Domestic Homicide Review

"Erin" who died in October 2021

LDHR23SQ Overview Report March 2023

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1 The Review Process

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

1.2 Erin and her partner, Peter, left Ireland in December 2020 and registered with services in Liverpool in January 2021. When registering as homeless in Liverpool, Erin said that the couple had fled Ireland due to threats and abuse from family. Erin had a young child who was looked after by family in Ireland.

1.3 Erin and Peter are pseudonyms chosen by the DHR panel from a list of names.

1.4 Between January and October 2021, Erin and Peter were involved with a number of services in Liverpool. Domestic abuse was reported to the police, and Erin in particular, was engaged with medical services.

1.5 Between January and October 2021, Erin and Peter were involved with a number of services in Liverpool. Domestic abuse was reported to the police, and Erin in particular, was engaged with medical services.

1.6 In addition to agency involvement, this review will also examine: any relevant background or trail of abuse before Erin's death; 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.

1.7 The review considers agencies' contact and involvement with Erin and Peter from 1 December 2020 until her death in October 2021. This time period was chosen as it covers the period from when the couple moved to England, up until Erin's death.

1.8 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.

1.9 Note:

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

2 Timescales

2.1 This review began on 16 June 2022 and was concluded on 14 March 2023.

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 December 2020 until Erin's death in October 2021.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Erin, aged 26 years

Erin's partner: Peter, aged 39 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Erin as a victim of domestic abuse, and what was your response?

2. How did your agency ascertain the level of risk faced by Erin from Peter? What risk assessments did your agency undertake, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

3. Was there sufficient focus on reducing the impact of Peter's alleged abusive behaviour towards Erin by applying an appropriate mix of sanctions (arrest/charge) and other interventions?

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

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

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

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

8. How did your agency ascertain the wishes and feelings of Erin, and were her views taken into account when providing services or support?

9. 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?

10. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

11. What knowledge did family, friends, and employers have that Erin was a victim of domestic abuse, and did they know what to do with that knowledge?

12. Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Erin and/or Peter, or on your agency's ability to work effectively with other agencies? Did Covid-19 related work practices affect your response?

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

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

5 Methodology

5.1 On 2 December 2021, Liverpool Community Safety Partnership held a Standing Group Meeting to consider multi-agency information held in relation to Erin and her partner, Peter. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review (para 18 Statutory Home Office Guidance)[1] and recommended one should be conducted. The Home Office was informed of the decision to undertake a review on 13 April 2022. This delay was because there were also discussions with the Liverpool Safeguarding Adults Board as to whether the case should be taken forward as a Safeguarding Adults Review. The decision was that the case would be reviewed as a Domestic Homicide Review and that the safeguarding practice lead for Adult Social Care would be a member of the DHR panel, to ensure that there was appropriate safeguarding expertise on the panel.

5.2 The start of the process was delayed pending the conclusion of the police investigation into Erin's death; with the first meeting of the DHR panel taking place on 16 June 2022.

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

5.3 The panel obtained information from relevant agencies in Merseyside. The panel made a request to An Garda Siochana (Ireland's National Security and Police Service) to share information with Liverpool Community Safety Partnership for the purposes of the review. The request was made in order to obtain background information and because Erin had indicated to practitioners in Liverpool that the reason she and Peter moved to Liverpool, was because of abuse from their families. The panel thought it relevant to obtain as much information as possible. An Garda Siochana declined to share information with the DHR, and a request for information was made by Merseyside Police via Interpol. An Garda Siochana indicated that information could be shared with Merseyside Police, but that consent was not given for Merseyside Police to share that information with the DHR.

5.4 The panel also wrote to relevant local authorities in Ireland, seeking background information about Erin and her child. The authorities declined to provide any information and referred the panel to An Garda Siochana. As the review panel was unable to access information about events in Ireland, this restricted the review panel's knowledge of previous incidents prior to the couple moving to England.

5.5 DHR meetings took place using Microsoft Teams video conferencing: the panel met five times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 9 February 2023, after which minor amendments were made to the report that were agreed with the panel by email.

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

6.1.1 The Community Safety Partnership and the DHR Chair wrote to Erin's mother inviting her to contribute to the review. The panel was aware that as Erin's mother did not live in England and/or Wales, support from the Victim Support National Homicide service was not available, and the letters included the appropriate Home Office leaflets and information about other advocacy services. No reply was received. The DHR Chair followed this up by email, text, and phone calls but was unable to establish contact.

6.2 Employer

6.2.1 Neither Erin nor Peter were employed during the time period of the review. Erin indicated to her Crisis UK lead worker that she had found employment and had spent money on work equipment; however, the DHR panel has not been able to verify this information. Erin had an active claim for Universal Credit for the entirety of the review period and did not inform the DWP of any work.

6.3 Friends

6.3.1 The police investigation following Erin's death, did not identify friends of Erin or Peter in England. Following Erin's death, a friend from Ireland contacted services in England seeking information. The Chair contacted the friend in Ireland who agreed to speak about their knowledge of Erin. The information from that conversation is contained within section 13 of the report.

6.4 Peter

6.4.1 It is believed that Peter returned to Ireland after Erin's death. The panel did not have an address or telephone number for him and were unable to contact him to ask for his contribution to the review. The Chair also utilised social media in an attempt to make contact with Peter, but this was unsuccessful.

7 Contributors to the Review / Agencies Submitting IMRs[2]

7.1.1

Agency	Contribution
Merseyside Police	IMR
Liverpool Clinical Commissioning Group	IMR
Merseycare NHS Foundation Trust	IMR
Liverpool City Council Adult Social Care	IMR
Liverpool University Hospital Foundation Trust	IMR
Liverpool City Council Housing Options	IMR
Crisis UK Skylight Merseyside	IMR
North West Ambulance Service	IMR
Department for Work and Pensions	Brief information

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

7.1.2 The National Centre for Domestic Violence (NCDV)[3] was contacted, as Erin had been referred to them, but held no record of any contact with Erin.

7.1.3 In addition to the IMRs, each agency provided a chronology of interaction with Erin 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 Erin or the perpetrator, nor had any involvement in the provision of services to them.

7.1.4 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 Erin and the perpetrator; and any other action taken.

7.1.5 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.

7.1.6 The IMRs in this case focussed on the issues facing Erin. 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.

[3] https://www.ncdv.org.uk/

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 NHS Cheshire and Merseyside

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

7.2.3 Mersey Care NHS Foundation Trust

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

7.2.4 Liverpool City Council Adult Social Care

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

7.2.5 Liverpool University Hospitals NHS Foundation Trust

The Trust was created on 1 October 2019 following the merger of two adult acute Trusts: Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust. The merging of the two organisations was integral to regional NHS plans to deliver improved quality of care and to make changes in existing care models. The merger

provided an opportunity to reconfigure services in a way that provides the best healthcare services to the city and improves the quality of care and health outcomes that patients experience. The Trust runs Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital, and the Royal Liverpool University Hospital. It serves a core population of around 630,000 people across Merseyside, as well as providing a range of highly specialist services to a catchment area of more than two million people in the North-West region and beyond.

7.2.6 Liverpool City Council Housing Options

Liverpool City Council's Housing Options service is responsible for the administration of the council's statutory duties towards households who present to the authority as homeless or threatened with homelessness.

The aim of the service is to:

- Stop people from losing their homes
- Help people to find their own solutions to housing problems
- Assess people's housing needs and to offer a range of housing options
- Give free, impartial, and confidential advice about housing issues.

7.2.7 Crisis UK Skylight Merseyside

Crisis UK Skylight works directly with thousands of homeless people every year. The charity provides vital help so that people can rebuild their lives and are supported out of homelessness for good. Crisis UK Skylight offers one-to-one support, advice, and courses for homeless people in 12 areas across England, Scotland, and Wales. How someone is helped depends on their individual needs and situation. It could be with finding a home and settling in, getting new skills and finding a job, or help with their health and wellbeing. Crisis UK Skylight uses research to find out how best to improve services, but also to find wider solutions to homelessness. Together with homeless people and Crisis supporters, Crisis UK Skylight campaigns for the changes needed to end homelessness for good.

7.2.8 North West Ambulance Service

NWAS serves more than seven million people across approximately 5,400 square miles – the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire, and Glossop (Derbyshire). They receive approximately 1.3 million 999 calls and respond to over a million emergency incidents each year. NWAS makes 1.5 million patient transport journeys every year for those who require non-emergency transport to and from healthcare appointments. NWAS delivers the NHS 111 service across the region for people who need medical help or advice: handling more than 1.5 million calls every year.

7.2.9 Local Solutions

Local Solutions is a charity that, since 1974, has been generating and delivering services to support individuals, families, and communities, with a primary focus on those experiencing disadvantage, exclusion, and vulnerability. Their work is focussed on serving the communities within Liverpool City Region and North Wales.

The charity provides the IDVA (independent domestic violence advisors) service to males and females in the Liverpool area who have been identified as being at high risk of ongoing domestic abuse. The aim is to provide a short/medium-term service to reduce the risk of domestic violence and abuse and minimise the harmful effects that domestic abuse can have on individuals and families.

8 The Review Panel Members

8.1

Name	Organisation
Ged McManus	Author
Carol Ellwood-Clarke	Chair

Name	Organisation
Deborah Mayne Semple	Safeguarding Matron, Liverpool University Hospitals NHS Foundation Trust
Carla Whittaker	Safeguarding Lead Nurse, Mersey Care NHS Foundation Trust
Kerry Dowling	Local Solutions, Independent Domestic Violence Advisor (IDVA)
Susan Hewitt	Safeguarding Practitioner, North West Ambulance Service NHS Trust
Sandy Williams	Safeguarding Practice Lead, Quality Assurance and Adult Safeguarding, Adult Social Care
Paul Grounds and Leanne Hobin	Detective Chief Inspector, Merseyside Police
Kathryn Duffy	Crisis UK Merseyside Skylight
Jayne Cook	Liverpool City Council Public Health – Suicide Prevention Lead
Karen Kelleher	Liverpool City Council Housing Options
Beverley Hilton	Liverpool City Council Safer and Stronger Communities Team
Debbie Phillips	Liverpool City Council Safer and Stronger Communities Team
Helen Smith	NHS Cheshire and Merseyside (Primary Care)

Name	Organisation
Michelle Hulse	Team Leader Victims & Vulnerable People, Liverpool City Council

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 separate people.

9.2 Carol Ellwood-Clarke was chosen as the DHR Independent Chair. She 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[4].

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

9.3 Ged McManus supported the Independent Chair and wrote the report. 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 Adults Board (not in Merseyside or an adjoining authority). He has chaired two previous reviews in Liverpool.

9.4 Both practitioners served for over 30 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 60 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 DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA.[5] Both practitioners have worked on previous DHRs in Liverpool.

10 Parallel Reviews

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

Ligature compression of the neck, consistent with hanging.

[5] Advocacy After Fatal Domestic Abuse

The circumstances of death are recorded as follows:

On [date redacted] the Deceased died as a result of compression of the neck from a ligature made from thin blue rope, which she had suspended from a clothes hook on the bathroom door at her home at [address redacted]. Her reported history included mental health difficulties and upset concerning her relationship with her former partner, who resided at the same address. There were no suspicious circumstances identified by the Police investigation. On balance it is likely that the deceased took her own life intending to do so.

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

10.2 Erin’s GP practice conducted a significant event analysis. The report from this was shared with the DHR.

10.3 Mersey Care NHS Foundation Trust conducted a rapid review followed by a StEIS (Strategic Executive Information System) report. That report was used to inform the IMR completed for the purposes of the DHR.

10.4 Crisis UK Skylight Merseyside completed an internal review following the death of Erin. This identified areas for learning/development and improvement. Information from the review was used to inform the IMR provided for the DHR, and all relevant information was included. The internal review has informed the learning for this DHR.

10.5 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.

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 Erin was of white Irish ethnicity and was heterosexual. During the review period, she lived with her partner, Peter, in Liverpool. Her faith was not recorded by any agency involved in the review. After Erin's death, Peter informed Crisis UK Skylight Merseyside that they were both Catholic.

11.3 Erin was diagnosed with Emotionally Unstable Personality Disorder (EUPD)[6] and bipolar disorder[7]. She was registered with a GP in Liverpool and attended regularly for appointments until the last few weeks of her life. She was taking various medications, and the GP had initiated a process of rationalising Erin's medication. This was supported by a detailed review by a psychiatric consultant. According to The World Health Organisation (WHO) in 2019, 40 million people experienced bipolar disorder[8]

11.4 The review has not seen any evidence that Erin used alcohol or illicit drugs whilst in Liverpool.

11.5 Peter is of white Irish ethnicity. None of his medical records has been shared with the review. The review has not seen any evidence that Peter used alcohol or drugs.

