# Domestic Homicide Review

## “Mary” who died in February 2020

**LDHR21 Overview Report January 2022**

# Contents

# 1 Introduction

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

1.2 Mary was a single woman with no children and was thirty years old when she took her own life. She was a qualified nurse and was described by colleagues as an articulate individual with a passion for her work. She was very much liked by her colleagues.

Mary lived alone at the time of her death in a rented property in Liverpool. Her partner, Simon, lived with her at the property from the start of her tenancy in 2019, until his arrest one week prior to her death. After his arrest he was released on police bail with a condition not to go back to the property.

1.3 Prior to the timeframe of the review, Mary reported domestic abuse incidents to the police. Those incidents involved previous partners who were subject to arrest. In 2007, she reported domestic abuse by a previous partner when she was subjected to physical assault, including strangulation to the point of unconsciousness.

1.4 In some of her interactions with healthcare professionals in February 2020, Mary outlined that her partner Simon[2], had been physically abusive towards her. This was also reported to Merseyside Police, although just a week later, Mary took her own life whilst alone at home.

[1] A pseudonym chosen by the DHR panel from a list of names.

[2] A pseudonym chosen by the DHR panel from a list of names.

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

1.6 The review considers agencies' contact and involvement with Mary from 1 January 2019 until her death in February 2020. This time period was chosen as it covers the period immediately prior to her forming an intimate relationship with Simon and ensures that relevant interactions with support agencies were captured.

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

1.8 **Note:**

It is not the purpose of this DHR to enquire into how Mary died. That is a matter that has already been examined during the coroner's inquest.

# 2 Timescales

2.1 This review began on 12 March 2021 and was concluded on 18 January 2022. More detailed information on timescales and decision-making is shown at paragraph 5.2

# 3 Confidentiality

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

3.2 Pseudonyms have been used in the report to protect the identity of the subjects of the review.

# 4 Terms of Reference

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

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

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

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

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

### 4.2 Timeframe Under Review

The DHR covers the period from 1 January 2019 until Mary's death in February 2020.

## 4.3 Case Specific Terms

Subjects of the DHR

Victim: Mary, aged 30 years

Mary's partner: Simon, aged 34 years

**Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Mary?

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

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

4. Did your agency consider that Mary could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?

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

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

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

8. How effective was inter-agency information sharing and cooperation in response to Mary and Simon, and was information shared with those agencies who needed it?

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

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

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

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

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

# 5 Methodology

5.1 On 15 October 2020, Liverpool Community Safety Partnership held a Standing Group Meeting to consider multi-agency information held in relation to Mary and the perpetrator, Simon. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review [para 18 Statutory Home Office Guidance][3] and recommended one should be conducted. The Home Office was informed of the decision to undertake a review.

5.2 The start of the process was delayed as a result of agency work pressures during the Covid-19 pandemic, with the first meeting of the DHR panel taking place on 12 March 2021. Meetings took place using Microsoft Teams video conferencing: the panel met four. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 15 October 2021, after which minor amendments were made to the report which were agreed with the panel by email.

5.3 At the time of the final panel meeting, the Chair of the review was still hopeful of engagement with one of Mary's friends and therefore the report was not finalised immediately. Unfortunately, as set out at paragraph 6.3.1, that engagement was not successful, and the report was finalised in January 2022.

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

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

6.1.1 The DHR Chair wrote to Mary's sister, inviting her to contribute to the review. The letter included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[4] leaflet. The letter was delivered and explained by a police officer who knew Mary's sister.

6.1.2 Mary's sister initially said that she would contribute to the review but was not able to do so immediately. She did not respond to further attempts at engagement. The Chair of the review also wrote to Mary's mother, enclosing Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA) leaflet, but she did not reply to the letter.

6.1.3 At the conclusion of the DHR process, the Community Safety Partnership made a decision to publish the review and wrote to Mary's sister to inform her of the publication. As a result of that letter Mary's sister contacted the Community Safety Partnership. A meeting with a Community Safety Partnership representative and the Chair of the review was arranged. Mary's sister was supported by an advocate from AAFDA. During the meeting Mary's sister was able to articulate a number of points of additional information and factual accuracy which the chair considered and then made changes to the report. Mary's sister had originally felt unable to contribute to the review due to the overwhelming nature of Mary's death and the range of other issues that had to be dealt with.

### 6.2 **Employer**

6.2.1 Mary was employed as a nurse by Mersey Care NHS Foundation Trust. Her role was in physical health care. The Trust also provides mental health services. The Trust has contributed to the review and their contribution is shown as appropriate in the report. In making their contribution to the review, the Trust spoke to Mary's line manager and colleagues, and their input is reflected in the report.

### 6.3 Friends

6.3.1 The review was provided with a summary of statements made by friends in relation to the prosecution case against Simon, which indicated some knowledge of domestic abuse, and these are reflected in the report. The Chair wrote to the friends, inviting them to contribute to the review and enclosing a Home Office DHR leaflet. As a result of receiving a letter, one of Mary's friends contacted the Chair of the review and had an initial discussion about involvement in the review. Having considered what to do, the friend did not provide further information to the review. Other friends did not respond to letters and there has therefore been no substantive engagement with Mary's friends for the purposes of the review. Mary's sister commented that Mary's death and the subsequent trail had been a lot for family and friends to cope with and the timing of the review may have impacted on the friend's decision.

### 6.4 The Perpetrator

6.4.1 Simon was approached about the review via his probation offender manager. Although he was given a prison sentence following Mary's death, he had been released from prison prior to the review starting. Simon spoke to the Chair of the review by telephone and his contribution is appropriately referenced in the report. His contribution is uncorroborated and has not been challenged.

# 7 Contributors to the Review/ Agencies Submitting IMRs[5]

7.1.1

[5] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Mary and/or the perpetrator.

| Agency | Contribution |
|---|---|
| Merseyside Police | IMR |
| Liverpool Clinical Commissioning Group | IMR |
| Merseycare NHS Foundation Trust | Short Report |

7.1.2 In addition to the IMRs, each agency provided a chronology of interaction with Mary and the perpetrator, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of Mary or the perpetrator, nor had any involvement in the provision of services to them.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Mary and the perpetrator; and any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 The IMRs in this case focussed on the issues facing Mary. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

## 7.2 Information About Agencies Contributing to the Review

### 7.2.1 Merseyside Police

Merseyside Police is the territorial police force responsible for law enforcement across the boroughs of Merseyside: Wirral, Sefton, Knowsley, St Helens, and the city of Liverpool. It serves a population of around 1.5 million people, covering an area of 647 square kilometres. Each area has a combination of community policing teams, response teams, and criminal investigation units.

### 7.2.2 Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group (CCG) is responsible for planning and buying most NHS services for the people of Liverpool. Since April 2015, they have also had responsibility for GP services in Liverpool.

They work in close partnership with those involved in providing care in the city, such as local hospitals, to make sure that NHS services meet the needs of the community.

### 7.2.3 Mersey Care NHS Foundation Trust

The Trust provides specialist in-patient and community services that support mental health, learning disabilities, addictions, brain injuries, and physical health in the community.

