evaluation of the Wrightington, Wigan and Leigh NHS Trust IDVA service and encourages the relevant partners to build a case for replicating this good practice and expanding and/or enhancing the provision of specialist hospital based IDVA services; • WLCSP shares this learning with the Office of the Police and Crime Commissioner and health Sector commissioning services in

	The Panel also noted that not all Hospital services enjoy the support of a dedicated 'on-site' IDVA or ISVA service.	These outcomes also turn on the ability for agencies to share with one another information arising from risk assessments that have been undertaken. The rationale for the sharing of this information – in an appropriate forum – is to work together to prevent a serious crime.	Lancashire, including the NHS Integrated Care Board with a view to explore the feasibility of developing an operating procedure to allow the co-location of these services within hospital based IDVA services; • WLCSP to share the research undertaken by Safe Lives and Gentoo examining the role of housing providers in helping victims of domestic abuse with the WLBC Housing Service.
6	NICE Guidance (PH50) and Quality Standard (116) concerning domestic abuse and violence contains a number of recommendations to assist agencies to improve the service they offer to clients.	The intended outcome is that front line staff in all agencies are trained to recognise the indicators of domestic violence and abuse and to ask relevant questions that enable people to feel safe to disclose their past or current experiences of such violence or abuse.	The Panel recommends that the West Lancashire Community Safety Partnership: • WLCSP to seek assurance from all partner agencies that have formed part of this Panel, that front line staff in all agencies are trained to recognise the indicators of domestic violence and abuse and to ask relevant questions that enable people to feel safe to disclose their past or current experiences of such violence or abuse and to know how to signpost victims of domestic abuse for suitable support. • WLCSP to encourage the NHS Lancashire Integrated Care Board to re-emphasise and promote awareness of the safeguarding duty of independent clinical practitioners.
7	The Panel noted concern expressed by the Author of the submission from the CCG that the 'handover' of MARAC information could be improved.	The outcome is that General Practice can receive information from their respective MARAC in a consistent format and in a time-efficient way.	The Panel recommends that the West Lancashire Community Safety Partnership: • WLCSP to seek assurance from General Practice and the MARAC, that the template currently used to share MARAC information with General Practice is effective and efficient;

			• If areas of improvement are identified, to construct a means to deliver these changes.

Appendix 1

Domestic Abuse

The new Domestic Abuse Act 2021 defines domestic abuse as a behaviour by a person towards another and:

a) Both persons are each aged 16 or over and are personally connected, and
b) The behaviour is abusive

Where perpetrators direct their conduct towards another person (e.g., the child of a victim), this is also considered to be abusive behaviour towards the victim. Behaviour is considered abusive if it consists of any of the following:

- Physical or sexual abuse.
- Violent or threatening words or actions.
- Controlling or coercive activity.
- Economic abuse (see notes below).
- Psychological, emotional, or other abuse.

Economic abuse means any behaviour that has a substantial adverse effect on a victim's ability to acquire, use, or maintain money or other property, goods, or services.

Personally Connected

The new definition seeks to ensure that opportunities for identifying domestic abuse are not limited and includes where people:

- Are, or have been, married to each other.
- Are, or have been, civil partners of each other.
- Have agreed to marry one another (whether or not the agreement has been terminated).
- Have entered into a civil partnership agreement (whether or not the agreement has been terminated).
- Are, or have been, in an intimate personal relationship with each other.
- Is a child in relation to whom they each have a parental relationship.
- Are relatives.

Section 63 (1) states that a "relative" in relation to a person means:

a) the father, mother, stepfather, stepmother, son, daughter, stepson, stepdaughter, grandmother, grandfather, grandson or granddaughter of that person's spouse, former spouse, civil partner or former civil partner, or
b) The brother, sister, uncle, aunt, niece, nephew or first cousin (whether of the full blood or of the half-blood or by marriage or civil partnership) of that person or of that person's spouse, former spouse, civil partner or former civil partner.