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[6] 'The ICD-10 classification of mental and behavioural disorders' by World Health Organization (WHO).

Emotionally Unstable Personality Disorder (EUPD) is one of ten personality disorders defined in the ICD-10 classification system. Emotionally unstable personality disorder type is characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour.

[7] People with bipolar disorder experience alternating depressive episodes with periods of manic symptoms. During a depressive episode, the person experiences depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day. Manic symptoms may include euphoria or irritability, increased activity or energy, and other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behaviour. People with bipolar disorder are at an increased risk of suicide. Yet effective treatment options exist, including psychoeducation, reduction of stress and strengthening of social functioning, and medication.

[8] https://www.who.int/news-room/fact-sheets/detail/mental-disorders

Institute of Health Metrics and Evaluation. Global Health Data Exchange (GHDx), (https://vizhub.healthdata.org/gbd-results/, accessed 14 May 2022).

11.6 The panel discussed whether the 13-year age difference between Peter [39] and Erin [26] could have created an imbalance of power between the couple. The panel was unable to come to a conclusion on this as there was no information in agency records to indicate that the age difference was the source of any issues that the couple may have had.

11.7 According to the Office for National Statistics[9], in 2021, there were 5,583 suicides registered in England and Wales: equivalent to a rate of 10.7 deaths per 100,000 people. While this was statistically significantly higher than the 2020 rate of 10.0 deaths per 100,000 people, it was consistent with the pre-Coronavirus (COVID-19) pandemic rates in 2019 and 2018.

11.8 Around three-quarters of suicides were males (4,129 deaths; 74.0%), which is consistent with long-term trends, and equivalent to 16.0 deaths per 100,000. The rate for females was 5.5 deaths per 100,000.

11.9 Among females, the age-specific suicide rate was highest in those aged 45 to 49 years (7.8 deaths per 100,000). While among males, it was highest in those aged 50 to 54 years (22.7 deaths per 100,000).

11.10 Although Erin took her own life, the panel thought it appropriate to include information on disparities in the way that women are affected by domestic abuse. Domestic homicide and domestic abuse predominantly affects 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:

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations

‘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)’.

11.11 The panel discussed whether Erin and Peter’s Irish nationality had any impact on the services that they received. Erin and Peter’s nationality made it more complicated for them to access housing and benefits. The panel saw that they were provided with temporary housing, which later led to a permanent home. They were able to access medical services freely and claimed benefits quickly after arriving in Liverpool. Extensive help to access services was provided by Crisis UK Merseyside Skylight and other agencies to obtain identification, housing, benefits, and a bank account. Based on Erin and Peter’s nationality, the panel did not identify any negative impact on services provided.

12 Dissemination

12.1 Home Office

Liverpool Community Safety Partnership

Liverpool Police and Crime Commissioner

Domestic Abuse Commissioner

All agencies contributing to this review

Erin's family

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 Erin'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 Erin's friend in Ireland told the Chair of the review that they had met Erin at college, and they became very close friends. As a teenager, Erin had spent several years in the USA when her family moved there, before moving back to Ireland.

13.1.2 The friend described a very close relationship with Erin during their college years. Whilst at college, Erin had a part-time job working in a call centre for an IT company, where she assisted customers with technical queries. Erin was sometimes admitted to hospital regarding her mental health: Erin's friend thought that this may have been affected by recreational drugs that they took together. Whilst at college, Erin became pregnant and gave birth to her child. The friend said Erin was a good mum who looked after her child well and took the child to creche so that Erin could continue her studies. The father of the child was not involved in the child's life. Erin completed her degree in criminal justice studies and had an ambition to be a lawyer.

13.1.3 The friend said that, in 2019, Erin went to a residential rehabilitation facility in Ireland, which was paid for by her family and cost in the region of 10,000 Euros.

13.1.4 The friend said that Erin appeared to be well supported by her family. Erin lived in a nice apartment that was paid for by her mother, and the friend was not aware of any incidents or background of disharmony or abuse in the family.

13.1.5 The friend was aware that Erin had met Peter, and from that point on, had much less contact with Erin. The friend described Peter as 'a bad lot': someone who would look out for younger women who he could take advantage of.

13.1.6 The friend lost touch with Erin and was not aware that Erin had moved to Liverpool until she was contacted by a family member to ask if they knew where Erin was.

13.2 Events within Timeframe of Review

13.2.1 On 6 January 2021, Erin contacted the Liverpool City Council Housing Options service (by telephone). Erin said that she and Peter had moved to Liverpool from Ireland, where they were fleeing domestic abuse from their family. The couple were placed in temporary accommodation pending an assessment of their housing need. The couple said they had arrived in Liverpool on 26 December 2020 and stayed in a budget hotel until they ran out of money.

13.2.2 On 7 January 2021, Erin approached Shelter UK (Merseyside). She disclosed physical and sexual abuse in Ireland and that she and her partner had travelled to Liverpool and were homeless. She was given housing advice and practical support, for example, supermarket vouchers and advocacy with the council regarding housing. On the same day, Erin and Peter made a claim to the DWP for Universal Credit.

13.2.3 On 20 January 2021, a Crisis UK worker completed a ‘Mainstay’ (an assessment of housing needs) with Erin and Peter. Crisis UK was, at this time, assisting Liverpool City Council by completing Mainstay assessments due to an increase in demand in the Covid-19 pandemic.

During the assessment, both Erin and Peter disclosed abuse from their family, accompanied by threats of violence. Erin said that her family did not know of the move to Liverpool. During the assessment, Erin disclosed a diagnosis of dysthymia (persistent depressive disorder), severe anxiety, depression, bipolar, and borderline personality disorder. Erin stated that she took medication to control the symptoms. Erin also said that she had attempted to take her own life seven times in the previous twelve months.

13.2.4 On 25 January 2021, A Crisis UK lead worker contacted Erin to introduce themselves and arrange an appointment at the Crisis UK office. Erin was concerned about a lack of money and was advised regarding interaction with DWP. Crisis UK agreed to arrange a taxi so that Erin and Peter could attend the appointment.

13.2.5 On 1 February 2021, Erin attended the Crisis UK appointment with Peter. The couple said that Peter supported Erin with appointments.

A homeless Outcomes Star[10] session was completed, with Erin's scores

recorded as:

Motivation and taking responsibility – 10

Self-care and living skills – 10

Managing money & personal administration – 10

Social networks & relationships – 10

Drug and alcohol misuse – 10

Physical Health – 7

Emotional and mental health – 4

Meaningful use of time – 8

Managing tenancy and accommodation – 2

Offending – 9

Overall score – 8

Note: 1 is the lowest score, 10 the highest.

Erin and Peter were booked into temporary accommodation until 4 February (this was later extended). It was explained to them that, at that time, Housing Options did not accept a responsibility to house them permanently.

Erin stated that they had been offered work but did not have sufficient identification – having travelled from Ireland using their driving licences. Support was arranged to obtain passports.

The couple were given a £30 supermarket voucher and advised to register with a GP. Erin said that she had a prescription but not enough money to pay

[10] https://www.outcomesstar.org.uk/about-the-star/what-is-the-outcomes-star/

for it. It was established that a Universal Credit payment was due on 11 February, and the couple would be able to apply for an advance payment.

Peter was allocated a separate Crisis UK lead worker.

Erin's Crisis UK lead worker continued to provide support to her, by telephone and email, on a range of practical issues. Erin missed a number of appointments.

13.2.6 On 25 February 2021, Erin registered at a GP practice in Liverpool. She described a history of Emotionally Unstable Personality Disorder and bipolar disorder.

13.2.7 On 26 February 2021, Erin called the police, on 999, reporting a domestic abuse incident. On police attendance at the B&B where the couple were accommodated at, Erin said that during an argument over her mental health, Peter was verbally abusive, pushed her, and told her to kill herself. Peter said that the argument started when he said he was going to return to Ireland.

Erin did not support an assault investigation. Peter told officers that Erin had self-harmed in the previous week, and the police witnessed a small and superficial cut. A VPRF1[11] was completed and graded as bronze: this recorded Erin as suffering from depression and Peter with schizophrenia. A referral was made to Adult Social Care for Erin regarding her mental health issues. The

[11] Merseyside Police use the MeRIT risk assessment tool to evaluate domestic abuse incidents. The VPRF1 (which includes the MeRIT risk assessment tool) contains 40 questions formulated to illicit information from the parties about the incident and the state of the relationship between them. The questions are divided into three sections: a violence assessment; a breakdown assessment; and a social assessment. The answers calculate a score, which in turn provides a bronze, silver, or gold grade: gold indicating the most serious level of risk. A secondary assessment is done at The Safeguarding Hub, and a final grade is decided: the grade can be increased on the professional judgement of a supervisor. Intervention for the victim is determined by the final grade, and referrals are made based on the individual needs of the parties involved.

referral was not recorded, and no action was taken. This was not in compliance with Adult Social Care policy.

13.2.8 On 16 March 2021, the Housing Options service made a decision that Erin and Peter could be allocated permanent accommodation.

13.2.9 On 26 March 2021, Erin and Peter attended a meeting with Erin's Crisis UK lead worker. Erin said that they had been in receipt of Universal Credit for two months. She said that she was feeling well but that their relationship was strained due to their living conditions in temporary accommodation. Erin said that she wanted to bring her child over from Ireland to live with them, and the worker referred the couple to the housing allocations panel for a two-bedroom property. Erin was given a phone so that the worker could contact her.

13.2.10 On 16 April 2021, following a number of failed contacts, Peter's Crisis UK lead worker spoke to him on the telephone. Peter raised concerns about the temporary accommodation he and Erin were staying in: this related to the behaviour of other guests. As a result of this, the couple were moved to a different hotel.

13.2.11 On 19 April 2021, Erin and Peter agreed to 'swap' Crisis UK lead workers, as Erin thought that she would relate better to Peter's worker. This was agreed with Crisis UK.

13.2.12 On 28 April 2021, Erin's new Crisis UK lead worker spoke to her on the telephone and completed a homeless Outcomes Star, with Erin's scores recorded as:

Motivation and taking responsibility – 7

Self-care and living skills – 8

Managing money & personal administration – 10

Social networks & relationships – 7

Drug and alcohol misuse – 10

Physical Health – 7

Emotional and mental health – 7

Meaningful use of time – 7

Managing tenancy and accommodation – 10

Offending – 10

Overall score – 8

Erin said that both she and Peter now had National Insurance numbers and Universal Credit in place. Erin said that she had her purse stolen, with £320 in it. She was supported to obtain an £80 grant through the Liverpool Support Scheme Grant and told that supermarket vouchers would be available next week.

13.2.13 On 7 May 2021, Erin's Crisis UK lead worker met Erin (at the hotel Erin and Peter were staying at) and assisted her to complete a passport application.

13.2.14 On 14 May 2021, Erin's Crisis UK lead worker supported Erin to set up a bank account. Erin was asked to attend the office to pick up a phone, as she was using Peter's phone.

13.2.15 On 18 May 2021, Erin's Crisis UK lead worker attended a bank with her to finish setting up a bank account. Erin was also given a phone with credit on it.

Later that day, Erin and Peter were offered a one-bedroom flat (Provided by Torus Housing) by the Housing Options service.

13.2.16 On 20 May 2021, Erin and Peter had made arrangements to view the flat. Erin contacted her lead worker to say that she would be viewing the flat alone. Erin viewed the flat and took a video to show Peter.

Peter disclosed to his lead worker that Erin needed to have an operation and that the diagnosis may be cancer. The panel has not been able to find any other information to corroborate this. Peter's assertion does not appear to be correct.

13.2.17 On 28 May 2021, Erin attended at the Crisis UK office to collect her new passport. Erin and Peter also picked up the keys for their new flat from Torus Housing on this day. It was arranged that a furniture pack would be delivered to them. They were allowed to stay at the hotel, where they had been living, until 4 June – to allow a reasonable moving in period.

13.2.18 On 2 June 2021, Erin's GP made a referral to the Mersey Care Single Point of Access (SPA) due to Erin struggling with her mental health and increased anxiety. She had reported suicidal ideation and poor sleep. The GP was concerned because of the mix of medications Erin was taking and requested advice in relation to Erin's medication being reduced.

