Domestic Homicide Review

“Paul” who died in March 2023

LDHR29 Overview Report June 2024

A Tribute to Paul

Paul was a young man whose life ended extremely prematurely in starkly violent circumstances. The reviewers, DHR panel and CitySafe Partnership extend their deepest condolences to Paul's family and friends for their tragic loss.

Paul's family described him as being an 'old fashioned soul', having the warmest hello and a 'courageous laugh'. They say Paul was family focused and that he doted on his gran, was patient and caring of his younger siblings and cousins. In his younger years he'd aspired to become a professional footballer, making it to a local club's academy. He'd later became a keen fisherman and had enjoyed working when he could, taking pride in his ability to help with household bills.

Paul had a group of close and loyal friends that miss him deeply. They spoke of the devastation at his loss and of missing someone they thought of as a brother. They spoke of their sadness at not being able to help him more. The following are taken from his friends and family's Victim Personal statements.

he was my world. He was the most pleasant lad… he would always meet me at the bus stop, walk me home on dark nights or carry my shopping. I will never again see his beautiful, big smiling face or feel his arm swing around my shoulder.'

'*.. the best person I have known and had in my life. His straightforward cheeky and funny personality was the best thing .. he was a very special person and will always hold the key to everyone's heart.'*

'He was so isolated from the outside world by her, the minute his friends got that phone call every single person was there at his side… sleeping on the hospital floors. We knew him to the core, before she suffocated him. The nurses said they'd never seen a patient so loved and mates so loyal'.

'A young, kind, loving, funny, well-respected man who had his life taken away from him far too young and in such a brutal and horrific way. After [Paul] became involved with [Julie] I watched my friend slowly lose himself.'

'he had this amazing energy… to think I couldn't protect him kills me every day.'

'His family is missing a soul they will never meet again, they won't share his laughs when he's telling a story but laughing so hard he cant finish. His little cousin will never experience a fishing trip with him again or have the role model of a big brother figure to guide him through life.'

'He was the easiest person to speak to and get along with. He would speak to strangers in the street, and everyone loved him. He obviously had his cheeky ways but doesn't everyone.'

'a happy go lucky kid.. he always made people around him smile. He would make everyone feel wanted. My family is broken into a million pieces. At his funeral the streets of our community were lined and flooded with love, the community took a stand and stood still for him. Every shop closed, people lined the streets and others walked beside the carriage... if there is anyone fighting a battle with domestic abuse or mental health issues man or woman- stand up tall and be your voice. Speaking up is not a weakness, it is the biggest strength you can show. Don't let your families go through what we are going through'.

Glossary

ACE's	Adverse Childhood Experiences
Citysafe or Partnership	Liverpool Community Safety Partnership
CMHT	Community Mental Health Team
DHR	Domestic Homicide Review
EIP	Early Intervention Psychosis services
HMRC	His Majesty's Revenue and Customs
LDAS	Liverpool Domestic Abuse Service
LUHFT	Liverpool University Hospital Foundation Trust
ICB	Integrated Care Board
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-disciplinary team
NPS	National Probation Service
OCG	Organised Criminal Group

RLUH	Royal Liverpool University Hospital
SPOC	Single Point of Contact
VPRF	Vulnerable Person Referral Form
VRP	Violence Reduction Partnership
YPAS	Young Person Advisory Service

1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to 'Paul', a resident of Liverpool prior to the point of his death in March 2023. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 In March 2023 Paul was stabbed with a knife while at Julie's address. Injured, he fled to request help from a neighbour, where Julie was then filmed further attacking Paul with a knife. Paul was taken by ambulance to Liverpool University Foundation Hospital Trust [LUFHT] where he received emergency surgery and was placed on life support. In subsequent days the hospital advised Paul's family that he had suffered significant brain damage from which he could not survive, the decision was taken to withdraw his life support and as a result Paul subsequently died. Julie was found guilty of Paul's murder and sentenced to a minimum term of 18 years.

1.3 The DHR panel and reviewers wish to express sincere condolences to Paul's family and friends. We thank them wholeheartedly for their contributions to this review during this immensely difficult time.

Purpose of a Domestic Homicide Review

1.4 This review has been conducted in line with the statutory guidance under s9(3) of the Domestic Violence, Crime and Victims Act 2004 and the final review report and executive summary will be subject to oversight from the Home Office Quality Assurance Panel.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

1.6 The review will consider agencies' contact and involvement with Paul and Julie from 1st December 2019 when Paul requested assistance with his mental health to his death in March 2023.

1.7 Liverpool City Council (LCC) received notification on the 10th of May 2023 of Paul's death by Merseyside Police and requests for information were then sent to local agencies. The Liverpool CitySafe DHR Standing Group met on 6th June 2023 to consider information available following the tragic death of Paul, they recommended a DHR should be conducted. This was agreed by the Citysafe Board, and it was decided that the review should be paused pending criminal investigation and subsequent criminal proceedings. The Home Office were informed on the 6th of June 2023 and reviewers were appointed.

1.8 This review began on 30th October 2023 and was concluded on 16th July 2024. The Home Office suggests that reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review was delayed beyond this period while criminal proceedings against Julie took place, and a draft Early Analysis Report setting out the reviewers' preliminary findings was provided in April 2024, to ensure that learning that had been identified could be disseminated without delay.

Confidentiality

1.9 The findings of each review are confidential until publication. Information is available only to participating officers/professionals and their line managers. Pseudonyms have been agreed with the victim's family and used in the report to protect the identity of the individuals involved.

Terms of Reference

1.10 The review will seek to illuminate the experiences of Paul and to respond to the following lines of enquiry:

- Were agencies involved in responding to concerns aware of the risks associated with adverse childhood experience and trauma?
- Were assessments and interventions trauma-informed?
- What safeguarding, drug and alcohol, mental health and domestic abuse policies and procedures applied to this case, were they adequate and were they followed?
- Is there evidence that partners were 'thinking family' in response to the risk identified, including taking into account heightened risks associated with drug and alcohol misuse, mental health and domestic abuse, during the review period?
- How well was domestic abuse understood, risk assessed and responded to by the services that were involved in this case?

- Given concerns expressed (including by Paul) that he may pose a risk to family members, what could services have done together to risk assess this and assist him find more stable accommodation?

- What learning can be taken from this case and national research on domestic abuse and knife crime to inform local strategic priorities and prevent future deaths.

- What services/ support are currently available to children, young and older adults (given Julie's reported involvement) exposed to organised criminal groups to support them to stay safe, where these services aware of risks to Paul?

- How did agencies work to overcome barriers, including engagement with drug and alcohol service and mental health support, to reduce known risks, what more might be needed locally or nationally to address similar risks in the future?

1.11 The Domestic Abuse Act 2021 clarified the different relationships within which domestic abuse can occur. It confirmed any abusive behaviour that occurs between two people (16 or over) who are 'personally connected' to each other should now be responded to as domestic abuse. This includes people who are, or have been, in an intimate relationship, shared a parental relationship and any relatives.

Methodology

1.12 The review used a hybrid methodology incorporating best practice from evidence-based approaches including some elements of the Social Care Institute for Excellence Learning Together method.

1.13 The methods included the review of information provided by the agencies in contact with Paul and Julie and their families through an integrated chronology, summary reports and individual management review (IMR's) reports as detailed in 1.20 below.

1.14 In addition, two multi-agency learning events took place, attended by front-line practitioners and their managers who had contact or worked with Paul and Julie and their families. These were grouped into key service areas to enable thematic discussions and reflections to take place. The purpose of the events was to enable reviewers to gain an understanding of the challenges and issues faced by local services and in relation to this case, as well as to identify learning that could strengthen the system for other people who find themselves in similar circumstances. Prior to the learning events reviewers had drafted an early analysis report that was used to facilitate the discussions.

1.15 The case has been analysed through the lens of evidence-based learning from research and the findings of other published reviews. The reviewers also met with Jade Levell of Bristol University's Centre for Gender and Violence research to understand how her research into Gender Violence should inform learning in this case. Local partners leading on violence reduction also met with the reviewers and contributed to this review. The learning identified social and organisational factors that make it harder, or in some situations make it easier, for practitioners to proactively safeguard victims of domestic abuse, this is known as 'systems' learning.

Engagement with family members

1.16 In consultation with police family liaison officers and their advocate, Citysafe contacted Paul's close family members to explain the review process and facilitate an introduction to the reviewers. Reviewers are extremely grateful to have met with several members of Paul's close family along with their advocate from Victim Support. Paul's family were able to provide a heartfelt vibrant picture of Paul, his caring nature, love for his family, his friendships, aspirations and achievements in his short life. They were also able to provide very valuable insights into the harm and risk that Paul faced in the latter part of his life. Their insights have been incorporated into this report.

1.17 The final report was shared with Paul's family on 12.07.24, and they were invited to comment on the report and recommendations.

Engagement with the perpetrator

1.18 Citysafe also contacted Julie to explain the review process, through her link practitioner in the prison where she is held. Reviewers then met Julie at the prison, hearing her account of her relationship with Paul, her family history, as well as her views on what interventions or support may have reduced the risks posed to Paul.

1.19 In the meeting, Julie said she took responsibility and that she "deeply regretted" Paul's death. She said, at times, she wished she had never met him and that she wished he was still alive. She said, "one night can wreck everything, it has taken him, it has wrecked my life, my family's life and his family's life".

Engagement with agencies

1.20 The table below shows the organisations that were contacted to establish if they had knowledge of Paul or Julie and how they then contributed information that was then considered in the review.

Organisation Name/Job Title	Chronology	IMR or summary	Learning event participation	Panel
Department for Work and Pensions	Y	Y	Y	
GP Practice for Paul	Y	Y	Y	
GP Practice for Julie	Y	Y	Y	
Independent Domestic Violence Advisors (IDVA) Operational Manager	N/A	N/A	Y	Y
Independent Reviewers Safeguarding Consultant	N/A	N/A	Y	Y
Integrated Care Board (ICB) Designated Nurse for Safeguarding Adults, representing Health & GP, named GP for Safeguarding	N/A	N/A	Y	Y
Liverpool City Council Adult Social Care, Head of Safeguarding and Assurance	Y		Y	Y
Liverpool City Council Children's Social Care, Service Manager Quality Assurance & Safeguarding		Y	Y	Y
Liverpool City Council Housing Options Service Manager	Y	Y	Y	Y
Liverpool City Council Victims and Vulnerable People Team (coordinating the review)	N/A	N/A	N/A	Y
Liverpool University NHS Foundation Trust (LUHFT)	Y	Y	Y	
Mersey Care NHS Foundation Trust	Y	Y	Y	
Merseyside Police D/Insp PVP Policy & Strategy Unit & Domestic Homicide Lead	Y	Y	Y	Y
North West Ambulance Service	Y	Y		
Probation Service North West Division	Y	Y	Y	

1.21 The IMR authors for each agency set out their job title and role within the agency, and completed a declaration confirming that they had no direct involvement in the case.

The Review Panel

1.22 The reviewers were supported by a review panel, the membership of which included representatives of the organisations listed above. The panel met initially on 30th October 2023 to agree terms of reference, the methodology and panel membership. Panel members have not been identified due to safety concerns, but all confirmed they were independent and had not previously been involved in the case or had responsibility for line managing staff supporting Paul or Julie. The panel met on 12th March 2024 to review the early draft report, and again on 4th June 2024 to agree to the full final draft. An action plan was discussed on 16.07.24. This is included as Appendix A.

Independent Reviewers

1.23 Fiona Bateman and Sarah Lawrence were commissioned as independent reviewers to deliver this DHR. Both fulfil the requirements of DHR author and chair as set out in the statutory guidance and have a background and expertise in safeguarding and domestic abuse. They also have considerable experience undertaking statutory safeguarding practice reviews to identify systems learning and prevent future harm. Both are independent of the CitySafe and have no direct association with any of the agencies involved in this review.

Equality and Diversity

1.24 This review has examined barriers to accessing services, in addition to wider consideration as to whether service delivery was impacted, in relation to the following relevant protected characteristics under the Equality Act 2010:

<u>Age:</u>

1.25 Paul was under 25 at the time of his death, Julie was over 45. Contributors to the review have suggested age was a factor in the risk posed to Paul by Julie. Local police data[1] noted only 14% (n5) male victims under 25 reported experiencing controlling and coercive behaviours. The highest proportion of female perpetrators of controlling and coercive behaviours within intimate or family relationships were aged 35-44 (39%, n11). Over this age, police crime data fell considerably with female perpetrators aged 45 or older accounting for only 24% (n9) of offences. Data from the Paul Lavelle Foundation (who support male domestic abuse victims in Liverpool) report that during this review period they did not support any male victims aged under 55. Recognising this is likely to be due to hesitancy for younger men to report abuse or even to recognise they were at risk of domestic abuse; the Paul Lavelle Foundation have developed a mobile phone app targeting young people aged 12 and over. This app provides information, advice and guidance on managing healthy relationships.

1.26 Almost one third of victims of domestic abuse related crimes in 2020-21 in Liverpool are aged 25-34 years (31%, 3,140). A further quarter (25% 2,501) are aged 35-44 years. Together these age bands make up over half of all victims of domestic abuse related crimes in 2020-21 in Liverpool (56%). A more recent report for CitySafe identified that 25% of victim/survivors of domestic abuse were aged 19-24[2]. Although women were most likely to experience domestic abuse in the 25-34 year age group (29.6% of female victims), men were more likely to experience domestic abuse in the 35-44 year age group (26% of male victims). It is important that practitioners are aware of the increased risk to this age group of men, to facilitate their identification of domestic abuse victims.

<u>Gender:</u>

[1] Drawn from the Merseyside Police Delphi system in June 2024
[2] As reported within the Mainstay Data System between 01.04.22-31.03.23.