For further information on this subject, please refer to the College of Policing, Authorised Professional Practice (APP) on Domestic Abuse.[16]

[16] College of Policing, Authorised Professional Practice (APP) on Domestic Abuse

Positive Action

Police officers have a positive obligation to take reasonable action, within their lawful powers, to safeguard the rights of victims and children. This includes the duty to:

- make an arrest where it is necessary and proportionate to do so, see the authorised professional practice (APP) on detention and custody, lawful arrest
- protect the victim and vulnerable people within the household from harm

Children as victims in their own right

Under section 3(2) of the Domestic Abuse Act 2021, a child is a victim of domestic abuse **for the purposes of the Act** where they see, hear, or experience the effects of domestic abuse and are related to either a perpetrator or victim of abuse, or either individual has parental responsibility for the child

The 2021 Act does not create a specific offence of domestic abuse against a child and there are no requirements to record a crime on the basis of a child either being present or residing at the location of the abuse.

The purpose of this Act is to ensure that children's needs are appropriately assessed and met. **Existing safeguarding, risk assessment and referrals processes and procedures should be followed** to ensure children receive support and remain visible in the multi-agency response to domestic abuse. Statutory guidance in Working Together to Safeguard Children sets out expectations for inter-agency working to safeguard and promote the welfare of children, including those experiencing domestic abuse.

Stalking or Harassment

Stalking and/or harassment are clear indicators of future harm to a victim and can be very common in domestic abuse incidents. Offences of stalking or harassment are classed as "as well as crimes" and must be recorded in addition to any other offences under NCRS/HOCR.

Stalking

Stalking is a pattern of fixated, obsessive, unwanted, and repeated behaviour which is intrusive and causes fear of violence or serious alarm or distress. Stalking tends to focus on a person, rather than a dispute.

Harassment

Harassment is unwanted behaviour which can be found offensive, or which makes the victim feel intimidated or humiliated. Harassment tends to focus on a dispute rather than a fixation with a person.

Controlling or Coercive Behaviour

Section 76 of the Serious Crime Act 2015 provides the offence of controlling or coercive behaviour where the perpetrator and victim are personally connected. In this legislation, 'personally connected' means intimate partners, or former intimate partners, or family members who live together. The Domestic Abuse Act 2021 introduced an amendment to the legislation which removes the co-habitation requirement. This ensures that post-separation domestic abuse and familial domestic abuse is accounted for when the victim and perpetrator do not live together.

Acts of controlling or coercive behaviour may include: isolating a person from their family or friends; monitoring a person's time; using spyware to monitor a person; taking control over aspects of a person's everyday life (such as where they can go, who they can see, what they

can wear, and when they can sleep); repeatedly putting a person down (such as telling them they are worthless); threats to harm a child; and many other types of behaviour.

Harmful Traditional Practices

This is a broad term used to describe a combination of practices used principally to control and punish the behaviour of a member of a family or social group, to protect perceived cultural and religious beliefs in the name of 'honour'. There is currently no statutory definition of honour-based abuse.

Appendix 2
The MARAC National Dataset

There are approximately 290 MARAC across the UK. MARAC data is data submitted to SafeLives, by individual MARAC, on a quarterly basis. It comprises the date of meetings held within the quarter and basic information about the cases discussed at each meeting date (for example, the total number of cases, number of cases referred by a certain agency, number of cases where the victim has a disability, etc). Each quarter the data is collated and published to create the national dataset shown below.