# 8 The Review Panel Members

8.1

| Name | Agency |
|---|---|
| Ged McManus | Chair and Author |
| Carol Ellwood-Clarke | Support to Chair and Author |
| Emma Briscoe | Safer & Stronger Communities |
| Angela Clarke | Safer & Stronger Communities |
| Crispin Evans | Interim Safeguarding Lead<br><br>Merseycare NHS Foundation Trust |
| Chantelle Carey | Designated Nurse, Safeguarding Children, Liverpool Clinical Commissioning Group |
| Lindsay Devine | Merseycare NHS Foundation Trust |
| Kerry Dowling | Local Solutions, Independent Domestic Violence Advisor (IDVA) |
| Susan Hewitt | Safeguarding Practitioner, North West Ambulance Service NHS Trust |
| Jan Summerville | Team Manager, Quality Assurance and Adult Safeguarding, Adult Services |
| Paul Grounds | Detective Chief Inspector<br><br>Merseyside Police |
| Sue Neeley | Public Health/Suicide Prevention |

| Name | Agency |
|---|---|
| Dan Bettison | Support to Chair and Author |

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

# 9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author were the same person.

9.2 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board [not in Merseyside or an adjoining authority] and has chaired and written previous DHRs and Safeguarding Adults Reviews.

9.3 Carol Ellwood-Clarke retired from public service [British policing] during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[6].

[6] https://safelives.org.uk/

9.4 Both practitioners served for over thirty years in different police services [not Merseyside] in England. Neither of them has previously worked for any agency involved in this review.

9.5 Between them, they have undertaken over sixty reviews including the following: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHR's. They have also completed accredited training for DHR Chairs, provided by AAFDA.[7]

# 10 Parallel Reviews

10.1 The Liverpool coroner held an inquest into Mary's death on [date redacted]. The record of inquest states the medical cause of death as hanging.

The circumstances of death are recorded as follows.

Mary was a 30-year-old lady who filed a report with the police of domestic abuse which was being investigated by Merseyside Police. Prior to her death Mary had informed a friend she was at the 'lowest point of her life'. Though there was no formal diagnosis it was felt that Mary was depressed. On [date redacted] Mary was found deceased hanging in the stairwell of her home, using a ligature made from a very long length of TV aerial cable which had been woven through the first-floor landing spindles. There was a notepad at the foot of the stairs which contained handwritten notes to family members. The notes were clearly suggestive of the fact that Mary was going to take her own life because of, in the main, her relationship issues and challenges. She referenced previous relationships and her perception of her failure to hold down a relationship.

[7] Advocacy After Fatal Domestic Abuse

She mentioned the fact that her partner who was currently being investigated by the police for domestic abuse would lie and persuade the authorities that it was her fault. There is no doubt Mary carried out the act of self-harm with the intention of taking her own life. There is also no doubt from the notes she has written, the central factor involved in influencing her to take her own life, was in her mind the long term mental and physical abuse she had been made subject to as part of her relationship.

The conclusion of the coroner, as to the cause of death, was suicide.

10.2 No agency has undertaken any form of internal review separate to the DHR process.

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

10.4 Mary's sister informed the chair that she had made a complaint to the Independent Officer for Police Complaints regarding the conduct of the investigation into Mary's allegations of domestic abuse. The fact of this complaint was unknown to the review and had not previously been disclosed by Merseyside Police due to an oversight. The outcome of the complaint was that

"Organisational guidance is to be given to all officers regards importance of verifying the content of the auto-populated sections of VPRF documents". This action was completed by Merseyside Police in July 2020.

# 11 Equality and Diversity

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

age [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].

disability [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].

**gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

**marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].

**pregnancy and maternity**

**race** [for example colour includes being black or white. Nationality includes being a British, Australian, or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].

**religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism

would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

**sex**

**sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines ‘disability’ as:

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

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

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

11.2 Historically, prior to the timeframe of the review, Mary had engaged with local mental health services. Referrals were made to them following incidents of medical overdose, reportedly triggered by domestic abuse by previous partners. Mary did not always attend appointments with mental healthcare professionals and as such, was discharged. She was, however, diagnosed with emotionally unstable personality disorder[8].

11.3 Both Mary and Simon drank alcohol socially. There is no evidence that either had a drinking problem which required any type of intervention.

[8] National Institute for Health and Care Excellence (NICE) describe emotionally unstable personality disorder as ‘characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour’.

11.4 Mary was white British. Simon was a British citizen of Chinese ethnicity. He is known by an English name and the pseudonym chosen by the panel reflects that. During the period of the review, they were living in an area which is predominantly of white British demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.5 Domestic homicides and domestic abuse predominantly affect women, with women making up the majority of victims and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

‘There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner’.

‘Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)’.

‘Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)’.

11.6 The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has recently conducted a study to establish preliminary data about women who died by suicide while employed as nurses. The study revealed that over fifty percent of nurses who died were not in contact with mental health services.

Their June 2020 report stated:

‘Some indicators of suicide risk in female nurses, such as depression and substance misuse, are common to most groups who are at risk. They show the

importance of comprehensive, needs-based clinical care in improving prevention'.

# 12 Dissemination

12.1 Home Office

Liverpool Community Safety Partnership

Liverpool Police and Crime Commissioner

Domestic Abuse Commissioner

All agencies contributing to this review

# 13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, and material gathered by the police during their investigation following Mary's death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

## 13.1 Relevant History Prior to the Timeframe of the Review

13.1.1 Prior to the timeframe of the review, Mary was recorded as a victim in 11 domestic abuse incidents reported to Merseyside Police: the earliest being in 2004. She was the victim of abuse and physical assault by a number of previous partners, who were arrested and convicted of relevant offences.

Mary's description of the behaviour of one previous partner would now constitute an offence of coercion and control[9].

Mary had been referred to MARAC before the timeframe of this review.

13.1.2 Mary had attended the same GP surgery for most of her life. Her GP knew her well and had interacted with her for many years. She had divulged current and previous incidents of controlling and coercive behaviour and domestic abuse to her GP, who recorded that Mary was known to experience flashbacks to previous assaults. She was issued with intermittent fit[10] notes between 2016 and 2018 due to anxiety.

13.1.3 In December 2018, Mary's GP recorded that she was experiencing stress and anxiety. This was immediately prior to the timeframe of review.

## 13.2 Events within Timeframe of Review

13.2.1 The following paragraphs summarise domestic abuse and safeguarding issues affecting Mary within the timeframe of review, which the panel felt were most relevant.

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

[10] https://www.gov.uk/government/collections/fit-note

Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

13.2.2 On 2 June 2019, Mary reported the repeated and unwanted contact from a former partner. She informed police that since the end of their relationship a number of months earlier, he had made daily phone calls and sent her multiple emails. He had also driven past her home, and those of her family members, in his car.

Mary described the individual as manipulative and stated that his behaviour was affecting her mental health. Mary subsequently informed police that she did not wish to pursue any complaints against her former partner and as such, no further police action was taken, although a Vulnerable Adult referral was made to Adult Services in relation to the effects on her mental health. The case was closed by Adult Services with 'safeguarding needs being met', and Mary was signposted to the police.

13.2.3 Simon told the review Chair that he had known Mary for over 10 years, and they had originally met when they worked together in a clothing store. At that time, they were both in relationships with other people and although they were friendly, their relationship did not go any further. At some stage in 2019, Simon and Mary established contact via social media and formed a relationship, moving in together in August that year.

13.2.4 Simon stated that when they started their relationship, he had £10,000 from a previous business interest, which he used to pay for the deposit on the house they moved into and some initial rent. After that, Mary paid the rent and Simon contributed to their living costs. Mary's sister disputes this, stating that Simon had no money at the start of the relationship and Mary asked family for help when he took money from her. Mary had loans which she struggled to pay, and Mary's sister helped Mary pay off credit cards. Mary also undertook overtime shifts over Christmas in order to pay for the house.

Simon explained that he did not have a job during this period and stated that Mary was very supportive of him taking time out away from employment. He stated that she was keen for him to start another business rather than work for

someone else, as he would find it hard to return to being an employee after having his own business.