1.27 Paul was male, Julie female.

1.28 Societal pressures and cultural assumptions around masculinity can impact on the ability for boys and men to identify themselves as victims of abuse.

1.29 The current political strategic boundaries between domestic abuse, male victims, and serious youth violence policy does not support a full and humanizing approach to those affected. Research has highlighted a need for serious consideration of the way in which the current siloed policy and support structures create gaps for vulnerable young people.[3] A system approach should consider the ways in which early experience of male violence and can impact on boys' sense of masculine identity. Loaded with pressure to protect, to provide, and be strong, against the experience of being victimised and subordinated through abuse creates complex conflicts for some boys[4]. The Domestic Abuse Commissioner for England and Wales found in consultation with Violence Reduction Units that reporting emerging patterns and narratives of young boys and girls joining OCGs to feel protected from domestic abuse in the home, or to 'feel strong'[5]. This concurs with Levell's research, which found that some boys address the relative vulnerability and powerlessness of child DVA victimisation by enacting a tough masculine performance.[6]

1.30 There is emerging research which highlights the barriers that young men experience when being at-risk of sexual exploitation perpetrated by women. Research by Levell[7] highlighted the gendered barriers both internally, due to masculinity pressures and expectations, as well as external issues such as services framing sexual exploitation as a 'women and girls' issue' can limit the ability of male victims identifying themselves as such.

[3] https://bristoluniversitypress.co.uk/boys-childhood-domestic-abuse-and-gang-involvement
[4] https://bristoluniversitypress.co.uk/asset/11226/boys-childhood-domestic-abuse-and-gang-involvement-policy-briefing.pdf
[5] https://domesticabusecommissioner.uk/wp-content/uploads/2023/10/Home-Affairs-Select-Committee-call-for-written-evidence-on-Policing-priorities-v.1-3.docx
[6] Levell, J. (2020). Using Connell's masculinity theory to understand the way in which ex-gang-involved men coped with childhood domestic violence. *Journal of Gender-Based Violence*, *4*(2), 207-221. Retrieved Jun 12, 2024, from https://doi.org/10.1332/239868020X15857301876812
[7] https://bristoluniversitypress.co.uk/boys-childhood-domestic-abuse-and-gang-involvement

1.31 In Liverpool in 2020-2021 recorded domestic abuse victims were 75% female (7,641) and 25% male (2,531) (Source Merseyside Police, Delphi 2021), and these percentages remained the same in Liverpool's 2023 Strategic Intelligence Analysis (SIA) which analysed data from October 2022 to September 2023. Data from local IDVA services for the period under review reported 20% (n59) of victims supported were male. Crimes recorded with male victims had been increasing year on year over the previous 5 years. This increase (as with overall domestic abuse figures) may be impacted by His Majesty's Inspectorate of Constabulary and Fire Rescue Service crime recording integrity inspection and an improvement in police recording practices which have led to more police callouts resulting in a crime being recorded. Domestic abuse against male victims had increased by 157% since 2016/17 (949 crimes recorded in 2016/17 increasing to 2531 crimes recorded in 2020/21). Merseyside police also reported that during the period 01.01.22-31.12.23 frontline officers submitted 15,592 VPRF forms to their vulnerable persons unit relating to male victims of domestic abuse.

1.32 Local data from Merseyside Police shows that from December 2020-April 2022, 71% of domestic violence incidents recorded a male perpetrator and 22% of cases recorded a female perpetrator. MARAC data from 2023-24 report that 52/1893 cases considered involved male victims. The Paul Lavelle Foundation (working with Liverpool John Moores University) completed an evaluation of service responses to male victims of domestic abuse which has identified difficulties faced by men experiencing domestic abuse of overcoming gender stereotypes and victim blaming. This concluded a need to educate children from a young age regarding healthy characteristics within relationships and stressed the importance of training resources for service providers, this also reiterated the need for providers to offer a flexible approach to interventions, including peer-based support.[8]

[8] 'Guilty until proven innocent', Dominic O'Shea, 2023

Merseyside police arrested 22% of male perpetrators and 11% of female perpetrators. 13% of cases involving male perpetrators were referred to the Crown Prosecution Service, compared to 4% of the cases involving female perpetrators. From October 2022 to September 2023, the 2023 SIA recorded that 72% of perpetrators of domestic abuse were male and 28% of perpetrators were female. Whilst this data does not indicate the seriousness of incidents involved (which would impact on police decision-making), Citysafe partners may wish to explore this to ensure gender bias is not influencing arrest and charging decisions across Merseyside.

1.33 Gender-based assumptions and bias in society impact on victims' confidence in reporting and seeking help. The same bias is likely to affect local areas strategic and operational approaches to domestic abuse, exploitation and knife crime and can lead to barriers for victims and perpetrators in accessing support. In particular, it is clear from the information provided to reviewers of this DHR that male victims appeared less likely to access the services available to support them in Liverpool, and this may be exacerbated by other factors that increase risks to personal safety, including being identified speaking to services by OCGs.

Disability:

1.34 Paul reported poor mental health and substance misuse throughout the period under review. Local MARAC data from 2023-24 report 104/1893 cases involved victims with disabilities. Safelives has highlighted concerns that nationally there is underuse of the MARAC process to support disabled victims of abuse.[9] It is notable therefore that during 2023-24 only 23/1893 cases were referred by LCC's Adult Social care.

[9] https://safelives.org.uk/sites/default/files/resources/Disabled_Survivors_Too_Report.pdf

1.35 Both Paul and Julie are White British. In Liverpool from October 2022 to September 2023, 90% of recorded domestic abuse crimes were against White British victims (8280), although according to the 2021 national census, 77% of Liverpool's population was White British. MARAC data from 2023-24 report 245/1893 cases involved people from BME communities. This may indicate either that White British people may be more likely to experience domestic abuse, than people who are black or are from global majority communities or that people who are black or are from global majority communities may not be as confident to report domestic abuse. The Liverpool 2023 SIA indicates that there is little difference in respect of the proportion of male and female victims of domestic abuse by ethnicity.

Religion or belief:

1.36 Religion was not recorded for Paul or Julie by professionals. Paul's family confirmed he was Roman Catholic and that his faith helped to shape his view of the importance of community. There is no indication that their respective belief systems were relevant to the abuse or the circumstances of Paul's death.

Sexuality and gender reassignment:

1.37 Paul was a cisgender heterosexual male. Julie is a cisgender heterosexual woman. While this report discusses services for male victims and female perpetrators in the context of a heterosexual cisgender relationship, the recommendations to improve service provision for male victims and raise public awareness of male victims will equally apply to and benefit the LGBTQ+ community.

Marriage or civil partnerships:

1.38 Paul and Julie were not married or in a civil partnership.

1.39 It is understood that prior to the development of the Domestic Abuse Partnership Strategy for Liverpool 2024-27 an Equality Impact Assessment [EIA] was completed. It identified the proposals within the strategy would have positive impacts and no negative impacts on any group with protected characteristics. It also planned for commissioned domestic abuse services to be robustly monitored to enable, in the event any unforeseen impacts occur, an efficient framework would be in place to identify these and address them immediately. The Strategy has also been informed by a Liverpool wide needs assessment, as required by the Domestic Abuse Act. The needs assessment covered all victims-survivors in Liverpool, including those who require cross-border support. It expanded to include outreach and community-based service provision to enable a holistic assessment across the spectrum of provision. Citysafe reported they regularly undertake EIAs on newly commissioned services so the impact on all protected characteristics is captured. For example, via a small grants programme, Citysafe reported increasing capacity to reach and support the 'harder to reach communities' including LGBTQ+, male victims, ethnic minority communities. They also have an Experts by Experience group who are actively seeking to engage with hard-to-reach groups to provide the Partnership with the voice of those communities to feed into commissioning decision making.

Dissemination

1.40 The report will be published in March 2025 and disseminated to Liverpool's Community Safety Partnership, Safeguarding Adults Board and Safeguarding Children Partnership. The final report will be shared with the Police and Crime Commissioner for Liverpool and the Domestic Abuse Commissioner for England and Wales to inform their work.

2 The Facts

2.1 In March 2023, Paul died at LUHFT after being stabbed at his partner, at Julie's home address in Liverpool. At the time of his death Paul was 24 years old.

2.2 Paul and his siblings had been known to social care from young age due to concerns of maternal neglect and domestic abuse, Children's Services / Children's Social Care (CSC) information from this time suggests his mother misused alcohol and spent long periods away from the family home. Paul lived with his grandparents from the age of 6 years old, following non-fatal stabbing of his father by his mother.

2.3 As a child, Paul had been a keen footballer and was scouted by a high-level football club which Paul described to a practitioner as ending when he started to smoke cannabis and hang around with friends. His family also describe how Paul was family orientated and 'doted' on his grandmother, Paul described to practitioners that he was close to his aunt and nan. Paul's grandmother sadly died 2 years before him. Paul himself described to practitioners that her death had a devastating impact on his life, this was reinforced by his family who detailed the negative affect her death had on his wellbeing. The agency reports indicate a correlated decline in his appearance and increase in substance use around this time.

2.4 In 2018, when Paul was aged 19, a relationship started with Julie who was aged approximately 42. They are said to have met at a party, and that this was linked to drug use and dealing.

2.5 Initially his family say they were unaware of the relationship. Once they became aware they describe to reviewers how they warned him against the relationship, because of concerns for his safety following their knowledge of Julie and her family and her negative reputation in the community. Paul's family described to reviewers that not long after the start of his relationship with Julie they noticed changes in his behaviour he stopped visiting them as much, started drinking heavily, took less care of his appearance, became withdrawn and lost interest in work. His family described also noticing physical injury which Paul would try to hide. They describe warning him of their fears (especially when they saw him with injuries) but he would always deny Julie was abusive – giving explanations for injuries including that he had fallen. They explained he was never afraid of anything, but they knew he was scared of her. They felt that over time Julie manipulated Paul and isolated him from them, his wider family and his friendships.

2.6 Julie described their relationship to reviewers, stating that they met while she was separating from her partner who was also the father to her children, that they'd been together for 5 years before his death, and that she also knew his mother quite well before this. She said that Paul was 'there with the right smile at the right time' in her life. She said he made her feel good at a vulnerable time. She recognised there was a big age gap, and he was very young and said, "I know I am no angel". Julie said her and Paul would separate regularly and sometimes for months, she stated he would go back to his family. He would come back to her if he fell out with his family, but he would '*go missing for months*'. She said Paul was '*always hiding somewhere – at his families or mine, because he owed money or drugs*'.

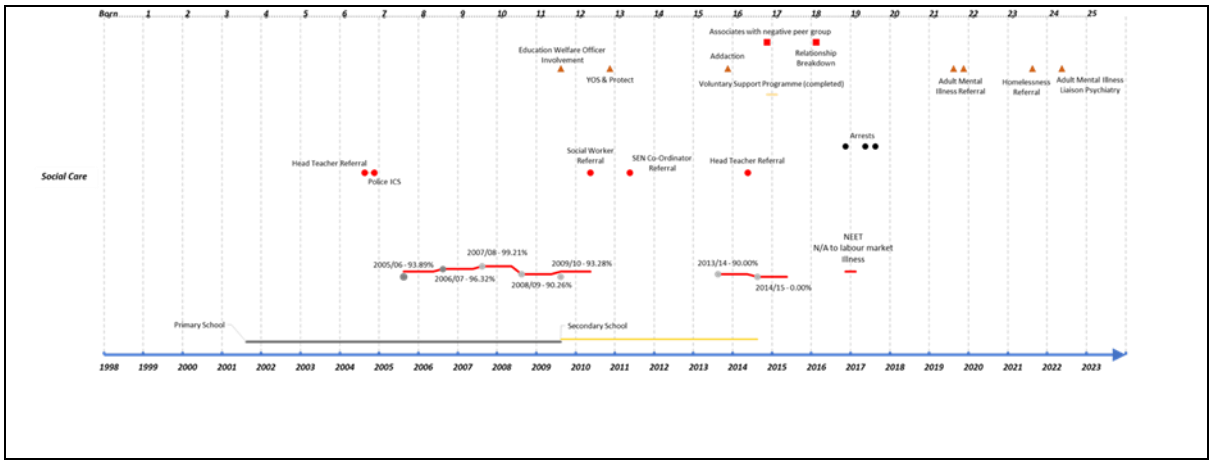
2.7 Over the time covered by this review, Paul requested support from agencies for his mental health and housing. A pictogram of contact throughout his life is included below.

2.8 Following the stabbing Julie was arrested, after his death she was re-arrested and charged with murder. She has been sentenced to life in prison with a minimum term of 18 years.

3 Chronology & Overview

This section of the report gives an overview of Paul and Julie's interactions with agencies within the period of this review and according to the terms of reference. It also includes a summary of agencies' engagement with them before this, to support the context for the analysis and learning that is later identified in the report.

Paul's Service Interaction Timeline



Pre 2019

3.1 A Child protection [CP] plan for Paul and his siblings was initiated in September 2003, was initially ended in December 2003. CP Planning commenced again in June 2004 for his siblings under the category of neglect. At that time Paul had moved to reside with his paternal grandmother, but with regular contact with his siblings and parents.

3.2 In August 2004 when he was 6 years old Paul witnessed his mother stabbing his father and, consequently Children Social Care [CSC] made him subject to a CP Plan in line with his siblings. CSC reported that during this he had low school attendance and a significant amount of missed health appointments. They report one of his siblings subsequently became a looked after child. Paul was cared for by his grandparents. In November 2005 Paul's parents separated and his father became the main carer for Paul's siblings, Paul remained with his grandparents.