Overview	**Latest Quarter 12 months 01/07/2021 to 30/06/2022**	**Previous Quarter 12 months 01/04/2021 to 31/03/2022**
Total number of MARAC who submitted data	293	290*
Number of cases seen at these MARAC	120,634	120,495
Year-on-year change in number of cases	+4%	+6%
Number of children	152,504	151,207
Number of cases per 10,000 adult females	46	47
% of repeat cases seen at these MARAC	33%	33%
% of partner agency referrals to these MARAC	33%	33%

Key statistics about domestic abuse in England and Wales

- Each year nearly 2 million people in the UK suffer some form of domestic abuse - 1.3 million female victims (8.2% of the population) and 600,000 male victims (4%)
- Each year more than 100,000 people in the UK are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse
- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- In 2013-14 the police recorded 887,000 domestic abuse incidents in England and Wales
- Seven women a month are killed by a current or former partner in England and Wales
- 130,000 children live in homes where there is high-risk domestic abuse.
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others
- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help

- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse

What are the characteristics of victims that mean they are more likely to be abused?

- **Gender:** Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- **Low income:** women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000
- **Age:** Younger people are more likely to be subject to interpersonal violence. The majority of high risk victims are in their 20s or 30s. Those under 25 are the most likely to suffer interpersonal violence
- **Pregnancy:** Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant [6]
- **Separation:** Domestic violence is higher amongst those who have separated, followed by those who are divorced or single
- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction (whether or not it is related to domestic abuse)
- **Drug and alcohol abuse:** Victims of abuse have a higher rate of drug and/or alcohol misuse (whether it starts before or after the abuse): at least 20% of high-risk victims of abuse report using drugs and/or alcohol
- **Mental health issues:** 40% of high-risk victims of abuse report mental health difficulties

How long do victims live with domestic abuse?

- On average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help

Appendix 3

Home Office Feedback Letter

West Lancashire
(Anne) Resubmission

West Lancashire Community Safety Partnership (WLCSP) – DHR (20210527/2 f)

DHR Multi-Agency Action Plan

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Agency and Lead Officer *see key at end of action plan	Target date to complete
1.	West Lancashire Community Safety Partnership (WLCSP) encourages all agencies that have formed part of this Panel to seek out training and education opportunities to become 'trauma informed' in their day-to-day practice and to develop a knowledge base and best practice procedures concerning the impact of Adverse Experiences on adult clients	Access the Lancashire Violence Reduction Network (LVRN) website and use their available resources to ensure each agency is working towards becoming trauma informed. https://www.lancsvrn.co.uk/	Written assurance that the LVRN website has been accessed and evidence provided of what resources have been used and what stage of TIP (trauma Informed Practice) each agency has achieved.	To ensure each agency is making concerted efforts to become trauma informed	LCON - ND WLCSP - CO&JE LCCSA – HCC&LL ICB – LE&BW WW&L - BC S&OHT - SS L&SCFT - LH LVS - CP LIBC – JH&MG NWAS - SMcQ ICAT – HCC&AS LCCRES -HCC&DF AGEUK - MT	Awaiting response AGEUK. All other agencies have completed this action
2.	WLCSP encourages all agencies that have formed part of this Panel to	Access the LVRN website and use their available resources to ensure each	Written assurance provided including evidence of what	To ensure each agency is making	*see key at end of action plan LCON - ND	Awaiting response from AGEUK. All

	consider developing policies and practices to achieve a standard of 'Trauma Informed Practice' in the delivery of their service to reflect the ambition of the LVRN	agency is working towards becoming trauma informed.	examples have been accessed and how these are being incorporated into agency practice	concerted efforts to become trauma informed	WLCSP - CO&JE LCCSA – HCC&LL ICB – LE&BW WW&L - BC S&OHT - SS L&SCFT - LH LVS - CP LIBC – JH&MG NWAS - SMcQ ICAT – HCC&AS LCCRES -HCC&DF AGEUK - MT	other agencies have completed this action
3.	WLCSP encourages all agencies that have formed part of this Panel to appoint a specific point of contact to report back to WLCSP on progress against the implementation of the above 'trauma informed' recommendations.	Each agency to provide the name of their Specific Point of Contact (SPOC) who will be responsible for ensuring the actions in this action plan are completed and fed back to WLCSP within the timescales agreed	SPOC name provided and feedback on actions provided within agreed timescales	Feedback on actions provided from SPOC within agreed timescales	LCON - ND WLCSP - CO&JE LCCSA – HCC&LL ICB – LE&BW WW&L - BC S&OHT - SS L&SCFT - LH LVS - CP LIBC – JH&MG NWAS - SMcQ ICAT – HCC&AS LCCRES -HCC&DF AGEUK - MT	Completed
4.	WLCSP to share the 'suicidal ideation' learning opportunity for suicide prevention with all agencies that have formed part of this Panel, Lancashire and South Cumbria Health and Care Partnership: Start the	WLCSP to provide all DHR panel members with information on the Suicidal Ideation learning opportunity	Hyperlink to this information to be provided to all the DHR panel members	To ensure all agencies have been provided with the suicidal ideation learning opportunity	WLCSP - CO&JE	Completed