Mary's sister said that Simon was very controlling about Mary and the finances and Mary had added stress and pressure to provide for them both. Mary's sister felt that while it may have appeared 'Mary was supportive' this was Simon's control over Mary and Mary couldn't have 'appeared' any other way without going against Simon and what he wanted.

13.2.5 Simon acknowledged that during his relationship with Mary, he was gambling and would often spend time in casinos. This was a source of tension in their relationship and Simon also stated that Mary suspected that he was being unfaithful with a person he had met at a casino. He denied this. The panel wished to restate that Simon's narrative has not been challenged and is uncorroborated.

13.2.6 Mary informed the police that on 17 January 2020, following an argument with Simon at their home address, she asked him to leave and return his key. She stated that he became physically aggressive, throwing her into a wall, pushing her down the stairs, and throwing objects around the room. Although he packed his belongings, he did not leave. Mary stated that Simon grabbed her around the throat and continued to verbally threaten her. She managed to leave the house and ran away through a local park, pursued by him [This incident was not reported until 17 February 2020].

13.2.7 Following this incident, Mary went to a friend's address where she disclosed the incident and showed her the physical injuries. She stated that she met Simon at the address again later that day, but another argument ensued: this resulted in her again fleeing the address but this time in her vehicle, colliding with a lamppost in the process. She spent the night at a friend's address but then returned home the following day: she reconciled with Simon.

13.2.8 On 20 January 2020, Mary began a period of absence from work, which was recorded by her manager as being sickness in relation to domestic abuse. She was provided with advice by her manager and signposted towards internal well-being support.

13.2.9 On 3 February 2020, Mary attended a GP appointment to request a fit note due to increased levels of stress which had been ongoing for a month. She informed her GP that she had been in a relationship for a year and that her partner had gambling problems, resulting in her lending him money and incurring her own debts.

She also informed her GP of the incidents where she had been assaulted by Simon and said that she had photographs of the injuries she received. The GP recorded her mood as *'very low over debts and having flashbacks of a previous assault from an ex-Partner'*.

13.2.10 On 10 February 2020, Simon left Liverpool and went to stay with a friend in another city, from where he rang Mary and informed her that he was ending their relationship. He returned to Liverpool to collect his belongings on 16 February 2020. Simon told the Chair of the review that when he returned to collect his belongings, he became involved in an argument with Mary which led to the police being called.

13.2.11 At 01:15 hours 17 February 2020, Simon contacted the police and reported a domestic incident involving Mary at their address. He alleged that she had assaulted him and was attempting to 'set him up'. Mary could be heard in the background alleging that she had been assaulted by Simon, who had also damaged her phone.

Simon informed the police call handler that Mary had punched him and thrown his clothes about to 'set some kind of scene'. He stated he had left her alone downstairs, and she harmed herself while out of his sight, before telling him she was going to 'get him done' by alleging he had punched her.

13.2.12 During the call, Simon could be heard shouting and swearing at Mary and at one stage he asked her why she had not called the police to which she replied she had no means of doing so, due to him damaging her phone. Simon put his phone on loudspeaker and directed her to speak with the call hander. She informed them that she had been assaulted by him.

The conversation between Simon and the call handler lasted over twenty minutes. Throughout, Simon protested his innocence and stated that Mary left and returned to the property multiple times. Both had alleged physical assault and Mary had alleged criminal damage.

13.2.13 The incident was categorised by the police as a 'Priority' incident, requiring their attendance within one hour of the initial call.

13.2.14 At 01:28 hours, the call was passed to another member of police staff to arrange resource allocation. The initial call handler completed the Merseyside Police 'THRIVE' question set, as follows:

'Threat' – described as being a verbal disagreement with no reference to Simon's claims that he was assaulted.

'Harm' – nothing was recorded regarding Mary being assaulted.

'Risk' – nothing was recorded regarding the allegations made by Mary.

'Investigation' – assessment was that there was no requirement for an investigation as the incident was 'verbal only' and allocated a priority response.

'Vulnerability' – recorded that neither Simon nor Mary was vulnerable due to the current situation or circumstances.

'Engagement' – recorded that a priority response was the most effective way of engaging with the victim, due to the incident being 'verbal only'.

The call handler advised Simon to remain at the address in a separate room from Mary until police arrived, but to ring back if the situation escalated.

13.2.15 The incident was reviewed by a contact resolution supervisor who recorded that if police were informed that the two parties were at the same location again, the log should be upgraded to emergency response.

13.2.16 At 02:41 hours, Mary rang the police, asking when officers would attend. She explained that although by that stage she had a family member with her, she was scared as Simon was still upstairs in a bedroom.

13.2.17 At 03:07, another supervisor reviewed the incident log. They questioned the priority grading and also the fact that it was endorsed as a 'verbal only' incident; considering, Mary had stated she was injured, and her lip was bleeding. However, the incident retained its priority grading and police were still not directed to attend the address.

At 06:13, the same supervisor requested enquiries be made with Simon to ascertain if the incident was still ongoing. Contact could not be established; therefore, a text and voicemail message were left asking him to make contact with an update.

13.2.18 Following a staffing change, at 08:01 hours, the incident was reviewed by another supervisor. They endorsed the incident 'this should have been emergency response at the time the log was received. We cannot now contact the caller; this log requires deployment as soon as possible.'

At 09:42, unsuccessful attempts were made to contact both parties by telephone.

13.2.19 At 10:14 hours, police attended the address and spoke with both Simon and Mary. Mary had been attended to by her sister who had stayed downstairs with her for the remainder of the night while she waited for police. Simon was arrested for assault occasioning actual bodily harm after elbowing Mary in the face, causing a split lip. He was also arrested for criminal damage to her mobile phone.

13.2.20 Mary also disclosed the previously unreported incident from 17 January 2020, alleging Simon kicked her causing bruising to her face, neck, hands, arms, and legs. She told police that she confided in her sister about the incident but was afraid to contact police fearing she would not be believed. Simon was also arrested for the earlier incident. He denied the allegations and was bailed with conditions not to attend at Mary's address or contact her.

13.2.21 A Vulnerable Person Referral Form (VPRF 1), which included a MeRIT risk assessment [see para 14.12.12 for full explanation], was completed for each incident and both were graded as Bronze. Mary declined a referral to the National Centre for Domestic Violence (NCDV) and did not consent to information being shared with support agencies.

13.2.22 On 20 February 2020, Mary had a telephone consultation with her GP during which she reported domestic abuse incidents. She outlined the assault and damage on 17 February and also the assault a month previous. She informed her GP that she had visible injuries sustained during the assault. The GP recorded that Mary was reporting feelings of anxiety and was advised to stay at her sister's address where she may sleep easier. The GP asked Mary to make a further appointment for a face- to-face consultation. The appointment was made and was to take place on the day that Mary was found deceased.

13.2.23 On a date later in February 2020, Mary's sister and a friend raised concerns about her safety as she had been out of contact for a few days. Police were contacted and, after forcing entry to the address, found Mary had passed away: she left notes to her mother, sister, and grandfather.

13.2.24 The police investigation found no evidence of third-party involvement in Mary's death. Mary left a number of letters for members of her family expressing a desire to end her life. Included within the letters were a number of references to her being a victim of domestic abuse, committed by previous partners and most recently Simon. The letters made it clear that those experiences contributed to her decision to end her own life.

13.2.25 Due to the domestic incident that had occurred days prior to this, a Home Office post-mortem was authorised. The Home Office pathologist determined that the injuries sustained during the alleged assault had no causal bearing on Mary's death, giving the cause of death as hanging.