Erin was seen regularly by a GP and was given weekly prescriptions. Not all appointments are documented here.

13.2.19 On 3 June 2021, the referral for Erin was discussed in the Mersey Care Single Point of Access multidisciplinary team meeting. The outcome was for a routine appointment with a doctor or advanced practitioner.

13.2.20 On 4 June 2021, Erin asked her Crisis UK lead worker about carpets for the flat. By 11 June, an arrangement had been made for a contractor to attend and deal with the carpets.

13.2.21 On 23 June 2021, Erin's Crisis UK lead worker left the service. Erin was informed. From this point, Erin and Peter were both supported by the same lead worker.

13.2.22 On 1 July 2021, Erin had a telephone assessment with a Mersey Care advanced practitioner.

Recommendations from the assessment were made, which included Erin's sertraline[12] prescription being stopped, and for Erin to commence venlafaxine[13]. It was suggested that Erin's diazepam[14] should be reduced. A referral was made for Erin to be seen by the community mental health team (CMHT) for further assessment/monitoring and review of medications.

On the same day, Erin's replacement Crisis UK lead worker contacted her, by telephone, to confirm that they were taking over as lead worker. Erin said that she and Peter were well, everything was fine with the new flat, and that the carpets had been fitted.

[12] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI).It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

[13] Venlafaxine is from of a group of antidepressants called serotonin and noradrenaline reuptake inhibitors, or SNRIs. It is thought to work by increasing the levels of mood-enhancing chemicals called serotonin and noradrenaline in the brain. It's used to treat depression and sometimes anxiety and panic attacks.

[14] Diazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety, muscle spasms and seizures or fits.

13.2.23 On 8 July 2021, Erin was discussed in the Mersey Care CMHT referrals meeting. It was agreed to arrange a telephone appointment with a consultant psychiatrist on 23 July 2021. Erin did not receive a telephone call; she therefore contacted her GP. As a result, another appointment was made for 27 August.

13.2.24 On 30 July, Erin contacted the Crisis UK lead worker, by telephone, and the Outcomes Star was completed. Erin's scores were:

Motivation and taking responsibility – 9

Self-care and living skills – 10

Managing money & personal administration – 10

Social networks & relationships – 10

Drug and alcohol misuse – 10

Physical Health – 10

Emotional and mental health – 7

Meaningful use of time – 7

Managing tenancy and accommodation – 10

Offending – 10

Overall score – 9

Erin said that she and Peter were managing their accommodation really well. She said that her child came to England three weeks ago and now lived with them. She had notified Torus and Universal Credit of the changes. There is no other evidence that the child came to the UK. After Erin's death, Peter told a worker that the child did not come to the UK because Erin's mother would not allow it.

Erin was given assistance with practical issues on council tax and her National Insurance number. She was told that the lead worker would be on leave until 20 August and was given an alternative contact should it be required.

13.2.25 On 12 August 2021, Erin and Peter attended a GP appointment together. They discussed that they had been trying to start a family for the last 18 months but had not been successful. Peter said that he had four children to a previous relationship, and Erin said that she had one child. None of the children were living with them. The GP agreed to a referral to a fertility clinic but was clear that the couple did not meet the criteria for IVF treatment. A number of routine tests were ordered, all of which later proved to be normal. The fertility clinic appointment did not take place before Erin's death.

13.2.26 On 13 August 2021, Peter called the North West Ambulance Service on 999. He said that he had found Erin laid on the bed unresponsive and surrounded by empty tablet packets. Erin was transported to the emergency department at Liverpool University Hospitals NHS Foundation Trust (LUHT). A safeguarding concern was completed by NWAS (This resulted in Adult Social Care sending a letter to Erin advising her to contact her GP for mental health support).

Erin was transferred to the intensive care unit (ICU). It was recorded that Erin had a bruise to her left calf and a bruise and tender area to her left neck. The cause of the injuries was not explored. Erin was later transferred to a general medical ward.

During this admission to hospital, there were restrictions on visitors due to Covid-19. Peter was unable to visit but dropped off personal items for Erin at the hospital.

13.2.27 On 15 August 2021, whilst still in hospital, Erin was seen by a practitioner from Mersey Care Core24 (psychiatric liaison team). During the assessment, Erin reported several diagnoses, including bipolar, personality disorder, and anxiety. Erin said that she had frequent mood changes and experienced highs and lows, which could cycle quickly.

She felt low when she took the overdose leading to Peter calling an ambulance. During the assessment, Erin reported feeling fine, that she regretted taking the overdose, and she denied any suicidal plans or intent. She said that overdoses were her main coping skills and that she had moved to Liverpool for a new start. She had previously had a care coordinator in Ireland and had a history of involvement with mental health services in Ireland and the USA.

Erin said that she was living with her partner and relied on benefits. She was awaiting a job in a call centre and had a degree in criminology. Erin said that her mum was an alcoholic. Erin said that she had been sexually abused by her stepfather.

The community mental health team and Erin's GP were informed of the assessment.

13.2.28 On 16 August 2021, the community mental health team were advised that Erin had self-discharged from hospital. They contacted her by telephone. She appeared bright in mood and was with Peter. She denied any thoughts of self-harm/harm to others or suicidal ideation. Erin enquired about her medication. She was advised that she would need to speak to her GP regarding this. Erin confirmed that she was currently getting her prescriptions on a weekly basis and that she would contact her GP. Erin was advised of her appointment with the consultant psychiatrist on 27 August and was provided with urgent mental health contact details.

13.2.29 On 22 August 2021, Erin attended the LUFHT emergency department. Erin said that she was feeling suicidal and had thought of hanging herself, but the hook on the door was not high enough. Erin had a superficial wound to her left wrist, which required no treatment.

Erin was contacted by a practitioner from the Mersey Care Core24 team. Erin said that she had had an argument with Peter, who was very manipulating, and that she missed her child, who was currently in Ireland. Erin reported that she was trying for a baby and that she was in considerable pain with her back, arms, and legs.

The impression of the assessment was a diagnosis of personality disorder. Erin reported that she acted impulsively when she was overwhelmed and stressed. No risk from others was identified, and there was no evidence of self-neglect. Erin was discharged from the Core24 team, with follow-up at the planned appointment on 27 August. Crisis information was provided.

13.2.30 On 27 August 2021, Erin had a telephone appointment with a psychiatric consultant. Erin identified to the psychiatrist, uncontrolled mood swings as her primary difficulty, which was longstanding. Erin said out of the blue, her mood could readily flip between states of elation, dejection, or even relative normalcy.

When her mood was elated, she experienced increased activity, enthusiasm, racing thoughts, impulsivity, alongside being overtalkative and overconfident.

When her mood dipped, she was unable to function. She could not get out of bed or motivate herself. She was devoid of energy, loathed herself, and experienced intense suicidal thoughts. During these episodes, she indulged in self-injurious acts in the form of cutting and overdoses, with the former providing a short-lived emotional release. Her last overdose was a month ago, which she said she took with the intention of dying.

Besides having trouble with anger control, Erin said that she did not manage stress or setbacks well and became irritable over minor stressors, resulting in verbal hostility towards others. She denied trouble with voice hearing but acknowledged that she struggled with increased generalised paranoia when she was out – associated with exacerbated levels of anxiety.

Erin's risks were identified and recorded as follows:

Erin did not report active thoughts, intent, or plans of self-harm/suicide at the time of this review. She displayed forward planning and keenness to engage with treatment plans, including further psychological therapy and medication changes.

In the long term, she retained an increased risk of self-harm and death by completed suicide or misadventure (compared to the general population). This is so, considering her diagnosis of EUPD and the history of previous acts of self-harm and suicide attempts.

The outcome of the meeting was a detailed review of Erin's medications – intended to reduce polypharmacy. Her GP, who had already begun a gradual reduction of medication, was notified of the new regime and asked to prescribe weekly.

Erin was also referred to the Managing Life Together group for level two psychological therapy – aimed at the acquisition of coping skills to manage her EUPD difficulties. She was not engaged in this group prior to her death due to being on a waiting list.

13.2.31 On 27 August 2021, Erin was detained at a local supermarket on suspicion of theft, and the police were called. On arrival of the police, Erin related her recent hospital attendances and the reasons for them. Erin said that she didn't know what she was doing due to her taking prescription medication for her mental health. Peter arrived and expressed his concerns for Erin. He said that he was paying privately for Erin to speak with a mental health professional. The store manager did not wish to take things further and there was no action, regarding the incident, by the police. A VPRF1 was submitted by the attending officer to Adult Social Care. Adult Social Care ascertained that Erin was under the care of a psychiatric consultant and shared the VPRF1 with Erin's GP.

13.2.32 On 1 September, a GP spoke to Erin on the telephone. Erin's presentation to LUHT emergency department on 22 August, was discussed. Erin said that she had been very stressed at the time but was now much calmer. She was given the news that a blood test, taken in relation to her fertility appointment, was normal. Also, some of her medications were reviewed.

13.2.33 On 7 September 2021, Erin attended a GP appointment (in person), where recommendations from her appointment with a psychiatric consultant, on 27 August 2021, were implemented. Medication was now issued weekly.

13.2.34 On 8 September 2021, Erin contacted the Crisis UK lead worker and asked for a food voucher. Erin was told that it was not possible as she and Peter were claiming Universal Credit. Erin said that she had started work two days previously and had spent money on equipment that the employer did not provide. Erin was provided with a £45 supermarket voucher, on the understanding that this would not be repeated.

13.2.35 On 23 September 2021, in a telephone call with a GP, Erin was told that a scan taken in relation to her fertility issue, was normal. This was her last contact with her GP surgery. The surgery attempted to contact Erin (by phone) several times, without success. Erin continued to collect her medication until two weeks before her death. This means that she was potentially without medication for a week before her death.

13.2.36 On 30 September 2021, Peter contacted North West Ambulance Service on 999. On their attendance at Erin and Peter's flat, ambulance staff found that Erin had taken an overdose and had superficial cuts to her wrists. Erin was transported to the LUFTH emergency department.

Erin disclosed to the ambulance staff that Peter had previously tried to suffocate her by putting pillows over her face, had put a knife to her throat and made threats to slit her throat, and had been generally physically abusive.

Erin said that Peter did not allow her to leave the flat. Erin said that she went out yesterday to go to the shop and on her return, he accused her of having a 'gang bang' and threw her onto the bed. Erin said that if Peter found out that she had spoken to the ambulance crew today, he would kill her. She also said that she was scared to go home. Ambulance staff raised a safeguarding concern with Adult Social Care. This was shared with the community mental health team, with no further action by Adult Social Care. Arising from Erin's hospital admission on 30 September 2021, Erin was followed up by the Crisis Resolution Home Treatment Team [see paragraphs 13.2.39 – 13.2.42], and there was no further involvement with the community mental health team.

13.2.37 Whilst at the hospital, Erin was visited by police officers. A VPRF1, including a MeRIT risk assessment, was completed: this was graded as silver. Erin did not wish to make a complaint.

13.2.38 Erin was also seen by the Mersey Care Core24 team. Erin told them that she had had an argument with Peter, which led her to take an impulsive overdose of 24 aspirin, and that she was missing her family in Ireland and wanted to go home. She reported that Peter was verbally hostile towards her, and that she felt that she would benefit from two days' admission to 'get her head sorted'. She reported that she was unable to go back to her home address as she was now homeless.

Erin was discharged from hospital, with a plan for the Crisis Resolution Home Team (CRHT) to contact her the following day.

13.2.39 On 1 October 2021, a CRHT practitioner contacted Erin to confirm a home visit on 2 October.

13.2.40 The CRHT attempted contact with Erin on 2 and 3 October 2021 by telephone, and home visits on multiple occasions. These were all unsuccessful. Written notes and telephone messages were left.

13.2.41 On 4 October 2021, Erin was discussed in the CRHT MDT meeting. It was decided to offer Erin an outpatient appointment with the CMHT in December, and if she did not respond, she would be discharged.

13.2.42 On 6 October 2021, a CRHT practitioner attempted to contact Erin by telephone and personal visit. No contact was made. Following discussion with the team clinical lead, Erin was discharged from the service, and a letter was sent to her GP.

13.2.43 On 8 October 2021*, Peter called an ambulance after he had found Erin hanging in the bathroom. Peter told the police that he and Erin were in separate rooms that night, as they were breaking up and planning to go back to Ireland. Peter said that the last time he had spoken to Erin face to face was about 12.30 am. He later heard noises and got up to see where Erin was. He then found Erin hanging from the bathroom door.