	conversation (healthierlsc.co.uk)					
5.	To share this (action 4) learning opportunity with the pan-Lancashire DHR Task and Finish Group, in order to encourage services to consider the possible links between 'suicidal ideation' and Domestic Abuse as part of the intelligence gathering process to identify "victim suicides" who should be considered for the DHR process. Lancashire and South Cumbria Health and Care Partnership:: Suicide prevention (healthierlsc.co.uk)	WLCSP to provide DHR Task & Finish Group with information on the Suicidal Ideation learning opportunity	Hyperlink to this information to be provided to the DHR Task & Finish Group	To ensure that the DHR Task & Finish Group have been provided with the suicidal ideation learning opportunity	WLCSP - CO&JE	Completed
6.	WLCSP to encourage all agencies that have formed part of this Panel to ensure a process is in place to identify domestic abuse victim suicides and ensure they are considered for a DHR	Each agency to provide assurances that their referral processes for DHR consideration in cases of suicide where DA is suspected/confirmed are robust, including where coercion and control are present in the cases reviewed.	Written evidence of the process in place to assure that consideration for referral is considered in cases of suicide where DA is suspected or confirmed	To ensure that all agencies have processes in place for referrals for DHR consideration in cases of suicide where DA is suspected/confirmed	LCON - ND WLCSP - CO&JE LCCSA – HCC&LL ICB – LE&BW WW&L - BC S&OHT - SS L&SCFT - JM LVS - CP LIBC – JH&MG NWAS - SMcQ ICAT – HCC&AS LCCRES -HCC&DF AGEUK - MT	Awaiting response from AGEUK. All other agencies have completed this action

7.	WLCSP to share this learning opportunity with the Lancashire Domestic Abuse Board and request they consider the findings of the Home Office Report with the aim of developing an assessment process that identifies any risk of victim suicide, i.e., where coercion and control (and according to the evidence – non-fatal strangulation) are present in the case they are reviewing	WLCSP to recommend that the Lancashire Domestic Abuse Board promote the Home Office report with all Lancashire CSPs.	Written assurance the Lancashire Domestic Abuse Board have considered this recommendation to share learning and promote the Home Office Report.	Panel agencies to ensure robust process is in place that enables Lancashire CSP's and other relevant authorities to refer into WLCSP for Increased awareness in Lancashire of the Home Office Report and understanding of processes and procedures for referring DHR in cases were suicide related to DA is suspected/confirmed.	WLCSP - CO&JE	Completed
8.	WLCSP to share the learning from this DHR review with Lancashire Constabulary and the Office of the Police and Crime Commissioner (OPCC) so that they may jointly consider the most appropriate Domestic Abuse Risk Assessment	The OPPC & Lancashire Constabulary to work together to consider what is the most appropriate DARA tool to use going forward	Written feedback from OPPC & Lancashire Constabulary that evidences a rationale for the choice of DARA tool to be used.	To ensure the DARA tool being used is evidenced as the most effective tool currently available	LCON - ND WLCSP - CO&JE	Completed