13.2.26 Following Mary's death, Simon was charged and convicted of the assault and criminal damage offences from 17 January and 17 February 2020. He was sentenced to four months' imprisonment for each offence; the sentences were to run concurrently. Simon has no other convictions.

# 14 Analysis

14.1.1 What indicators of domestic abuse, including coercive and controlling behaviour,[11] did your agency identify for Mary?

14.1.2 During the period of the review, there were three known domestic abuse incidents involving Mary.

As outlined at paragraph 13.2.2, in June 2019, she reported harassment from a former partner, who she described as a manipulative individual who had threatened to take their own life if she did not take him back. The harassment took place after their relationship ended and therefore did not constitute an offence of coercive or controlling behaviour. Mary did not wish to pursue a prosecution in relation to any other offences.

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

However, Mary did describe feeling trapped by his behaviour, which was adversely affecting her mental health, and a referral was made to Adult Services.

14.1.3 Merseyside Police were unaware of Mary's relationship with Simon until 17 February 2020. Mary passed away one week after she reported domestic abuse by him. Police records do not suggest that those attending or investigating the incident identified coercive or controlling behaviour by him. The same officer who recorded harassment in June 2019 also completed both the VPRF 1 and Mary's statement following the incident on 17 February 2020. This is a learning point and the panel felt that the inclusion of a direct question relating to coercive or controlling behaviour on the VPRF 1, may prompt staff to consider this more effectively.

14.1.4 However, it is very clear that there were opportunities to recognise such behaviour during the initial call to police on 17 February, and the subsequent internal monitoring of the initial response.

The initial call to police was made by Simon. That call lasted more than 20 minutes and, throughout, he appeared to elicit control over the conversation with the call handler and certainly controlled what Mary was able to say and when.

The overbearing manner of Simon was evident throughout the call, and this may have distracted the call handler from objectively assessing risk, resulting in a significant delay in the police response to an ongoing domestic incident which had already escalated to violence.

14.1.5 The panel felt that there would have been a more effective and timely response on 17 February if Merseyside Police had fully considered all previous incidents where Mary had been the victim of domestic abuse.

14.1.6 Merseyside Police acknowledge that the incident was not correctly categorised as an emergency, requiring immediate response, and that a response time of over nine hours is unacceptable.

14.1.7 Mary was known to her GP who had engaged with her for many years.

14.1.8 GP records reveal that between April and October 2019, Mary attended multiple appointments as a result of an exacerbation of her asthma. Other conditions were also recorded, such as skin irritation and bruising.

The panel discussed at length whether these issues may have been an indicator that Mary was suffering with increased levels of stress as a result of domestic abuse, and whether this may have been something which her GP could have identified.

The panel felt that although these conditions may have been related to an increase in stress, there was nothing which directly linked them to domestic abuse, and it would be unreasonable to expect a GP to arrive at that conclusion based on what they knew at the time.

14.1.9 During a consultation on 3 February 2020, Mary requested a fit note due to stress. Indicators of domestic abuse were identified during this consultation and recorded by the GP as her having ‘financial problems resulting from her partners gambling and him not contributing to any household bills.’ She also disclosed to her GP that she had been assaulted by him the month before, leaving her with bruising.

The GP recorded that Mary was afraid to stay with her family due to concerns that her partner would damage their property.

14.1.10 The panel discussed the impact of financial and economic abuse on Mary. Surviving Economic Abuse[12] provide the following definitions:

Financial abuse

Controlling finances, stealing money, or coercing someone into debt

Economic abuse

Financial abuse plus restricting, exploiting, or sabotaging other resources such as housing, food, property, transportation, and employment.

14.1.11 The panel thought that the debts resulting from Simon's gambling, and his failure to contribute to household bills, was a significant factor which combined with other indicators pointed towards financial abuse and controlling and coercive behaviour.

14.1.12 During a telephone conversation with her GP on 20 February 2020, Mary again disclosed the assault by Simon the previous month. She reported feelings of anxiety and the GP recorded that she was concerned as she had provided authority for police to access her medical records. This led the GP to place an alert on the records highlighting that they should not be disclosed. There is no evidence to show that the GP considered the possibility that her change of mind may have been due to an element of controlling or coercive behaviour on the part of her partner.

1.1.1.1 [12] Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

14.1.13 The panel felt that this may have been an example of the GP allowing their relationship with Mary to influence their assessment – subsequently missing an opportunity to identify such behaviour, and rather concentrating on the physical elements of abuse. The panel felt that the GP could have been more professionally curious.

14.1.14 Mary's medical records were not flagged to suggest she was currently, or historically, a victim of domestic abuse.

14.1.15 The panel considered whether there was evidence that Simon had subjected Mary to coercion and control and, in doing so, referred to the Crown Prosecution Service's policy guidance:

14.1.16 The Crown Prosecution Service's policy guidance on coercive control states:[13]

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

Isolating a person from their friends and family

Depriving them of their basic needs

Monitoring their time

Monitoring a person via online communication tools or using spyware

Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep

Depriving them access to support services, such as specialist support or medical services

Repeatedly putting them down such as telling them they are worthless

Enforcing rules and activity which humiliate, degrade, or dehumanise the victim

[13] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities

Financial abuse including control of finances, such as only allowing a person a punitive allowance

Control ability to go to school or place of study

Taking wages, benefits, or allowances

Threats to hurt or kill

Threats to harm a child

Threats to reveal or publish private information (e.g., threatening to 'out' someone)

Threats to hurt or physically harming a family pet

Assault

Criminal damage (such as destruction of household goods)

Preventing a person from having access to transport or from working

Preventing a person from being able to attend school, college, or university

Family 'dishonour'

Reputational damage

Disclosure of sexual orientation

Disclosure of HIV status or other medical condition without consent

Limiting access to family, friends, and finances

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

14.1.17 Considering the Crown Prosecution Service's guidance, the panel felt that the physical abuse which Mary was subjected to on at least two occasions, the financial abuse, and fear of property being damaged, were clear indicators that she was being subjected to coercive and controlling behaviour by Simon.

14.1.18 The panel concluded that whilst they could now recognise that Mary was subjected to coercive and controlling behaviour, it may have been difficult, in the absence of any formal risk assessment, for her GP to recognise this at the time.

It was also felt that even in the absence of this being identified by her GP, a referral for financial support may have presented opportunities for other professionals to assess the circumstances and perhaps identify that Mary was a victim of such abuse. Mary indicated to the GP that she would look into obtaining debt support herself. The panel was told that GPs in Liverpool are aware of pathways for referral and signposting. Citizens Advice have a simple referral form which is well embedded in surgeries. On this occasion, the pathway was not followed – as Mary said that she would look into it herself.

The CCG has agreed a single agency action on this point.

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

14.2.1 The GP did not use any specific model to assess risks to Mary. It appears that decisions were made using professional judgement alone and, based on what they knew at the time, the GP did not consider it appropriate to refer to MARAC or a domestic abuse agency.

At the time that Mary disclosed incidents of domestic abuse to her GP, Liverpool Community Safety Partnership did not have a policy requirement for partner organisations to complete a formal risk assessment for domestic abuse cases. They did, however, publish guidance in the form of 'MARAC

Combined Protocol 2019 – 2020', recommending that the Merseyside Risk Identification Tool (MeRIT) be used – an explanation can be found at paragraph 14.2.12.

14.2.2 The panel was informed that historically within Liverpool, GPs have not completed risk assessments in domestic abuse cases, mainly due to time and capacity constraints. The general approach appears to have been to refer or signpost patients to domestic abuse agencies where appropriate.

