Joint Domestic Homicide Review

"Matt" who died in April 2022

LDHR26 Overview Report January 2024

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A tribute to Matt

Matt's mother lovingly described Matt as a happy-go-lucky gentle giant, "a pain in my bum" who loved to joke and tease but was protective and caring. He and his brothers were raised to walk away from a fight, and never to raise their hand to a woman and his mother was proud of the kind, thoughtful man he had become.

When Matt first brought Penny home to meet his family, he seemed really happy, and she appeared nice. Although she was on an electronic tag, his mother didn't want to judge her or pry into the reasons, giving Penny the benefit of the doubt. One of Penny's ex-partners approached Matt's mother and warned her that she was dangerous, but she thought this was sour grapes – his mother's distress about not taking this warning seriously was heartbreaking, but this is a testament to her generous nature.

Matt soon became withdrawn and started to avoid seeing his parents, but his brothers were aware that he had black eyes, and that she was hurting him in places that his mother could not see. Penny was taking his money to buy drugs and alcohol, and depressed, Matt started drinking more too. On one occasion, Matt and Penny both stayed at his parents' home and although they were not aware of her history of stabbing a former partner with scissors, during the night, his mother went downstairs and hid the kitchen knives, instinctively recognising the danger Penny posed.

Later in their relationship, on one occasion Matt pushed Penny to the ground and restrained her when she was assaulting him, resulting in his arrest and he was distraught that he had put his hands on a woman. His mother was very upset, telling him that he had not been raised to hurt women. Penny sent Matt's mother a photo of her bloody nose, but her father later told his mother that this was a photo she had taken years earlier after hitting herself in the face with a remote control, and that she had previously used the same photo to make allegations about other ex-partners. This was later confirmed by police during the murder investigation, as the photograph had an electronic date stamp.

As the abuse intensified, on one occasion Matt came home with blood streaming down his face after Penny tried to bite his nose off, although he had walked out of hospital without treatment and had not reported this to police. Matt's mother told him that she didn't want him to keep seeing Penny, but he replied that he was "*old enough and ugly enough*" to know his own mind. However, unknown to his mother, Penny was reportedly threatening Matt that she would send a gang to his parents' house to burn it down or shoot his mother and she had said to one of his cousins that "*with my mental health history, I can get away with stabbing people*".

Matt's father provided a victim impact statement during Penny's sentencing:

> *"Family was important to [Matt] and he had a close relationship with all of us… As his dad I saw the person I had known for 35 years change before my eyes as this is how old he was when he met [Penny]. The son I knew and loved disappeared, he was a shadow of his former self. We tried to give [Penny] the benefit of the doubt when we first met her, that was the biggest mistake we made. Had we have known about her past we would have done more to get [Matt] away from her. We did not know just how dangerous she was."*

Matt's mother described that his father "*lost his spark*" after Matt's death and tragically died himself a few months after Penny was sentenced. In his final hours, he saw Matt waiting in his hospital room, and Matt's mother takes comfort that they are looking after each other, as Matt's brothers are looking after her.

Matt's mother expressed her hope that this review will help develop better support systems for male victims of domestic violence. She is devastated that Matt did not tell her about the abuse he was experiencing and wished to encourage men to speak out when they are being harmed.

She pleaded: "*Please, don't be silent.*"

1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Matt, who was a resident of Knowsley prior to his death in April 2022. 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 Liverpool Citysafe Board (Citysafe) and Knowsley Community Safety Partnership (KCSP) have jointly commissioned this domestic homicide review (DHR) following Matt's death, as his partner, 'Penny', who was the perpetrator, was well known to services in Liverpool prior to the murder. 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.

1.3 In April 2022 Penny stabbed Matt in the chest at her home address in Liverpool. Penny called an ambulance, reporting that she was performing CPR although it transpired that she had not done so, and Matt was taken to Royal Liverpool Teaching Hospital where he tragically died of his injuries. Two days later Penny was charged with murder and remanded into custody. She was found guilty of this offence in October 2022 at Liverpool Crown Court and sentenced to life in prison with a minimum term of 18 years.

1.4 The DHR panel and author wish to express sincere condolences to all members of Matt's family for their loss. His mother met with the author with the support of two of his brothers to share her memories of Matt, and her insights into his relationship with Penny. We are very grateful for her contributions to the report, her love, warmth and grief were very moving.

2 Governance

Purpose of a Domestic Homicide Review

2.1 The review will consider agencies' contact/involvement with Matt and Penny from May 2021 when Matt and Penny were known to be in a relationship to Matt's death in April 2022. However, Penny's relationship history has also been explored during the review, as this is relevant to agencies' understanding of the risks she posed as both a perpetrator and victim of violence.

2.2 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

2.3 Liverpool City Council (LCC) Safer and Stronger Communities received the notification of the death by Merseyside Police on 14 April 2022 and requests for background information were sent on 19 May 2022. The DHR Standing Group met in on 4 August 2022 to consider the case and recommended a DHR should be conducted. The Citysafe Board approved this recommendation on 23 August 2022. The Home Office were informed of the recommendation to conduct a DHR on 21 December 2022. This delay was due to the ongoing criminal investigation and trial. Further, due to staff sickness in Knowsley CSP, there was delay in approving a decision from them to conduct a joint DHR.

2.4 This review began on 15 February 2023 and was concluded on 19 July 2024. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

This review has been delayed to facilitate the participation of Matt's mother, who wished to contribute but was unable to meet with the reviewers for several months due to personal circumstances. Citysafe and KSCP agreed that this delay was necessary. A draft report setting out the author's preliminary findings

was provided to the Citysafe and KSCP in May 2023, to ensure that learning could be disseminated without delay.

Confidentiality

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

2.6 Matt was a white British man who was aged 36 at the time of his death in April 2022.

2.7 Penny was a white British woman who was aged 30 at the time of Matt's death.

Terms of reference

2.8 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. The 2021 Act also introduced new measures designed to '*drive consistency and better performance in the responses to domestic abuse across all local areas, agencies and sectors*.[1]

2.9 The key lines of enquiry will be:

- How was the support offered tailored to Matt as a male victim of abuse? What resources are available to male victims locally?
- Given what was known of Penny's behaviours when intoxicated and recent criminal convictions, could more have been done to put in place protective measures through MARAC partners?

[1] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet

- How well do partner agencies understand and respond to risks associated with female perpetrators of domestic abuse?
- Penny had experienced sexual abuse as a child and domestic abuse throughout her life, and had her children removed from her care; what impact did these traumas, her learning difficulty and substance misuse have on her ability to engage with support offered to address her mental health, substance misuse and abusive behaviours?

Methodology

2.10 The review used a hybrid methodology incorporating tools from the Social Care Institute for Excellence Learning Together method. In addition to reviewing internal management reviews and chronologies prepared by each agency, multi-agency learning events took place, both with front-line practitioners who worked with Matt, Penny and her father, 'Kieron' and the leaders who oversaw the services involved in supporting them. By this time information had been collated into an early analysis report to facilitate a system wide view of activity with Matt, Penny and Kieron. The early analysis report was used to facilitate the discussions with practitioners and managers, to obtain an accurate understanding of the challenges and constraints they faced in working with Matt and Penny, to identify learning about potential improvements that could strengthen the system for other people who find themselves in similar circumstances.

2.11 The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published reviews. Learning from good practice and a discussion of the legal framework will also be included.

By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing good practice, adopting a whole system focus. The learning produced concerns 'systems findings. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard in response to domestic abuse, within and between agencies.

Involvement of family

2.12 After careful consideration of the personal circumstances of Penny's father, who is referenced in this review, Citysafe took a decision that it would not be appropriate to initiate contact with him.

2.13 After consultation with the police family liaison officers who had closely supported Matt's family, Citysafe took an initial decision to delay contacting his parents as a consequence of their personal circumstances. In July 2023, the family liaison officer contacted Matt's parents to explain the review process and facilitate an introduction to the review author. The author sent a letter on 6 July 2023, explaining the review process, offering advocacy support and enclosing the Home Office DHR leaflet and terms or reference. The author spoke with Matt's mother, who explained that she and her husband would like to participate in the review, but due to their personal circumstances, they requested a delay of 2 months. Very sadly, Matt's father passed away in September 2023. Matt's mother generously agreed to meet with the author, although a further delay was agreed in respect for her bereavement, and a meeting took place in December 2023. Although it was initially intended that this meeting would be in person, this took place by way of videoconference to support the mother's health needs, and two of her sons supported her during the meeting.

2.14 The final report was shared with Matt's family on 16 July 2024, and they were invited to comment on the report and make amendments. The author and LCC's Team Leader for Victims and Vulnerable People met with Matt's mother on 19 July 2024 and although saddened by the missed opportunities to protect Matt against Penny's violence, she was positive about the learning from the review and the commitment by Citysafe and KCSP to take steps to reduce the risks to male victims of domestic abuse.

Contributors to the review

2.15 The following agencies provided returns indicating whether they had contact with Matt and/or Penny that was relevant to the review.