	tool for improved risk identification					
9.	WLCSP to encourage all agencies that have formed part of this Panel to consider the evaluation of the Wrightington, Wigan and Leigh NHS Trust IDVA service and to encourage the relevant partners, to build a case for replicating this good practice and expanding and/or enhancing the provision of specialist hospital based IDVA services where appropriate	All relevant health agencies to evaluate the WW&L NHS Trust IDVA service with the aim of replicating this process where appropriate	Written evidence of this evaluation, alongside an outcome of the evaluation, as to whether this type of IDVA service has been taken up and the rationale for decisions made	To ensure all relevant agencies have evidenced that have evaluated the WW&L NHS Trust IVDA service and where possible put this service in place.	ICB – LE&BW S&OHT - SS L&SCFT - SP	Completed
10.	WLCSP shares this learning with the Office of the Police and Crime Commissioner and health Sector commissioning services in Lancashire, including the NHS Integrated Care Board, so that they may explore the feasibility of developing an operating procedure to allow the co-location of these services within hospital based IDVA services	OPPC and ICB to review the good practice identified in the DHR review regarding the WW&L NHS Trust IDVA Service and consider if this can be replicated in other relevant agencies or health settings.	Written assurance that the good practice identified in the DHR report regarding the IDVA Service offered by WW&L NHS Trust has been considered	To ensure that all relevant agencies have given serious consideration to the implementation of the IDVA scheme operated by WW&L NHS trust	WLCSP - CO&JE ICB – LE & BW	Completed

11.	WLCSP to share the research undertaken by Safe Lives and Gentoo examining the role of housing providers in helping victims of domestic abuse with the WLBC Housing Service.	Safe Lives & Gentoo research to be shared with WLBC Housing Services	Written evidence of how and when the Safe Lives & Gentoo research was shared with WLBC Housing Services	To ensure that the WLBC housing services team are aware of and take in into account this research when interacting with their tenants	WLCSP - CO&JE	Completed
12.	WLCSP to seek assurance from all partner agencies that have formed part of this Panel, that front line staff in all agencies are trained to recognise the indicators of domestic abuse and to ask relevant questions that enable people to feel safe to disclose their past or current experiences of such abuse and to know how to signpost victims of domestic abuse for suitable support.	All agencies that formed part of the panel to review their staff domestic abuse training and ensure that such training enables all staff to recognise the indicators of domestic abuse, can ask relevant questions that enable people to feel safe to disclose their past or current experiences of abuse and know how to signpost victims for relevant support.	Written feedback that provides assurance that all agencies have reviewed their current domestic abuse training and gives assurances that such training includes recognition of the indicators of domestic abuse, that staff have the skills to ask relevant questions that enable people to feel safe to disclose abuse and that they know how to signpost victims for relevant support.	To ensure that staff in all agencies have access to relevant and up to date domestic abuse training	LCON - ND WLCSP - CO&JE LCCSA – HCC&LL ICB – LE&BW WW&L - BC S&OHT - SS L&SCFT - JM LVS - CP LIBC – JH&MG NWAS - SMcQ ICAT – HCC&AS LCCRES -HCC&DF AGEUK - MT	Awaiting response from AGEUK. All other agencies have completed this action
13.	WLCSP to request the NHS Lancashire Integrated Care Board West Lancashire locality re-emphasise and promote awareness of the safeguarding duty of	Lancashire ICB to ensure that all independent clinical practitioners are aware of their safeguarding duties	Written assurances that al Independent Clinical practitioners have been made aware of their safeguarding duties	To ensure that all independent clinical practitioners are aware of their safeguarding duties	ICB – LE&BW	Completed