14.2.3 The panel was also informed that GPs still have the option of referring directly to MARAC using professional judgement alone and, if this happens, the MeRIT would be completed by MARAC staff. Since April 2018, there have been seven MARAC referrals made by GPs across Liverpool.

14.2.4 On 19 October 2021, Liverpool City Council launched further guidance – 'Multi-agency guidance for staff working with adults and families living with Domestic Abuse'. This includes recommendations that partner organisations conduct risk assessments in domestic abuse cases.

14.2.5 The panel was informed that the GP identified 'protective factors' for Mary during the period under review. This included her previous ability to recognise domestic abuse when she ended an abusive relationship. The GP also noted that Mary had family members who she could stay with for support.

14.2.6 It was perceived by the GP, at this time, that Mary's current situation and relationship did not pose as much risk to her as on previous occasions. The GP also felt that on this occasion, the assault was less violent, and the main concerns identified related to financial issues and property damage.

The panel discussed the possibility that Mary may have minimised the extent of abuse from Simon, due to having a higher threshold following previous experiences of domestic abuse. It was agreed that training in this area could be considered for GPs.

14.2.7 It was also noted that the GP appeared to consider Mary's existing family support network as sufficient to mitigate risks to her and presumed that due to her own credible profession, she was able to manage and arrange relevant support herself.

14.2.8 It could be the case that due to Mary being employed by Mersey Care NHS Foundation Trust, there was a reluctance on the part of the GP to make any formal referrals for counselling or support in relation to her mental well-being, or for Mary to accept them. However, the panel felt there were sufficient alternative support agencies within the Liverpool area to still identify discreet support options. The panel discussed whether an out-of-area referral could have been considered but were told that options from the wide range of third sector and statutory agencies in Liverpool should have been explored before a consideration of an out-of-area referral.

14.2.9 The panel noted that Mary's supervisor did take action to support her, in line with Mersey Care NHS Foundation Trust policy on Safeguarding and Domestic Abuse, by signposting her towards internal counselling support services after she disclosed, she was a victim of domestic abuse. There is no record of Mary accessing this service.

The panel discussed whether it would have been more likely for Mary to take up support if it had been offered externally. The panel was told that the Mersey Care NHS Foundation Trust internal counselling service is a confidential service provided to staff, separately to their line management, and it would only be after accessing that initial support that an external provision could be considered.

14.2.10 The panel agreed that Mary may have been hoping that someone would take responsibility for helping her, and refer her into appropriate support services, rather than being left to arrange it herself. Mary's sister said that Mary felt under pressure due to conversations that had taken place at work about previous absences. Mary was therefore reluctant to take time off for appointments such as counselling. Mary was also concerned about the possibility of information being shared with her employer.

14.2.11 Merseyside Police had an opportunity on 17 February 2020 to assess the risk posed to Mary by Simon. The initial assessment was carried out at the scene by the attending officers.

14.2.12 The MeRIT risk assessment tool was used. It consists of forty risk factors laid out as questions on the VPRF 1.

Officers are frequently reminded that the questions are designed as triggers for themselves and should not merely be read to victims, who may not always understand the terminology used. Divided into three sections, the questions require a 'Yes' or 'No' response, with qualifying information if an explanation is deemed necessary. They are designed to illicit information about various facets of the relationship: breakdown, social and violence. The answers help to provide an understanding of the incident in order to identify the appropriate intervention.

The incident is automatically scored between 1 and 72, resulting in a risk level of Bronze, Silver, or Gold. Officers are trained to use their professional judgement during the assessment and to increase the risk level if they consider it necessary. It was not increased in this incident, which was graded as Bronze.

14.2.13 As MeRIT is a dynamic risk assessment process, any change in circumstances, escalation of violence or new information which indicates a previously unknown risk factor, triggers a re-score by the risk assessor or the investigating officers.

A further risk assessment took place at the Multi Agency Safeguarding Hub (MASH). The original risk assessment was quality assured by MASH staff who deemed that no adjustments were necessary.

14.2.14 The incidents on 17 January and 17 February were both reported at the same time in February. Although the strangulation allegation was from a month earlier, it remained a high-risk indicator, along with separation.

The strangulation was not recorded on the MeRIT. Had it been recorded, there is a strong likelihood that the MeRIT would have been graded as Gold, resulting in a referral to MARAC and the application of other resources. For example, Mary would have been contacted by an Independent Domestic Violence Advisor.

Mary's sister said that when Mary disclosed the previous incident on 17 January of Mary driving into a lamppost the officer attending asked about the 'damage to the lamppost' and why Mary hadn't reported it. This appeared to Mary to override her report of domestic abuse. Mary's sister said that this 'put the fear of god into Mary' that she was going to get in trouble and that this backed up Simon's threats that no one would believe her or care if she told anyone. Mary was also worried about the impact any reporting would have against her job and didn't want to risk losing her employment.

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

14.3.1 GP records revealed that Mary was suffering with increased stress during the weeks preceding her death. She attended the surgery on 3 February 2020 and requested a fit note for work due to stress as a result of her relationship with Simon.

14.3.2 GP records appeared to suggest that Mary did reveal indicators that she was a victim of coercive and controlling behaviour. In addition to physical abuse, she disclosed other incidents such as incurring debts as a result of lending Simon money to gamble, and a reluctance to leave her home for fear of what damage he may cause.

It now appears clear that this behaviour was impacting on her mental health.

14.3.3 Research shows that men who gamble are more likely to act violently towards others – with the most addicted gamblers, the most prone to serious violence.

The study, published in the journal Addiction, found that gambling in any capacity: pathological, problem, or so-called ‘casual gambling’, related to significantly increased risk of violence, including domestic abuse.

The researchers found a statistically significant link between gambling and violent behaviour: the more severe the gambling habit, the greater chance of violence. Just over half of pathological gamblers, 45 per cent of problem gamblers, and 28 per cent of ‘casual gamblers’, reported some form of physical fight in the past five years.

The study also found that pathological and problem gamblers are more likely to have hit a child: with almost 10 per cent of pathological gamblers and just over 6 per cent of problem gamblers admitting to such behaviour. Those with likely pathological gambling problems also had increased odds of committing violent behaviour against a partner.

The study was led by psychologists from the University of Lincoln, UK, working with researchers from Queen Mary University, University College Cork, University of East London, Imperial College London, and AUT University in New Zealand.

https://www.lincoln.ac.uk/news/2016/09/1262.asp

The CCG has agreed a single agency action in relation to this point.

14.3.4 Information on police systems reveals that Mary took an overdose in 2007. This information is uncorroborated. In 2017, Mary made a comment regarding ending her own life after a dispute with a relative. When this was explored by the attending police officer, Mary said it was an off-the-cuff comment and she did not intend to harm herself.

14.3.5 During the period under review, there is nothing held on Merseyside Police systems which suggests that Mary was at risk of suicide.

14.3.6 The panel was made aware of research indicating a significant number of domestic abuse victims suffer from suicidal ideation. A study[14] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. In addition, research has identified higher risk occupations including women working in the arts and media or nursing profession and male and female carers[15].

14.3.7 A report by the Cavell Nurses Trust[16] [Skint, shaken yet still caring] concluded that nurses are three times more likely to have experienced domestic abuse in the last year than the average person, according to research for a nursing charity. The report states that 14% of nurses had experienced domestic abuse in the past year, compared with 4% of people nationally.

[14] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse[14] [*Vanessa E. Munro & Ruth Aitken]*

[15] Suicide by occupation, England: 2011 to 2015. Office for National Statistics.

[16] A charity supporting UK nurses, midwives, and healthcare assistants, both working and retired, when they're suffering a personal or financial crisis often due to illness, disability and domestic abuse.