- Liverpool City Council- Community Safety Partnership, Housing team and Adult Social Care, Children's Social Care
- Liverpool MARAC
- Knowsley City Council- Community Safety Partnership, Community Safety team and Adult Social Care
- Knowsley MARAC
- Merseyside Police
- Probation service
- GP practice for Penny and Matt
- Liverpool University NHS Foundation Trust (LUH)
- Liverpool Women's Hospital
- Mersey Care NHS Foundation Trust (in respect of Penny's involvement with Criminal Liaison and Diversion Service and CMHT)
- North West Ambulance Service (NWAS)
- LIVV Housing Group
- We Are With You (Substance Misuse Service)
- Whitechapel Centre (Homeless and Housing Charity)
- National Society for the Protection of Children
- Liverpool Domestic Abuse Service (LDAS)
- Person Shaped Support (a social enterprise that supports people in the community to live fulfilled lives)
- Independent Domestic Violence Advocacy (IDVA)

2.16 The following agencies provided internal management reviews and chronologies detailing their involvement with Matt and/or Penny.

- Liverpool City Council - Adult Safeguarding
- Knowsley Community Safety Partnership
- Mersey Care NHS Foundation Trust
- Merseyside Police (chronology only)

- North West Ambulance Service
- Probation service

2.17 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 members

2.18 The author was supported to complete this review by the review panel, the membership of which is listed below. The panel met initially on 15 February 2023 to agree terms of reference, the methodology and panel membership. Panel members confirmed they were independent and had not previously been involved in the case or had responsibility for line managing staff supporting Matt or Penny.

Name	Job title	Organisation
Sarah Williams	DHR Panel Chair & Overview Report Author	Independent Consultant, Safeguarding Circle
Michelle Hulse	Team Leader Victims and Vulnerable People	Safer and Stronger Communities, Liverpool City Council
Maria Curran	Risk Assessment Co-ordinator	Safer and Stronger Communities, Liverpool City Council
Debbie Phillips	Domestic Abuse Officer	Safer and Stronger Communities, Liverpool City Council
Leanne Hobin	Detective Chief Inspector	Merseyside Police
Kerry Dowling	Senior Manager	Local Solutions (IDVA Service)
Sandy Williams	Head of Safeguarding	Adult Social Care, Liverpool City Council

Name	Job title	Organisation
Julie Johnston	Safer Communities Service Manager	Safer Communities, Knowsley Metropolitan Borough Council
Rita Chambers	Head of Services Children & Families	PCC Turnaround Project/Ruby Project
Anne Monteith	Assistant Director Nursing Safeguarding	St Helens and Whiston Hospital
Chantelle Carey / Carmel Hale	Designated Nurse for Safeguarding Children / Adults – Liverpool Place	Cheshire and Merseyside Integrated Care Board
Nick Woods and Alex Hadyn	Specialist Lead for Safeguarding Adults	Mersey Care Mental Health Trust
Carla Jones	Head Of Probation Delivery Wirral PDU & Merseyside Courts	Probation Service
Catherine Shaw		Change Grow Live (substance misuse service)
Craig Rigby		LIVV Housing
Ann Marie Cresham	Safeguarding Lead Nurse	Liverpool University Hospital Foundation Trust

2.19 The panel met again on 16 May 2023 to review the draft report and on 22 January 2024 to ratify the final report and devise an action plan. Citysafe approved the final report and action plan on 11 July 2024. The action plan is included within Appendix A.

Author of the overview report

2.20 In February 2023, Citysafe commissioned Safeguarding Circle LLP to conduct this Domestic Homicide Review. Sarah Williams (the lead author and chair) was a qualified solicitor for 20 years specialising in safeguarding for children and adults, including 7 years in senior management as head of law for safeguarding for a London local authority, providing legal advice to local authorities on health and social care responsibilities, strategic priorities and good governance. In 2020 she co-founded Safeguarding Circle, an independent safeguarding consultancy supporting systems improvements, complex case resolution between agencies and championing legal literacy through case workshops and training. Sarah has extensive experience as an author of safeguarding adult reviews, child practice reviews, thematic reviews and domestic homicide reviews, exploring systemic response to issues such as transition to adult services, exploitation, co-morbid health, mental health and/or neurodiversity, self-neglect, homelessness and domestic abuse. Sarah is trained in SCIE's safeguarding adult review in rapid time methodology and has completed the Home Office online training on domestic homicide reviews, including the modules on chairing reviews and producing overview reports. Sarah and Safeguarding Circle are not directly associated with any of the agencies involved in this review and had no involvement in the case.

Parallel reviews

2.21 The author has been provided with the report completed by the Independent Office for Police Conduct, which concluded that there was no indication that any police officer or staff behaved in a manner that would justify the bringing of disciplinary proceedings or committed a criminal offence and did not identify any formal learning.

2.22 The author has also been provided with the Serious Further Offence review completed by the probation service, which was independently scrutinised, and quality assured by His Majesty's Inspectorate of Prisons, providing a robust and transparent account of practice by way of an internal management review, including an action plan.

Equality and diversity

2.23 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 protected characteristics under the Equality Act 2010:

Age:

2.24 Matt was aged 36 at the time of his death. 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%).

2.25 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.

Gender:

2.26 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. 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).

2.27 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. However, in response to those incidents, Merseyside police arrested 22% of male perpetrators and just 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. This requires further exploration to determine whether gender bias is influencing arrest and charging decisions across Merseyside, as this data does not indicate the seriousness of the incidents involved, which may have impacted police decision-making.

2.28 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. This may indicate that there has been an improvement in recording or reporting of the gender of perpetrators, as in December 2020-April 2022, the gender was not recorded in 7% of cases.

2.29 Gender-based barriers to accessing domestic abuse services were identified as a significant issue in this review and need for additional services for male victims and female perpetrators of domestic abuse is discussed in detail in the analysis, conclusions and recommendations below. In particular, panel members noted that male victims appeared less likely to access the services available to support them. Consequently, recommendation 1 sets out that Citysafe and KCSP should work with experts by experience to identify the barriers to men accessing services and consider how to design more accessible services. Recommendations 2, 12-14 and 16 also specifically relate to gender-related inequalities identified within this report.

Race:

2.30 Both Matt and Penny 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. This may indicate either that White British people may be more likely to experience domestic abuse, than other ethnicities or that ethnic minority groups may be under reporting domestic abuse. However, the 2023 SIA indicates that there is little difference in respect of the proportion of male and female victims of domestic abuse by ethnicity.

Disability:

2.31 Both Penny and Kieron were identified as having disabilities. Penny required mental health support and had a chronic health condition and Kieron had care and support needs in respect of his physical health. However, panel members noted that the data is not currently analysed in respect of whether victims or perpetrators have a disability.

Recommendation 17 sets out that partner agencies should review referrals forms for support services such as substance misuse or independent domestic violence advocate (IDVA) / domestic abuse advocate (DAA) services to identify known disabilities or known trauma responses, so that reasonable adjustments can be made to facilitate access to support for victims and perpetrators.

Recommendation 3 also advocates for adult social care to carry out a review of the care and support needs of adults who have alleged domestic abuse by their carer.

Pregnancy and maternity:

2.32 Matt and Penny did not have children together and Penny was not known to be pregnant during this relationship, although each had children from previous relationships, who did not live with them. The fact Penny's children had been removed from her care by children's social care is considered in the analysis in respect of her experiences of trauma.

Religion or belief:

2.33 Neither Matt nor Penny's religion was recorded by professionals, however, there is no indication that their respective belief systems were relevant to the abuse or the circumstances of Matt's death.

Sexuality and gender reassignment:

2.34 Matt was a cisgender heterosexual male. Penny 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 female perpetrators and raise public awareness of male victims will equally apply to and benefit the LGBTQ+ community.

Marriage or civil partnerships:

2.35 Matt and Penny were not married or in a civil partnership.

Dissemination

2.36 The report will be published and disseminated to the representatives on the Citysafe Board, KCSP, Domestic Abuse Partnership Board and their wider professional network.

3 Background information

The facts

3.1 In April 2022, Matt died at Royal Liverpool University Hospital after his partner, Penny, stabbed him in the chest at her home address in Liverpool. Penny was arrested and charged with Matt's murder. She was found guilty of this offence in October 2022 at Liverpool Crown Court and sentenced to life in prison with a minimum term of 18 years.

3.2 A post-mortem examination revealed Matt died from a stab wound to the chest. A coroner's inquest was opened in October 2022, following Penny's conviction, and adjourned for a date yet to be determined.

3.3 Prior to Matt's murder, he had been in a relationship with Penny for around 12 months, although he continued to live with his parents and adult brothers in Knowsley. Penny lived with her father, Kieron in a one-bedroom flat in Liverpool, with no other occupants.

Chronology

3.4 Penny was known to Liverpool MARAC both as a victim and perpetrator of domestic abuse. She had been discussed in the context of three previous intimate relationships: 'Nick' (as a victim in November 2011 and as a perpetrator of abuse in October 2013), 'Simon' (referred as a victim in February, March and May 2019 and by Knowsley MARAC as a victim in March 2021) and 'Michael' (referred as a victim in July 2020).

She was also discussed in MARAC as both a victim (1991 and August 2020) of abuse by her father, and perpetrator of abuse against him, having been reported to have assaulted Kieron on at least three occasions (May 2018,

February 2019 and August 2020). Additionally, a record held by Liverpool Children's Social Care from 2019 noted that Penny had previously stabbed a former partner with scissors, although the date of that incident is not recorded, and this may be connected to one of the referrals previously noted.