*The panel discussed at length whether to include the date of Erin's death. Taking into account the short period between the last contact with services and Erin's death, the panel felt that it was important to include the date. In coming to this view, the panel acknowledged that this reduced anonymity but felt that including the date was proportionate.

14 Analysis

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Erin as a victim of domestic abuse, and what was your response?

14.1.1 Housing / Homeless

The first record held by agencies that Erin was a victim of domestic abuse was in January 2021, when she presented as homeless to Housing Options. During contact with professionals, Erin stated that she had fled Ireland due to domestic abuse from her family. There was no information shared that Peter was a perpetrator of abuse towards Erin.

14.1.2 The panel thought that this early contact was an opportunity to refer or signpost Erin to domestic abuse services in Liverpool. She made clear disclosures of domestic abuse from her family in Ireland. It is likely that the fact that Erin was thought to be physically safe from the abuse in Ireland meant that domestic abuse referrals were not considered. Erin may have benefited from support in relation to the abuse that she had faced. The panel also acknowledged that Erin may have also been suffering from ongoing emotional abuse. Since Erin's death, Housing Options has employed two domestic abuse navigators. These posts ensure that any person contacting Housing Options is assessed appropriately and referred to domestic abuse services as necessary.

14.1.3 Between January and October 2021, Erin was in contact with Crisis UK Skylight Merseyside. The IMR author from Crisis UK has identified a number of indicators of domestic abuse that were present during their engagement with Erin and Peter, which on reflection could have indicated domestic abuse and coercive and controlling behaviour. These included:

The use of one telephone.

When Erin and Peter were present at meetings or when contacted via telephone, the telephone was on 'speaker' mode.

Non-attendance at meetings.

No response to messages left.

Erin requested a change of her lead worker to discuss her problems more easily.

14.1.4 Crisis UK Skylight Merseyside responded to these, at the time, in the following way:

On two occasions, Erin was provided with her own mobile phone.

Separate lead worker sessions provided, to allow one-to-one contact with Erin to explore her needs further. Some of these sessions were off site.

Varying methods of contact undertaken to seek engagement with Erin via her own mobile phone, including texts, telephone calls, e-mails, zoom meetings, and one-to-one meetings.

Change of lead worker.

14.1.5 Erin did not disclose domestic abuse with Peter during her contact with lead workers. When asked about her relationship, Erin's response was positive, except for one occasion, when Erin inferred that their relationship was strained. Erin attributed this to the circumstances of their homeless situation and living conditions: these were alleviated by a supported move by the Housing Options service following Crisis UK Skylight Merseyside advocacy for Erin and Peter. Crisis UK Skylight Merseyside has identified single agency learning, which is addressed at paragraph 14.14.6.

14.1.6 Erin did not disclose domestic abuse to her GP. Nor did her GP identify any signs of domestic abuse, including in a joint consultation with Peter when the couple discussed fertility.

14.1.7 Domestic Abuse Incident 26 February 2021

On this day, Erin contacted the police via a 999 call and reported that she had been assaulted by Peter. This was the first reported incident of domestic abuse, in the United Kingdom. It was recorded by the police that Erin and Peter had argued. Erin and Peter alleged that they had both been assaulted. The police completed a MeRIT risk assessment and graded the incident as bronze. Erin and Peter were both recorded as victim and perpetrator. There were no indicators of coercive control identified at this time.

14.1.8 Merseyside Police use the MeRIT risk assessment tool to evaluate domestic abuse incidents. The tool contains 40 questions formulated to illicit information from the parties about the incident and the state of the relationship between them. The questions are divided into three sections: a violence assessment; a breakdown assessment; and a social assessment. The answers calculate a score, which in turn provides a bronze, silver, or gold grade: gold indicating the most serious level of risk. A secondary assessment is done at The Safeguarding Hub, and a final grade is decided: the grade can be increased on the professional judgement of a supervisor at the Safeguarding Hub, regardless of the score. Intervention for the victim is determined by the final grade, and referrals are made based on the individual needs of the parties involved.

14.1.9 Erin agreed for a referral to the National Centre for Domestic Violence (NCDV), and she was signposted to Merseyside Police website[15] for information about seeking support for domestic abuse. Erin consented to information about the incident being shared with other agencies, and a referral was made to Adult Social Care for mental health support. The referral was not correctly recorded on the Adult Social Care Liquid Logic computer system, and as a result, no action was taken. The panel was assured that appropriate steps have been taken to ensure that all referrals are now appropriately recorded, and therefore no recommendation is made on this point. No referrals were made for Peter, as he did not consent to the information being shared.

[15] https://www.merseyside.police.uk/advice/advice-and-information/daa/domestic-abuse/

14.1.10 No further action was taken regarding the complaints of assault that both Erin and Peter had made. Erin referred to this incident in further contact with the police in September 2021. [See 14.1.11].

14.1.11 In researching Merseyside Police website, there is a link to local domestic abuse services; however, except for details of a freephone number for a Merseyside organisation, the remaining support services are for surrounding local authority areas. This was brought to the attention of Merseyside Police during the review process and immediately rectified. The Review Panel concluded that as Erin had only been living in Liverpool for a couple of months, a more proactive response and direction to local services would have been more beneficial in helping Erin reach out to services. The panel was informed that as the risk to Erin identified in the MeRIT was graded as bronze, there was no automatic referral to domestic abuse services.

14.1.12 Hospital Admission 13 August 2021

Erin was admitted to Liverpool University Hospitals NHS Foundation Trust following an overdose. Erin was transferred to the intensive care unit. It was recorded that Erin had a bruise to her left calf and a bruise and tender area to her left neck. The cause of the injuries was not explored. Erin was later transferred to a general medical ward. The panel acknowledged that the initial priority on Erin's admission to hospital was her immediate medical needs and the necessity to stabilise her condition, which was achieved during her time in the intensive care unit. The panel felt that there was an opportunity to explore the cause of Erin's injuries after she was transferred to a general medical ward, which was missed. This is a single agency learning point for LUHFT.

14.1.13 Domestic Abuse Incident 30 September 2021

North West Ambulance Service's contact with Erin on 30 September, was the only incident they had in which domestic abuse was disclosed. Erin asked NWAS for help around 'partner abuse' and stated that she had taken an overdose of aspirin. Erin described to ambulance crew, incidents where her partner had tried to suffocate her by putting pillows over her face, put a knife to her throat, and made threats to slit her throat. Erin stated that her partner was physically abusive and did not allow her to go out of the flat. Erin stated that the previous day, her partner had accused her of being intimate with other persons and had thrown her onto a bed. Erin told the paramedics that if her partner found out she had spoken to them, he would 'kill her'. Erin stated that she was scared to go home and felt suicidal.

14.1.14 After Erin was taken to hospital on 30 September, the ambulance staff dealing with her, approached police officers who were already at the hospital dealing with another matter. The ambulance staff relayed their concerns following the disclosure to them by Erin that Peter had attempted to smother her with a pillow, put a knife to her throat, and that she had kept a diary of the abuse, which contained a record of incidents of coercive control. No documentation or risk assessment was completed by these police officers, who did not speak to Erin as they were already fully engaged on another matter at the hospital that they were not able to leave. They correctly requested that another officer was deployed to speak to Erin.

14.1.15 Later that day whilst still at the hospital, Erin was seen by different police officers. During this contact, Erin stated that she had taken an overdose as she was struggling with her mental health, which had been aggravated by verbal abuse she had received from Peter. Erin also told the police that after contact with the police in February 2021, she had been assaulted by Peter as a 'punishment' for calling them. A MeRIT risk assessment was completed, and the risk was graded as silver. Erin agreed to a referral to NCDV and for information to be shared with partner agencies. Erin was advised to stay at the hospital pending being seen by the Core24 team from Mersey Care and was provided with information about the Whitechapel Centre in relation to the provision of emergency accommodation. Erin declined to make a statement to the police and declined to discuss the assaults that she had disclosed earlier in the day.

14.1.16 Later the same day, after Erin had left the hospital, she was contacted by the police again (by telephone). Erin was asked about the disclosure that she made to paramedics about Peter attempting to suffocate her and strangle her. She stated that she did not know if she said this or what she said. When asked if this had happened, she stated that she did not want to discuss it any further. Erin said that her mental health was her priority. The record of this conversation includes the following:

"called Erin after leaving the hospital and questioned her about the disclosure she made to paramedics about Peter attempting to suffocate her and strangle her".

This is the first police record of strangulation in relation to Erin's disclosures. A review of the MeRIT risk assessment shows that the answer to a question on strangulation was recorded as "No". A further detailed review has shown that had the MeRIT risk assessment recorded the answer as "yes" to strangulation, or been amended later, then according to the numerical scoring of the MeRIT risk assessment, the risk would still have been graded as silver.

14.1.17 The MeRIT risk assessment for Erin, in relation to her disclosures, was graded as silver. This was based on the answers Erin gave to the questions asked and the consequent numerical scoring. The panel discussed the particular high-risk features of the case, for example, smothering and a knife being put to Erin's throat. The MeRIT form also indicated that Erin was afraid, had mental health issues, that there was 'extreme jealousy', social isolation, unreported incidents, and emotional abuse. The police IMR author and the police panel representative concluded that the MeRIT should have been flagged to a supervisor and consideration given to increasing the risk assessment to gold (based on professional judgement). The panel agreed with this assessment.

14.1.18 In reviewing the subsequent responses, the Review Panel agreed that a more proactive response by the police or hospital staff in relation to supporting Erin to find alternative accommodation, should have taken place. The panel was informed that Erin could have been referred to the Whitechapel Centre's hospital in-reach service, which may have generated a duty to refer[16] to the Housing Options service.

The fact that there was not a referral may have been affected by the way Erin's relationship with Peter was perceived. Health records show that Peter was seen as a protective factor regarding Erin's safety, yet the same records also indicate self-harm, arguments, and potential controlling behaviour. This is a learning point for hospital staff, which is addressed by a single agency recommendation.

[16] https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-4-the-duty-to-refer-cases-in-england-to-housing-authorities

14.1.19 By the time Erin was contacted by the third police officer, Erin had left the hospital. There was no record that Erin was asked where she was living, and more importantly, if she was in the company of anyone, i.e., Peter. It is the Review Panel's belief that at the time of this telephone call, Erin may well have returned to Peter, which would have prevented her ability to openly discuss with the police, the allegations that she had made to paramedics and the initial attending police officers. It may also have increased the risk to Erin, had Peter heard the conversation.

14.1.20 No action was taken by the police to address the allegations that Erin made against Peter. This is analysed at Term 3.

14.1.21 The Review Panel identified that health records within Liverpool University Teaching Hospital NHS Foundation Trust, documented Erin's presentation at the accident and emergency department following an overdose and poisoning, which was triggered by an argument with Peter. Further documentation stated that Erin: 'cut arms with Stanley knife - superficial: had rope and wanted to hang herself, feels at high risk of suicide'. It was recorded that a safeguarding referral was required. This was not completed. There was no record that Erin was asked about domestic abuse. A MeRIT or DASH[17] risk assessment was not completed.

[17] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

14.1.22 Whilst at hospital, Erin was seen by the Core24 team from Mersey Care. During contact, it was noted that Erin was reluctant to discuss her attendance at the hospital and appeared guarded: looking at the floor and was tearful. Erin stated that her partner remained verbally hostile towards her, and that she felt that she would benefit from two days' admission to 'get her head sorted'. Erin reported that she was unable to go back to her home address as she was now homeless. Erin was not asked about domestic abuse and routine enquiry was not undertaken. A MeRIT or DASH risk assessment was not completed. A safeguarding concern was not submitted. Erin was not admitted to hospital; however, she was referred to the Crisis Resolution Home Treatment Team (CRHT).

14.1.23 The response of both LUFT and Mersey Care to Erin's disclosures, did not meet their own policies. Further questions should have been asked, and a domestic abuse risk assessment should have been completed. This is identified as an area of learning for both agencies.

14.1.24 Adult Social Care reviewed the safeguarding concern submitted by NWAS. The concern documented the allegations that had been made by Erin, including that Erin was isolated, had nobody to turn to, and that she was at breaking point. The concern documented that Erin had stated that she had been disowned by her mother, and her child was in her mother's care.

14.1.25 After reviewing the safeguarding concern from NWAS, it was not recorded as a safeguarding matter. There was no rationale as to why this decision was made. A request was made to gather information from the police. It was not clear to the Review Panel if this request was made. Information was shared with the community mental health team, and the safeguarding concern was closed. No contact was made with Erin.