14.3.8 According[17] to the National Centre for the Study and Prevention of Violence and Abuse, one of the many, complex reasons nurses were experiencing higher levels of domestic abuse could be because of the values they uphold in their daily roles, such as care, compassion and courage.

Claire Richards, an expert from the NCSPVA, which is based at the University of Worcester, said: "The values that nurses adhere to in their career – including the 'six Cs' of nursing – care, compassion, competence, communication, courage, commitment – may increase the likelihood of them staying with an abusive partner for reasons of altruism or a possible belief their partner needs them".

14.4 **Did your agency consider that Mary could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?**

14.4.1 Both Merseyside Police and Liverpool CCG state that their own reviews found no evidence that Mary was an adult at risk, and consequently missed no opportunity to raise an alert or hold a strategy meeting in relation to her circumstances**.**

14.4.2 The Care Act 2014 section 42, states:

*'…where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)*

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

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

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

[17] Nursing Times report October 2016

14.4.3 Following the incident on 2 June 2019, where Mary reported repeated and unwanted contact from a former partner, a referral was made by Merseyside Police to Adult Services.

The social worker who triaged the referral provided advice which was in keeping with how Careline responded to VPRFs of this nature in 2019.

The social worker advised that there was no indication that Mary had identified care and support needs. There was an indication that she had reported the incidents to Merseyside Police and was not at that time willing to participate in any further enquiries. She was therefore signposted to the police website and the matter was finalised with no further action being required.

14.4.4 There appears to have been a number of assumptions made in relation to this decision, and an absence of professional curiosity or confirmation that Mary did not have care and support needs. No exploration took place as to why, at the time, she may have been reluctant to engage further with the police or to elicit any additional information to identify potential support or signposting opportunities.

14.4.5 When Mary visited the GP in February 2020, a referral was not made to Adult Services. Although documentary records do not include the rationale behind not submitting any safeguarding adult alerts or referrals to any support services, it appears that the GP based that judgement on a reasonable knowledge of her family history and an assumption that she was sufficiently resilient to address her abusive relationship and arrange her own support.

14.4.6 The panel discussed the likely outcome, had a referral been made by the GP in February 2020. Given the outcome of the previous action in 2019 – the fact that Mary appeared to be capable of arranging her own counselling support and was indeed being offered such through her employer – the panel did not feel that a referral would have elicited any further support from Adult Services.

14.4.7 The panel has been provided with updates from Adult Services in respect of current practice when managing and assessing such referrals. The panel has been assured that if a referral of this nature was received today, a decision would not be made to take no further action. Instead, further consultation with the GP, mental health services and Mary, would be undertaken prior to any decisions being made on how to respond.

Information is now routinely shared with GPs if a decision is made for no further action. However, there is no evidence that this was undertaken in 2019.

Given this assurance, no recommendation is made on this point.

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

14.5.1 As outlined at paragraph 13.2.9, Mary's GP recorded that her mental health had deteriorated as a result of 'financial abuse' by Simon. In addition to her disclosing physical abuse incurring visible injuries, Mary also informed the GP that she was suffering flashbacks of assaults by a previous partner.

14.5.2 It appears that the extent of consideration in this area was that Mary would 'look into' counselling again herself, along with debt support. It is noted that she had previously engaged with Mersey Care Community and Mental Health Services, following referrals due to domestic abuse related low mood and suicidal thoughts, although she had not been engaged with them since 2015.

14.5.3 It is possible that the reason Mary ceased engagement with that service in 2015 was because, by that stage, she was working for the same NHS Trust as a nurse in a physical health care role.

14.5.4 Mary's GP also acknowledged her feelings of anxiety during a telephone consultation on 20 February 2020. She relayed the circumstances of the incident with Simon on 17 February, and the GP requested that she arrange a face-to-face appointment with her at a later date: she was advised to stay with her sister for support. There were no onward referrals for support.

14.5.5 The Mental Health Foundation www.mentalhealth.org provides the following information on their website.

If you're affected by someone's gambling

If you can see that gambling is a problem for someone you care about, it's best to be honest with them about how it's affecting you. You can let them know that help is available.

You can get support for yourself too.

GamCare offers support and information for the partners, friends, and relatives of people with gambling problems.

GamAnon and GamAnon Scotland run support groups for anyone affected by someone else's gambling.

https://www.mentalhealth.org.uk/a-to-z/g/gambling-and-mental-health

The CCG has agreed a single agency action in relation to this point.

14.5.6 From a policing perspective, other than historic information suggesting Mary may suffer with poor mental health, there was nothing to suggest the incident on 17 February (or the incident the month previous) needed to be considered in the context of mental health or substance abuse.

14.5.7 Recent research conducted by the University of Manchester intrinsically links elements of coercive and controlling behaviour with heavy use of alcohol and drugs by both offenders and victims.[18]

The panel was of the opinion that, in this case, there was no evidence that alcohol or drug use were contributory factors.

14.5.8 Following the discussion with Mary's sister the chair of the review asked for the toxicology report completed following Mary's death. This had not previously been seen by the chair.

[18] https://www.mmu.ac.uk/media/mmuacuk/content/documents/rcass/Briefing-on-alcohol-and-domestic-abuse-in-context-of-Covid-19-1st-April-2020.pdf

The toxicology report outlined that Mary had taken Diazepam[19], Mirtazapine[20] and Trazodone[21] at levels consistent with therapeutic use.

Mary was not prescribed any of these drugs. Mary's sister said that Mary was obtaining these medications off prescription as she feared there may be professional consequences if she obtained them from her GP.

14.5.9 The panel has been provided with updates from Adult Services in respect of current practice when managing and assessing such referrals. The panel has been assured that if a referral of this nature was received today, a decision would not be made to take no further action. Instead, further consultation with the GP, mental health services and Mary, would be undertaken prior to any decisions being made on how to respond.

Information is now routinely shared with GPs if a decision is made for no further action. However, there is no evidence that this was undertaken in 2019.

Given this assurance, no recommendation is made on this point.

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

[19] Diazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety, muscle spasms and seizures or fits. It's also used in hospital to reduce alcohol withdrawal symptoms, such as sweating or difficulty sleeping. It can also be taken to help a person relax before an operation or other medical or dental treatments. It works by increasing the levels of a calming chemical in the brain called gamma-aminobutyric acid (GABA).

[20] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety. It works by increasing the amount of mood-enhancing chemicals called noradrenaline and serotonin in the brain.

[21] Trazodone is an antidepressant medicine. It's used to treat depression, anxiety, or a combination of depression and anxiety. Trazodone works by increasing levels of serotonin and noradrenaline. It can help with problems like low mood, not sleeping (insomnia) and poor concentration.

14.6.1 The Liverpool CCG IMR outlines regular consultation between Mary and her GP, including the reporting of domestic abuse 14 days prior to the incident on 17 February, and again on 20 February.

14.6.2 On both occasions, the GP acknowledged that domestic abuse had taken place and that, as a result, Mary's mental health had deteriorated.

No referrals were made for additional support, no other services were offered, and no safeguarding adult alerts were made. There was an expectation on the part of the GP that Mary would arrange her own private counselling.

As a result of the GP not completing a MeRIT risk assessment, it is unclear what levels of risk were identified; it appears that they had left the sourcing of further support to Mary herself. On 20 February, the GP did however ask that she make a face-to-face appointment. This appointment was due to take place on the day that Mary was found deceased. This would have been an opportunity for the GP to review Mary's case and consider at that point whether a referral to a domestic abuse agency was appropriate.