3.5 Penny was also known to Liverpool Domestic Abuse Service from 2016 when she self-referred as a victim of domestic abuse and had been encouraged to refer as her children were subject to child protection proceedings. She attended three Freedom programme sessions. In 2019 she declined support (having been referred from the MASH). In January-April 2020 she also requested an assessment on advice from the IDVA but failed to attend assessment appointments or respond to LDAS' attempts to make contact. In June 2020 she was referred to LDAS by Citizen's Advice but again refused to speak other than to confirm she had fled her home due to abuse (by Michael). In March 2022 following a MASH referral, LDAS did make contact and explained what support they could offer. She refused input. LDAS managers also raised concerns subsequently regarding the referral and risk assessment questioning if Matt should have been referred as the victim.

3.6 In addition to the violent offences outlined at paragraph 3.4 above, Penny was convicted of Section 39 Assault in 2014 for which she received a community order.

In 2015 she was convicted of possessing a prohibited weapon, namely a gas cannister, which she reported belonged to an ex-partner and that the items were in the car she was driving without her knowledge. She has six other recorded offences relating to theft of petrol and driving matters, as well as breaches for non-compliance with community penalties.

3.7 Prior to his relationship with Penny which started in March 2021, Matt was not known to Liverpool or Knowsley MARAC, although he had a recorded history of domestic incidents with two previous partners dating back to 2008, these were low level verbal incidents graded bronze. When attending domestic abuse incidents, Merseyside Police officers complete a MeRIT risk assessment, which consists of 40 questions on the VPRF, to assist in information gathering at the scene, and will result in incidents being graded bronze, silver or gold.

3.8 In July 2020, Penny racially abused staff at a barber shop while intoxicated and attempted to punch the owner and put him in a headlock. When police attended, she shoved an officer and was arrested. Consequently, she was convicted of racially/religiously aggravated intentional harassment/alarm/distress and assault of an emergency worker in January 2021, for which she received an 18-month community order with a 6-month alcohol treatment requirement (ATR). In advance of the hearing, probation completed a pre-sentence report and risk of self-harm assessment (initially graded medium but regraded as low risk in an automated error, before being corrected to medium).

3.9 After the hearing, the case was allocated to a probation officer, who completed an Offender Risk Notification to EMS and after an unsuccessful telephone call, a letter was sent to Penny to arrange a telephone induction in January 2021. Before this meeting took place, the probation officer received notice that Penny had breached her curfew, but that this was because she could not live at the address provided to the Court due to being subject of domestic violence from her ex-partner, who lived at the address. The probation officer requested a police check of the address and found that there had been 16 reported incidents of domestic violence between 2004 and 2020. However, this was not discussed with Penny, and it is understood that from this time until Matt's death, Penny was staying with her father at his address. This was a one-bedroom property, and she slept on an airbed in the living room.

3.10 Although Penny failed to attend (FTA) her initial probation appointment in February 2021, no enforcement activity was taken, and this was noted to have been a pattern over the next year, with no enforcement action taken in respect of 15 FTAs. In February 2021, Probation completed a risk assessment at the start of Penny's community order, rating her as a medium – high risk to others both in the community and in custody. The sentence plan identified objectives of raising Penny's awareness of the effects of cannabis, cocaine and alcohol on her and her violent behaviour after drinking. Probation referred Penny to Women's Turnaround Project, a safe, female-only service offering a drop-in, individual and group work support, and counselling to adult females involved in the criminal justice system. The project works closely with several agencies to offer support with advocacy, housing, education, substance misuse and domestic abuse support.

3.11 On three occasions in February and March 2021 Penny was discussed at MARAC as a victim after she was elbowed in the face by Michael, resulting in a chipped tooth. In late February, Penny's probation officer recorded a curfew violation, which Penny explained was due to her ex-partner banging on the front door late at night, so she left out the back door in fear of her safety. The probation officer did not penalise Penny for this breach, but nor did they make referrals in respect of ongoing domestic abuse. In early March 2021, Penny contacted the police after her ex-partner sent her father abusive messages, she believed this was due to her ending the relationship and he was aware she had a new partner. She did not want to prosecute Michael but wanted police to warn him about his future behaviour. She provided a signed entry declining to prosecute, there is no record that Michael was spoken to by police, although a crime of Harassment was recorded. She learned from a Domestic Violence Disclosure Scheme (DVDS) that he has seven counts of domestic abuse perpetrated against previous partners. The DVDS enables police to disclose information to a victim or potential victim of domestic abuse about their partner's previous abusive offending. Penny was already a Gold victim with Michael identified as perpetrator, but the matter did not meet the criteria for referral back to MARAC.

3.12 Penny told her probation officer that she was trying to work with Housing to obtain alternative accommodation and had not heard from her ex-partner since changing her number. Penny started sessions with the Women's Turnaround Project (WTP) in March 2021 and agreed to participate in Recovery, Intervention, Support, Education (RISE). Penny disclosed that she was binge drinking and used cocaine, often daily, spending approximately £100 per day. She agreed to engage with sessions of Positive Solutions to help her manage her emotions, designed to assist participants to problem solve and develop improved interactions with others, however, it does not appear this was started. Penny agreed to be referred to PSS's Ruby Project by the IDVA with a plan to complete 1-2-1 work and the Freedom programme. She disclosed that she was in a new relationship with Matt, and that she could be pregnant. The Ruby Project keyworker agreed to support Penny to apply for a non-molestation order against her ex-partner. PSS reviewed Penny's support plan in March 2021 and were informed that she was in a new relationship with Matt, but Penny disclosed no concerns. Following this, she did not engage with the service, either due to safety concerns as a male was in the room or she did not answer calls, so the service was closed.

3.13 In April 2021, Penny was involved in two altercations at her father's house when she was intoxicated, firstly when her father contacted police to ask for her to be removed saying he 'could not take it anymore', and the following day when Penny and a neighbour made counter allegations that each had pushed the other during a verbal altercation.

In late April, Penny told her WTP worker that her alcohol intake had increased, and she recognised that she struggled when alone or had thoughts of her children but had had no contact with the substance issue team despite her ATR, which had still not commenced. Two days later, an independent domestic violence advocacy service notified police that Kieron felt suicidal because Penny would not leave the house, and they were arguing constantly. He told police that he still loved her but had many issues with her behaviour, mainly her alcohol and cocaine use and recently she had brought a man back to his home. He was not keen on the idea of obtaining a banning order, as he

wanted to see Penny and relied on her as a carer, he felt stressed and feared a third heart attack. Kieron declined help from NCDV, but a referral was sent to Adult Services and Probation.

3.14 In May 2021, Penny's probation officer sent a final warning letter to Penny stating that she had been trying to contact her including sending three letters although a record of these was not on in the system, but these had gone to Penny's previous address, not Kieron's home so the warning was cancelled. A referral was made to We Are With You in respect of Penny's court-imposed Alcohol Treatment Requirement.

An assessment was completed, and Penny met with the We Are With You Nurse. In late May, Kieron called the police after an incident when Penny kicked a car, damaging the vehicle, then punched Matt. When police located them, they were both intoxicated but did not complain of violence, so they were told not to return to Kieron's address. A VPRF was completed, identifying Penny as the victim and Matt as the perpetrator and the report was graded silver. No VPRF was completed for Matt, although officers recorded a crime of a section 39 assault for Matt and Penny but recorded that neither would support a prosecution, and no corroborating evidence was available. Police notified the ambulance that Kieron felt suicidal, but he then denied suicidal thoughts, so Kieron was not seen face to face by ambulance staff. Four days later, Penny told her Ruby keyworker that she no longer wished to pursue the non-molestation order, or to attend the Freedom programme because this was near Michael's work, so the Ruby worker offered the sessions by telephone, demonstrating flexibility. In early June 2021 Penny attended LUFHT's emergency department after self-harming by cutting her arm and was treated then discharged to police custody.

3.15 In June 2021, police received a 999 call to Kieron's address due to an ongoing domestic incident and both Penny and Matt were found heavily intoxicated. Penny was obstructive to police; Matt was calm and compliant with numerous cuts and bruises all over his body including a laceration to his eye which was bleeding, he did not require medical attention, but he denied he had been assaulted, saying he fell over in the garden. Penny was arrested to prevent a further breach of the peace and Matt went home in a taxi after signing an entry declining to prosecute. A Vulnerable Person Referral Form (VPRF) was completed for Matt, graded silver. Officers reported that they told him he should end his relationship with Penny. Penny told her probation officer on 9 June that there had been an incident of domestic abuse between her and her (unnamed) partner where they hit each other and police were called, but that this was now 'resolved'. This was shared with WTP and the Ruby keyworker, who obtained the police callout information and shared this with the probation officer. The following day, Penny did not engage well with her probation officer, would not discuss the DA incident but the probation officer withdrew the breach proceedings in respect of Penny's non-engagement. During the last appointment Penny attended with We Are With You on 14 June 2021, she stated that her current partner Matt was also a drinker, and a decision was taken that due to this address checks should also be made with Knowsley alcohol and substance misuse services, CGL, although it is unclear whether this was actioned. The We Are With You keyworker attempted to re-engage Penny until September 2021. In mid-June, Penny's Ruby keyworker was unable to deliver her Freedom Programme session by telephone as a male was in the room who sounded intoxicated, so the session was rearranged, and the probation officer recorded this as a breach.