14.1.26 The IMR author from Adult Social Care has identified learning in relation to their response to this incident. The IMR author has informed the Review Panel that this matter should have been accepted as an adult safeguarding concern. Had this occurred, it would have set off a process of information sharing with a view to assessing whether the local authority had a duty to undertake an enquiry in accordance with Section 42 Care Act 2014.

14.1.27 It is the view of the panel, that agencies who responded to Erin's presentation and disclosures of domestic abuse, did not recognise nor acknowledge the severity of the domestic abuse and the presenting risk factors to Erin from Peter, as well as the risk factors that she presented to herself in relation to suicidal ideation.

14.1.28 There was clear evidence to the Review Panel, throughout Erin's contact with professionals, that she had been a victim of domestic abuse and coercive control, which included the following indicators:

Physical abuse

Emotional abuse

Isolation

Psychological abuse

Preventing her leaving the flat

Restricting her contact with professionals.

14.1.29 The Review Panel has acknowledged that agencies have identified learning and made relevant recommendations. However, the Review Panel was concerned as to the apparent consistent lack of understanding – across those agencies that were aware of domestic abuse – in responding to the concerns raised. The Review Panel agreed that this was a strategic area of learning for this review and have made a recommendation for Liverpool Community Safety Partnership to address the strategic learning.

14.1.30 The Review Panel discussed the information that had been provided by Crisis UK Skylight Merseyside in relation to Erin stating, on more than one occasion, that she did not have any money. It was noted that Erin was provided with food vouchers and other financial support at these times. The Review Panel has seen information that when Erin and Peter came to the United Kingdom, they did not have any money, and they were supported in applying for financial support through the Department for Work and Pensions.

14.1.31 Erin was paid benefits by the DWP on a monthly basis, starting on 11 February 2021. Initially, this was through the Payment Exemption Service[18] (a way for people who do not have a bank account to collect benefit or pension payments). Later, from 11 July 2021, the money was paid into a bank account held in Erin's name. The panel heard that Peter was not thought to have a bank account. The Review Panel is aware that financial abuse is a form of domestic abuse. The Review Panel concluded that, based on the information provided to the review, Erin's financial situation was linked to the move to the United Kingdom, her not being in employment, and awaiting her application with the DWP to be progressed.

14.2 How did your agency ascertain the level of risk faced by Erin from Peter? What risk assessments did your agency undertake, and what was the outcome? Were risk assessments accurate and of the appropriate quality?

14.2.1 The police are the only agency involved in this case to have completed a risk assessment in response to domestic abuse.

14.2.2 Merseyside Police use the MeRIT risk assessment tool to evaluate domestic abuse incidents.

[18] https://www.gov.uk/payment-exception-service

The VPRF1 (which includes the MeRIT risk assessment tool) contains 40 questions formulated to illicit information from the parties about the incident and the state of the relationship between them. The questions are divided into three sections: a violence assessment; a breakdown assessment; and a social assessment. The answers calculate a score, which in turn provides a bronze, silver, or gold grade: gold indicating the most serious level of risk. A secondary assessment is done at The Safeguarding Hub, and a final grade is decided: the grade can be increased on the professional judgement of a supervisor. Intervention for the victim is determined by the final grade, and referrals are made based on the individual needs of the parties involved.

Note: Not all agencies in Merseyside use MeRIT. Some health agencies use the DASH risk assessment.

14.2.3 The police completed two MeRIT risk assessments: one in February 2021 and the second at the end of September 2021. These were graded as bronze and silver, respectively. In the first incident, Erin and Peter were recorded as victim and perpetrators against each other – as during this incident, allegations were made that they had both been assaulted during the incident. The incident in February was the first record of domestic abuse that had been reported to agencies in the United Kingdom. There was nothing in this contact that identified that Erin had previously been a victim of domestic abuse by Peter, either whilst in the United Kingdom or whilst living in Ireland.

14.2.4 The Review Panel discussed the response by the police in recording Erin as a 'perpetrator' during the incident in February – following an allegation that she had assaulted Peter. The Review Panel acknowledged the complexities that police officers can face when responding to incidents of domestic abuse and in having to establish who is or has been the perpetrator. This decision can be compounded due to the physical and emotional presentations of those involved. The Review Panel acknowledged the recording by the police but agreed it was relevant to reference research that details how victims of domestic can present to professionals. Studies show that domestic abuse can have a longstanding and traumatic effect on victims:

Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances, and emotional detachment[19]

Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD) – as many as two-thirds of victims of abuse (64%) developed PTSD in one study.[20]

14.2.5 The Safelives Practice briefing for Idvas/Idaas[21]

"Engaging and working with people with mental health difficulties", identifies that people with mental health difficulties can face significant barriers to reporting abuse.

These can include;

Recognising abuse

Recognising and naming abuse within a relationship is challenging for anyone, but for someone with a mental health problem, it may be even more difficult. The perpetrator may convince their partner that the problem is 'in their head' or that they are suffering from paranoia or confusion. Victim/survivors may have problems with their memory which makes it harder to see a pattern of coercive control. The perpetrator may also having a caring role, which may create uncertainty for victim/survivors over what is care and what is control.

[19] CTC (2014), Website of the US Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.

[20] 1 Golding, J., Intimate partner violence as a risk factor for mental disorders: a meta-analysis in 'Journal of Family Violence', 14 (2), 99-132.

[21] https://safelives.org.uk/sites/default/files/resources/Practice%20briefing%20-%20mental%20health.pdf

Minimisation

Victim/survivors may anticipate that a disclosure of domestic abuse will not be taken seriously by professionals. Especially when there has been failure by professionals to respond to signs of abuse previously. Many will have been living with the domestic abuse for a number of years before disclosing, whilst simultaneously engaging with professionals regarding their mental health condition. The dominance of the medical diagnostic and treatment model often means professionals focus on mental health symptoms, rather than exploring underlying factors, such as domestic abuse.

Fear of not being believed

Victim/survivors with mental health needs are often fearful that agencies will judge them or will assume they are not telling the truth. Perpetrators will often disguise their abuse, and victim/survivors may have a recorded history of mental ill-health with additional concerns regarding substance misuse, self-harming behaviour, suicide attempts, and/or periods of psychosis or depression, which may make it difficult for the client to feel being believed is likely.

Abusive tactics

Perpetrators of domestic abuse may use their partner’s mental health problems as a tool to isolate and further abuse. For example, they may threaten their partner with sectioning, they may interfere with medication and/or disrupt attempts to seek help and support.

Substance use

Many people attempt to manage domestic abuse and symptoms of their mental illness alone, which can lead to further psychological distress. They may find unhealthy ways to cope with these symptoms, such as using substances to self-medicate which can worsen their situation, heighten their risk and increase the barriers to accessing support.

Fear of coping alone

For many there is a fear of consequence, particularly regarding perpetrators in a caring role. Victim/survivors may have additional concerns regarding their ability to care for themselves or any dependents. This is increased when the perpetrator has been part of their mental health recovery and is seen as a protective factor by other professionals/agencies. This fear can be intensified by perpetrators telling them that they will not be able to cope alone.

Self-blame

Studies suggest that self-blame is exacerbated when the victim/survivor has mental health problems as they may view this as part of their own involvement in provoking the abuse.

Shame

To engage with domestic abuse services for many clients may mean multiple disclosures, domestic abuse, mental ill health, substance use, etc. The stigma that surrounds these issues, can mean that survivors feel shame and worry that they will be judged. For some, expectations linked to 'honour' placed upon them by family or community, can make disclosure very difficult and even a risk to their safety.

The impact of mental ill-health

Many clients are isolated due to their mental ill-health, for example not feeling able to leave the house, struggling to talk on the phone, not being able to remember appointments. Being able to engage with domestic abuse services is often very difficult. It is important that services are pro-active and avoid rigid policies, such as three contact attempts before case closure, which can increase the barriers for those with complex needs.

14.2.6 The Review Panel noted that based on the information provided by Peter in terms of his name and date of birth, he was not recorded on Merseyside Police systems. However, a search undertaken on other police systems, identified a male from the Irish Republic with the same name as Peter but a different date of birth. That individual had an extensive criminal record for drug offences, fraud, and domestic abuse. Whilst the Review Panel has not been able to ascertain if this was the same male, the panel concluded that it would have been useful for the police to have considered further exploration around this potential link to identify if there were any safeguarding concerns and indicators of risk that needed to be considered for Erin.

14.2.7 In the second incident, the risk was graded as silver. The Review Panel and the IMR author have already identified that, given the allegations disclosed by Erin regarding smothering and threats with a knife, the risk level should have been upgraded to gold (based on professional judgement). Analysis on this has been captured at 14.1.14-14.1.19.

14.2.8 Adult Social Care did not complete a risk assessment in response to the safeguarding concern submitted by NWAS. On receipt of the safeguarding concern, this should have prompted consideration for the completion of a MeRIT or DASH risk assessment. The Review Panel was informed that had the concern progressed to a safeguarding enquiry, this would have resulted in a safeguarding risk assessment being completed. This has been identified as a single agency area of learning.

14.2.9 Crisis UK Skylight Merseyside completed a number of risk assessments with Erin, which included an initial assessment and a progression and learning plan. The Mainstay risk assessment, which forms part of the Mainstay initial assessment, only highlighted that Erin was at risk of abuse/violence from her family in Ireland. The risks were recorded as high; however, as Erin was now in Liverpool and had advised that they were not aware of their location, the associated risks were perceived as low. None of the assessments completed, identified domestic abuse perpetrated by Peter.

14.2.10 Mersey Care utilises its own clinical risk assessment tools that are universal across mental health services and are underpinned by the 5 Ps: Predisposing, Precipitating, Presenting, Protective, and Perpetuating.

14.2.11 In Erin's risk assessment completed on 15 August 2021, it was documented that Erin had fled violence from her family in Ireland, and that she was supported by her partner, who was described as a protective factor. The risk assessment included ongoing risk of misadventure due to history of impulsive overdoses. There was no risk of harm from others identified, and in response to domestic violence, this was recorded as 'no'.

14.2.12 The risk assessment was further reviewed on the 23 August 2021 and 30 September 2021, following Erin having taken an overdose on both occasions. It was documented on the risk assessments that the precipitating factor was due to Erin having an argument with her partner, who she reported was verbally abusive towards her. On 30 September, it was further documented that ‘her partner remains verbally hostile towards her’.

14.2.13 The Review Panel was informed that the staff involved in the risk assessments did not consider the disclosure of frequent arguments, the disclosure of Erin’s partner being manipulative, and the verbal abuse, as indicators of domestic abuse and therefore routine questioning was not utilised. This has been identified as a single agency area of learning.

14.2.14 There was a similar response by staff within Liverpool University Teaching Hospitals NHS Trust: that following Erin’s presentation at the end of September and information shared with health staff about the surrounding factors of Erin’s overdose, this did not result in routine questioning and the submission of a safeguarding concern. The panel was informed that LUFTH staff have the capability to conduct a DASH risk assessment.

14.2.15 The Review Panel also reflected on the information that Erin’s mother had provided to the police after the death of Erin, in relation to the plans for Erin to return to Ireland, alone. Whilst this information was not known to any agency or professional at that time, the Review Panel acknowledged that separation increases the risk to victims of domestic abuse.

14.2.16 It is known that victims of domestic abuse are at an increased risk at the time of separation.

The Femicide Census 2020[22] (released on 13 February 2022) identified that 41% (37 of 91) of women killed by a male partner/former partner in England, Wales, and Northern Ireland in 2018, had separated or taken steps to separate from them, and that 11 of these 37 women were killed within the first month of separation and 24 were killed within the first year.

14.3 Was there sufficient focus on reducing the impact of Peter's alleged abusive behaviour towards Erin by applying an appropriate mix of sanctions (arrest/charge) and other interventions?

14.3.1 Peter was not spoken to by the police regarding any of Erin's allegations until after her death. This is addressed later in the Terms of Reference. [14.3.8].

14.3.2 The disclosures by Erin that Peter had tried to suffocate her, strangle her, and that she had kept a diary of the coercive control she was subjected to, did not progress into a criminal investigation. Erin disclosed these allegations to more than one professional.

14.3.3 Whilst it was documented that Erin was unwilling to co-operate with an investigation, there was an opportunity for the police to have progressed a criminal investigation. Peter could have been seen and interviewed about the allegations as part of an evidence-led prosecution. Had this taken place, there would have been an opportunity for the police to have obtained further evidence to support their investigation, including Erin's diary.