3.3 Paul was referred to CSC again aged 12 to 16 years old, predominately by his school. Youth Offending & Protect are said to have been engaged with Paul aged 12. Of note is a referral to CSC in 2012 when Paul was 13/14 years old because of concerns he was being exploited by an Organised Crime Group [OCG]. These concerns continued throughout his adolescent years until he turned 18 years old. In 2014 he was offered support by Youth Offending services, but little else is known of what additional safeguarding and protection interventions were offered to Paul during these years.

3.4 In 2018, when Paul was aged 19, a relationship started with Julie who was aged approximately 42. In 2018 Paul was arrested for possession of cannabis, he was also arrested in 2019 on suspicion of assaulting a police officer and theft of a motor vehicle. In October 2019 he was arrested (and later charged in January 2021) with threatening with an offensive weapon following an argument outside a pub during which knives were brandished.

2019

3.5 In November 2019 Paul made an application for universal credit stating he was single with no housing costs. This application was subsequently closed in December 2019 as he had not attended appointments. In November 2019 police advise that Paul was the subject of a Threat to Life notice unconnected to his death. He was served a letter in person.

3.6 In December 2019, Paul's GP made an urgent referral to Merseycare which was discussed at their multi-disciplinary team [MDT] concerned Paul was presenting with severe mental distress, agitation and possible underlying psychosis. He had indicated he was scared he presented a risk to himself or others. The following day he was offered an appointment with the Early Intervention Psychosis [EIP'] team for the 9th of December, though when they subsequently attended his home, he did not answer.

2020

3.7 A letter was sent from Merseycare offering a home visit on the 07.01.20 with details of how to contact the service in the event of a crisis. He attended that meeting and was assessed. During the EIP MDT on the 8th January 2020, the team were aware of the threat to life notice sent to him by letter, received in late 2019, and that he had been advised to move away from the area. The practitioner advised reviewers that Paul had been vague on the background to this letter, but says he was being bullied and stood up for himself and this was the fallout from this. A detailed history was taken which was cognisant of good practice, recording his views of past trauma, current presentations (including suicidal thoughts) and that his family were a protective factor.

Paul agreed to speak with his GP to review his medication and to a referral to the Young Person's Advisory Service [YPAS] [10]. The plan was communicated in writing to his GP, requesting an increase in his medication to support him to manage depression.

[10] YPAS is an independent organisation providing support to young adults - www.ypas.org.uk).

3.8 Paul spoke with his GP later that week while intoxicated. He informed the GP he was residing in a hostel in another part of Liverpool and was advised to re-register with a local GP; there was no further contact with him until February 2021.

3.9 Later that month he made a further claim for universal credit. This did not declare any health conditions and it was again closed by the Department for Work and Pensions in January 2020 after he made no contact and did not arrange a 'First Commitments' appointment.

3.10 In January 2020 police attended Paul's father's home as Paul was wanted for affray. Whilst they didn't see Paul, the officers submitted a VPRF1 form[11] raising concerns regarding his younger sibling and another young person residing at the address highlighting risks regarding possible exploitation given Paul's involvement in organised criminal groups. This was good practice and followed the protocols in place at the time. He was later found, arrested and subsequently sentenced to a suspended sentence with a rehabilitation activity requirement.

3.11 During this period Julie was residing in a Women's Centre. On the 31.01.20, 10.02.20 and on the 12.02.20 the hostel submitted a VPRF1 following three separate incidents, the first when Julie was threatening to staff whilst intoxicated, the second when she fell and required medical attention and the third was submitted as Julie had threatened to attack another resident (and was accompanied by two men). Adult social care noted 'no further action' as these were low level incidents that would not have benefitted from social care input.

3.12 Julie was in regular contact with her GP. During March 2020 Julie refused antibiotics and dressing for a burn wound but spoke about her problem drinking and requested sleeping tablets. Those weren't issued as she continued to drink. The same day the GP followed up with a telephone consultation to discuss choices for rehab. In April 2020 it was noted by Julie's GP during a

telephone consultation[12] she was awaiting detox placement. In May 2020 she reported to her GP she was drinking 2-3 cans of alcohol per day. Throughout the rest of 2020 Julie continued to have monthly telephone consultation with her GP, she reported stress related problems and sleeping problems due to anxiety. She reported losing her medication or requesting alternatives and support agencies numbers given, but (apart from one reference in November 2020) there is no record that her alcohol issues were discussed.

3.13 In May 2020 Paul was arrested at a large gathering (contrary to the restrictions in place during the Covid-19 lockdown) in possession of cocaine and cannabis. During his detention, the Criminal Justice Mental Health Liaison Team carried out checks to ascertain if he was known to any services and welfare checks were made on him whilst in his cell. The custody officer reported no concerns regarding his mental health, so he was released in line with police protocol.

3.14 In August 2020 he was arrested having failed to appear in Court for the offence. Whilst in custody he was seen and considered fit for detention by a Health Care practitioner.

3.15 In December 2020 Julie twice requested repeat prescription stating she had lost her medication. Her GP records note discussion of her anxiety and depression and that she was provided with the crisis team's safety net details.

2021

3.16 During February- May 2021 Julie remained in frequent contact with her GP, she was reportedly aggressive in February when co-dydramol medication was restricted to 30 tablets due to poor mental health. Consideration was also given to making a referral for a 12-week activity programme, known locally as 'lifestyles'.[13]

[12] By this time the UK was in the first Covid-19 lockdown so most GP appointments were held virtually.
[13] This was not taken forward due to covid restrictions: https://lifestyles.liverpool.gov.uk/

3.17 Her GP refused sleeping tablets, concerned she was slurring her words and possibly intoxicated in June 2021. During further appointments in June-September she continued to report lost medication.

3.18 In August 2021 Paul was assessed by the Probation Service, during which it was noted he was 'medium risk' linked to organised crime and weapons. He informed the pre-sentence report author he was not in a relationship. In September 2021 Paul was given a suspended sentence order[14] for threatening with an offensive weapon in a public place. Paul was allocated a probation officer. Shortly after, the induction appointment was completed by telephone. Records suggest he was working at a local warehouse.

3.19 In October 2021 Paul met with his Probation worker, he completed the initial sentence plan which reported:

'No evidence of domestic abuse identified, either as victim or perpetrator. No history of difficulties in previous relationships identified. It is identified that he … was mostly raised by his grandmother who had recently died. Issue of relationships not linked to risk of reoffending or risk of serious harm. Although there were no current indicators of him being an active OCG member, the assessor identified that there should be regular checks with Police re OCG involvement. It was assessed that there was no current drug use (previous for cannabis and cocaine), and no alcohol use. Assessed as medium risk of serious harm to public in the community, low risk in all other categories. The sentence plan indicated that the focus of supervision will be community integration, attend Thinking Skills Programme and drug relapse prevention. No direct focus upon trauma experienced.'[15]

3.20 In October 2021 Julie requested a referral regarding her mental health.

[14] 16 months imprisonment, suspended for 12 months with requirements to complete unpaid work 180 hours as well as an Accredited Programme - Thinking Skills and Rehabilitation Activity Requirement - 15 days`
[15] Taken from the combined chronology drawn from agencies' case records for this review

3.21 A police check confirmed in October 2021 Paul was an inactive member of an OCG. Paul received details of the Thinking Skills programme which was due to start on early November. He attended the first appointment but reported being ill for the second (which was recorded as an acceptable absence) but then did not attend the following. The reasons were not recorded, and no enforcement action was taken. Paul met with his probation officer in November and was recorded as 'more open', he reported having changed jobs after an altercation in November.

3.22 In December 2021 Paul reported having been kicked out of his aunt's home following an argument. He reported he was staying on his girlfriend's couch. The following day he asked his probation officer for assistance with a housing referral, and this was completed in line with the Duty to Refer obligations (Homelessness Reduction Act). He also made a fresh claim to the DWP for universal credit, noting within the application his poor mental health. He was allocated a telephone appointment for the 06.12.21, but did not attend.

3.23 Paul later reported to the JobCentre he had lost his mobile phone so was re-issued an appointment which he attended, providing a '*fit note for one month which stated health conditions of anxiety and depression*.'[16]

3.24 In December 2021 Paul was withdrawn from the Thinking Skills programme after a further failure to attend but advised to recommence this in January 2022. He was issued a final warning notice after failing to attend a planned probation visit on the 09.12.21. It is noted within the agency return that this should have been a breach letter and that breach proceedings should have been initiated. Paul contacted his probation worker on the 16.12.21 stating he now had another phone and that he had been unwell (anxiety). His probation worker referred him to Commissioned Rehabilitative Services to support his personal wellbeing on the 20.12.21 but there was no consideration if the

[16] Taken from the combined chronology drawn from agencies' case records for this review

phone changes could indicate increased risk.

3.25 Paul attended a re-booked appointment to confirm his First Commitments with the DWP. He reported he have recently stopped work following the death of his grandmother and a deterioration in his mental health. He stated he was homeless, and sofa surfing and was currently living on his girlfriend's sofa, though they did not usually live together. No other details are held regarding his partner. The DWP made payment in advance, noted he had reported difficulty attending appointments due to anxiety and followed up non-attendance, but closed the claim in February 2022 after no further contact from him.

3.26 Paul subsequently reported to the Growth Company (wellbeing service linked to the probation service) he had recently lost his nan and was experiencing depression and anxiety on the 23.12.21, but on the 06.01.22 reported he was back staying with his aunt and feeling much better.

2022

3.27 In January 2022 Paul was commended by his probation worker for his transparency and asking for help. He confirmed he was working, had moved back in with his aunt to whom he was close and was '*feeling in a better plan since re-entering employment. He relishes having a routine and is sleeping better and reducing his cannabis consumption*.'[17]

Paul failed to attend the Thinking Skills programme and was issued a final warning letter. In their submission to this review the Probation service noted that this should have been an enforcement letter and that breach proceedings should have commenced. Two days later, Paul attended the programme however he failed to attend further sessions in February resulting in a breach letter being issued and breach proceedings commencing. The breach was withdrawn in March 2022, there is no record of programme facilitators notifying of a subsequent appointment. Again, Paul subsequently reported his mobile number had changed and was therefore re-referred to Thinking Skills.

[17] Taken from the combined chronology drawn from agencies' case records for this review

3.28 On 3rd March Paul reported to his probation officer he was in a relationship with a 45-year-old but that this has broken down after 5 years. His probation officer noted within case notes 'Further exploration of this required. Paul reported his mental health has improved and he no longer requires intervention from the Commissioned Rehabilitative Services. Advised this can be reopened if a decline in mental health occurs again.' Paul did not attend 12 further scheduled appointments with Thinking Skills, unpaid work or his probation officer – he was suspended from the Thinking Skills programme.

3.29 On 12th May he was reallocated a different probation worker following an internal reorganisation. He was suspended from unpaid work later that month following another non-attendance, Probation service's chronology noted this should have occurred sooner.

3.30 During May 2022 Julie had reported to her GP poor pain control and overusing medication from a friend to better control pain. She attended a face-to-face appointment where support to address her distress was offered.

3.31 A breach letter was issued by Probation to Paul in June. Paul reported he was homeless and '*having a difficult time with his family*' later in June to his probation officer. They made a referral under the Duty to Refer obligation and asked he attend on 23rd June 2022; however, he did not attend. Paul did attend Probation offices on the 28.06.22 when he presented with a black eye. The case notes report '*no clear explanation received about this*'. Probation records suggest Paul remained homeless but would like to use his aunt's address for correspondence. Paul advised he was no longer working, that he has not used cannabis for 4 days. He advises he has been diagnosed with anxiety and depression and is currently prescribed Mirtazapine. He says he often struggles to sleep. No further arrests are noted, and case records show that monthly supervision will continue.'

3.32 The following day Paul re-engaged with DWP support after the appointment was changed to a telephone-based interview.

3.33 Paul's GP reported that *'between Jan 22 and June 22 despite numerous attempts we could not contact him despite us trying to respond to him contacting the Practice requesting a mental health review.'*

3.34 Paul contacted the DWP in July requesting support and help with cost of living. For the remainder of the review period Paul regularly notifies the DWP and his GP that he is homeless, that this is impacting on his ability to work and his mental health but that he was working with his probation worker to address this.

3.35 On 6th August Paul was stabbed and taken to hospital. Hospital notes detail he was 'stabbed to left lower posterior chest wall / flank. Ran from scene and called an ambulance. Cold, clammy on admission, required major haemorrhage protocol activated.' It noted he 'lives alone.' By the 7th August Paul was reported by the hospital to be maintaining own airway and was stable. He was advised to rest in bed, but it was noted he was mobilising independently with nil walking aids and that he was 'going off the ward for fresh air with his girlfriend, has nil concerns regarding home.'[18]

3.36 Prior to his discharge, he was also seen by a clinical psychologist. He disclosed pre-existing conditions of low mood, anxiety and bereavement following the death of his grandparent who had raised him. He explained he currently lived with his aunt, but the relationship was fractious and that he got angry, especially when anxious. He refused referrals for ongoing support with his mental health, explaining to the consultant he wouldn't answer a call from support services. He explained he would speak to his GP as believed he needed stronger medication and that he was sourcing this from others. There is evidence within the case notes of the consultant taking time to explain to Paul the risks associated with self-medication. Paul thanked the consultant and stated, *'it had been good to talk'*.[19]

[18] Taken from the combined chronology drawn from agencies' case records for this review
[19] Taken from the combined chronology drawn from agencies' case records for this review

3.37 Paul was discharged on 8th August with a plan for follow up through outpatients. Police reported they were unable to progress the investigation as Paul refused to explain what had happened, so it was noted as an 'undetected' crime.