3.16 The following day Matt called 999 and a woman could be heard asking for an ambulance, but he said the woman grabbed his keys, refusing to give her name before ending the call.

Police were not deployed and a VPRF for Matt was graded bronze. Penny was reported to be engaging well with her probation officer at the end of June and her WTP worker agreed to support her with accessing the housing property

pool. In early July Penny's Ruby project worker was unable to contact her and put her on notice that if she missed another appointment, the service would close, and probation subsequently sent her a breach warning notice. The following week, Penny declined to engage further with the Ruby Project and shouted at her probation officer. The case was subsequently transferred to a new probation officer without a recorded handover. In mid-July, probation wrote to Penny advising that her Alcohol Treatment Requirement had come to an end, despite only attending 2 sessions and disclosing that she was continuing to drink heavily. She was also advised at the end of July that as she had completed the ATR, her office visits could reduce to monthly and as Penny said that she could not attend the Women's Turnaround Centre due to its proximity to her ex-partner's work. Penny states there have been no further arrests or offences, and the probation officer recorded that she 'has no information to suggest that is not the case'. At the beginning of August, police attended on a Grade 1 response following an abandoned 999 call, Penny was heavily intoxicated and Matt less so, Kieron described this as a regular occurrence that she would start an argument with anyone while drunk. Both denied any offences, telling officers that it had been a verbal argument and Matt left the property, Penny remained at the property and became abusive to officers. A VPRF for Matt was again graded bronze.

3.17 In mid-August 2021, Kieron called police reporting Penny and Matt were fighting outside his house and told officers that he wanted Penny to leave as he was a 'bag of nerves'.

A few minutes later, Matt called 999 reporting that Penny was punching him. When officers arrived, Matt said that an argument became physical when Penny punched him in the face, and his nose was bleeding. Officers took Matt home, but he did not support further action being taken. A VPRF was completed for Matt, graded bronze. With Matt's consent, a referral was sent to Knowsley Safer Communities team, and this was heard at BRAG on the following week. A domestic abuse advocate (DAA) was allocated on 1 September, but Matt declined support, advising that he had ended the relation with Penny and blocked her number. From the end of August to early

December, Penny missed all her probation appointments, proffering a variety of explanations, but no enforcement action was taken.

3.18 In early September 2021, Kieron called 999, reporting that Penny and Matt were arguing and that he 'was petrified of her when she was drunk, she was dangerous' and was smashing the house up. Matt was trying to leave, and she was stopping him. Penny continued to be aggressive when officers arrived and was arrested for criminal damage, then treated at Royal Liverpool University Hospital (RLUH) for a self-inflicted cut.

Penny was referred to Mersey Care's Criminal Justice Liaison Team and reported that she was in a toxic relationship but did not want to end this and wanted help with respect to her substance misuse. Mersey Care contacted Liverpool Careline to see whether she was known to adult social care, and they advised that she should be referred to domestic violence services if she was willing to engage. Penny was added to Mersey Care's Outreach database for support with substance misuse services and talking therapy services, however, she was not contacted by Outreach until February 2022, but she did not attend the appointments offered. Police completed a VPRF for Matt, grading him as silver, noting that he was *"visibly shook up around the presence of the perpetrator"* but again Matt did not want to make a complaint and felt that he was not at risk. A further referral was sent to Knowsley Safer Communities Team for Matt as the victim in the incident, but Matt again refused support from the DAA, who consequently closed the case.

3.19 Matt called 999 from Kieron's address at the end of September when a woman could be heard shouting "get off me" and Matt could be heard saying that he had called the police to "set her up" so that the police could "hear everything".

Matt could be heard saying to a woman that he did not want to be with her anymore and 'go on smack me again' but then denied being assaulted to police. As Matt did not consent to any referrals, officers recorded that there was insufficient risk to override his consent, grading his VPRF bronze. In late December Kieron called 999 reporting a domestic incident between the couple and Matt could be heard shouting about his phone being smashed. When

officers arrived, Penny alleged that she had been assaulted but then would not engage with officers. A VPRF for Kieron was graded bronze, but no VPRF was completed for Matt. Penny was re-referred by probation to Women's Turnaround Project for accommodation support in December 2021, but no current domestic abuse was identified on the referrals and Penny did not engage (and sent a text in error where she appeared to encourage a third party to lie about her non-attendance), so the referral was closed. In late December, a 999 call was received from Penny, reporting that she had been assaulted but did not know where she was. After considerable effort to locate her, Penny denied to officers that anything had happened and her VPRF was graded bronze. Adult Safeguarding received a VPRF at the end of December for Penny to receive mental health support as she had expressed suicidal ideation and was noted to have significant marks on her arms and legs.

3.20 In early January 2022 Matt called 999 reporting that Penny had assaulted him, and he was bleeding from the eye, but he and Penny had left by the time police arrived at Kieron's address. Penny was located the following evening and denied the assault, and Matt was spoken to over the phone and said that he had lied to get back at Penny.

However, Matt made an abandoned 999 call the next evening, so was seen by officers and had bruising to his eye consistent with the allegation, but he did not want to provide any further details, so no further action was taken, and the incident was graded silver, noting that Matt was a repeat victim. The next day, Matt contacted Merseyside Police stating that he wanted to make a statement, reporting that Penny had hit him in the eye and punched him 3-4 times, then smashed a glass and had "gone for him with the smashed glass". He reported being a repeat victim of DV and that he was safe and away from Penny at his mother's address. Officers arranged an appointment with Matt the following week to take a formal statement, but he did not attend so no further action was taken.

3.21 In early February 2022, Matt called 999 from a different address, stating 'she's trying to stab me, my ex-girlfriend is trying to stab me, get the police here right now'. While officers were deployed, Matt called again 4 minutes later, reporting that Penny was attacking him. Both parties appeared intoxicated on police arrival. Matt was distressed, stating that "he had had enough" and had been assaulted by Penny. He said that Penny had started shouting and screaming at him and lashing out, so he locked himself in the bathroom. When he came out, Penny smashed a large vase, picking up a large shard of glass and that he felt threatened. Matt reported that a third party had intervened, then Penny had picked up a knife, and although he subsequently denied this, a third party confirmed that she had threatened Matt with a knife. Penny was arrested for affray, wrapping a bandage around her neck and banging her head on the cage while transported to custody. Matt subsequently refused to engage with police, saying that they were both drunk and that it was *"a silly argument".*

3.22 The police officer submitted the file to their supervisor for review, noting that they felt there was "not enough evidence in order for this case to pass the threshold test" and that there were "numerous evidential issues with this case", primarily that there were no supporting witnesses or victim and no CCTV.

The officer added that Matt did not want to pursue the matter and that "there is no evidence to pursue [an] evidence led prosecution". It is unclear why a statement was not obtained from the third party who had confirmed Matt's account. A VPRF was graded silver, noting the history of violence and although Matt did not consent to a referral to relevant services, a referral was made to Knowsley Safer Communities. The referral was heard at the Knowsley BRAG meeting in mid-February 2022 where it was agreed the incident met the criteria of domestic abuse and progressed to Safer Communities triage. The case was allocated to a DAA, and contact was made with Matt a week after the BRAG meeting where the DAA outlined the support available including protective orders. Matt advised the incident was a drunken argument and that he was still "sort of" in a relationship with Penny. Matt told the DAA he had followed his own safety plan and locked himself in the bathroom away from Penny. Matt asked if he could save the DAA's number in case he decided to

apply for a non-molestation order in the future. It was explained should he decline support that day the case would be closed to the Safer Communities Service. He was advised to contact The First Step should he feel, he would like to move forward with a non-molestation order in the future.

3.23 A duty probation officer was notified in early February 2022 that Penny was due to attend court the following day, in relation to the incident in September 2021 when she committed criminal damage. It appears that this was the first-time probation was made aware that Penny had reoffended. In early February Penny was sentenced at North Liverpool Community Justice Centre Magistrates Court to a 6-month community order with 6-month alcohol treatment requirement (ATR). Probation records do not indicate what information the court was given in respect of Penny's compliance during her previous sentence.

3.24 The following week, Kieron called 999 reporting that Penny and Matt were 'having a domestic' and that Penny had a large bump on her head, although he did not witness this incident. Penny was seen safe and well, Matt reported that after Penny took his phone during an argument on a bus, he had followed her back to Kieron's address where she had started hitting herself in the head with her fists. She had damaged Matt's phone to prevent him returning to work after Covid, however, he declined to make a complaint about the theft. Kieron confirmed that Penny was "the aggressor and instigator of the matter", and Matt returned home. A VPRF and referral to Knowsley Safer Communities were made, but Matt did not answer the DAA, and a message was not left as the referral noted Penny had taken his phone.

Later that night, a 999 call was received from Penny's phone and the couple could be heard arguing, with a female saying, "give me my phone". No response was received at Kieron's address and the following day, officer spoke to Kieron who confirmed Penny was safe and well. A VPRF was completed for Matt, graded bronze and did not feel at risk, declining referrals to relevant services. Penny attended an induction appointment with a new probation officer

the next day, but missed her next three appointments before an enforcement warning letter was sent in early March.