14.3.4 The police could have considered applying for a Domestic Violence Protection Notice (DVPN)[23].

[22] https://www.femicidecensus.org/reports/

[23] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

The College of Policing[24] states: ‘Officers have a duty to take or initiate steps to make a victim as safe as possible. Officers should consider Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) at an early stage following a domestic abuse incident as part of this duty. These notices and orders may be used following a domestic incident to provide short-term protection to the victim when arrest has not been made but positive action is required, or where an arrest has taken place, but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions. They may also be considered when a case is referred by MARAC’.

14.3.5 A DVPN is designed to give breathing space to victims by granting a temporary respite from their abuser and allowing referral to support services without interference. A DVPN/DVPO can be pursued without the victim’s active support, or even against their wishes, if this is considered necessary to protect them from violence or threat of violence. The victim also does not have to attend court, which can help by removing responsibility from the victim for taking action against their abuser. DVPNs and DVPOs are governed by sections 24 to 33 of the Crime and Security Act 2010 (CSA). The victim does not have to be living with the abuser for a DVPN to be issued.

14.3.6 The police have identified learning and made relevant recommendations around their response to the domestic abuse in this incident. [See Term 14].

14.3.7 On 25 September 2021, Erin sent three emails to her mum. The content of these emails was shared by Erin’s mum with the police after Erin’s death. A summary of the emails has been shared with the review by Merseyside Police.

[24] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/

Erin described being "in a horrible situation" and she was "abused daily".

She mentioned building up finances to return to Ireland and said that she was not using drugs.

She said that she wanted to make a plan of how to get back to how she used to be.

She stated in the final email:

"I'm just saying if anything happens to me it's him who done it. The last time I was badly beaten and tried to be suffocated".

This information was not known to any agency prior to Erin's death. The information was known and taken into account by the police investigation following Erin's death.

14.3.8 On 21 December 2021, Peter was interviewed by the police for offences of common assault, which had occurred on 26 February 2021, and offences of coercive and controlling behaviour throughout their relationship. Peter denied all the allegations. The police sought advice from the Crown Prosecution Service, who advised that no further action was to be taken against Peter due to evidential difficulties.

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

14.4.1 The police were the only agency who assessed the risk to Erin in relation to domestic abuse.

14.4.2 In February 2021, following the completion of a VPRF1, the police referred Erin to Adult Social Care for support in relation to her mental health that had been identified during the completion of the MeRIT. Erin consented to this referral. As described at paragraph 14.1.6, the referral was not correctly recorded, and no action was taken.

14.4.3 The safeguarding concern submitted by NWAS at the end of September 2021, stated that Erin was paying privately for mental health support. The Review Panel has not identified if any agency were providing this support.

14.4.4 Adult Social Care shared NWAS's safeguarding concern with the community mental health team. There was no evidence that upon receipt of the safeguarding concern, the community mental health team contacted Adult Social Care to discuss the content and to enquire if other processes were taking place, such as a safeguarding enquiry under the Care Act 2014.

14.4.5 On 30 September, Erin was seen in hospital by the Mersey Care Core24 team, who referred Erin to the Mersey Care Crisis Resolution Home Treatment team (CRHT). Erin was discharged from hospital with a plan for CRHT to contact her the following day. After an initial telephone call to Erin, attempts at contact (including telephone, home visits, and written notes) were unsuccessful.

14.4.6 The lack of contact was discussed in a CRHT multidisciplinary team meeting, and it was decided to offer Erin an outpatient appointment with the CMHT in December. Further contact by the CRHT was unsuccessful. Erin was discharged from the service, and a letter was sent to her GP. The panel heard that there had been a disjointed response to Erin's case from Mersey Care. There is no evidence of communication between the CRHT and CMHT. Both teams worked in isolation and provided brief updates to Erin's GP. There was no consideration of linking in with other agencies who may have been able to facilitate contact with Erin, for example, Crisis UK Skylight Merseyside. This learning around information sharing contributes to panel learning and recommendation 1.

The panel heard that a number of staff involved have now left the Trust, and it has not been possible to speak to them to elicit further information.

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

14.5.1 In the space of six months, Erin had three contacts with the police: self-harm, suicide, and mental health issues featured in all three. However, without the additional indicators of domestic abuse and coercive control, Erin was not considered to be at risk of suicide on those facts alone.

14.5.2 In February 2021, Erin told the police that Peter was goading her, telling her she should kill herself. In August, Erin told the police that she had tried to hang herself, and that Peter had saved her life by cutting her down. At the end of September, Erin took an overdose. Whilst at hospital, alone, she disclosed domestic abuse and coercive control perpetrated by Peter.

14.5.3 The IMR author for the police has identified that the police did not recognise that Erin was at potential risk of suicide as a result of coercive and controlling behaviour.

14.5.4 The Review Panel was informed that Merseyside Police continue to develop its Suicide Prevention Strategy, along with partner agencies. A Suicide First Aid course is being rolled out to all police officers and staff, and whilst attendance is on a voluntary basis at the time of this review, the aim of the course is to raise awareness of the signs of suicidal thoughts and ideation in those they encounter every day, and some communication training, specific to the issue.

14.5.5 Merseyside Police are also represented at the National Suicide Prevention Strategy Working Group meetings and use information from these meeting in the Force’s continuing response around suicide prevention.

14.5.6 On 23 June 2022, Merseyside Police Academy introduced a three-day training package. This is currently being delivered to all police officers (up to the rank of Inspector), police staff at the Force Contact Centre, custody suite staff, and other relevant police staff. The course is designed to raise awareness of the suicide risk associated with domestic abuse. It aims to highlight the signs that someone may be at risk: be they a victim, perpetrator, or other family member. There is a module aimed at ensuring comprehensive checks on police systems are undertaken prior to attending a report of an apparent suicide, so that any domestic abuse history can be considered at the scene. The investigation strand will receive additional training around scene management. The Review Panel acknowledged the work that is being undertaken by the police in responding to this area of learning.

14.5.7 Risk assessments completed by Mersey Care between July and October 2021, identified that Erin was at risk of death by misadventure because of overdoses of prescribed medications due to poor coping skills. During those assessments, Erin reported that her main coping strategy was overdose; however, she reported that she wanted to learn new coping skills and to work with services.

14.5.8 Within these risk assessments, it was reflected that Erin would take an overdose following an argument/hostility from Peter. However, this did not result in signposting or referrals to domestic abuse services.

14.5.9 Adult Social Care received four safeguarding concerns regarding Erin: two of these were in August 2021 and related to Erin's mental health. On one occasion, Erin had made an attempt on her life and was transported to the hospital. The second was following an incident when she had been stopped for stealing: she disclosed that she had made an attempt on her life. There are no explicit references to domestic abuse or coercive and controlling behaviour in these two safeguarding concerns.

14.5.10 It was not until the fourth safeguarding concern, in September 2021, that information indicated that Erin was at risk of suicide due to domestic abuse. However, this did not result in any further contact or engagement from Adult Social Care.

14.5.11 The Review Panel was made aware that research has indicated a significant number of domestic abuse victims suffer from suicidal ideation. A study[25] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation.

14.5.12 Erin's young child was being looked after by family in Ireland. Direct contact with the child would have been difficult or impossible without the assistance of Erin's family. She expressed a wish for the child to move to England to be with her, and on one occasion in July 2021, she told a support worker that the child was living with her. This was incorrect. The panel reflected that it was very likely that Erin was missing her child, and as the child was young, contact would have been practically difficult. The panel looked for evidence that may point to increased suicide risk for mothers who struggle to keep in contact with their children.

14.5.13 An article in 'The Conversation'[26], written by Elizabeth Wall-Wieler (a PhD student at the University of Manitoba, Canada), highlights key research that shows an increased mortality rate for mothers who lose their children to the care system.

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

[26] https://theconversation.com/losing-children-to-foster-care-endangers-mothers-lives-

Wall-Wieler explains that, while mothers whose children are taken into care sometimes have underlying health conditions, the studies take those pre-existing conditions into account, meaning that the data is directly linked to the impact of losing a child to the care system.

The first study, published in December 2017 in the Canadian Journal of Psychiatry[27], was co-produced by Wall-Wieler, and examines suicide attempts and suicide completions among mothers whose children were placed in care. The researchers discovered that suicide rates among these women was almost three times higher, and the death rate almost four times higher, than those mothers whose children had not gone into foster care.

More research co-produced by Wall-Wieler and published in the American Journal of Epidemiology[28], in March 2018, found that mothers whose children were placed in care were almost five times more likely to die from avoidable causes such as unintentional injury and suicide, and almost three times more likely to die from unavoidable causes, including car accidents and heart disease.

A third study, published in the British Medical Journal of Epidemiology and Community Health, in October 2017[29], shows that when a mother loses her child to the care system, her physical and mental health become significantly worse.

14.5.14 Whilst Erin had not 'lost' her child to the care system, the panel thought that her position of relative isolation in Liverpool, with little or no contact with her child, was analogous to that position.

[27] https://journals.sagepub.com/doi/full/10.1177/0706743717741058

[28] https://academic.oup.com/aje/article/187/6/1182/4956003

[29] https://jech.bmj.com/content/71/12/1145.info

14.5.15 On 15 November 2022, the CHAMPS suicide prevention strategy was launched. This strategy brings together all areas in Cheshire and Merseyside, with the aim of preventing as many suicides as possible. The panel thought that it was important for the learning from this review to be shared with the CHAMPS collaborative[30] in order to inform future work. This leads to panel recommendation 6.

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

14.6.1 Crisis UK Skylight Merseyside supported Erin and Peter at the point they presented as homeless. They continued to support them both during their interim placement in bed and breakfast accommodation, and again when the service advocated for Erin and Peter to successfully gain an offer of permanent accommodation.

14.6.2 During the period of engagement with the service, Erin was supported to obtain access to finances, bank account, identification, and welfare benefits. Erin was provided funds to access food provisions, mobile telephones, and taxis to ensure engagement with Crisis UK Skylight Merseyside and other services.

[30] https://champspublichealth.com/about-us/

The Champs Public Health Collaborative has developed a comprehensive and systematic approach to improving public health priorities by large scale action and working together as system leaders across Cheshire and Merseyside. The Collaborative is a long-standing formal partnership of Cheshire and Merseyside's nine Directors of Public Health and their teams, serving a population of 2.6 million people. The Collaborative also has a strategic influencing role within the Liverpool City Region Combined Authority and the Cheshire & Warrington sub-region.

14.6.3 At the point of permanent accommodation being secured, the service assisted with the provision of furniture, setting up of essential accounts (utilities, etc.), and ensuring that their tenancy was sustainable. The provision of this service was timely and fit for purpose in reducing the levels of risk/impact that being homeless had on the mental and physical wellbeing of Erin and Peter.

14.6.4 Crisis UK Skylight Merseyside was not aware of the domestic abuse. They have informed the Review Panel that had they been aware, then the service would have linked up with specialist domestic abuse services and considered a different route of accommodation for Erin.

14.6.5 At intermittent times during the review period, Erin was open to the following services:

Community Mental Health Team

Mental Health Liaison (Core24)

Crisis Resolution Home Treatment Team

Contact was made within the expected timeframes. Due to the Covid-19 pandemic, and in line with Government guidance and internal policies, several assessments took place over the telephone rather than face to face.

14.6.6 It was documented within Erin's clinical records that she had a diagnosis of Emotionally Unstable Personality Disorder (EUPD). Mersey Care has a 'Psychotherapy and Personality Disorder Hub' that provides psychological interventions to individuals with a diagnosis of personality disorders. There was no consideration of Erin being referred to this service. This has been identified as a single agency area of learning for Mersey Care.

14.6.7 Erin told staff from Mersey Care that she was known to mental health services in Ireland, and that she had been engaging in Cognitive Behaviour Therapy (CBT). Mersey Care did not hold any records from Ireland that supported this information.

14.6.8 No agency referred Erin to domestic abuse services in Liverpool. Erin was referred to the NCDV (a national charity). Checks have been made and there is no record that Erin made contact with NCDV. During contact with the police in February 2021, Erin was signposted to Merseyside Police's website, for details of support agencies within the local area. There is no record that Erin made contact with local support agencies. This has been analysed in Term 1.