3.38 Paul's GP contacted him on 9th August during which he reported low mood, high levels of anxiety and feeling he may lose his temper with others. He explained his sleep was disturbed but reported no thoughts of hurting himself or plans to self-harm. They discussed a referral to talking therapies, Paul confirmed he had counselling while in hospital and would consider again, but 'not at the moment as things are too fresh.` He confirmed his mum was supporting him and he had gone for a walk today which was helpful. His GP agreed to restart medications, but whilst he requested an increase dose of pregabalin, his GP advised anxiety is not really an indication we would normally prescribe pregabalin for. It was agreed to increase his antidepressant (Mirtazapine), keep Pregabalin the same and to review in two weeks.

3.39 However, by the 12th of August Paul reported to his GP he was 'feeling angry as he has been stabbed, stated his head has gone.' The case records note evidence that GP was professionally curious and keen to engage with Paul, calling him back when Paul rang off to speak with his father. His GP persisted to gain insight into Paul's concerns regarding his mental health, but Paul appeared pre-occupied and was holding another conservation throughout the telephone consultation, he then subsequently hung up.

3.40 Paul's next contact with his GP was on the 25th of August requesting a fit note which he explained was because he was having anger issues and was arguing with his family. He reported a bad childhood, memory issues that bothered him, difficulty concentrating and agitation/ pacing. He explained he became anxious if he went out of the house, but that he was also sofa surfing. He had lost his pregabalin, but that this helped though he *'sometimes takes more than he should'*. He also disclosed using other people's prescribed medication.

His GP spent time offering self-help measures and asked he consider counselling, agreed to review his medication in 2-3 weeks and issued the fit note.

3.41 On 25th August, Julie's GP reported she sounded intoxicated and raised a safeguarding concern in respect of her children.

3.42 In August Paul notified probation he couldn't pursue employment opportunities as had been stabbed. He also reported to the DWP he was 'sofa surfing'

3.43 On 31st August Paul again attended A&E but did not wait to be seen. The following day Paul notified DWP he had lost his phone in a car accident. The DWP note within his file that he was unable to attend, due to poor mental health following the stabbing so he should be treated as a vulnerable claimant and not suspended.

3.44 On 3rd September, Paul's suspended sentence expired. At this time, Probation services noted the error in recording the conditions of his probation. Neither the rehabilitation activity requirement days or the Thinking Skills programme had been completed and of the 180 hours of unpaid work Paul had completed only 19 hours. They describe that there was insufficient time to list the breaches before a Court prior to the expiration of the suspended sentence. They also note that the OASys[20] termination review was also not completed, and it is noted that there had been no update (despite a requirement to review circumstances and risk a minimum of once every six months) throughout the time period.

3.45 On 6th September, Paul's GP called, speaking to him on the second occasion at 7pm when he requested more pregabalin and mirtazapine.

He disclosed that *'his head is 'banging', he is shouting and arguing with his family, worried that he will end up in prison, finding it difficult with anger issues at the moment feels counselling wouldn't tell him anything he didn't know*

[20] Prison and probation services use a tool called the Offender Assessment System. This is often called OASys

already, says he has had a lot of trauma in his life, says he isn't really going out, is currently homeless. No thoughts of self-harm currently.' Paul's GP encourages him to use correct dose of mirtazapine rather than over-rely on pregabalin, signposted him to 'Talk Liverpool[21]' and makes a referral to the Community Mental Health Team ['CMHT'].

3.46 In September Paul's DWP work coach contacted Paul, but reported a woman answered and was abusive, stating Paul was working. HMRC confirmed the same, so his universal credit was reduced to take into account his earnings.

3.47 On 3rd October, Paul's aunt called the police after Paul had assaulted his father and left the property with a knife. His aunt reported he was 'off his head and threatening to murder everyone'. His father did not provide further information to the police but stated his son needed help with alcohol and drug abuse and for his mental health. The police officer provided security advice for the family and raised a VRPF1. Though ASC reported to this review that their records suggest the VPRF was recorded against a family member and had not identified Paul as an adult at risk, but rather as a perpetrator of domestic abuse. Initially this was graded at 'bronze', but the attending officer advised this should be 'silver' due to the weapon and mental health element. Consideration was given by the police to upgrading this to 'gold' so that it met the threshold for consideration at a Multi-Agency Risk Assessment Conference [MARAC][22]. Following this and in applying the relevant policies in place, it was concluded to grade as silver. Paul's family did not support the sharing information with other agencies or agree to support a prosecution, so no further action was taken. Consideration was not given to initiating a safeguarding adults enquiry, initiating a MARAM or to making a referral to Mersey Care's Integrated care team for a multi-disciplinary meeting for people living with complex lives despite his circumstances appearing to meet the criteria for any of those processes. This may be because insufficient focus was given to Paul vulnerabilities, because he was identified within this incident as the perpetrator. This is explored in more detail below.

[21] Describe Talk Liverpool?
[22] MARAC is a meeting to discuss and share information on the highest risk domestic abuse cases.

3.48 On 11th October, Paul was referred to Liverpool City Council's Housing Options Service [HOS] via Careline[23], notifying them he required emergency accommodation following a family breakdown. He disclosed he suffered from anxiety and depression.

3.49 The following day Paul's mother called the police after she was assaulted by Paul. She disclosed she, he and Julie had been drinking, that he had become abusive towards her, poured lager over her and had damaged her TV and front door after she asked him to leave. She confirmed she would not support a prosecution. Paul was found outside the house and arrested for assault and criminal damage; he was bailed with conditions not to contact her. Whilst in custody he was referred to the Mersey Care's Criminal Justice Liaison Team [CJLT] and offered a vulnerability assessment, he refused and was assessed to have capacity. The police completed a VPRF1 and considered a DVPN notice, but (after speaking with his mother and her confirming she would not support such a measure) the matter was filed as 'undetected'.

3.50 The following day he reported to his GP he had threatened his mother with a knife and asked for advice about his mental health because '*his head is everywhere says going off the rails bad*'.[24] Paul spoke with the advanced nurse practitioner who explained he would be criminally liable if he acted with violence, but he responded stating he wasn't violent.

3.51 On 13th October Paul chased HOS and was told to call after 7 working days. He advised he had exhausted all his options and had nowhere to stay or 'sofa surf'.

3.52 On 15th October Paul attended A&E after his mother's friend had contacted Mersey Care's Urgent Care Crisis line as he was in distress and had said he wanted to die. She and his mother had prevented him taking an overdose, but

[23] During the review period Careline acted as LCC's front door for Adult and Children social care and housing need services. Since the review period the front door has been redesigned and Careline ne longer exists.

reported he didn't feel able to maintain his safety and would act on suicidal thoughts. The Crisis line practitioner wrote to advise his GP. At A&E he disclosed he was also having violent thoughts towards others and had '*smashed up the house.'* He was seen by the Mental Health Liaison Team (at 4.15pm and 5pm). His mum reported his behaviour had escalated, that three days ago he had pinned her to a bed and tried to stab her, she had bruises all over her body from that. She explained he was on bail following that assault and not supposed to be in contact with her. He had also kicked his aunt downstairs the day before. Consideration was given to referring him to Whitechapel[25], but he made threats to harm other residents if sent there. He reported he was using cocaine once a week (last used a few days ago), that he noticed his behaviour worsening with it, but did not wish for help to address this. The assessor also reported he was offered support with housing issues but declined. The mental state examination was completed which recognised his strengths (appropriately dressed, maintained eye contact), he was oriented in time, place and person and had insight into his mental health. He had future orientated plans, but equally understood he posed a risk to others. A decision was made to discharge Paul to the care of his mother, but the hospital also notified police he had breached his bail conditions.

3.53 He was discharged at 6.30pm but asked to remain at A&E (he was not advised that this was so the police could attend re breach of bail, because of flight risk). The mental health liaison team were subsequently advised (by A&E staff) Paul had left A&E at 9.30pm making threats to kill.

They advised the police who contacted his mother to check on her and his wellbeing. She confirmed she was caring for him and believed she was preventing him from harming others by doing so. Police felt, despite possible public order offence, it was not in the public interest to prosecute so took no further action despite bail conditions-imposed days earlier.

[24] Taken from the combined chronology drawn from agencies' case records for this review
[25] The Whitechapel centre is a support service for people who are homeless in Liverpool

3.54 During October 2022 Julie attended A&E and was assessed using the AUDIT[26] assessment as a high-risk drinker as she had stated that she had suffered from blackouts. It was reported that she had consumed excessive alcohol for some time and wakes up due to alcohol withdrawals. She requested assistance to achieve abstinence and was referred to Liverpool Community Alcohol service.

3.55 In November, Paul attended a DWP work capability assessment and was found to have 'limited capability for work- and work-related activity'. His benefits were increased and an arrears payment generated. He subsequently asked (and was granted) payments on a fortnightly rather than monthly basis.

3.56 On 24th November Merseycare received the referral from Paul's GP. This described historical information about Paul's adverse childhood experiences, including child protection planning in 2006. This was reviewed the following day by the 'Step Forward' MDT who agreed to write back to his GP for more information regarding up-to-date risk. It isn't clear if the MDT had reviewed Merseycare records which would have contained the information from the Mental Health Liaison Team completed the month before.

2023

3.57 On 16th January Julie attended her GP surgery and reported poor sleep. She was prescribed a short course of zopiclone.

3.58 In March Paul was fatally stabbed. On calling for assistance, Paul advised police he had been stabbed but that he didn't know who had done it. Julie took the phone and advised she had helped him. Paul was taken by ambulance to RLUH where he received emergency surgery and was placed on life support. In subsequent days the hospital advised Paul's family that he had suffered significant brain damage from which he could not survive, the decision was taken to withdraw his life support and as a result Paul subsequently died.

[26] AUDIT (Alcohol Use Disorders Identification Test).

3.59 A Gold referral was made by the police and VPRF1 submitted for Paul, but the subsequent MARAC referral was withdrawn following his death. LUFT also made a referral to the youth violence crime navigator.

3.60 Julie was initially arrested for attempted murder and, after Paul's death, re-arrested for murder. Julie was found guilty of Paul's murder and sentenced to a minimum term of 18 years in November 2023.

4 Analysis

Several key themes for learning have arisen from the review of Paul's experiences and tragic death including.

- Pauls experience as a child victim of domestic abuse, trauma and his adverse childhood experiences.
- Knife crime and domestic abuse
- Barriers to identifying and responding to domestic abuse, particularly for male victims
- The provision of safe accommodation.

The following analysis draws together learning from this with evidence from wider research.

Child Victim of Domestic Abuse / Adverse Childhood Experience:

4.1 Paul's experience as a child victim of domestic abuse is evident in the chronology and wider information considered in this review. In their IMR, Liverpool CSC report that Paul '*witnessed significant domestic abuse'* as a child. They state, *"The impact for Paul, as a child may have informed his later years and had an impact on his relationships …"*. Paul witnessed the stabbing of his father in 2004, by his mother, when he was 6 years old. This was an adverse and traumatic event in his young life.

4.2 Considering the context of the time, it is likely that practitioners' awareness of children as direct victims of domestic abuse would not have been as advanced as it may be now because of recent legislation and statutory guidance. It is likely that Paul and his siblings would have been seen by practitioners as a being '*exposed*' to domestic abuse, and as the CSC IMR indicates, as '*witnesse*s' to the abuse, rather than being directly victims of abuse in their own right. This is likely to have impacted how risk was assessed and how their needs were responded to. The Domestic Abuse Act 2021 now defines a child victim as one who "*sees or hears, or experiences the effects of, the [*domestic*] abuse*"[27], and places a duty on local authorities to respond as such. Local Authorities now have a duty to support all victims of domestic abuse including, if necessary, into safe accommodation such as refuges.

4.3 While this domestic abuse legislation was not in place at the time of Paul's childhood, it is helpful for future learning to understand how agency responses to his early life experiences and needs for support because of domestic abuse may have contributed to his risk of exploitation, safety needs, wellbeing and health outcomes in later life.

4.4 Adverse Childhood Experiences (ACEs) such as domestic abuse are stressful or traumatic experiences that can have a huge impact on children and young people throughout their lives. There is a well-established evidence base that having experience of ACE's increases the likelihood of poorer mental and physical health throughout a person's lifespan.[28] Trauma, as Paul experienced (arising from a single event or repetitive events) is also understood to have sustained impact, which can be '*subtle, insidious, or outright destructive*'.[29]

[27] Domestic Abuse Act 2021, HM Government
[28] National Institute for Health and Care Research
[29] Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

4.5 People who experience trauma at a young age, as Paul did, are more likely to exhibit difficulty regulating emotions. Traumatic stress usually evokes feeling either overwhelmed or numb. Responses are varied, but there is significant research that links behavioural responses to trauma and associated emotional dysregulation to self-medication (substance misuse) and self-harm or high-risk behaviours to regain emotional control. The link between trauma, ACEs and co-occurring conditions resulting in multiple disadvantages is also well documented.[30]

4.6 People who experience trauma at a young age, as Paul did, are more likely to exhibit difficulty regulating emotions. Traumatic stress usually evokes feeling either overwhelmed or numb. Responses are varied, but there is significant research that links behavioural responses to trauma and associated emotional dysregulation to self-medication (substance misuse) and self-harm or high-risk behaviours to regain emotional control. The link between trauma, ACEs and co-occurring conditions resulting in multiple disadvantages is also well documented.

4.7 In her meeting with reviewers, Julie described that Paul began to use crack cocaine at this time. Whilst there is evidence that consideration was given to information provided by his family, there is little evidence that practitioners explored domestic abuse risks posed by and to Paul, and as a result there was no consideration given to completion of a domestic abuse risk assessment through the nationally approved risk indicator checklist[31].