3.25 In mid-February, police received multiple 999 calls from members of the public reporting that the couple were fighting in the street, and that a woman was being 'battered' by a male. They had separated by the time patrols arrived; Penny was seen at her uncle's address but declined to make a formal complaint. Matt was arrested and was interviewed in custody, stating that "he was attacked by [Penny] and had to pin her to the ground to stop her assaulting him further". He was released under investigation with bail conditions preventing further contact. Penny was contacted but was not willing to make a statement and although one of the witnesses was no longer in the country, other enquiries were outstanding, including contacting one of the other witnesses. The incident was graded silver. The IDVA service received a referral from MASH four days later, identifying Penny as a victim and Matt as a perpetrator but challenged this, as they identified Matt as the victim based on previous VPRFs. MASH acknowledged the error, agreeing that Penny was not a high-risk victim. MASH also referred Penny to LDAS, but three attempts to contact her were all unsuccessful.

3.26 In early March, Penny contacted police for an update and was told that enquiries were outstanding, but that the bail conditions were still in place. Later that day, Matt called the police after Penny followed him from his home and after trying to speak to him inside a pub, attacked him outside the pub. He alleged that she pulled him to the ground, punched him in the face three times before biting him on the nose and taking his mobile phone. He attended A&E but left before being seen.

Matt supported a prosecution and Penny was arrested, but police reported that there was no CCTV in the area of the alleged attacked and that CCTV from inside the pub undermined his account of the incident to the extent that no further action was possible. VPRF completed, graded silver. A referral was made to Knowsley Safer Communities Service, and again, the DAA tried to call but could not leave a message for him as Penny had taken his phone. An

engagement letter was sent to Matt two days later advising that contact had been attempted with him to offer support and that if no response was received within 7 days it will be presumed the offer of support was not required and the case would be closed. The case was closed the following week as there was no response to the engagement letter. Police also reviewed the mid-February incident and took a decision not to prosecute Matt, as Penny did not support the prosecution, he had stated that this was self-defence and there was no evidence that she was in fear of him, given that she had sought him out while he was on bail. Police noted that there was *"no realistic prospect of conviction".*

3.27 LDAS contacted Penny but she was adamant she did not need support. During a planned probation appointment, Penny reported that she was 'in despair', feeling suicidal most days and that she wanted to *'sort herself out',* so the officer supported her to arrange an emergency GP appointment. The GP referred her to an alcohol service and a drug crisis team. During the next probation meeting in late March, Penny stated that she and Matt were in an 'on/off' relationship, and just texting one another, but were planning to see each other at the weekend *'if the charges are dropped'*. The probation officer set Penny tasks to reduce her alcohol and drug use and made a referral to another substance misuse service.

3.28 At the end of March 2022, a member of the public called 999 from Liverpool city centre reporting a male and female arguing outside a restaurant. The female was reported to be the aggressor and had punched the male in the face. Patrols were at scene in 14 minutes. Both were very intoxicated after drinking all day would not provide any details of the incident, stating it was a verbal argument and no offences had occurred. Both appeared 'safe and well if very drunk'. A VPRF was completed for Matt and graded bronze, noting that there had been numerous previous incidents.

3.29 In April, Penny murdered Matt at her father's address. Mersey Care's Criminal Justice Liaison and Diversion Service assessed Penny in custody, she presented as very emotional, but she did not present with acute mental illness. She reported consuming excessive amounts of alcohol, cocaine, and cannabis use. She also reported having depression and anxiety which is managed by GP however she reported she stopped taking the medication as felt it was not working. She reported being the victim of domestic abuse previously, however this was not explored further at that time due to her level of distress. At the end of March 2022, Penny told her probation officer that she had not yet had contact with substance misuse services.

3.30 The day after the stabbing, LDAS (unaware of Matt's death), reviewed the MASH referral and raised concerns about contradictory information about Penny being the perpetrator, asking for a risk assessment and consideration of whether Matt was using tactics identified in DHRs whereupon the abuser contacts police in an effort to be seen as the 'victim' which is extremely concerning, and both have significant complexities for drugs and alcohol which heightens risk. MARAC escalation was sought.

Overview

3.31 Matt was one of six children, who lived with his parents and adult siblings in Knowsley. He worked with one of his brothers, had worked hard to grow their business and was well respected by his clients. It is understood he also had a recorded history of verbal arguments with two previous partners dating back to 2008, these were low level incidents graded bronze. Matt had been in a relationship with Penny for approximately one year and had predicted his own death at her hands in a text message. He was described by his family as *"a caring lad who brightened everyone's day".*

3.32 Penny's childhood was characterised by trauma, with her parents separating when she was two years old and her mother taking her siblings whilst she remained with her father, whom she reported to misuse alcohol. At the age of 11, she reports having been sexually abused by a friend of her father, with the perpetrator receiving a custodial sentence as a result. Penny began offending aged 13 when she was reprimanded for a theft matter. As an adult, Penny's two children (born in 2009 and 2010) were adopted following safeguarding concerns.

3.33 Penny has a history of substance misuse including alcohol, cannabis and cocaine, at times she was reported to spend hundreds of pounds per month which she was not financially able to sustain, so would resort to borrowing money or incurring debt. In addition to her problematic substance misuse, Penny reported having been diagnosed with bipolar disorder, anxiety and depression and reported low mood and thoughts of suicide during supervision. In 2018, Penny was noted to have injuries associated with historic self-harm on her wrists. Penny reported (also in 2018) that her diagnosis of neurofibromatosis affected her as she had tumours and a learning difficulty. However, on other occasions (such as when she booked at the LWH with her second child in 2010) she denied domestic abuse or having mental health or a learning difficulty. A review of her educational records established that although Penny attended a boarding school for young people with behavioural needs, she obtained 11 GCSEs and was not involved with learning disability services.

3.34 Since 2011 Penny had been heard at Liverpool MARAC six times as a victim to three different men and as a perpetrator on two occasions, including her father Kieron on one occasion. Penny was supervised by the probation service at the time of Matt's death, in relation to an offence of criminal damage committed at Kieron's address, following an argument with Matt in February 2022. She was sentenced to a 6-month community order with an alcohol treatment requirement. She had a previous offence for assaulting police and was sentenced in January 2021 to an 18-month community order.

3.35 Between May 2021 and March 2022, Merseyside Police responded to 16 incidents between Matt and Penny. Although police had been contacted on a number of occasions after incidents where Penny had been physically or verbally abusive towards Matt, he was not well known to services, having declined to give evidence to progress a prosecution or to receive support from domestic abuse services. Most notably, following an incident in February 2022, Matt was referred to Knowsley's MARAC as a victim. Initially, this referral was understood to be for Penny as a victim but later clarified and he was offered support by a DAA. He turned this down and was advised how to access support if he wished to apply at a later date for a non-molestation order.

4 Analysis

Support for male victims of abuse

• How was the support offered tailored to Matt as a male victim of abuse? What resources are available to male victims locally?

4.1 The Government's 'Supporting male victims' policy paper[2] 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, and recognises its responsibilities under the Public Sector Equality Duty provided for in the Equality Act 2010.

The paper set out that 13.8% of men and 27.6% of women aged 16 to 74 have experienced domestic abuse behaviours since the age of 16, equivalent to an estimated 2.9 million male victims. In the year 2019/20, 3.6% of men (757,000) and 7.3% of women (1.6 million) were victims of domestic abuse. Data on the details of cases discussed at Multi-Agency Risk Assessment Conferences (MARACs), which represent the highest risk domestic abuse cases, show that 6.1% of MARACs held between April 2020 and May 2021 had male victims and from 2018-2020, 24% of victims of domestic homicides were men. The report

[2] Supporting male victims (accessible) - GOV.UK (www.gov.uk)

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.

4.2 A local profile of those most at risk[3] indicate that although domestic abuse in Liverpool is predominantly perpetrated against women (75%),[4] over the last 5 years crimes recorded with male victims/survivors have been increasing year on year.[5] 57% of male victims[6] were aged between 20-39 years (30-34 age group most at risk) and this is disproportionate to Liverpool's demographic profile. Although general services such as Liverpool's IDVA service, Knowsley's DAA 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. No specific services were identified in Knowsley where Matt resided.

4.3 Research[7] highlights men's inability to recognise and accept their victimisation, so 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. "*A lack of recognition, an inability to accept and recognise domestic abuse and limited knowledge of support lead to low numbers of men coming forward*."

Matt's mother reported that his cousin had also been in a relationship with an abusive woman in the past, and Matt made him watch a BBC documentary 'Abused by my Girlfriend',[8] supporting him to recognise the abuse and separate from his partner. It is a tragedy that he was unable to follow his own advice. The fact that Matt was a tall, physically fit man and Penny was a petite woman

[3] Source- Liverpool City Council's Domestic Abuse Needs Assessment, Maura Carr, September 2022
[4] 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
[5] Taken from the LDAPB's Safe accommodation strategy 2021-24
[6] 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'.
[7] 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
[8] BBC iPlayer - Abused By My Girlfriend

may have impacted his ability to recognise the risk she posed to him as her violence, including use of weapons, escalated.