14.6.3 As outlined in paragraph 14.1.8, the service provided by Mary's GP focussed on various medical conditions rather than the wider domestic abuse implications for her.

14.6.4 The response provided by Merseyside Police on 17 February 2020 was not timely; the nine-hour delay in deploying a patrol to the scene was unacceptable and fell far below what should be expected.

Internal enquiries have not identified this as a widescale problem, although it is accepted that greater understanding and awareness is required by call handling staff in relation to coercion and control.

14.6.5 Once police did attend, the arrest of Simon addressed immediate safeguarding concerns. A statement was taken from Mary and a VPFR 1, including MeRIT, was completed. However, as outlined in paragraph 14.2.14, the assessment did not consider that Simon had placed his hands on Mary's throat during the incident a month earlier. Had this been considered, it is highly likely the incident would have been graded as Gold and considered for MARAC.

14.6.6 As outlined in paragraph 13.2.20, Mary stated that the reason for not reporting the assault in January 2020 was a fear of not being believed. The panel agreed that the service received during the policing response in February 2020 may have served to exacerbate that fear or deepen a lack of trust in the police.

14.6.7 The panel was aware that there are a number of barriers to victims reporting domestic abuse. The Victim Support report 'Surviving Justice' 2017, contains the following information:

Barriers to reporting, as cited by Victim Support caseworkers

| Barriers to reporting | Percentage of respondents citing barrier |
|---|---|
| Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger | 52% |
| Fear they would not be believed or taken seriously | 42% |
| Fear, dislike, or distrust of the police/criminal justice system (CJS) | 25% |
| Concern about their children and/or the involvement of social services | 23% |
| Poor previous experience of police/CJS | 22% |

| Barriers to reporting | Percentage of respondents citing barrier |
|---|---|
| Abuse normalised, not understood, or believed to be deserved | 15% |
| Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator | 14% |
| Cultural or community concerns | 9% |
| Financial concerns | 7% |
| Housing concerns | 4% |
| Embarrassment | 3% |

14.6.8 In relation to the suicide risk, this incident also reflects significant vulnerabilities in process – as highlighted in a recent Domestic Homicide Review for another Merseyside local authority. In that review, a victim took her own life just hours after she was confronted by the perpetrator, who had recently been released from prison after a custodial sentence for assaulting her.

14.6.9 That review identified the lack of a question set on the Merseyside Police VPRF 1 form, which asks a victim whether their mental health is suffering as a result of the abuse, and whether they are having suicidal thoughts or thoughts of self-harm. The question sets currently used refer to 'mental health issues', which may not be clear for victims, especially those who have not yet acknowledged the effect domestic abuse is having on their mental health.

While that review acknowledged such matters are best addressed by mental health professionals, the case demonstrates that in some cases, time is absolutely of the essence when arranging access to mental health support.

14.6.10 On this occasion, Mary did not consent to police referring her for such support; potentially, a direct question may have caused her to acknowledge her situation and engage with mental health services as a priority. Mary's sister said that Mary had previously mentioned a concern about a potential impact on her job from reporting things to the police. She had also mentioned that she had felt under pressure at work for having time out. Mary therefore felt that she would not have been supported had she taken time out further to deal with police involvement or even if referrals to other agencies.

14.6.11 The previous review made two recommendations aimed at reducing the number of domestic abuse victims who take their own lives. The first was to amend the VPRF 1 form with a suitably worded question for victims about their state of mind in relation to self-harm and suicidal thoughts. The second recommendation was to incorporate the same concerns into the ongoing Merseyside Police review of their Mental Health Strategy.

The VPRF 1 form has now been amended [after Mary's death]. The Merseyside Police Mental Health Lead has agreed to incorporate domestic abuse related suicide risk within the force response to the national Suicide Prevention Strategy Action Plan.

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

14.7.1 Mary engaged with the police investigation and indicated that she was willing to attend court to support a prosecution. There was no opportunity to provide her with the services of the Witness Care Unit or other support which may have been identified in preparation for the court case. She did not consent to a referral for domestic abuse support.

14.7.2 Simon did not acknowledge his offending during his interview with police. It was therefore not possible for them to engage with him regarding referrals for support to address his behaviour. He did, however, plead guilty to both assaults.

14.7.3 As outlined previously within this report, when speaking with her GP, Mary made it clear that she was a victim of domestic abuse and was experiencing feelings of stress, anxiety and worry as a direct result.

The CCG IMR author is of the opinion that the impact of domestic abuse on Mary's mental health may not have been fully understood by her GP. They are also of the opinion that Mary's ability to seek out support independently, including identifying counselling and debt management services, was misjudged. The panel agreed with this opinion.

14.8 **How effective was inter-agency information sharing and cooperation in response to Mary and Simon, and was information shared with those agencies who needed it?**

14.8.1 Following the arrest of Simon on 17 February, Mary did not consent to any information being shared with other agencies. The incident was assessed by Merseyside Police as not meeting their safeguarding threshold; she was not considered to be an adult at risk as per the Care Act 2014. Subsequently, a safeguarding adult alert was not made.

14.8.2 In the opinion of the investigating officers, Mary presented as a person with full mental capacity. As a health professional with responsibility for others, she appeared resilient enough to cope.

14.8.3 Whilst this may have been a reasonable assessment, based on the facts of this particular incident alone, it should be noted that there was still the domestic abuse incident involving a previous partner in June 2019. Although the incidents are unconnected, in 2019, the investigating officers did make a referral to Adult Services, such was their concern for Mary's mental health as a result of the abuse. It is not clear whether this incident was considered by officers when assessing the risk to her following the events of 17 February 2020.

14.8.4 Liverpool CCG did not share any information with any other agency in relation to the domestic abuse disclosures made by Mary, including those made to her GP on 3 February. That disclosure also outlined that Mary's mental health was deteriorating as a result of that abuse.

14.8.5 The panel felt that had the GP completed a referral to a domestic abuse agency or MARAC, information may have been shared with other agencies, including Merseyside Police. It was also felt that had Merseyside Police been aware of the disclosures made to the GP, their own assessment of risk would have been better informed.

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

14.9.1 Liverpool CCG had no involvement with Simon.

14.9.2 Mary's GP was aware of police involvement following the events of 17 February 2020. However, the domestic abuse recorded by the GP during contact with Mary on 3 February, appeared to confirm that she had not reported that abuse to the police and the GP did not advise her to do so. Had Mary reported the domestic violence from 17 January, it may have presented opportunities for interventions prior to the escalation of further violence on 17 February.

14.9.3 The incident on 17 February was the first opportunity for Merseyside Police to reduce the impact of Simon's abusive behaviour towards Mary. He was charged with two assaults and criminal damage to her phone: he had bail conditions not to approach her or enter the road where she lived.

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

14.10.1 Merseyside Police stated that: *'MARAC and MAPPA protocols are embedded in practice with Merseyside Police'.*

The panel was assured that appropriate procedures are in place with regard to MARAC. Those procedures rely on accurate risk assessment and, as already outlined at paragraph 14.2.14, the MeRIT in Mary's case lacked information which may have resulted in a referral to MARAC.

Simon was not eligible for MAPPA.

14.10.2 The GP did not identify any requirement to refer to MARAC and did not complete a MeRIT risk assessment. This, the panel agreed, may have led the GP to not fully consider levels of risk or what further actions should be taken.

As outlined in paragraph 14.2.1, although use of MeRIT is recommended within partnership guidance, it does not constitute policy, and did not at the time.