[30] See, for example, 'The Knot' Lankelly Chase and Revolving Door agency
[31] Safelives DASH Risk checklist: https://safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf

4.8 For example, Merseycare's IMR explains from their perspective this was because their records did not indicate he was in a relationship. Their IMR acknowledges that Paul's history of ACEs should prompt practitioners to consider heightened risk, given research indicates that an individual who has experienced ACEs may be at risk of poorer health outcomes in adulthood and could influence intimate partner violence. There was also reasonable cause to suspect Paul posed a risk as a perpetrator of domestic abuse to his relatives on the 15.10.22 based on the disclosures that he had tried to stab his mum and pushed his aunt downstairs that week. The referral by his GP to Mersey Care's single point of access [SPOA] (received later that month) also disclosed ACEs and ongoing anger issues.

4.9 Within the GP's IMR, there is a description that helps to contextualise the ability of practitioners to carry out in depth work to consider adults experiences in childhood including trauma, '*More generally, while we know the risk factors for domestic abuse, both being a victim of it, as well as being a perpetrator, but we are increasingly likely to miss some of them in our patients and therefore underestimate the risks and vulnerabilities. We do not have the time to look back beyond the last few consultations and the list of 'current problems' a patient has when they present. The 'system' no longer affords GPs the ability to be the 'Family Doctor', from birth to grave, we no longer have the in-depth knowledge we used to about our patients and their family contexts, sometimes over the course of a couple of decades*.'

4.10 There is clear evidence of the effect of trauma in Paul's life on his wellbeing. For example, in their IMR, LUHFT reported Paul disclosed to the clinical psychologist that he had anger issues and anxiety and low mood.

A further traumatic life event had happened to Paul as an adult in the year prior- a bereavement of a close family member. The IMR describes that he had used "Weed and Alcohol" to cope with this. The discharge notification to his GP from this event also reported 'dependency on medication which he feels is not sufficient and he is purchasing additional medication online'. The GP was asked to review his mental health and medication.

4.11 Following the traumatic event 'witnessed' by Paul and his siblings they were subject to a Child Protection Plan and care arrangements. Paul later became cared for by his grandparents, with a care arrangement that is now known as 'kinship care'. Research suggests that this kind of arrangement, gives children stability without legally separating them from their birth parents, and where safe, reduces the likelihood of negative outcomes faced by children looked after by the local authority. In meetings with reviewers, it was clear from family members that Paul considered his grandparents' home a place of stability and safety, returning there as an adult during crisis situations or when he felt threatened.

4.12 Paul's kinship care was a private, informal arrangement without a legal order attached. Liverpool Children's Services described to reviewers how this kind of private arrangement for care by family members as a common occurrence, now (and as it was in his childhood). One of Paul's siblings became a looked after child under the care of the Local Authority, while his remaining siblings returned to the care of their father. Paul would not have been deemed a 'looked after' child because of his kinship care arrangement. Therefore, he would not (unlike his sibling), have been entitled to the related support in place for looked after children from the local authority or partner agencies, into young adulthood.

4.13 Paul was vulnerable to exploitation in childhood and adolescence, and the risks to him outside the home environment are evident. The chronology of his contact with agencies includes referrals to CSC because of exploitation risk, and this is described in several of the agencies IMR reports.

4.14 Research has also evidenced that children who are victims domestic abuse may be more vulnerable to exploitation, including criminal exploitation by OCGs.

In particular, for boys and young men there are specific issues that may indicate risks later in life to consider and highlight as a result of this case. Research by the Office for the Children's Commissioner found that children offenders in OCGs compared to other young offenders were 37% more likely to

have experienced domestic violence and abuse in childhood[32]. Research by Levell[33] focused on the gender-specific masculinity-related pressures that impacted boy child-survivors of domestic abuse who became involved in life 'on-road' including OCG and youth crime. The research highlighted the risks of siloed working around domestic violence and other forms of serious youth violence and gang-involvement. In 2019, Croydon Children's Services did a deep dive into 'vulnerable adolescent' cases with a focus on the relationship between childhood adversity and those who were identified as involved with OCGs. They looked at 60 cases that were part of a cohort identified as facing multiple adversity, 42 per cent of whom had experienced domestic violence in childhood: '*38% (23/ 60) of children came to the notice of police due to reports of domestic abuse (primarily from aged 1 year to 12 years old – 13 were boys and 10 girls)*'[34].

4.15 Practitioners involved in this review recognised related cultural barriers to accessing support in relation to involvement in criminal activity. They recognised Paul had shared concerns that he was 'worried he will end up in prison', or 'didn't go to the police'.

This could have provided opportunities to explore further, but practitioners accepted criminal and gang culture is not an area that most practitioners are even remotely familiar with so 'don't open that box'.

Knife Crime and Domestic Abuse

4.16 Paul was murdered with a knife in a domestic homicide. He was also the victim of a stabbing with a knife in 2022.

A College of Policing briefing[35] found young people, particularly those who have experienced adverse childhoods and school exclusion/ poor attainment were at higher risk of knife crime. Paul's family described to reviewers that carrying and use of weapons including knives is not uncommon in their local community.

[32] https://assets.childrenscommissioner.gov.uk/wpuploads/2019/02/CCO-Gangs.pdf
[33] https://bristoluniversitypress.co.uk/boys-childhood-domestic-abuse-and-gang-involvement
[34]https://safeguarding.network/content/wp-content/uploads/2019/05/2019CroydonVunerableAdolescentsOverview.pdf
[35] Available at: https://assets.production.copweb.aws.college.police.uk/s3fs-public/2022-03/Knife_Crime_Evidence_Briefing.pdf

4.17 Research by HMIP ‘Promising approaches to knife crime’, 2022 details that victimisation, poverty, gang involvement, bullying and ACEs have all been found to influence knife crime prevalence.

4.18 In Liverpool, serious violence has been a priority for the Community Safety Partnership, Citysafe, for many years. As one of the Citysafe partners, Merseyside Police reported they continue to tackle and fight violent crime through operations like Op Sceptre (Knife Crime), Op Stonehaven and Op Medusa (County Lines) and through developing preventative approaches such as employing a youth worker in their prevention team to support children who regularly go missing or come into contact with the Police.

4.19 The DISARM Partnership is a sub-group of Citysafe which specifically focuses on serious violence and serious organised crime. It is the mechanism through which Citysafe can oversee the local plan is delivered and governed, quality assure practice and hold organisations and people to account for delivering on identified actions to reduce and prevent serious violence in Liverpool.

DISARM regularly reviews data, intelligence and insight from communities and partner organisations to best support all those across the city working to change cultures of violence, challenge behaviours and attitudes and work to rehabilitate people who have been victims of/perpetrators of violence.

4.20 The focus of Liverpool’s approach is to combine early intervention and prevention from education partners, support for parents/carers and develop a strong and sustainable voluntary, community offer, alongside the Police and Criminal Justice Service’s efforts to disrupt, divert and enforce.

SAFE Taskforces in schools harness the leadership, expertise and distinct position in children and young peoples’ lives held by schools, as they work collaboratively with multi-agency partners and experts across their local authority area. Their purpose is to make a tangible difference in young people’s lives, through commissioning and investing in evidence-informed

interventions which tackle serious violence either directly, or through improved behavioural/attitudinal indicators and increased engagement in education.

4.21 The HMIP briefing also states *"although a significant proportion of knife crime is carried out in domestic situations between adults (and in half of all knife crime cases the weapon is a kitchen knife from the home; Hern et al., 2005), primarily knife crime is thought to be undertaken by anti-social and gang-related youths. This view is likely exacerbated by the media attention given to knife crime, which portrays it as out of control, carried out by gangs of young people* (Cook et al., 2020)." [36]

4.22 Similarly, in 'Gendered Objects and Gendered Spaces: The Invisibilities of 'Knife' Crime', an article published by Liverpool University, the researchers suggest that the knife is the most used weapon in intimate partner homicide and highlights that there is a *'contemporary pre- occupation with 'knife' crime illustrates the ongoing and deeply held assumptions surrounding debates on public and private violence.*

Whilst criminology has much to say on gender and violence the gendered, spatialized, and material presence of the knife remains poorly understood. In prioritising 'knife' crime as a 'public' problem over its manifestation as an ongoing 'private' one, its gendered and spatialized features remain hidden thus adding to the failure of policy to tackle 'knife' crime in the round.'

4.23 The relationship between childhood domestic violence and later involvement in 'knife crime' or other forms of violence is complex and cannot prove causation.

However, it is clear that childhood experience of domestic abuse enhances young people's risks of involvement in later crime and violence, in particular for boys who are also otherwise marginalised[37]. Living in a home where violence and abuse is present, as well a range of other issues, can '*push young people out of home/ care and into environments that increase the risk of being targeted*

[36] Her Majesty's Inspectorate of Probation; "Promising approaches to Knife Crime", 2022.
[37] https://bristoluniversitypress.co.uk/boys-childhood-domestic-abuse-and-gang-involvement

by exploitative peers or adults'[38]. Her Majesty's Inspectorate of Probation inspection of Youth Offending Teams in 2017[39] found that, out of a sample of 115 young people who had committed violence, sexual and/or other offences where there were potential public protection issues, 81 per cent had experienced "*emotional trauma or other deeply distressing or disturbing things in their lives*" and one third had grown up in a household where there was a formal record of domestic abuse, and other traumatic experiences. Similarly, a Prison Reform Trust[40] study of 200 young people in custody found that just under two fifths had been on the child protection register and/or experienced abuse or neglect, and 28% had witnessed domestic violence. In addition to the connection between childhood DVA and later criminal activity, there has also been an emerging connection made to involvement in knife crime. Longitudinal evidence from the Millennium Cohort Study shows that children experiencing DVA in early childhood are more likely to carry a knife at age 17[41]. As noted earlier though, this is a minority of the wider DVA child-survivor population and so occurs within a wider milieu of marginalisation[42].

4.24 In reviewing Paul's situation, enlightened by this research, it does seem feasible that criminal justice agencies, when in contact with Paul saw the risks to him more through a lens of gang/criminal activity than domestic abuse, which was invisible to them.

This was echoed in the discussions within City Safe practitioner groups. Local leads for the Violence Reduction Unit and DISARM described relevant work and issues reflected on Paul's experiences, identifying potential issues for future consideration. These included 'transitions' for young adults - from being seen as a child criminally exploited, to an adult 'consenting' to being within criminal activities in young adulthood.

[38] Shuker, L. (2013) 'Constructs of safety for children in care affected by sexual exploitation', in M. Melrose and J. Pearce (eds) *Critical Perspectives on Child Sexual Exploitation and Related Trafficking*, London: Palgrave Macmillan, pp 125–38.
[39] https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/10/The-Work-of-Youth-Offending-Teams-to-Protect-the-Public_reportfinal.pdf
[40] https://prisonreformtrust.org.uk/wp-content/uploads/2010/10/unjustdeserts.pdf
[41] Villadsen, A., Fitzsimons, E. (2021) Prevalence and predictors of weapon carrying and use and other offences at age 17: Evidence from the UK Millennium Cohort Study. CLS Working Paper 2021/8. London: UCL Centre for Longitudinal Studies. https://cls.ucl.ac.uk/wp-content/uploads/2021/06/CLS-working-paper-2021-8-Prevalence-and-predictors-of-weapon-carrying-and-use-and-other-offences-at-age-17.pdf
[42] https://bristoluniversitypress.co.uk/boys-childhood-domestic-abuse-and-gang-involvement

4.25 They also described approaches to those, like Paul that may have previously been exploited as a child and then been involved in organised criminal group activity, that they can continue to be labelled in their future lives, which then influences multi agency responses in interactions with them. They talked of how important it is for operational and strategic responders to see the 'whole picture' of what is happening to ensure that the risk of harm to them is assessed and responded to. They described potential areas for development in how this risk and vulnerability could be responded to, particularly for adults, referencing better information sharing, shared thresholds for interventions across the partnership and a police presence in multi-agency points of access for adults as well as child safeguarding. It was clear that knife crime and use of weapons linked to domestic abuse is not currently identified within strategic and operational plans to tackle knife crime and weapon use in Liverpool. The leads attending the practitioner group explained the potential challenges in responding proactively to reduce this in their operational work, particularly given that every home will have knives readily available and intelligence on who might be at higher risk may be limited. This is addressed below in the recommendations.

4.26 Northwest Ambulance Service [NWAS] confirmed they were aware of the violence reduction network and navigator scheme for patients taken into hospital. Currently there is no direct electronic referral into this scheme for NWAS. Meaning they can only refer via a safeguarding concern to either child or adult social care.

4.27 Merseycare detailed to this review that they offer training to staff and partner agencies to support the identification of violence and OCG activity and would be keen to support wider development across partners of the impact of ACEs and trauma, particularly as this relates to domestic abuse, knife crime and OCG activity.

They confirmed they found nothing within Julie's or Paul's clinical records setting out the details of the services and support which is available to children, young people, or older adults who are exposed to Organised Criminal Groups,

nor is there any reference within the clinical record of services being aware of the risks to him from OCGs. There was no mention in Julie's records of her using a weapon. They confirmed practitioners were aware of Paul's adverse childhood, that he had been stabbed previously and that this indicated potential victimisation. Concerns regarding his mental distress had prompted referrals to mental health services (in October 2022 when he was advised to go to A&E and be assessed there). Similarly, practitioners understood that Julie had a history of heavy drinking and had reported aggression when intoxicated. This had prompted referrals to alcohol services, but she did not respond to opt in letters.

4.28 Julie's GP had no record of her using weapons or that OCG involvement had been referenced in any consultation with her, and they were not aware of the assault until notified she had been detained following Paul's murder. Paul's GP was aware of the stabbing injury in August 2022 and that he had assaulted his mother in October 2022.