4.4 During each incident of domestic abuse reported between Penny and Matt, Merseycare Police officers had complied with its procedures in respect of ensuring Matt's immediate safety, providing him with opportunities to disclose abuse and challenging inconsistencies in his story when he denied this and completing VPRF and MeRIT risk assessments.

4.5 There was one incident in December 2021 when a VPRF was completed for Kieron and not Matt and another incident in May 2021 when Kieron reported that Penny had damaged a car and punched Matt, but the VPRF was completed identifying Penny as the victim and Matt as the perpetrator. It is unclear whether this was a misunderstanding on the part of the officer, or a consequence of gender stereotypes. However, as Matt did not support prosecution in respect of either incident, there was no evidence that this had impacted officer's response to Matt or the outcome of the incident. Likewise, although evidence-led prosecutions (where cases are prosecuted without the victim giving evidence) could have been considered in respect of some of the incidents, in particular those where third parties were present who may have been willing to provide witness statements if interviewed by officers, it is acknowledged that these are challenging and will only succeed when the supporting evidence is very strong. In each of these incidents, officers tried unsuccessfully to obtain CCTV evidence to support a prosecution. The only incident Matt was willing to support a prosecution in March 2021 when Penny bit his nose was undermined because CCTV of his interaction with Penny immediately prior to the alleged assault had not been consistent with the statement he gave to police, so officers assessed that a prosecution would have been unlikely to succeed.

4.6 Although both Matt and Kieron had refused offers of support from their respective DAA/IDVA services, there were missed opportunities following the incident in February 2021 when Penny had threatened Matt with a large piece of glass and a knife during an altercation. Given the serious escalation in the level of violence and frequency of incidents, Merseyside Police should have considered attempting to engage more intensively with Matt after the initial response to the incident, for example through its Protecting Vulnerable People Unit. Further, when the DAA contacted Matt, he declined a service, but asked the DAA if he could call back on that number if he wanted to seek a non-molestation order in the future. Although the DAA explained to Matt how he could self-refer to The First Step at a later time, it was explained should he decline support that day the case would be closed to the Safer Communities Service. In the context of the Cycle of Change,[9] it appears that Matt was ready to move from the contemplation stage (where the individual recognises that there is a need for change but is not ready to commit to action) to the preparation stage, where they are planning to address the problem.

4.7 Recognition of the additional difficulties that men may have in recognising that they are experiencing abuse and in asking for help could have resulted in a more facilitative response. This may have been a first step for Matt in establishing a trusted relationship with the service and knowing that he could return to a single point of contact who had some context of the harm he had experienced may have given him the confidence to reach out later. The tenets of a trauma-informed response include tenacity and consistency, and survivors of domestic violence have inherently experienced trauma, sometime over a lengthy period of time or since childhood, so embedding these principles into the police response and DAA/IDVA referral process rather than creating a 'revolving door' for each referral may create a system that is more reflective of the needs of male victims.

[9] The Cycle of Change Handout - Free Social Work Tools and Resources: SocialWorkersToolbox.com

4.8 The fact that Matt was unwilling or unable to support a prosecution does not appear to have been considered in the context of the potential for coercive or controlling behaviour from Penny. This is despite the local research evidencing that female perpetrators may be more likely to engage in coercion than male perpetrators. Agencies did not consider other criminal or civil justice tools such as domestic violence protection orders or victimless prosecutions. Further, at times police accepted Matt's assertions that he did not support a prosecution during the initial police attendance, despite officers noting that he was under the influence of alcohol. It is not recorded that consideration was given to whether his mental capacity to take this decision was temporarily impaired by his alcohol use.[10] Again, consideration of this issue could have triggered police to make contact with Matt on a later date, to enable him to take this decision when his capacity was not impaired.

4.9 During the review leaders commented that frontline staff did not always consider domestic abuse in the context of wider family relationships. For example, the Liverpool Ambulance Service had promoted the message to staff in respect of a wider definition of domestic abuse to include relatives and help them to identify when referrals need to be made to other statutory services, however this was not always picked up unless the individual themselves made a disclosure.

4.10 Partners noted that it could be difficult for parents to report that their children had been abusive towards them, in particular for fathers to report their daughters. Practitioners commented that Kieron was very good at reporting Penny being abusive towards Matt and incidents of mutual violence between the couple, but rarely reported incidents against him personally. However, in April 2021 Kieron reported that he was finding the situation overwhelming and that Penny's substance misuse was impacting on his well-being, but that he was reluctant to take any action against her as he was reliant on her as his carer. Kieron declined a referral to domestic violence services, but a referral was sent to Adult Services and Probation.

4.11 Section 11(2) provides an enduring duty to offer an assessment when an adult with care and support needs has experienced, or is at risk of abuse or neglect, including domestic abuse. Section 42 of the Care Act 2014 also requires that each local authority must make (or cause others to make) enquiries, decide what must be done and by whom whenever an adult with care and support needs is at risk of, or experiencing, abuse or neglect. However, ASC did not carry out a s42 safeguarding enquiry to investigate the situation, or a care assessment or carer's assessment, either to better understand Kieron's care and support needs, or Penny's ability to meet them, preventing adequate analysis of whether a formal care plan could adequately reduce the risk or further abuse or neglect. This was a missed opportunity to explore the risks that Penny posed in a holistic way, and whilst focussed on Kieron as an adult with care and support needs at risk of abuse, rather than Matt, a 'think family' approach to this assessment could have recognised that the increasing severity and frequency of incidents of violence in the household required a more proactive multi-agency safeguarding approach to address the risk that Penny posed.

4.12 Concerningly, frontline practitioners in LCC's Adult Safeguarding team responsible for triaging safeguarding enquiries commented during the learning event that when VPRFs were passed directly to the Locality team for allocation, they were always looked at episodically and never as a pattern. Although practitioners could access the system, there were no prompts in cases to look at the previous history to see whether prior referrals had been received. Managers noted that this was part of the safeguarding policy and was required at the point of triage, but it appears that there is a disconnect between policy and practice that will need to be addressed through robust supervision and socialisation of good practice.

4.13 Instead, the opportunity to identify the pattern of escalating risk was missed and the need for accommodation introduced a perverse incentive for Penny to persist in providing physical care to Kieron, even as the situation in the small household became increasingly strained, and her substance use appeared to escalate. Where concerns arise that someone's care and support needs are not being met by an informal carer, a careful assessment should be carried that focusses on understanding the experience of caring for that person, as well as the carer's capacity to meet their needs and what information and practical support they might require, this needs to be kept under review as the adult's health deteriorates or care and support needs escalate.

4.14 Section 10 of the Care Act 2014 gives anyone over the age of 18, who is looking after another adult with care and support needs, the right to a carer's assessment. These assessments should include consideration of the carer's physical and mental health and their ability and willingness to provide the quality of care that the person they are caring for requires. Section 20 of the Care Act then places a duty on councils to meet carers' needs according to the national eligibility threshold. The Local Government Association has produced a briefing on Carers and Safeguarding[11] to support frontline practitioners in applying the legal framework and improving practice when working with carers in situations where safeguarding is a concern. This highlights that the risk of abuse increases when the carer has unmet or unrecognised needs of their own, has little insight into the person's condition or feels emotionally and socially isolated, undervalued or stigmatised.

It is important to note that this situation was escalating during the Covid 19 pandemic, which placed extraordinary strain on health and care professionals, who had to balance the need for individuals with serious health conditions to receive care in the community, with the need to keep them safe from coronavirus infection before the vaccine became widely available.

Use of protective measures through MARAC partners

[11] Carers and safeguarding: a briefing for people who work with carers | Local Government Association

- **Given what was known of Penny's behaviours when intoxicated and recent criminal convictions, could more have been done to put in place protective measures through MARAC partners?**

4.15 During the course of Penny and Matt's relationship, the frequency and severity of the incidents of domestic abuse escalated significantly, particularly in the months prior to Matt's death. However, there was no corresponding escalation in efforts by partner agencies to manage and de-escalate this risk to Matt or Kieron.

4.16 The fact that Penny and Kieron lived in Liverpool, but Matt lived in Knowsley, resulted in gaps in the information held by different agencies. In Liverpool, Penny was known to MARAC primarily as the victim of domestic abuse by her previous partners, most recently Michael, and the Independent Domestic Violence Advocacy service, Local Solutions, had provided her with support on occasion. However, when incidents occurred when Matt was identified as the victim, these were referred to Knowsley's MARAC and Safer Communities Service (lower risk) service. There were also some inconsistencies across the different MARACs and practitioners commented that they would feel better support in using MARAC as a resource if a consistent process was in place across borders. This resulted in an approach that did not consider these relationships holistically.

4.17 Further, although the incident when Penny threatened Matt with a knife in February 2022 was referred to Knowsley using a VPRF, Matt's case was not presented Knowsley MARAC because he was risk assessed at silver grade. This was not consistent with Knowsley's procedures and senior leaders reported that any incident involving a weapon should be heard at MARAC.