14.10.3 The panel was told that training has been provided for GPs in relation to domestic abuse and adult safeguarding. The Royal College of General Practitioners requirement is that a GP attends eight hours of adult safeguarding training per year. In Liverpool, this includes domestic abuse training. The panel was told that the GP practice in question has a good record of attending training.

14.10.4 The panel was told that a number of training sessions are planned to inform GPs of the new guidance (launched October 2021) – 'Multi-agency guidance for staff working with adults and families living with Domestic Abuse'.

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

14.11.1 The DHR Chair wrote to Mary's sister and although she initially suggested that she may contribute to the review, she did not do so.

GP records suggest that Mary's sister and mother were aware that she was in a violent relationship and discussed the effects on her mental health directly with the GP.

14.11.2 Mary's employer was aware that she was in an abusive relationship from 20 January, when she began a period of sick leave. Her manager recorded giving advice to her and providing details of an internal cognitive behavioural therapy programme, procedure for accessing counselling, and out-of-hours support. There is no record of Mary accessing the support available.

14.11.3 Mary did confide in friends and family. Following Mary's death, her sister provided a statement to the police in which she said that she was aware at an early stage in Mary and Simon's relationship that Mary was being financially abused by Simon.

14.11.4 She recalled Mary crying on the phone to her following the assault on 17 January and described seeing photographs of bruising sustained during the assault by Simon.

Her sister stated that she told Mary she would contact the police, if Mary did not report the abuse herself, but Mary begged her not to do so, saying it would only make the situation worse for her. She described being relieved when she visited Mary, along with their mother, the next day to find that Simon had gone to stay with his brother. She therefore respected her sister's wishes and did not contact police.

A friend of Mary's described, to the police, Mary attending her home early one morning around the middle of January 2020, in a distressed state with red marks visible around her neck. She stated that Mary told her that she and Simon had argued and then fought, revealing more injuries to her arm, legs, and hip. She stated that Mary described Simon as an angry, violent man and was terrified to return to the house they shared. She described him causing damage to the house including kicking a hole in an internal door during an argument.

Mary also told her friend that she had incurred debts to the value of around £2,000 due to Simon's gambling addiction. Mary's friend informed police she was aware that Simon had tried to end the relationship with Mary a couple of times, which had made Mary angry.

14.11.5 Another of Mary's friends informed the police that Simon had an elderly mother who lived in supported accommodation but would occasionally stay with them for a number of days. Simon would leave Mary to care for her, in addition to working her shifts as a nurse. The friend stated that Simon was using his mother's benefit money to fund his gambling addiction, in addition to borrowing money from Mary.

She witnessed a deterioration in Mary's general health during her relationship with Simon, as she lost weight, was not eating, and became withdrawn. Mary would describe 'mind games' Simon played with her, which made her feel that

she was not good enough for him. Mary also told her friend about the assault in January 2020.

14.11.6 During the police investigation into Mary's death, it was discovered that a previous partner of Mary's was contacted by her in February 2020 and was informed of the criminal case involving Simon. He was also sent Facebook messages by Simon, which he forwarded to Mary, although the content is not known. He spoke with Mary the day before she passed away and stated that she described feeling depressed about her current situation.

14.11.7 Although friends and family members appeared to be aware that Mary was in an abusive relationship, they respected her wishes and did not contact police. Her family did, however, discuss matters with her GP and may have felt that in doing so, they were generating an opportunity for her to receive suitable support.

Mary's sister said that she had raised concerns about Mary's welfare with the GP and was told that due to confidentially the GP couldn't discuss Mary with her. This did however generate an appointment for Mary with the GP. On the day that Mary was found deceased her sister contacted the GP surgery to see if Mary had attended the GP appointment which had been booked as Mary's sister was unable to contact Mary. The GP surgery declined to disclose any information. Mary's sister feels that Mary missing this appointment should have triggered some form of welfare check. This has to be seen in the context that Mary had a telephone consultation a few days earlier in which the GP asked Mary to book a face-to-face appointment. Mary did book the appointment which she did not attend. The appointment was not urgent and at the time there were no overt indicators that Mary would take her own life.

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

14.12.1 The panel did not identify any examples of outstanding or innovative practice.

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

14.13.1 Liverpool CCG has identified that their staff would benefit from a greater understanding of the risks posed to someone suffering domestic abuse, particularly around mental health, and risk of suicide.

They would also benefit from an improved awareness of types of domestic abuse and risk indicators, particularly around coercive and controlling behaviours.

14.13.2 The panel agreed that CCG staff should be more aware of alternative options for signposting patients to specialists' services when required. Especially, when considering that victims of domestic abuse may feel helpless and disempowered to take the next steps and may require professionals to support them with this.

14.13.3 On 17 February 2020, Merseyside Police failed to classify the initial report of a domestic incident correctly, resulting in a significant and unacceptable delay in response.

14.13.4 The incidents on 17 January 2020 and 17 February 2020, were both reported at the same time in February. Although the strangulation allegation was from a month earlier, it remained a high-risk indicator, along with separation. This was not included on the MeRIT risk assessment. It is important that all available risk information is included when risk assessments are completed.

# 15 Conclusions

15.1 Mary had been subjected to domestic abuse by a number of men over several years. Simon was to be her last partner. He also abused her, and the panel thought that this accumulation of abuse, over a number of years, was likely to have been a significant factor in Mary's life.

15.2 Mary told her GP about the abuse from Simon and made an emergency call to the police to report abuse from him. The GP's response did not follow the existing multi-agency guidance. The initial police response was unduly delayed, although when officers did attend, Simon was arrested and charged with assaulting Mary.

15.3 As outlined within paragraph 14.2.14, the police MeRIT assessment did not consider strangulation and as such, a grading of Gold was not attached to Mary's case: this resulted in a missed opportunity to refer to MARAC and offer support to her.

15.4 The panel thought that the limited opportunities to support Mary had not been maximised and more could have been done.

15.5 Sadly, we cannot now hear Mary's voice. That her mother and sister felt unable to contribute to the review means that the panel acknowledge a regrettable gap in the review in terms of Mary and her family's voice.

# 16 Learning

This multi-agency learning arises following debate within the DHR panel.

16.1 **Narrative**

The panel thought that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

Learning

Professionals will be better able to manage risk if they are familiar with research linking domestic abuse and suicide

Panel recommendation 1

16.2 **Narrative**

The panel thought that there was evidence of elements of coercive and controlling behaviour in the case that had not been recognised by practitioners.

**Learning**

Practitioners need to be provided with appropriate support and training in order to be able to recognise and act upon signs of abuse.

Panel recommendation 2

16.3 **Narrative**

The panel thought that a greater degree of professional curiosity could have been used by Mary's GP, rather than relying on information gleaned from their personal relationship or assumptions made due to her being a professional person.

**Learning**

Practitioners to be provided with training or support to develop professional curiosity and identify unconscious bias.

Panel recommendation 3

16.4 **Narrative**

The panel thought that the absence of a referral to specialist domestic abuse agencies or use of a formal risk assessment tool by Mary's GP, resulted in missed opportunities to support Mary and share information with other agencies.

**Learning**

Practitioners need to be clear on Liverpool City Council's multi-agency guidance and consider referrals or a MeRIT risk assessment when appropriate.

Single Agency recommendation 1

# 17 Recommendations

DHR Panel

17.1.1 Agencies contributing to the review should provide Liverpool Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.

17.1.2 Agencies contributing to the review should provide Liverpool Community Safety Partnership with detailed information on their plans to train staff in the coercion and control elements of domestic abuse.

17.1.3 Practitioners should be provided with training or support to develop professional curiosity and identify unconscious bias.

17.2 **Single Agency Recommendations**

17.2.1 All single agency recommendations are shown in the action plan