4.29 Within their IMR his GP acknowledged reporting patients for criminal activity can impact on the therapeutic relationship. The GP expressed confidence in the established systems to make safe, lawful decisions regarding patient confidentiality.

'We were not approached by family or friends with any concerns about previous incidents of harm to Paul. GPs would treat patient confidentiality in line with the GMC guidelines (Confidentiality: good practice in handling patient information - professional standards - GMC (gmc-uk.org) We have a Safeguarding Lead at the Practice who supports all staff (clinical and administrative) who need help in decision making around when it is necessary legally and ethically to breach patient confidentiality. We also have the Safeguarding Team at Liverpool Place who can support the Safeguarding Lead, and clinicians have their Medical Defence Organisations who also offer support and guidance around confidentiality.'

4.30 Paul's GP confirmed they did not directly contact (or receive contact) from his Probation officer or from the police until 31.3.23 when they were asked for his patient notes following his death. They confirmed they were aware he was engaged with Probation, but explained this alone would not have triggered concerns that he might be at risk from OCGs or domestic abuse. They were clear that, when they do have safeguarding concerns, they refer to social services. They would also report a serious, credible threat to harm to police. Below that threshold there is no consistent approach.

4.31 Reflecting on what learning arose from Paul's experiences, primary care practitioners involved in this Review commented how important it is for the partner agencies to come together and respond to the risks of criminality and exploitation. Highlighting there were multiple contributing factors that make people vulnerable to poor health outcomes often referred to as 'the wider determinants of health'. Supporting someone to 'stay safe' in this context is therefore broader than simply 'the police' or the criminal justice system and could involve many public or third sector services from debt support to housing support services, to charities that support those with neurodiversity, to substance misuse services etc. They spoke of the challenge in balancing the need to maintain therapeutic trusted relationships by respecting the young adults stated wish not to pursue help, with the longer-term benefits of engagement with partner agencies to better understand risk. They were acutely aware, as one person put it '*how much 'choice' these young people really have is debatable. If harmful and criminal behaviours have been normalised in their formative years as a result of ACEs +/- neurodiversity (diagnosed or undiagnosed +/- social stressors) then arguably such individuals have limited 'choices' about the risks, they expose themselves to. Support and intervention need to be better coordinated.*

4.32 Practitioners proposed:

- Progress is made on the digital intra-operability agenda at System Level toward a meaningful and accessible Shared Care Record

- Growth and development in implementation of Integrated Care Teams at Neighbourhood Level, in line with all the National evidence and DHSC guidelines around Integrated Care
- We need to take a whole family approach when children are open to an EHAT/CIN/CP – often primary care is not involved in the Team Around the Family and often when we look into the health records of the parents/guardians there are multiple health/social/addiction needs evident about which the TAF are not aware
- GPs are the only Practitioners in Health who care for both adults and children; all other services are either 'adult services' or 'paediatric services'. Often patients fall-through-the-gap during that transition.
- often when services are over-stretched, we deal with the crisis at hand and then 'discharge' the individual, without dealing with the 'wider determinants of health' that brought the individual to the place of crisis in the first place. This results in 'revolving door' patients. We need to invest in 'up-stream' services too, not spend most of the DHSC budget and staffing resource on acute/urgent care/crisis services. A population health approach, utilising data better (including from third sector organisations) to identify individuals/families who would benefit from an integrated care team approach before they become of serious concern.

4.33 LUHFT's IMR report suggests there is 'no evidence to suggest a referral was made to the Safeguarding Service, following his attendance at hospital because of being stabbed. Checks were made by the ward to establish if he had any dependent children, and the Police had been notified. There is no evidence to suggest a referral was made to the new navigator service (for gun and knife crime) at this time.

But at this time this was a new service and not fully established. Since this time, the Navigator Service is established on both LUFT's sites, with members of the team visible for support and advice in both A&E departments. A referral was made to the navigator service on admission prior to Paul's death. It is difficult to say if professional curiosity was lacking as it is recorded that Paul

was reluctant to engage with staff verbally. The IMR also reported “Professional Curiosity “and “Routine Enquiries “are highlighted within the LUHFT’s training, and that a significant number of staff including A&E and the Safeguarding Team, have received a two-day training in “Trauma informed Care”.

Barriers to identifying domestic abuse, responding to male victims

4.34 Following his murder, family members have since reported to investigating police officers, and in their meeting with reviewers, concerns they had regarding the risks posed by Julie to Paul in relation to physical harm and coercive control that they did not feel able to voice at that time prior to his death. They told us *“We didn't think of going to the police. We thought we'll just deal with it in house, within the family. We tried.”*

4.35 They also reflected that they felt they or Paul would never have gone to the police, suggesting that he would have felt that Julie would have *‘twisted it and said he's done this to me”.* They spoke of the fear they knew he felt; that they had never known him to be scared of anything or anyone until he met Julie. They felt fear for him and for themselves about repercussions *“we didn't want to phone the police because we didn't want to get him into trouble. He was being scared off. We were scared off because we didn't want him to get more hate from her because we've got him into trouble by phoning the police”*.

4.36 Their further reflections also indicate additional risks to victims and families wanting to seek support from the Police or other agencies, because of how this will be perceived by others, particularly in being a ‘grass’; *“You can’t phone the police [you] will be called grasses, things like that…. So, it was all that well”.*

4.37 Paul's family also reflected a distrust of police in the community in terms of what could be done to protect victims once the police were notified, feeling that this is not a feasible option for most victims within their community, and would be a barrier to seeking police support. They reflected that the barriers were exacerbated for male victims because of issues of shame and it being a sign of 'weakness' for a man. They also described that a barrier in Paul's case, was fear of retribution.

4.38 His family described the reasons Paul may have hidden or not recognised the abuse he was clearly experiencing, specifically in relation to his gender. They described the indicators of coercive and controlling behaviour by Julie underpinned by Paul's fear of harm from her, they felt that she had a 'hold' over him that they couldn't explain. A male member of the family suggested:

'It feels to me like we're getting a bit better getting that message out to women...Men are totally different kettle of fish, aren't they? Men have gotten proud. Like I know women have it a lot. I'm good at hiding all my feelings …but they don't want to feel like the weak person. So, all I want to say is it's not weak to speak.'

4.39 Practitioners describe conversations or assessments with Paul and how he struggled to articulate indicators that would be recognised as signs of domestic abuse and coercive control.

His presentations at acute and community health services (including his GP) often focussed on his mental health, and emergency health situations (for example being in a car accident or being stabbed). These interventions were responded to or acted upon generally as would be expected. They described also how during these conversations Paul was not able to use the 'language' that may have ordinarily triggered practitioners to consider domestic abuse as an issue. His family suggest that he would not have thought that this was what

was happening to him and therefore it isn't surprising that he was unable to express what was happening to him in his interactions with practitioners.

4.40 Paul talked about other stressors affecting his life and mental health, including housing needs, family relationship breakdown and trauma from the death of his grandparent. At times he would state he was not in a relationship or that his problems were '*all in his head'* instead of perhaps being caused perhaps by abusive, controlling behaviour and the fear he was experiencing. One practitioner described that Paul was *'quite open….* [and] *sometimes when someone's very open, we hear about other areas of their life and others can be missed*'. This underpins the importance of professional curiosity and remaining live to unconscious bias in the context of who may experience domestic abuse.

4.41 Another factor explored by practitioners that may have prevented domestic abuse being identified by them and named by Paul was the high level of violence he had experienced in other areas of his life, through his experience of criminality, weapons, exploitation and as a child victim of domestic abuse.

The Government's 'Supporting male victims' policy paper[43] provided a commitment to ensuring that all victims/survivors of crimes including rape, sexual violence, domestic abuse, stalking, 'honour'-based abuse including forced marriage, 'revenge porn', and the harms associated with sex work, receive the support they deserve. The report noted that men and boys may face particular challenges to disclosing abuse due to stereotypes and out of fear of not being believed, and that in the year ending March 2018, only 50.8% of male victims of partner abuse reported telling anyone personally about abuse, compared to 81.3% of female victims. A local profile of those most at risk[44] indicates that domestic abuse in Liverpool is predominantly perpetrated against women (75%),[45] but that over the last 5 years crimes recorded with male victims/survivors have been increasing.[46] 57% of male victims[47] were

[43] Supporting male victims (accessible) - GOV.UK (www.gov.uk)
[44] Source- Liverpool City Council's Domestic Abuse Needs Assessment, Maura Carr, September 2022
[45] 75% female (7,641) and 25% male (2,531). Source Merseyside Police, Delphi 2021. NB: changes to children's status under the 2021 Act are yet to have a statistical presence
[46] Taken from the LDAPB's Safe accommodation strategy 2021-24
[47] Where we have data on survivors, we will use this term as a preference. Where there is no data available on the status of the person harmed we will use the terminology used within the data reports. ONS and Police data use the term 'victim'.

aged between 20-39 years (30-34 age group most at risk) and this is disproportionate to Liverpool's demographic profile.

4.42 Although general services such as Liverpool's IDVA service, and Merseyside Domestic Violence Service will provide services to male victims, specialist services for male victims are relatively limited across Merseyside, with only the Paul Lavelle Foundation (which sits on the Domestic Abuse Partnership Board) specifically designed to meet the needs of male victims. Research[48] highlights the impact of gender in terms of recognising abuse, how it is vital that criminal justice, domestic abuse and other agencies believe and validate their experience. Furthermore, men need to know that help is available and how to access it. Similar factors and may have impacted Paul's ability to recognise the risk posed to him as the coercive control and violence, including use of weapons, escalated.

4.43 Merseyside Police IMR identified that Paul was reported as the perpetrator of domestic abuse in each of the incidents they were involved in during the period under review, these did not directly involve Julie although she reported to reviewers that she was present at one incident where Paul is said to have assaulted his mother.

Police advise they are satisfied that the correct risk assessments were undertaken in line with MERIT processes and that appropriate referrals were made via the VPRF1 process, though they accept this could also have been shared with services already providing care (e.g. his GP). The IMR confirms responses were in line with Merseyside Police 'Calls and Response' and 'Domestic Abuse' policies. The reviewing officer commented within the IMR that domestic abuse was well understood by officers who attended incidents between Paul and members of his family. They recognised that his use of cannabis together with excessive consumption of alcohol and prescription medication was having a detrimental effect on his mental health, resulting in his bizarre and violent outbursts which his family were no longer able to manage.

[48] Wallace, Wallace, Kenkre, Brayford and Borja (2019), *Men who experience domestic abuse: a service perspective*, Journal of Aggression, Conflict and Peace Research Vol 11 No 2 pp127-137

However, it appears that because those notifications were submitted in the names of female family members (as victims) Paul's additional vulnerabilities (linked to his worsening mental health and reported substance misuse) were not explored. The two VPRF notifications were not linked (because he was named as a perpetrator, rather than a victim) and so did not trigger considerations (in line with s42 Care Act) of whether he was experiencing abuse and if any care and support needs prevented him from keeping himself safe.

4.44 While Paul's family members alerted police to their concerns, they subsequently withdrew as they did not want him prosecuted. The Police IMR report also recognises that, because the domestic abuse incidents were not reported within her home or involving her, Julie and Paul's relationship wasn't considered.[49]

4.45 Within their IMR and chronology, the Probation Service have identified learning on reflection of this case and their involvement with Paul in terms of identifying domestic abuse.

They explained the 'Probation Service has a national policy Domestic Abuse Policy Framework Document … confirms that identifying offending and behaviours that are indicative of domestic abuse are a priority, and that all Probation Practitioners should use professional curiosity to ensure that domestic abuse issues in terms of managing actual and potential victims remains a focus throughout any period of statutory intervention.'[50] Probation's IMR acknowledges that sentencing information was not accurately recorded for a non-domestic abuse related conviction that took place of Paul, and this impacted on the practice that followed. Paul's own history as a domestic abuse perpetrator (in relation to incidents concerning his parents/ grandparents and aunt) was not reviewed until later and that the request or the response from the police was then uploaded onto the case records. They accept that, when he later disclosed, he was in a relationship with Julie, this should have resulted in

[49] Taken from p9 of Mersey Police's IMR
[50] Taken from p8 of the Probation IMR

a review of the OASys assessment and that checks should have been undertaken, including to ascertain if Julie had children.

4.46 They acknowledge significant staff shortages[51] both at Court and within local probation delivery units reduced capacity. This was likely the cause of the inaccurate recording including in relation to his sentence.

They detail that, had breach proceedings been initiated, this could have resulted in an extended period of supervision which, in turn, may have enabled a refocus on the rehabilitation activity requirement days. The Probation IMR author explained, the "*Enforcement of Community Orders, Suspended Sentence Orders and Post-sentence supervision*" policy confirms that for any failure to comply a warning letter should be issued unless a warning letter has been issued within the previous 12 months in which case breach action should be commenced. For Paul, a final warning was issued on four occasions during this 12-month Order, and there were a further 13 occasions when there was non-attendance, or the status of the attendance was not recorded and there was no enforcement action. They also accepted that a home visit should have been undertaken both at the commencement of the order and when he reported a change of address. This may have increased the chance of identification of risks to Paul including domestic abuse. Probation suggest that officers displayed a lack of professional curiosity (measured against the extended standard set out in the 'Practitioner: professional curiosity insights guide' issued in October 2022). This is especially in relation to links to organised criminal groups, the degree of his mental ill-health and the nature of his relationships, levels of substance misuse and frequency of address changes and mobile phone numbers.