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

14.7.1 Erin was referred to Adult Social Care on four occasions during the time period of this review. There were no care and support needs identified within the referrals and it was determined that Erin was not an adult at risk within the terms of the Care Act. Adult Social Care identified that Erin was engaged with agencies to address her mental health and informed them of the referrals that had been received.

14.7.2 One of the referrals was a safeguarding concern submitted by NWAS. This stated that Erin had made disclosures of serious abuse and was open to the Mersey Care CMHT. The Adult Social Care IMR author concluded that it was therefore reasonable to assume that Erin was an adult with care and support needs, and this matter should have been treated as a safeguarding concern in line with the Care Act 2014 and associated guidance, as well as Local Government Association guidance published in September 2020[31].

It is unclear from Adult Social Care records why this referral was not recorded as a safeguarding concern.

[31] https://www.local.gov.uk/sites/default/files/documents/Appendices_0.pdf

If this had been treated as a safeguarding concern, then it should have progressed to an enquiry under Section 42 of the Care Act 2014. This would have allowed for an enquiry to establish the facts, ascertain Erin's wishes and feelings around the concerns, engage in a multi-agency discussion around the concerns, understand her needs for protection or support, and develop a safeguarding plan that would determine what follow-up action should be taken.

The referring agency would also be advised of the outcome and could issue appropriate challenge if they were not in agreement with the outcome.

This is a single agency area of learning for Adult Social Care.

14.7.3 The Review Panel agreed that the concern raised by NWAS should have progressed to a Section 42 enquiry: this would have allowed for Adult Social Care to ascertain Erin's wishes and feelings around the concerns and to understand Erin's needs for protection and support. The Section 42 would have facilitated a multi-agency discussion to develop a safeguarding plan that would determine what follow-up action should be taken.

14.8 How did your agency ascertain the wishes and feelings of Erin, and were her views taken into account when providing services or support?

14.8.1 Crisis UK Skylight Merseyside gathered Erin's wishes and feelings during the completion of assessments. These assessments shaped the service that was provided to Erin.

14.8.2 Clinical records held by Mersey Care document that Erin's wishes and feelings were obtained during the assessments of her mental health; however, there was little evidence that these were then taken into consideration in relation to further plans. An example of this is that Erin reported that she had previously been in receipt of CBT, which she found helpful; however, this was not considered, or progressed, whilst she was under the care of Mersey Care.

14.8.3 During contact with the police in February 2021, Erin stated that she did not support a prosecution, and this view was accepted.

14.8.4 In September 2021, Erin told the police that she was aware of the risk that she was exposed to with Peter. It was documented that Erin had stated that she had decided not to return to live with Peter in the immediate future. The review has already analysed the response to this incident by agencies [in Terms 1 and 3], and therefore will not repeat the analysis here.

14.9 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?

14.9.1 The circumstances of the case did not meet the criteria for MAPPA protocols to be followed.

14.9.2 This case did not result in a referral to MARAC or completion of MeRIT/DASH, with the exception of the police. This has been identified as a learning point earlier on in the analysis. [Term 1 and 2].

14.9.3 Agencies were not aware that Crisis UK Skylight Merseyside was providing support and services to Erin and Peter. Therefore, they were not part of the wider information sharing around risk and domestic abuse, and nor were Crisis UK Skylight Merseyside approached to share information (that they held) to inform risk assessment and management. This is a learning point that leads to panel recommendation 1.

14.9.4 The panel was told that third sector agencies, including the Independent Domestic Abuse Advocate service and temporary/short term homelessness services, are now linked into the Mainstay computer system used by Housing Options. This is significant in ensuring that there is a link between Housing Options, domestic abuse services, and other support services, in cases assessed as high risk.

14.9.5 All agencies involved in this review have identified learning around knowledge and implementation of policies and procedures. Where relevant, details of this learning have been covered within other Terms of Reference and in Term 14.

14.10 Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?

14.10.1 Adult Social Care

Three previous DHRs have identified issues with Adult Social Care's process of managing safeguarding concerns via the current Careline pathway.

The other reviews also involved safeguarding concerns in relation to domestic abuse where the adult at risk has complex needs (mental health/substance misuse needs). This suggests that action taken previously has not sufficiently improved the offer to adults like Erin. Erin was not recognised as a vulnerable young woman raising allegations of domestic abuse: who was feeling lonely and scared; who was away from familiar surroundings and support, having had her child removed from her care; and who had already made attempts to end her life.

A transformation programme has been launched within Adult Social Care and within the programme safeguarding pathways. Furthermore, decision points will be reviewed and strengthened, to ensure a robust and Care Act compliant response to incoming adult safeguarding concerns. It is envisaged the new pathway will be launched in October 2023.

The panel agreed that Adult Social Care should provide a report/presentation to the Community Safety Partnership outlining progress on the review and implementation of new pathways. This is addressed in a single agency recommendation for Adult Social Care.

14.10.2 Liverpool DHR20 includes the following action for LUHFT

The use of routine enquiry for all emergency department attendances.

The panel reflected that this DHR did not show evidence that the previous action had been embedded.

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

14.11.1 The police notified Erin's mother of her death. Erin's mother told the police that in the week prior to her daughter's death, she had exchanged emails with Erin in which Erin had described her relationship with Peter and that she feared for her safety. [see paragraph 14.3.7]. Erin's mother had arranged a flight to take Erin back to Ireland.

14.11.2 The panel could find no evidence of friends locally within Liverpool. Erin's friend from Ireland, who spoke to the Chair, was not aware that Erin had travelled to Liverpool until sometime after Erin left Ireland and was not in touch with her whilst she was in Liverpool.

14.12 Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Erin and/or Peter, or on your agency's ability to work effectively with other agencies? Did Covid-19 related work practices affect your response?

14.12.1 Erin and Peter came to the United Kingdom during the Covid-19 pandemic. All agencies had to adapt to new ways of working, which included a greater increase of contact taking place via telephone and through video conferencing facilities. Within health settings, restrictions were in place to limit face-to-face contact and there were restrictions in place for support services to be present within accident and emergency departments.

14.12.2 As part of the Government's emergency response to the Covid-19 pandemic, there was the introduction of 'Everybody in', in which the local authority had to ensure that all homeless individuals were placed in accommodation. Due to the increased demand and pressure that this had on the local authority and the commissioned services within Liverpool, Crisis UK Skylight Merseyside supported the local authority by assisting in the completion of housing assessments for homeless individuals.

14.12.3 This required Crisis UK Skylight Merseyside to quickly diversify in their working practices – as it was a new process that the team were undertaking, under high pressure, and with limited training. The staff were mainly learning through experience and with access to Mainstay (the local authority's housing portal). This helped them in understanding and developing a more effective multidisciplinary and holistic approach to highlighting and supporting members with their individual needs/risks. With the re-direction of staff, this resulted in more staff being available.

14.12.4 The Government's 'Everyone in' initiative resulted in high numbers of individuals being placed by the Housing Options service, and it increased demand on all homeless services, which was also impacted on by the Covid regulations of self- isolation. During this period, Crisis UK Skylight Merseyside continued to deliver face-to-face services to support its members; however, this was often challenging due to other essential services no longer providing face-to-face support. However, the implications of Covid and 'Everyone in' did result in homeless individuals having greater and quicker access to social housing. This was via the suspension PPP and the creation of the allocations panel for Registered Social Landlord properties, which is how Erin and Peter were able to secure a tenancy so quickly.

14.12.5 The Review Panel did not identify any issues in agencies' response during the Covid-19 pandemic that impacted on its ability to provide services to Erin and Peter.

14.13 Were there any examples of outstanding or innovative practice?

14.13.1 The Review Panel has not identified any examples of outstanding or innovative practice from agencies involved in this case.

14.14 What learning did your agency identify in this case?

14.14.1 Merseyside Police

A holistic approach to domestic abuse incidents so that previous incidents are considered as part of the risk assessment.

Risk grading where strangulation and suffocation are identified.

Consideration of evidence-led prosecution.

Link to suicide risk in cases of domestic abuse.

Action taken to address this learning:

Merseyside Police have introduced a three-day training package that is being delivered to all police officers (up to the rank of Inspector), police staff within the Force Contact Centre, custody suite, and other relevant roles. The course is designed to raise awareness of the suicide risk associated with domestic abuse and the requirement for all previous incidents to be considered as part of the overall risk assessment.

Further training is being delivered to investigators who respond to sudden deaths by suicide.

As part of the Domestic Abuse Intensification Period 2022, training was provided across the Force via a series of online sessions (also recorded for those unable to attend), in relation to quality investigations, res gestae, and evidence-led prosecutions. The aim of the training was to improve domestic abuse outcomes via the use of evidence-led prosecutions, incorporating the following:

1. Provide clear information as to how officers could strengthen cases where the victim or witness at scenes of domestic incidents, either refuse or are reluctant to support a prosecution or provide a statement.

2. Support officers and staff to investigate domestic abuse incidents ‘proactively’, with a view to building an evidence-led case and not necessarily relying on the support of the victim, and with ELP to be considered in every case (considering withdrawal could happen at a later date). This includes a presumption to arrest at scene.

3. To change the mindset around dealing with domestic abuse – to understand the impact that this offence type has upon all of those involved, not only the adults involved, but children who are often also present and discussing the actions that officers can and should take.

The specific slides relating to evidence-led prosecutions, particularly focussing upon res gestae evidence, but also incorporating the hearsay gateway of fear of giving evidence, were further widely distributed and specific guidance given to supervisors regarding the expectations of ELP. Note that all officers have not only been reminded to consider evidence-led prosecution at the point when a victim indicates an inability or unwillingness to support an investigation, but also to have this as a consideration from the start of any investigation, in anticipation that a willing and able witness may later withdraw support. Therefore, training was provided in relation to obtaining suitable evidence that could be introduced via res gestae or hearsay gateways and the importance of obtaining such evidence, at an early stage in the investigation, to allow prosecutions to be sought, regardless of whether a victim is assisting.

It was specifically stated in the training:

“It is important to understand that it is a longstanding national policy for the police and CPS to prosecute without victim’s support, if necessary, in appropriate cases. All staff need to see evidence-led prosecution as a realistic option from the moment a report of domestic abuse is made. If a victim doesn't want to support prosecution or expresses a wish that they do not want the suspect brought to justice, this is not a reason for the police to step back but is a reason to be MORE proactive in gathering evidence. ‘It needs to be made clear through police action, that it is not the victim’s responsibility to

bring domestic abusers to justice, but the job of everyone who works within the Criminal Justice System'".

14.14.2 Liverpool Clinical Commissioning Group (GP Practice)

The following areas of learning were identified during the significant event analysis:

Be suspicious of a sudden change in engagement from a patient.

Utilise all other engaged services to check on welfare and encourage engagement.

Action taken to address this learning:

Creation of a prompt on patients' records, for those who have a history of domestic abuse, to screen for thoughts of self-harm and suicidal ideation.

A search will be run of people with this code and ensure that every opportunity is given to patients to share their thoughts with the practice and receive appropriate support.

14.14.3 Mersey Care NHS Foundation Trust

Professional curiosity and routine questioning.

The need to measure the current level of confidence and competence, within the local division workforce, to respond effectively to indictors of domestic abuse and demonstrate understanding of standardised domestic abuse risk assessment and onward pathways of support.

The need to strengthen relationship and closer working between the Local Division Safeguarding Adults Service and the operational workforce.

The opportunity to optimise template forms within the clinical records system to better capture safeguarding information in one central reserve within the clients' records.

Insight of the need to increase awareness of the relationship and increased risk of suicide in victims of domestic abuse.

Action taken to address this learning:

Zero Suicide is a priority for Mersey Care. The aim is to implement the Trust's Suicide Prevention Strategy, thereby improving the quality of care delivered to patients as well as best practice for safety and service user experience, in order to help save lives. Within the strategy, there are 6 priority areas that will be the focus of work moving forward. A Trust-wide suicide prevention group oversees the implementation of the strategy and will continue to monitor and review progress in line with local, regional, and national learning and evidence. The 6 key priorities to be implemented across the organisation are:

1. To reduce ligature use through a ligature reduction action plan across inpatient services and to reduce the distress such incidents can have on all those involved. The action plan includes therapeutic interventions, trauma-informed care, self-harm interventions, safety plans, least restrictive practice, risk management, transitions in care, and operational issues.

2. Implement eRisk training (effective risk intervention skills) for all frontline staff. eRisk training aims to enhance knowledge, skills, competencies, and confidence of the workforce to carry out risk assessments, formulation, management plans, and safety plans. The eRISK training provides basic information into the development of a risk assessment and how to formulate this risk to develop management plans and collaborative safety plans.