	independent clinical practitioners.					
14.	WLCSP to seek assurance from General Practice and the MARAC, that the template currently used to share MARAC information with General Practice, is effective and efficient; If areas of improvement are identified, to construct a means to deliver these changes.	ICB and MARAC to work together to review and determine if the current MARAC template is sufficient, to ensure the sharing of information from any MARAC to GP practices is fit for purpose and if not, make changes to provide assurances it will do so in future	Written assurances that ICB & MARAC have completed a review of the template and that it is fit for purpose in terms of the sharing of information between MARAC & GP practices	To ensure effective and timely communication between MARAC & GP's	ICB – LE&BW LCON - ND	Completed
15.	West Lancashire Borough Council to ensure that information is available, to ensure tenants are aware to contact the Council, if they have problems when maintenance jobs are undertaken at their property.	WLBC Housing Services to consider providing information all tenants, advising that they can contact the Council, if they have problems with the repair.	Written assurances that WLBC housing have considered the proposals indicated, what the outcome of those considerations are and a rationale for decisions made	To ensure tenants understand how to manage repairs to their property	WLBCHT - NB	Completed
16.	WLBC Housing Services to encourage its maintenance contractors to make Housing staff aware of situations where they know or believe there is DA or a vulnerable adult.	WLBC to ensure all Housing Officers are aware to contact a tenant who they know or believe might be a victim of DA or a vulnerable adult, following a completed repair, to ensure there are no further problems relating to that repair and to	Written assurances that WLBC housing have considered the proposals indicated, what the outcome of those considerations are and a rationale for decisions made	tenants who are vulnerable adults can manage repairs to their property	WLBCHT - NB	Completed

		ensure that they are aware of support available.				
17.	Lancashire County Council Safeguarding Team to have a system in place, to support safeguarding staff, who have concerns there is an increased risk to an individual, linked to their reluctance to engage with professionals.	Members of the LCC safeguarding team to be aware they need to advise their team managers of this risk, who will then discuss this in team meetings with the option of social workers/SCSOs placing a risk marker on LAS if the person is reluctant to engage.	The County Safeguarding Operational Manager discussed this recommendation with Lancashire County Council Principle Social Worker, and they approved this action. They also recommended that, if required, a summery case note be added to LAS. This was confirmed during the safeguarding team manager meeting on 02/11/2021.	To ensure there is a protocol in place where individuals are at increased risk due to a reluctance to engage	LCCSA – HCC&LL	Completed
18.	WLCSP to seek assurance that Telecare referrals are not closed down if the service user did not answer a phone call particularly when poor telephone connection was the reason for the referral in the first place.	The Safeguarding Team Manager and Safeguarding Social worker to contact the Telecare manager to request that cases are not to be closed if a service user does not answer telephone calls and gain assurances that Telecare will discuss this issue of none contact, with the social worker involved before closing such cases.	Written assurances from the Safeguarding team that contact has been made with Telecare and that they are aware to discuss any case with the Social Worker involved before closing cases	To ensure no case is closed due to poor telephone connection or contact issues.	LCCSA – HCC&LL	Completed

19.	WLCSP to seek assurance from MARAC that the Lancashire Safeguarding team are aware of all MARAC meetings and are provided with the details of all those to be discussed at each meeting	The Safeguarding Team Manager and Safeguarding Social Worker to contact the MARAC manager to discuss the importance of Safeguarding being invited and/or updated re MARAC meetings when they are also working with the person concerned.	Written assurances that the safeguarding team and MARAC Managers have put a protocol in place to ensure the Safeguarding team are aware of all MARAC meetings and are provided with the details of those being discussed at these meetings	To ensure all agencies working with an individual can fully engage with the MARAC process	LCCSA – HCC&LL LCON - ND	Completed
20.	WLCSP to seek assurances that prompt contact is made between with Wrightington Wigan and Leigh Hospital and the Safeguarding Team	The Safeguarding Team Manager and Safeguarding Social Worker to contact WWL Hospital Safeguarding Manager to share contact telephone numbers/E-mail addresses, etc.		To ensure that prompt contact can be made between WW&L hospital and the Safeguarding Team	WW&L - BC LCCSA – HCC&LL	Completed
21.	WLCSP to seek assurances that formal COVID written risk assessments should be recorded prior to all LCC Safeguarding visits during present COVID risks.	Safeguarding staff to be reminded to record formal written COVID risk assessments prior to all visits during present COVID risks.	Member of staff discussed the matter in the Safeguarding Managers meeting (on the 02.11.2021) requesting that all teams are reminded to record formal written COVID risk assessments prior to all visits during present COVID risks.	To ensure that formal COVID risk assessments have taken place as per agency policy	WW&L - BC	Completed
22.	WLCSP to seek assurances that MARAC	All staff and agencies involved in the MARAC	Written assurances that MARAC have a	To ensure that there is timely	LCON - ND	Completed