As a consequence of this case, Knowsley has amended all their systems to ensure that at every transfer point, practitioners are prompted to ask, 'what is the risk, what has changed?' Knowsley's IMR confirmed that they have implemented learning from this case to ensure that any high-risk case, including those involving weapons or non-fatal strangulation will heard be

MARAC to enable risk management to be considered, albeit that in circumstances such as Matt's, where an adult with capacity to take the decision has refused a service MARAC cannot compel them to accept the support offered.

4.18 Panel members noted that completion of MeRIT risk assessments could be subjective and that although free text boxes allowed more detailed analysis of risk, the quality of this was often impacted by the officer's experience. However, police supervisors would review the outcome to ensure consistency and could upgrade the grading based on their professional judgement. As a further learning point, the Knowsley's IMR suggested that Merseyside Partners (police and domestic abuse services) should review the MeRIT form in line with the Domestic Abuse Act 2021 and clarify what constitutes an escalation to MARAC when the MeRIT score is bronze/silver, where the incident involves use of a weapon.

4.19 Panel members noted that this would need to be carefully considered, both to ensure a consistent approach with respect to national practice, and to ensure that MARAC did not become overwhelmed with case numbers, as they noted that in the preceding year there had been 211 incidents reported involving non-fatal strangulation alone. Further, on average, Merseyside Police receive 23,760 bronze and 7,590 silver VPRFs annually, compared to 1,650 gold VPRFs.

There are no formal referral pathways for individual bronze incidents due to the sheer volume of VPRFs at bronze level, and referrals can only be made for support services without consent for gold graded incidents. Panel noted that plans were in place for Multi-Agency Risk Assessment Meetings (MARAM) to consider cases that did not meet the threshold for MARAC, but that this process was not yet fully embedded. It is vital that systems are in place across Merseyside to ensure that repeated incidents of domestic abuse involving the same perpetrator that are graded bronze or silver are carefully analysed to determine whether the gravity and/or frequency of risk is increasing.

4.20 Merseyside Police have partnered with Bedfordshire Police to carry out a research project to improve data analysis and analysis of trends in respect of domestic abuse, support victims through data-driven, targeted interventions and hopefully, to allow for the identification of those most likely to become the victim of domestic homicides before cases escalate to murder. The Domestic Homicide Prevention tool was not operational at the date of the Panel meeting in June 2023, due to ongoing discussions with the Information Commissioner's Office.

4.21 Good practice could be seen from both of the domestic abuse services involved in terms of showing appropriate professional curiosity, based on the information each held. The Liverpool Domestic Abuse Service had been involved with Penny in the context of the abuse that she had experienced from Michael. Consequently, when they received a referral in February in respect of her as the perpetrator of abuse against Matt, they queried whether sufficient consideration had been given to whether this was a 'masking' technique commonly used by perpetrators of violence to make false referrals so that the real victim is disbelieved. Conversely, Knowsley's DAA service had received the series of referrals in respect of the harm Matt was experiencing, so when a referral was made that he was the perpetrator of abuse against Penny in February 2022, they challenged this on the basis that she was known to be the primary perpetrator. Although in some ways these responses were in direct conflict, both demonstrated a rigorous approach, examining the evidence each service had available to them and proactively seeking clarity on an issue that appeared inconsistent with that factual matrix.

4.22 Partners discussed the challenges in ensuring that key information was available to enable them to manage risks, in particular receiving notification when people they worked with had been involved in incidents of intimate partner violence, either as victims or perpetrators.

This posed a significant risk in respect of the probation service's ability to assess risk and take decisions in respect of enforcing breaches such as failing to attend appointments. Probation officers were not provided with information in

respect of a series of incidents where Penny was reported to have been violent to Kieron and/or Matt, and in each case these incidents were fuelled by alcohol. Furthermore, when Penny was convicted of a further incident of alcohol-related violence in February 2022, probation did not have this information available to enable them to give an appropriate recommendation to the court in respect of sentencing, and the sentence was therefore very similar to her previous sentence. This was exacerbated by probation only receiving notice of this court hearing the day before it took place, which allowed very little time for inter-agency enquiries to be made.

4.23 While this poor communication was unsafe, the response to Penny's failure to attend court ordered alcohol treatment was minimal and the probation IMR commented that this did not comply with service standards.

Little professional curiosity could be observed in terms of challenging the excuses the Penny gave for this, and although initially the explanations may not have seemed unreasonable in the context of her sporadic attendance, over time, these became increasingly superficial, possibly as Penny recognised that it was unlikely there would be consequences for her non-engagement.

4.24 The probation service's IMR noted that the domestic abuse evidenced in this case should have prompted the completion of a Spousal Assault Risk Assessment (SARA) to fully analyse the specific risks present within Penny's relationship with Matt on the two occasions when a probation officer did become aware of incidents of intimate partner violence (IPV).

This would have allowed practitioners to fully explore patterns and risks linked to Penny as a perpetrator by considering acute/critical risk factors and adjusting their management of her sentence accordingly. Further, this may have supported a closer working relationship between probation and the agencies that held the information in respect of the additional incidents of IPV.

4.25 The probation service acknowledged that one of the challenges they faced during this period was that cases involving a high risk of serious harm would be managed by their statutory team, the National Probation Service (NPS) but those assessed to be at low or medium risk of harm, including Penny, were managed by a private company, CRC.

At the time Penny was given a sentence of a community order in January 2021, England was in the middle of a Tier 4 Covid-19 lockdown and CRC and the NPS had different emergency procedures in place, with no face-to-face contact taking place by CRC. This made it far more challenging for staff to pick up cues that clients were becoming non-compliant. Further, both services, but CRC in particular were struggling to recruit staff. In August 2021 the two services were merged again using a phased approach, but leaders acknowledged that this was not well managed due to a time pressure arising from the end of the private contract date. Workforce pressures continue, with staff numbers at around 50% of establishment so cases needed to be prioritised in respect of assessed risk and very high numbers of trainee probation officers. Despite these challenges, senior leaders were clear that tools to identify unacceptable absences and manage cases were not used properly, and that these should have prompted management consideration of whether the case should be returned to court. However, internal reviews have determined that this is balanced by more robust supervision procedures, including a workload measurement tool which seeks to ensure that individual probation officers are not overwhelmed by case numbers and complexity. Further, closer relationships between probation officers and the wider Team Around the Person had strengthened risk assessment processes.

4.26 Although the probation service had a representative on the Liverpool MARAC, practitioners commented that information in respect of specific cases would not necessarily be consistently fed back to the allocated probation officer. On one occasion, their records indicated that they had asked colleagues from the Women's Turnaround Project to obtain information from MARAC, as WTP received the MARAC agenda from most local MARACs, with the exception of Knowsley MARAC.

Leaders explained that this because the General Data Protection Regulation (GDPR) required partner agencies to sign up to an information-sharing agreement, but that they were not aware of any requests for safeguarding information from partner agencies being refused. Good practice could be identified in Knowsley's approach of having a police officer embedded in the Council's Community Safety team, funded by the Council, who can provide intelligence in real time to support an agile risk management response in developing situations. Change Grow Live (their substance misuse service) also sit in the office once each week and before Covid, CRC (probation) were also located in the service, which facilitated a solid infrastructure to support multi-agency risk assessment. All VPFRs or other professional referrals are mapped to see who else is involved, however, this will only be available when the subject's partner also lives in Knowsley, so they were not aware of the extent of concerns in respect of Penny.

4.27 Probation officers commented during the practitioner event that they were not able to record information in respect of the victims of their clients on their ICT system, or information in respect of perpetrators when their clients were the victims of violence, due to data protection concerns. In particular, they understood that this would pose a risk if perpetrators made a subject access request pursuant to the Data Protection Act, as redactions were the responsibility of operational staff. Senior managers clarified that this was a misunderstanding, as redaction software was available and that their service expectations were that probation officers would record information in respect of the discussions with clients about both perpetrators and victims of violence to ensure records were complete. It appeared that restrictions in respect of recording victims' names when the individual had exercised their right to anonymity under the Victims Contact Scheme had been conflated with more general risk information and it was important that managers clarified this issue for frontline staff.

4.28 All agencies involved in the practitioner learning events took the view that strengthening processes around multi agency discussions would have supported more effective information sharing. This required a proactive approach on the part of all practitioners to ensure that each had a full understanding of the professional network involved with their clients and knew who to contact to obtain information when required.

Panel members noted that Liverpool's Adult Multi-Agency Safeguarding Hub (MASH), which had been hosted by Merseyside Police, had been discontinued. Liverpool City Council hosted the Children's MASH, and adult safeguarding referrals were triaged through Adult's Careline, which was co-located with the Children's MASH. Knowsley had an integrated Children's and Adults' MASH, with embedded domestic abuse advocates, and their panel representative noted that this facilitated analysis of low and medium risk MeRIT assessments to identify patterns of behaviour.

4.29 Panel members noted that Liverpool City Council was considering re-establishing an Adult MASH but commented on the importance of this being a high-functioning service. This will need to be strengthened by embedding practitioners from other frontline agencies such as police, probation, domestic abuse, substance misuse, health and mental health to greatly improve information sharing and a multi-agency analysis of risk that is consistent with best practice. An example of best practice identified within the review was the development of the triage car programme, which has an embedded mental health nurse who reviews all 101 calls to gather relevant background information, current care plan and risks in respect of the individual and feeds this back to police, developing an appropriate plan so that they can respond appropriately in real time.