[51] In the form of a very high vacancy rate and inexperienced staff group with substantial training needs. Probation Offices in Liverpool were under significant staffing pressures throughout 2021 and 2022. PSO2 has advised the IMR author that when she was allocated responsibility to manage Paul (on 12/05/2022) she was allocated multiple cases at the same time, and that she was under extreme pressure of work. As a result, she did not have the capacity to read the case record in detail, and was unable to identify the remedial actions that could have been undertaken, i.e. implement Rehabilitation Activity Requirement days, conduct a home visit, check with other agencies to see of there are an issues with domestic abuse for Paul as a victim.

4.47 It is important to note that in June 2021 the Probation Service reunified, bringing together the previous National Probation Service and the Community Rehabilitation Companies. Alongside the national structural change within Liverpool there was significant local change- a complex reorganisation of the management of cases in North and South Liverpool. This reorganisation of cases was undertaken in May 2022 (it was at this juncture that his second probation officer was allocated and had been allocated multiple cases in addition to those they were already carrying). This increase in cases added to their already high caseload. In addition, there was no handover of cases from the previous officer.

4.48 More positively, the Probation IMR author reports *'there has been significant recruitment and delivery of a regional a quality improvement plan which has driven practice development in several areas:*

- Extensive training on DV and Safeguarding practice
- Training and review of home visit practices
- The introduction of new allocation system from courts
- Enforcement practice.
- Professional curiosity in assessment and management of cases
- Improved Management feedback and oversight structures.

4.49 Mersey Care report within their IMR that practitioners complied with expected standards. During review period Paul was referred to their SPOA which resulted in an assessment by the Early Intervention in Psychosis Team.

Whilst there were no indications of psychosis, he was offered and accepted a referral to the Young Person's Advisory Service. The IMR confirmed the assessment was conducted in line with NICE guidance. He also came to the attention of Mersey Care following his arrest for possession and for assault. On the first occasion he was released prior to the referral but it was noted by the

custody sergeant there were no concerns regarding his mental health, on the second he refused to engage.

4.50 Paul's GP signposted him to referred him to TALK Liverpool counselling service, Samaritans, Mersey counselling, listening ear, Liverpool Independence, Anxiety UK, and the Liverpool Crisis Team and to Norris Green Debt Advice Service.

They also submitted a referral to CMHT which was returned by Primary Care MH team on the 25.11.22 requesting more information regarding risk factors. Shortly prior to this, however, he had spoken with the Crisis team on the 15.10.22 and been assessed by the MH Liaison Team in Aintree Hospital's A&E reporting suicidal ideation and that he posed a risk to others. Again, he was not assessed as presenting with psychosis so was discharged as detailed above.

4.51 Mersey Care's IMR concluded appropriate services were provided and/or offered to Paul during his contact with Merseycare NHS Foundation Trust.

The chronology evidence's professional curiosity during trust staff's contact with him, and evidence of a trauma informed approach to his care for example, taking into consideration his history of Adverse Childhood Experiences [ACEs] and subsequent offers of support being offered such as the Whitechapel Centre, Substance Misuse services and a referral to the Young Person's Advisory Service [YPAS]. There is evidence of good communication between Trust services to his GP. Though it is noted that there was no response from the GP from the Step Forward team's request for further information regarding his mental health sent in November 2022.

4.52 Within LUHFT's IMR they note that Paul said on his admission to hospital earlier in 2022 (due to being stabbed with a knife) that he didn't feel safe at home, they advise that he later didn't elaborate on this when spoken with and was aggressive to staff when they explained Julie should allow them to examine him alone.

4.53 His GP reflected in their IMR that they did 'not think we thought 'family' at all in supporting Paul since consideration of any support for them was not documented in clinical records.

I can only make assumptions based on my years of clinical experience that this was because he was an adult who had the capacity to make informed choices about whether or not to engage with services that were there to support him, to remove himself from people that posed a risk to himself, and to stop engaging in 'risky behaviour'. We are more likely to 'think family' when dealing with children and young people who are dependent on guardians/parents for their welfare, and to whom these guardians/parents have a statutory responsibility, because if we support the caregivers to be able to give that care then we are meeting our statutory safeguarding (if not moral!) responsibility as agencies and protect children from harm.'

4.54 His GP reported they were not aware of Paul's alleged threats to his father that resulted in a VRFP1 on the 3.10.22, (nor of the threat with a knife against his mother on 12.10.22 and throwing his aunt down the stairs in October 2022) that apparently led to his arrest and subsequent bail.

Had they been aware, they explained this might have changed the risk assessment a mental health colleague made during a consultation on 13.10.22 as documented above. Whilst the GP commented '*It is not feasible nor meaningful for every VRFP generated to be shared with the GP; however, is there any evidence to suggest/does any research need to be done into the criteria for when the sharing of VRFPs with key agencies would make a difference to the outcome? Anecdotally, there appears to be no inconsistency with when GPs receive VRFPs when children are involved either.'* Paul's GP

suggested using digital information tools overlayed on to LA data (CSC contacts, Youth Offending Services, Housing etc.) to highlight the most vulnerable adults/families so they could support with an integrated care approach to reduce the vulnerabilities. '*Ironically, while saving 'cost' in the long term, it will likely require extra funding in the short term*.'

4.55 Throughout the chronology, concerns regarding Julie's alcohol consumption are noted and she is referred for support both by the Consultant Psychiatrist (01.02.19) and Aintree Hospital's alcohol team (16.05.19, 10.10.19) to opt in to support from Liverpool Community Support Hospital. Similarly, there are examples of Paul being offered referrals for support to manage his substance misuse on the 15.10.22. On the 24.11.22, his GP also raised concerns regarding drug seeking behaviour within the referral to SPOA.

4.56 Merseycare's IMR notes Paul's reluctance to accept a referral to substance misuse services, along with the GP's observation of drug-seeking behaviour, indicated a resistance from Paul to addressing his substance misuse issues. But that appropriate offers were made to both Julie and Paul to address those issues.

They concluded that referrals were responded to and assessments completed within expected timescales, practitioners exercised professional curiosity and adopted trauma-informed approaches. Those assessments and interventions demonstrated Paul did not have a severe and enduring mental illness. Rather his low mood was attributable to social stressors including substance misuse, housing issues and violence. It is not clear how the 'violence' stress was explored or responded to. They also note evidence of strong multi-agency working across Trust services, police and with his GP. They found no evidence of Trust's capacity or resources adversely affecting services offered but commented that although Paul did not die from suicide, initial learning from this review includes the recognition of the link between domestic abuse and suicidal ideation. In addition, to the importance of professional curiosity and ensuring that a trauma informed approach is utilised in individuals who experience ACEs.

4.57 LCC's HOS recognise that Paul's application on the 11.10.22 should have been triaged as an urgent referral in accordance with their policy, as he had disclosed mental health concerns. Within their IMR, HOS comment that Careline staff (who forwarded the referral) could have been expected to review their IT records and include appropriate information to add to the referral. However, this is likely only to have identified he had been identified as a perpetrator of domestic abuse within a VPRF1 in January 2020 and again in October 2022. Careline do not have access to Merseycare, LUFT or GP records which is where his vulnerabilities had been recorded. They do highlight though, that the information he disclosed may have suggested a need to complete an assessment under the Care Act 2014. In any event, the HOS' urgent referral process should have been applied and required a response within 1-2 working days.

4.58 Furthermore, there is no explanation as to why, when he called again on the 13.10.22 this mistake was not rectified, or why he was not offered emergency accommodation in line with duties under the Homelessness Reduction Act 2017. Within their IMR, they offer to include this case within an internal review of access to their service. By way of mitigation, the service experience significant disruption during this period in response to the Covid-19 epidemic and Government guidance regarding the cessation of face-to-face assessments and the 'everyone-in' policy which placed considerable strain on existing resources. Since 08.01.24 HOS now offer some face-to-face assessments and have indicated they will be offering staff further training in 2024. Had Paul been identified as a victim of domestic abuse, the Local Authority would have been subject to the duty to provide safe accommodation to him under the Domestic Abuse Act 2021.

Safe Accommodation

4.59 Liverpool data demonstrates domestic abuse is a significant feature in immediate risks of homelessness in the area. In 2023-23, 11.5% of people supported via prevention or relief housing duties identified domestic abuse as a support need. Reliance on private sector or sofa surfing is unsustainable and too often results in those at risk, as in Paul's case, returning or remaining in abusive situations rather than face insecure housing.

4.60 Within their IMR, Merseyside police [at p8] highlighted the VPRF1 submissions following interventions by them *'good practice to ensure that mental health services and the GP involved with Paul were made aware of the incidents involving his family, and of the escalation in his behaviour which led to him living with Julie. This may have resulted in partner agencies discussing the provision of more suitable accommodation for Paul, while this may not have altered the outcome it may have reduced the opportunity for Julie to perpetrate further domestic abuse.'*

4.61 Paul's GP, within their IMR [p10], explained from their perspective the solution to better joined up working regarding safe accommodation was 'not straightforward; nor does it necessarily involve all the services – another multidisciplinary team meeting cannot be the answer – we don't have either the staff time or resources. It is not uncommon for GPs and Mental Health Services to hear patients describe 'having anger issues' or 'worried they might go to prison' or 'I want to hurt someone' – I do not think it the best use of resource to investigate/have MDTs about all of these. Nor do I think the current situation of people being advised to 'get a letter of support from your GP' to get them prioritisation on property pool is of any value in most cases.

Good Practice

4.62 There was good practice noted by Paul's GP who demonstrated professional curiosity and sought to engage Paul in talking therapies rather than rely solely on medication to address his poor mental health. Within their IMR the practice commented on this 'we tried to support the patient to take what control he could over the limited choices he had in his life. The reality on the 'front line' while we can and do try to support patients with the resources we have, we are so limited and so much of what is in our gift is simply a 'sticking plaster'.

4.63 There is evidence of good communication between health services, specifically the GP and Merseycare for Paul. In addition, Merseyside police VPRF1 submissions following interventions ensured that mental health services and the GP involved with Paul were made aware of the incidents involving his family, and of the escalation in his behaviour which led to him living with Julie.

4.64 Following Paul's death his family describe that the Police Family Liaison Officer they've worked with has 'been amazing' and would like to pass their gratitude to that officer.

5 Conclusions and lessons to be learnt

This review sought to illuminate the experiences of Paul as a victim of domestic homicide. This included how his childhood experience of domestic abuse may have impacted on his later life.

Given what was known, or could reasonably be expected to be known, no agencies involved in supporting either Julie or Paul believed they could have predicted (and therefore prevented) the tragic outcome. This view is supported by reviewers. However, there is learning to be gained from other factors arising within this review.

The review used the following lines of enquiry, the conclusions below reflect a summary answer to each question that was posed, and identifies key learning points, with full details contained within the review chronology and analysis sections.

Were agencies involved in responding to concerns, aware of the risks associated with adverse childhood experience and trauma? Were assessments and interventions trauma-informed?

5.1 There is evidence that some agencies and practitioners demonstrated a trauma informed response to Paul, particularly within health provision, in terms of assessing and responding to his mental health and substance use. It is evident that some adult health services had knowledge of elements of Paul's adverse childhood experiences and this information was shared in their referrals within health. This was limited initially to his 'history of trauma and neglect', with Paul giving some further details in his conversations with practitioners. This knowledge was not shared across the partnership but held in limited records by CSC and health services.

5.2 It is not clear if the full extent of his trauma was known or understood during contact or assessments with all agencies. In his contact with Probation, Paul gave information about his childhood experiences and trauma however this was not followed up in their response and learning from this has been identified by Probation services in their IMR for this review. There is evidence that within some (mostly health) agencies that a trauma informed strategic systems focused approach is happening or planned / aspired to, for example some agencies reported staff development has taken place to develop knowledge, and this is informing assessments. However, this is not, as yet, partnership wide.

Learning Point: Being a child victim of domestic abuse and experiencing significant trauma in childhood exacerbates the risk of harm and mental ill health in later life. It is vital that there is a partnership led, system wide commitment to implementing trauma informed practice in Liverpool. This is needed to inform every interaction with individuals, families, and communities. There is a specific need for this in criminal justice responses. This should include awareness raising of the impact of adverse childhood experiences and traumatic events throughout a person's lifespan. Practitioners should be encouraged, through policy and operational practice support, to exhibit

professional curiosity regarding adverse childhood experiences and their long-term impact for an adult at risk. Recommendation 1, 3, 4, 5, 7 and 8 are linked to this learning point.

What safeguarding, drug and alcohol, mental health and domestic abuse policies and procedures applied to this case, were they adequate and were they followed? Is there evidence that partners were 'thinking family' in response to the risk identified, including taking into account heightened risks associated with drug and alcohol misuse, mental health and domestic abuse, during the review period?

5.3 Over the period covered by this review, Paul requested support from agencies for his mental health and housing, but he was not able to disclose domestic abuse, and there is no evidence that he was regularly asked.

It is striking to hear from his family about the frequency and severity of the abuse he was experiencing, yet this was completely invisible to practitioners and services working with him. Paul talked to practitioners about other stressors affecting his life and mental health, including housing needs, family relationship breakdown and trauma from the death of his grandparent. At times he would state he was not in a relationship or that his problems were *'all in his head'* instead of perhaps being caused by possible abusive, controlling behaviour and the fear he was experiencing.

5.4 Several policies and procedures exist in the agencies participating in this review. Most agencies were able to identify where their agency policies and procedures were applied and where they were not, as is detailed in the 'analysis' section of the report.

5.5 There were opportunities missed by agencies working with Paul in their contact with him regarding his mental health, probation requirements and his housing needs, to proactively ask about intimate personal relationships. There is a chance that subsequently this may have led to conversations with Paul that may have flagged indicators of the coercive control and domestic abuse. However, as has been explored, it is likely given the evidence from family relating to issues of shame, his gender and distrust of services, that he would not have disclosed the abuse as a result.