	actions are being completed within the timescales agreed or are being followed up in a timely manner of not	process to ensure they complete MARAC actions within the timescales agreed and they feed this back to MARAC	process in place to ensure that all actions are completed within the agreed timescales and that they are followed up in a timely manner if not.	completion of all MARAC actions		
23.	WLCSP to seek assurances through the ICB that all GP Practices operating within West Lancashire are reminded of key points which are already recommended practice. To include the following: Read coding and recording Dealing with incoming letters Dealing with non-attendances by adults with care and support needs (the "vulnerable") The "Think Family" approach	All staff across the practices will be able to code letters correctly, understand how to deal with incoming letters and know how to manage non attending adults with care and support needs	Practices to confirm they have received the guidance and the ICB to provide written assurances to WLCSP that this has taken place	To ensure that dissemination of relevant guidance by e-mail or newsletter by the ICB takes place and to recirculate the sample DA policy to all practices	ICB – LE&BW	Completed
24.	NHS Integrated Care Board to consider providing staff West Lancashire Primary Care staff with bespoke DA update training that sits alongside the standard safeguarding update training	Practice team staff, including front facing and admin staff, to have access to bespoke training linking in with Think Family approach and recent updates around DA	Written assurances that each practice has confirmed they have received the update and training as agreed	To ensure that staff across the practices are in a position to use professional curiosity when managing domestic abuse enquires	ICB – LE&BW	Completed

				Easier identification of patients at risk		
25.	WLCSP to seek assurances that the process to ensure timely escalation of safeguarding concerns from other agencies, via letters are shared with GP leads via Practice administration staff regarding safeguarding risks/ vulnerability and DA	Each practice meeting needs to include, as a minimum, the Safeguarding Lead (+/- deputy), the Safeguarding Champion and the Practice Manager	Written assurances that the protocol for practice meetings has been agreed and actioned	To ensure safeguarding concerns are followed up and acted on timely	ICB – LE&BW	Completed
26.	WLCSP to seek assurances from the NHS Integrated Care Board that the follow up of patients where there is a lack of engagement with services and where vulnerability is a feature is inherent within its policy	Each practice to ensure that any patient identified as vulnerable has appropriate safeguards in place, particularly in cases where 'self-referral' is expected	Written assurances that the protocol for identifying and following up individuals who do not engage is in place	To ensure there is professional curiosity in place across the practice and that those assessed as vulnerable who do not engage are followed up appropriately	ICB – LE&BW	Completed
27.	NHS Integrated Care Board (West Lancashire locality) to Develop a DA Grab pack which will be circulated to Primary Care services	Grab Pack to be produced and circulated and also used as a reflective piece of learning within practice meetings	Written assurances that the grab pack has been produced and circulated	To support routine enquiry and provide accessible access to services	ICB – LE&BW	Completed
28.	NHS Integrated Care Board to share the lessons learned from the DHR with the individual practices	Development of a DHR learning brief and to circulate the learning	Written assurances that the DHR learning has been shared with all	To ensure that DHR learning is formally circulated	ICB – LE&BW	Completed