3. All single contact services to implement the safety plan flashcard as per mandatory eRisk training.

4. Implement agreed transition protocol to standardise practice and quality for all those who move within and out of our services, using a standardised approach (checklist/protocol).

5. Implement structured quality 48-hour follow-up post discharge from hospital (PRISM: a structure with suicide prevention interventions embedded within it).

Implement effective interventions programme of work via the strategy group. Brief safety questions for suicide prevention in infrequent contacts (5Q).

Urgent Care services have undergone a significant amount of transformation and reorganisation over recent months. In addition, North West Boroughs NHS Foundation Trust was acquired by Mersey Care NHS Foundation Trust on the 1 June 2021. This saw the amalgamation of a number of Urgent Care services who were working under different policies and procedures. The Urgent Care leadership team has commenced a review of existing practices based on learning from staff and patient feedback, along with a number of incidents. This review has identified several areas that require a particular focus in order to standardise the care offer, ensuring that we are striving for patient-centred evidenced-based care at every point of contact.

Areas of focus for the Urgent Care service line include a review of clinical pathways and interventions offered across the 3 service lines: Core24 (A+E services), Crisis Resolution Home Treatment Teams (CRHT), and the First Response Hub (which includes the crisis line and street triage cars). Governance of progress with work, sits within the Operational and Clinical Excellence meeting, with clear escalation and oversight into a divisional and Trust-wide operational management group. The Assistant Director of Nursing is leading on the clinical pathway review, with support from the multidisciplinary team across Urgent Care.

The standard operating procedure (SOP) for Urgent Care will be reviewed and updated as standards are set, ensuring there is clarity for frontline staff around expectations.

14.14.4 Liverpool City Council Adult Social Care

Adult Social Care's process for recording and accepting safeguarding concerns from other organisations.

Understanding different issues affecting adults at risk of abuse and how to process these.

The use of management oversight of decision-making in relation to accepting/closing safeguarding concerns.

The sharing of information with referring agencies in relation to their safeguarding concerns and outcomes.

A need for more robust preliminary information gathering and sharing information with partners once links are identified.

That all safeguarding concerns are recorded as such and all decision-making around these are evidenced in clear recording notes.

14.14.5 Liverpool University Hospital Foundation Trust

To review domestic abuse training and overhaul the Trust's mandatory level 3 training package.

Identified a safeguarding link to promote awareness of domestic abuse and violence presenting through accident and emergency department. Training at the frontline in completing the assessment tool for risk.

The need to raise awareness of professional curiosity: this will be fully incorporated within the updated level 3 safeguarding adult and children training.

14.14.6 Crisis UK Skylight Merseyside

The following areas of learning were identified in an internal review undertaken after the death of Erin. These relate to Crisis's existing case management systems and practices in relation to providing a holistic person-centred approach to supporting members in the community.

Safety and Inclusion Plans should always relate to holistic community needs and not only to delivery/attendance within service.

Clarification of the need for lead workers to pull through any needs/risks highlighted on internal/external assessments from external partners, through to the Outcomes Star, Progression and Learning Plan, Safety and Inclusion Plan, and Health and Support Needs tab, in line with data sharing agreements and GDPR.

Clarification that all assessments and reviews need to be inclusive of the narrative required to inform these tools, as well as evidencing all discussions of the support explored/provided – not just on case notes.

Increased awareness of partnership working and the use of a multidisciplinary teams' approach to provide holistic support to members.

All staff to be trained on changes to these systems and practices.

Staff to be trained on specialist support needs – identifying and managing risk, safely, around mental health and domestic abuse.

Training for staff to identify behaviours that may identify domestic abuse.

Consider the introduction and training for all staff on how to complete a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment for potential domestic abuse cases, which will indicate if they need to be referred to the Multi Agency Risk Assessment Conferences (MARAC).

All Skylights to have a domestic abuse lead and be the MARAC representative for their Skylight.

Action taken to address this learning:

Further training has been delivered to the Crisis UK Skylight Merseyside team on safety and inclusion plans, including the need to ensure that they relate to holistic community needs and not only to delivery/attendance within service. They continue to be reviewed by line managers as part of the case file reviews.

Clarification has been provided at team and individual staff meetings, of the need for lead workers to pull through any needs/risks highlighted on internal/external assessments from external partners, through to the Outcomes Star, Progression and Learning Plan, Safety and Inclusion Plan, and Health and Support Needs tab, in line with data sharing agreements and GDPR.

Clarification has been provided at team and individual staff meetings that all assessments and reviews need to be inclusive of the narrative required to inform these tools, as well as evidencing all discussions of the support explored/provided – not just on case notes.

Training on specialist support needs and increased awareness of partnership working, including the use of a multidisciplinary teams' approach to provide holistic support to members, has been provided through:

We Are With You introductions to services, substance awareness and Naloxone training delivered – Information Sharing Agreement signed July 2022.

MARAC – domestic abuse, local protocols and procedures training was arranged and delivered to the team on the 23 March 2022 by Liverpool's Risk Assessment Co-ordination Officer. We also signed the MARAC Operating Protocols on the 2 March 2022 and allocated a designated worker to be our representative at MARAC meetings.

City Centre complex lives MDT – staff have been encouraged to refer in and attend meetings: consequently, our referrals in and attendance at the MDT have significantly increased. Arrangements have been made for the manager to attend the full meeting from September 2022, for greater input to cases.

Life Rooms (Merseycare) – links have been made and the service promoted to staff in the interim of scheduled visits to the service in October 2022, to promote further partnership working to holistically support members' needs/risks: particularly, in relation to managing their own mental health in the community.

The organisation has also introduced a new 'Guidance for staff working with people who express suicidal thoughts and feelings' – May 2022.

15 Conclusions

15.1 Erin and Peter moved to Liverpool from Ireland at a time when significant Covid-19 related restrictions were in place. Despite those restrictions, they were provided significant support, in particular by Crisis UK Skylight Merseyside, and were able to access housing, medical services, benefits, and a bank account.

15.2 Erin disclosed a previous history of mental health diagnoses to her GP and was reviewed by a consultant psychiatrist. Her medication was reviewed, and an appropriate plan was put in place to rationalise and reduce her medications.

15.3 The response of agencies that knew about Erin's disclosures of domestic abuse, were not effective.

15.4 NWAS staff ensured that disclosures made by Erin were properly referred and also personally drew the disclosures to the attention of police officers. The police response was ineffective and had no practical effect on keeping Erin safe.

15.5 Staff in both Mersey Care and Liverpool University Hospitals NHS Foundation Trust did not follow established domestic abuse policies.

15.6 Erin was referred to Adult Social Care on four occasions. No effective action was taken, beyond sharing information with Erin's GP and Mersey Care. The voluntary agency that supported Erin most, was not made aware of concerns around domestic abuse because the police and Adult Social Care were not aware of Crisis UK Skylight Merseyside's involvement.

15.7 The panel reflected that Erin must have felt isolated in Liverpool. There is no evidence of any friendships in Liverpool, beyond the relationship with Peter. Erin's best friend did not know Erin had gone to Liverpool and was not in touch with her. Erin did receive support from Crisis UK Skylight Merseyside and statutory agencies.

15.8 The panel could not hear Erin's voice other than in the brief summary of emails to her mum. Within which, Erin indicated that she was suffering from domestic abuse.

15.9 The DHR panel is fully aware that Erin's voice is sadly lacking from this review. Unfortunately, attempts to engage with her family and Peter were unsuccessful, and whilst the panel regretted this, it felt that there were no further reasonable measures it could take.

16 Learning

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

16.1 Narrative

Statutory agencies were not aware of the extent to which Erin and Peter were being supported by the third sector and did not share information with third sector agencies.

Learning

The appropriate sharing of information between statutory and third sector agencies, is likely to improve outcomes for the people they are working with.

Panel recommendation 1

16.2 Narrative

The review identified a consistent lack of recognition and response, by agencies, to disclosures of domestic abuse.

Learning

Understanding and recognising the dynamics of domestic abuse will identify victims of abuse and provide opportunities to engage with those victims and ensure they are aware and have access to support.

Panel recommendation 2

16.3 Narrative

The panel recognised that not all risk factors had been taken into account in both domestic abuse and mental health risk assessments for Erin.

Learning

The further development and use of professional curiosity and adoption of a 'believe and verify' approach, when dealing with domestic abuse victims, is likely to lead to more accurate and useful risk assessment.

Panel recommendation 3

16.4 Narrative

Research identifies that there is an increased risk of suicide amongst parents who have either lost children or have limited contact with them – whether through care proceedings or other processes.

Learning

Professionals' understanding of these risks can improve engagement and identity opportunities for referrals and/or signposting for support.

16.5 Narrative

The review was unable to obtain information from Irish authorities, which may have assisted in understanding Erin's victimisation.

Learning

The inability to obtain relevant information may result in an incomplete picture of the issues affecting a victim and therefore reduce the effectiveness of a DHR.

17 Recommendations

DHR Panel

17.1.1 The learning from this review around the sharing of information between statutory and third sector agencies, should be used to inform work on the priority action within the recently launched Violence Against Women and Girls, Mayoral Strategy for Liverpool 2023 – 2026.

"Improve and strengthen the relationship between the statutory sector and voluntary sector VAWG specialist and wraparound services".

17.1.2 That Liverpool Community Safety Partnership requests evidence and assurances from agencies, as to how the learning from this case has been disseminated and embedded into practice. This could be achieved through the submission of a report that details how the learning has been embedded and the outcomes of case audits to demonstrate professionals' understanding.

17.1.3 Current work to develop a new domestic abuse strategy for Liverpool should take into account the learning from this review, with particular reference to the use of professional curiosity and a 'believe and verify' approach when providing services to domestic abuse victims.

17.1.4 That all agencies that have contributed to this review, should provide evidence to Liverpool Community Safety Partnership on how the learning on this case – around the indicators of increased risk of suicide, including where individuals no longer have contact and access with their children, and when this contact is 'controlled' due to the children living with and being cared for by others – has been disseminated and embedded into practice.

17.1.5 For the purposes of DHRs, the Home Office should seek to achieve agreement with relevant authorities on the provision of pertinent information within the Common Travel Area.

17.1.6 That Liverpool Community Safety Partnership should share the learning from this review with CHAMPS Public Health collaborative, to inform their ongoing work on suicide prevention.

17.2 Single Agency Recommendations

Mersey Care NHS Foundation Trust

17.2.1 Build confidence in the workforce for professional curiosity and routine questioning regarding indicators of domestic violence.

17.2.2 SGA duty service & supervision.

17.2.3 Safeguarding Training to be updated to reflect messages and advice relating to the increased risk of suicide in victims of DA / parents where children have been removed to care.

Merseyside Police

17.2.4 That all officers be reminded that evidence-led prosecution should be considered as soon as the victim indicates inability or unwillingness to support an investigation.

Liverpool City Council Adult Social Care

17.2.5 All incoming safeguarding concerns should be recorded as safeguarding concerns on Liquid Logic on the same day they are received.

17.2.6 LGA has created guidance on how to make decisions on safeguarding concerns. Adult Social Care should implement these guidelines to ensure a consistent and safe approach is taken when considering safeguarding concerns.

17.2.7 All ongoing safeguarding work should be recorded contemporaneously: that is, records should be created at the time or as soon as practicable. All adult safeguarding work must be recorded online in the adult safeguarding section of Liquid Logic or case notes.

17.2.8 Adult Social Care should ensure its staff develop a clear understanding of care and support needs in the context of ‘complex’ needs (mental health/substance misuse needs) and safeguarding criteria.

17.2.9 Adult Social Care must ensure its staff are aware of their duties under s11 Care Act 2014, whereby they must carry out a needs assessment if the adult is experiencing, or is at risk of experiencing, abuse or neglect, and how Section 11 should be applied in these circumstances.

17.2.10 Adult Social Care should implement a process whereby referrers are kept informed of decision-making throughout the safeguarding process – from initial referral up to and including the outcome of enquiries.

17.2.11 A presentation will be provided to the Liverpool Community Safety Partnership regarding the workstream to review the response to referrals from the police and ambulance service, and the implementation of wider changes to practice – to address the learning from this and other previous reviews.

Liverpool University Teaching Hospitals NHS Foundation Trust

17.2.12 Updated training level 3 package Adults.

17.2.13 Updated training level 3 package Child.

17.2.14 Bespoke training to AED, including safeguarding and homelessness referrals.