Learning Point: Exposure to serious domestic violence in childhood, together with the gender and cultural expectations described by his family likely prevented Paul from reporting abuse. Where he reported needing support, with his mental health, housing needs and substance misuse, services were offered but relied on Paul to follow up on referrals. It has long been established that ACEs, coupled with poor mental health and substance misuse can trigger violence within intimate relationships. Those within this review accept there was a lack of professional curiosity (despite a history of child exploitation) in exploring whether Paul may be subject to coercion or otherwise unable to protect himself. In addition, partner agencies were aware of risks posed by him to family members. Despite this, risk assessments did not trigger MARAC input in Oct 2022 notwithstanding the use of a weapon, until after the fatal stabbing. Citysafe may wish to review whether the current risk matrix is weighted appropriately, given the changes introduced by the Domestic Abuse Act 2021 and ensure this enables identification of risks to relatives. They should also review the gold, silver and bronze rating to consider if use of an offensive weapon within a domestic abuse incident should automatically trigger a MARAC referral. Recommendations 1, 3, 5 and 7 are linked to this learning point.

How well was domestic abuse understood, risk assessed and responded to by the services that were involved in this case?

5.6 There is little evidence that practitioners asked about domestic abuse, or that it was known to them. There is also little information to suggest that domestic abuse was explored with Paul, either as a victim or a perpetrator and as a result there was no consideration given to completion of a domestic abuse risk assessment to identify the risks posed to him. Paul was unable to articulate his experience as a victim of coercive control and domestic abuse to anyone. This led to 'silence' about the abuse; he was unable to disclose this to close family members, friends let alone Police and other practitioners that he was in contact with.

5.7 Paul's family were aware of the abuse he was experiencing, describing to reviewers how they saw visible signs of physical abuse, witnessed Julie's controlling behaviour and how they noticed his fear of her. They felt unable to report this in any way, and articulated the challenges for victims, particularly males, within their community in speaking about domestic abuse to Police or other statutory services. This includes shame, considering being a victim of domestic abuse as a 'weakness', fear of the repercussions for family or Paul from the perpetrator, fear of retribution, being seen as a 'grass' and lack of trust in services. The family described how they felt at the time it was better dealt with it in the family, but acknowledged that ultimately, they couldn't protect Paul. They suggested that peer led, community-based services would provide the opportunity for victims and family members to seek support. They also suggested city wide campaigns about domestic abuse, including targeting male victims and family members and how they can get help (beyond statutory services), suggesting a strapline along the lines of 'it is not weak to speak'.

5.8 On the occasions that domestic abuse was responded to in this case, it was because Paul was seen as a perpetrator of domestic abuse and a risk to his own family members. Police were called and the relevant risk assessments and responses took place. Most agencies were unaware of Paul's relationship with Julie, the coercion and control and domestic abuse that is alleged by his family to have been perpetrated. Therefore, no risk assessment took place that could have responded to the risks she posed to Paul.

5.9 Research further evidences the barriers explored in this review, particularly for male victims. This highlights how vital it is for criminal justice, domestic abuse and other agencies to believe victims and offer a trauma-informed response. Although some services are available for male victims across Merseyside, including a specialist service for men, the low uptake of these services indicates that barriers exist to men accessing domestic abuse services.

5.10 There is no evidence that specialist support was available to Paul as a child victim of domestic abuse. Specialist, therapeutic provision for child victims of domestic abuse is very limited nationally. It is crucial that any commissioning of such services considers national learning about specific impact for boys that have been child victims of domestic abuse.

Learning Points: Paul's family wanted the community to hear one simply message 'tell someone, get help!' There is a 'silence' about domestic abuse that prevents safeguarding of victims and their families, and justice for perpetrators prior fatal domestic abuse. Barriers to reporting domestic abuse and seeking support exist for all victims of domestic abuse and coercive control is often not recognised.

Male victims can be even more invisible to practitioners. This invisibility is compounded where communities are 'isolated' from statutory services because of fear of retribution if victims or families are known to be talking to statutory services such as the police. Community or peer led services may have more success in building trust and confidence to seek support.

Focused awareness raising is needed within communities targeting family members and male victims of domestic abuse. This should not replace or detract from work encouraging female victims to seek support.

Children should be recognised as victims of domestic abuse in their own right, as legislation suggests, with responses in place to meet their needs, including an evidence-based need for gendered approaches for child victims.

Recommendations 3, 4 7 and 8 are linked to this learning point.

Given the concerns expressed (including by Paul) that he may pose a risk to family members, what could services have done together to risk assess this and assist him find more stable accommodation?

5.11 Family members withdrew their complaints against Paul following incidents where he was deemed a risk to them, this was classified as domestic abuse by Police, risk assessed and VRPF's actioned appropriately. The assessments did not meet the threshold for a MARAC to occur and this meant no opportunities for sharing information beyond the VRPF process, including with housing services. As such no further action was taken by any agency.

5.12 Clear gaps existed in responding to Paul's accommodation needs as is explored in the analysis section. The lack of response and assessment to his housing needs following referral are of concern, particularly given the repeated referrals for emergency accommodation following a family breakdown and Paul disclosed he suffered from anxiety and depression. Housing Services highlight that the information he disclosed may have suggested a need to complete an assessment under the Care Act 2014. This mistake was not rectified later when Paul contacted the service, and he was still not offered emergency accommodation in line with duties under the Homelessness Reduction Act 2017. Within their IMR, Housing services suggest they will include this case within an internal review of access to their service. The service advises also that they now offer some face-to-face assessments and have indicated they will be offering staff further training in 2024.

Learning Point: Accommodation was not provided in this case as would have been expected under legislation. LCC should explore how the VPRF process informs wider departments, specifically with reference to duties to cooperate in respect of assessments across departments owed under s6-7 Care Act and how this interfaces with s42 safeguarding adult duties. Given Paul's history of ACEs and contact with CSC over concerns he was at risk of criminal exploitation, the learning from this review should be shared with the LCSP and LSAB to inform strategic priorities in respect to transitional safeguarding.

Recommendation 6 is written to address this learning point.

What learning can be taken from this case and national research on domestic abuse and knife crime to inform local strategic priorities and prevent future deaths.

5.13 Domestic abuse is not currently identified within City Safe, VRU or DISARM's strategic and operational plans to tackle knife crime and weapon use in Liverpool. There is evidence to suggest this is a national issue as well as local. However, a significant proportion of knife crime is carried out in domestic situations between adults, and in half of all knife crime the weapon is a kitchen knife from the home. The perception is, from media particularly, that knife crime is thought to be undertaken by anti-social and gang-related youths. Local leads for knife crime are aware of the potential challenges in responding proactively to reduce this operationally, particularly given that every home will have knives readily available.

Learning Point: Knives are used by perpetrators of domestic abuse, and this accounts for a significant proportion of knife crime nationally. Local strategic and operational strategies do not currently include domestic abuse or consider possible approaches to counteract the use of kitchen knives as a weapon.

Recommendation 7 relates to this learning point.

What services/ support are currently available to children, young and older adults (given Julie's reported involvement) exposed to organised criminal groups to support them to stay safe, were these services aware of risks to Paul?

5.14 As noted within section 4, the Violence Reduction Partnership and DISARM lead for the partnership in supporting responses to young adults exposed to OCGs. Merseyside Violence Reduction Partnership's website hosts a directory of services available to support victims and prevent serious violence, but this may not be widely understood within primary care or within services where young adults might come into sporadic contact, e.g. Housing Need services.

Learning Point: Services are weighted towards younger people who are more readily in touch with statutory services. Wider awareness of the support

available and detailed at https://www.merseysidevrp.com/ across Citysafe partners could enable a 'making every contact count' approach to have more impact in supporting young people to recognise risk, including those associated with intimate partner violence.

Recommendations 5,6 and 7 relate to this learning point.

How did agencies work to overcome barriers, including engagement with drug and alcohol service and mental health support, to reduce known risks, what more might be needed locally or nationally to address similar risks in the future?

5.15 Paul's substance use was known to services and is documented as forming part of conversations with him as well as referrals for specialist support and mental health assessments. Paul was referred to appropriate services. There is evidence of referral to Substance Misuse services and a referral to the Young Person's Advisory Service [YPAS]. There is evidence of good communication on this particularly between health providers and GP's. Julie's substance use was also known to health services and appropriate offers were made to both Julie and Paul to address those issues.

5.16 As the review evidence shows, risks to and from Paul escalated towards the end of his life – those close to him describe a change in his behaviour and appearance and this is likely to be linked to his use of crack cocaine. Multiple and escalating incidents in this later period occurred and were known to services. These highlighted the escalating risk Paul posed to others, and himself. Information was shared by health and mental health services and with Housing via Careline. Police shared information also using their VRPF notifications with the Local Authority, but these were not assessed as meeting the criteria for onward social care interventions, including for assessment under the Care Act or to safeguard him.

Learning Point: Paul was understood to be an adult with care and support needs due to poor mental health and substance misuse issues. It remains unclear why the VPRF notification submitted did not trigger further action. He had experienced significant ACEs and was known to the local authority (albeit to another department) to have at risk of exploitation.

Agencies shared the view he had capacity to protect himself. More exploration of the impact his experiences had on the 'normalisation of risk' and his executive capacity to follow up with support offered may have provided opportunities for him to recognise domestic abuse risks and secure support.

Recommendations 1, 5 and 8 relate to this learning point.

Recommendation 1: The current political strategic boundaries between domestic abuse, male victims, and serious youth violence policy does not support a full and humanising approach to those affected. There needs to be serious consideration of the way in which the current siloed policy and support structures create gaps for vulnerable young people. Partner agencies should report to CitySafe what actions they are taking to improve professional curiosity in this field and implement trauma informed practice across their organisation. CitySafe Together, working with partners, should consider how best to coordinate activity to socialise systemwide trauma-informed practice in Liverpool. This should inform every interaction with individuals, families, and communities, including within criminal justice agencies. There should be a focus on closer joint working between domestic abuse and gender-based violence organisations and youth offending/ OCG outreach organisations so that the impact of domestic abuse on boys can inform policy and practice development in response to the learning from this case.

Recommendation 2: Probation services provide assurance to the partnership on the impact of actions they have taken to address the learning identified in this review. Specifically, Probation Services to evidence how learning within their IMR has been integrated into practice and demonstrate how they monitor that there is now adherence to the 'Enforcement of Community Orders, Suspended Sentence Orders and Post-sentence supervision and Practitioner: professional curiosity insights' guidance.

Recommendation 3: Support services for children who have experienced domestic abuse have been cut significantly in the past decade. This is not only due to the wider cuts related to austerity, but also because of the increasing shift in domestic abuse support work to address 'high-risk' victims without adjoined children's support. Now children are explicitly recognised as direct victims through the Domestic Abuse

Act 2021, Citysafe should explore how a gendered understanding of how children process domestic abuse should inform health relationship programmes and direct support for child victims of domestic abuse. This should include the development of gender-specific and masculinity-aware interventions for male child survivors. This should recognise the impact for boys experiencing early male violence on their own identities and how this may affect the way in which they instrumentalise violence themselves. Community based and/or 'by and for' domestic abuse specialist services, together with specialist domestic abuse commissioners, should report to the partnership on the support that is available to encourage victims of domestic abuse, and their family members to seek support, particularly focussed on specific 'isolated' geographical communities and male victims.

Recommendation 4: City Safe and partner agencies should promote awareness of male victims across frontline services to facilitate improve professional curiosity and the identification of male victims within the wider community. This will better support abused men to recognise victimisation, understand what services are available and know it is acceptable to seek help and receive practical support.

Recommendation 5: Statutory safeguarding agencies should provide assurance to the Partnership (and Liverpool Safeguarding Children Partnership and the Safeguarding Adults Board) that children are recognised as victims of domestic abuse 'in their own right', with responses in place to respond to their trauma, consider gender and support their recovery. This should extend into adolescence and mirror the aspirations detailed within the knowledge briefing 'Bridging the Gap'.[52] This should include reporting on how agencies can work together to dynamically identify young people who are at increased risk due to transitional/ contextual safeguarding risks and what the expectation is for partners to work together to offer therapeutic, preventative support to reduce that risk into adulthood.

[52]DHSC, 2022 'Bridging the Gap' report available at: https://assets.publishing.service.gov.uk/media/60b108a88fa8f5489192fdb3/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

Recommendation 6: Housing Services should provide City Safe assurance in terms of their learning and actions taken following their internal review of this case. This should include assurance of how the service has improve professional curiosity within their teams regarding domestic abuse and that it is responding to requirements to provide safe accommodation as detailed in the Domestic Abuse Act 2021.

Recommendation 7: DISARM and the Violence Reduction Partnership [VRP] should ensure that domestic abuse is included in their strategic and operational responses to prevent and respond to knife crime and that this considers best practice / possible approaches to prevent the use of kitchen knives as a weapon as far as possible. DISARM and VRP should be invited to engage with the MARAC remodel to explore how support professionals to safely engage with victims and perpetrators where offensive weapons are a feature. CitySafe to consider if all domestic abuse incidents resulting in injury with an offensive weapon (including non-life threatening) should automatically be graded as Gold risk level.

Recommendation 8: Merseycare and Liverpool City Council should review guidance to partner agencies on when to use professional judgement and refer safeguarding concerns (including through VPRF forms submitted by the police). Merseycare and Liverpool City Council should also explore internal information gathering processes to ensure relevant case information is available to the triaging staff so that appropriate consideration can be given to whether duties under s42 Care Act (safeguarding adults) or access to multi-disciplinary meetings (such as the MARAM or Complex lives panel) are considered alongside referrals to the MARAC process.