	across Lancashire and South Cumbria Primary Care Networks	across the Named GP ICS GP Networks Additionally, the learning brief to be circulated across relevant L&SC Safeguarding networks and NHS England Lancashire and regional teams and to share the learning as a topic across the CCG GP safeguarding Forum	practices across the network GP learning from DHR's conference for primary care delivered 24th & 29th November 2021	individual practices, then, GP Networks, safeguarding networks and NHS England		
29.	WWLFT to consider how to raise staff awareness of how to facilitate the reporting of a crime following a patient's disclosure	To raise awareness of crime reporting following patient disclosure and to embed this into adult safeguarding supervision and to add this learning into domestic abuse policy and domestic abuse training.	Written assurances that all relevant staff are aware of crime reporting following patient disclosure	To ensure that all relevant staff have awareness of crime reporting after patient disclosure	WW&L - BC	Completed
30.	Southport and Ormskirk Hospital Trust to reinforce to staff the Importance of completion of the safeguarding questions in A&E and highlight this through safeguarding training	To reinforce the importance of completing the safeguarding questions in A&E via Safeguarding Team and A&E Managers and to complete a review of AED documentation and its ease of completion	Written assurances that all staff are aware of the need to fully complete all the safeguarding questions in A&E using an audit of compliance and feedback from that audit	To ensure that safeguarding is fully considered for all patient's attending A&E.	S&OHT - SS	Completed
31.	Southport and Ormskirk Hospital Trust to seek assurances that the Provider Enquiry Report is completed and returned to	The prompt reinstating of packages of care via patient safety meetings,	Written assurance that all relevant staff are aware of the process required to enable		S&OHT - SS	Completed

	Sefton Local Authority due to concerns regarding errors in reinstating a package of care	inter-ward transfer document being introduced & reinforcement of new D/C checklist and audit of compliance	packages of care to be reinstated promptly			
32.	West Lancashire Home Treatment Team to ensure that staff involved in the care of the service user have completed clinical risk training	The introduction of Mandatory training with staff within the West Lancashire Home Treatment Team to undertake the clinical risk Level 2 training	Written assurance that this action is complete and has been signed off on DCIQ incident reporting system	To ensure that risk formulations are completed to a high standard	L&SCFT - SP	Completed
33.	Completion of an audit by West Lancashire Home Treatment Team that focusses on the quality of risk assessments, with necessary further actions taken should there be evidence of further concerns in this regard	West Lancashire Home Treatment Team leader to complete an audit and evidence that actions have taken place to address any concerns raised within that audit	Written assurance that this action is complete and has been signed off on DCIQ incident reporting system	Clear evidence through audit outcomes that the quality of risk assessments has improved.	L&SCFT - SP	Completed

Multi-Agency Action Plan

*Agency Key

Agency		Lead name (S)	
Lancashire constabulary	LCON	Neil Drummond	ND
WLCSP	WLCSP	Cliff Owens & Jackie Edwards	CO&JE
WLBC Housing Team	WLBCHT	Nicola Bradley	NB
LCC Safeguarding Adults	LCCSA	Helene Cooper Clarke & Lisa Lloyd	HCC&LL
NHS ICB	ICB	Lorraine Elliot & Bridget Welch	LE&BW
WW&L NHS Trust	WW& L	Bridget Cheyne	BC
S & O Hospitals trust	S&OHT	Sharon Seton	SS
L&SCFT	L&SCFT	Susan Porter	SP
L&SCFT	L&SCFT	Laura Holt	LH
L&SCFT	L&SCFT	Jo Morrison	JM
Lancashire Victim Support	LVS	Claire Powell	CP
Liberty Centre	LIBC	Jackie Hill & Mark Grimes	JH&MG
NW Ambulance Service	NWAS	Sharon McQueen	SMcQ
LCC - ICAT	ICAT	Helene Cooper-Clarke & Amy Sharples	HCC&AS
LCC – Re-enablement	LCCRE	Helene Cooper-Clarke & David Francis	HCC&DF
AGE UK	AGEUK	Michelle Turner	MT