4.30 A factor which hindered risk analysis and identification of the pattern of increasing risk imposed by Penny was that incidents involving Kieron were referred to Liverpool's adult safeguarding and domestic abuse services, whereas the incidents where Matt was a victim were referred to Knowsley's domestic abuse services. A strategic group, led by Merseyside Police, had been set up across Merseyside to consider the regional response to perpetrators, which was addressing cross-border issues. The strategic group was considering setting up a Multi-Agency Task and Co-ordination pathway to coordinate the response to repeat and high-risk perpetrators who fell outside other statutory frameworks such as MAPPA. An algorithm was being developed to identify the perpetrators for each local authority area, which would factor the frequency, recency and gravity of offences, although this was being 'sense checked' across the different agencies involved, to ensure that this accurately captured the perpetrators identified as high-risk by practitioners.

Understanding of and response to female perpetrators of abuse

- **How well do partner agencies understand and respond to risks associated with female perpetrators of domestic abuse?**

4.31 Historically, research has tended to focus on the life histories and psychological characteristics of male perpetrators of domestic violence, resulting in intervention strategies that target male offenders. However, a large-scale study[12] found that male and female domestic violence offenders shared similar childhood family experiences, characterised by exposure to parental domestic violence and physical abuse, with over three quarters of female perpetrators having experienced this. Differences emerged in mental health functioning as women were three times more likely than the men to have attempted suicide and higher rates of personality disorders, but less likely to have substance abuse problems or childhood conduct disorders. Consequently, important themes to explore within this review are how well agencies understand and respond to risks associated with female perpetrators of domestic abuse.

4.32 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.[13] However, in response to those incidents, Merseyside police arrested 22% of male perpetrators and just 11% of female perpetrators. 13% of cases involving male perpetrators were referred to the Crown Prosecution Service, compared to 4% of the cases involving male perpetrators. This requires further exploration to determine whether gender bias is influencing arrest and charging decisions across Merseyside, as this data does not indicate the seriousness of the incidents involved, which may have impacted police decision-making.

4.33 The probation service's IMR concludes that Penny's Pre-Sentence Report (PSR) did not sufficiently consider all those to whom she posed a risk, nor did the author undertake appropriate enquiries to inform her recommendation to court.

Although probation staff were aware of Penny's relationship with Matt and incidents when she had been violent towards him, important risk information

[12] Henning, K., Jones, A. & Holdford, R. (2003). Treatment Needs of Women Arrested for Domestic Violence: A Comparison with Male Offenders. Journal of Interpersonal Violence, 18, 8, 839-856.

[13] In 7% of cases the gender was not known and/or not recorded.

was not communicated by way of Delius registrations, which meant that when Penny reoffended and was transferred between officers this detail was lost.

4.34 The IMR noted that the insufficiencies in the PSR risk assessment persisted into the risk assessment completed at the on the Offender Assessment System when the community order started, as there was an inadequate focus on those areas linked to risk of serious harm to others at this stage, particularly Kieron. Consequently, the risk management plan was generic and did not function as a prompt for practitioners to act efficiently when these risk areas became increasingly prevalent. Whilst the sentence plan objectives did have some links to the problematic features of Penny's circumstances, the alcohol treatment requirement was not sufficiently implemented, with delays in referral, lack of enforcement when Penny did not engage, and poor communication between practitioners and providers. The second ATR imposed by the Court in February 2022 was never commenced. These deficiencies meant that substance misuse, one of the most acute areas of risk in the case, and one that Penny had requested help with on several occasions, was never adequately addressed.

This is despite learning from local Domestic Homicide Reviews which evidences that alcohol is a feature in prevalence and severity of abuse (e.g., in 'Joan's' DHR). The Probation's IMR noted that Knowsley and St Helens PDU have recently implemented co-location of staff from CGL within the Probation Office. This is an effort to foster working relationships, reach harder to engage people on Probation and deliver effective interventions. This has potential to be a positive development and should be reviewed and expanded should it prove to be so. The Panel also noted that the probation service had recently introduced a safeguarding lead for each area, which was expected to support staff to improve safeguarding practice and risk assessment.

4.35 The probation service raised concern that a Spousal Assault Risk Assessment (SARA) was not completed in respect of Penny's relationship with Matt or the known incidents of violence. However, a 2007 Canadian study[14] of the profile of female perpetrators raised concern in respect of the SARA guide, which found that using this tool, most women were classified as low risk for intimate partner violence (64% compared to 32% for men), though a sizeable proportion (29% compared to 28% for men) was considered moderate risk. Just 7% of women were classified high risk, while 28% of male offenders were assessed as high risk. This research concluded that the most significant risk factors for women's domestic violence included past physical assault against intimate partners, substance abuse, and employment problems, although these factors were also prevalent among male perpetrators.

4.36 Importantly, research[15] indicates that in comparison to women who are only violent towards their intimate partner, generally violent women (i.e., those who were also violent to non-partners) were more violent toward their partner, were motivated by a desire to control their partner, were more emotionally abusive, and externalised more blame for their violence. Further, their violence was more instrumental and used in a greater variety of situations, reporting more trauma symptoms and psychological distress. This was of particular relevance in Penny's case, where she had initially become involved with Probation following her conviction for assaulting a barber and a police officer and had also been referred to MARAC for domestic abuse towards her father. Further, she had previously stabbed a former partner with scissors, which, in the context of the incident in February 2022 when she stabbed Matt, indicated a propensity for serious violence involving weapons, and very clearly indicated that she posed a high risk of violence to partners.

[14] Gabura, Stewart, Lilley and Allegri (2007) A Profile of Female Perpetrators of Intimate Partner Violence: Implications for Treatment, Microsoft Word - Research Final English R-175 for approval and publishing- August 12 2008.doc (csc-scc.gc.ca)

[15] Babcock, J.C., Miller, S.A.& Siard, C. (2003). Towards a Typology of Abusive Women: Differences Between Partner-only and Generally Violent Women in the Use of Violence. Psychology of Women Quarterly, 27, 153-161.

4.37 Further, despite strong indicators during 999 calls that Penny was engaging in coercive or controlling behaviour, including removing Matt's mobile to prevent him attending work, this was not effectively communicated in police VPRFs. Matt's mother described additional examples of this behaviour, which included financial abuse, isolating Matt from his family, falsifying injuries to portray him as the aggressor and making threats of violence against family members. This may reflect a lack of awareness across the professional network of research evidencing that female perpetrators may be more likely to engage in coercion than male perpetrators.

4.38 Concerningly, Matt's mother reported that on one occasion, police contacted her after an incident when Penny had assaulted Matt with a tool, requesting that she allow Penny to stay at her address, as officer felt it was unsafe for Penny's father for her to stay at his address, but she was on an electronic tag. Matt's mother had been very upset to hear that her son had been assaulted and refused to allow her to stay. It does not appear that the risk Penny could pose to Matt's parents, or to Matt himself as the victim of the assault and living at that address, was considered when making this request.

4.39 Practitioners commented that the pathways for women into criminality were often much more complex that for men, with women presenting as more chaotic, reactive and requiring significantly more resource for any meaningful intervention. Although women were often both victims and perpetrators of abuse, once they were identified as a perpetrator, many services were no longer available to them.

The Merseyside probation service has a separate women's service that not only offers specialist, bespoke co-located services such as WTP and Ruby Project, but it is physically separate from the men's service, to ensure that this vulnerable cohort of women is not at risk from male offenders. The independent reviewer was impressed by this holistic approach, although as the cost-of-living crisis places pressure on budgets, funding for some of these services is at risk, including a decision being taken not to continue funding the Ruby Project, who had been developing a project to work with female offenders to address trauma

that triggers violent criminal behaviour. Panel members noted that in the absence of the Ruby Project, it would be vitally important for the probation service to improve its internal tools to support female offenders.

4.40 Although the Domestic Abuse Act 2021 required the Home Secretary to publish a perpetrator strategy within one year of the Act gaining Royal Assent, this has not yet been released. This is intended to set out the Government's approach to detecting, investigating and prosecuting offences involving domestic abuse, assessing and managing the risks posed offenders, and reducing recidivism. It is unclear whether this will incorporate research-driven strategies to tackle female offenders, however, it is important that as Liverpool develops its local strategic approach to meet national targets, this is carefully considered.

Trauma-informed response to victims / perpetrators with additional needs

- **Penny had experienced sexual abuse as a child and domestic abuse throughout her life, and had her children removed from her care; what impact did these traumas, her learning difficulty and substance misuse have on her ability to engage with support offered to address her mental health, substance misuse and abusive behaviours?**

4.41 Penny had experienced sexual abuse as a child and domestic abuse throughout her life; these traumas, combined with her substance misuse had a significant impact on her behaviour and response to professional intervention into her adult life. As noted above, although Penny was not recorded to have a learning disability and achieved 11 GCSEs, she attended a specialist school for her behavioural needs. There is now a well-established evidential basis for the impact that trauma and adverse childhood experiences has on the development of the brain and, consequently, adult mental health has increased awareness of the prevalence of trauma in society and improved understanding of its long-term effects on survivors[16]. It is recognised that past trauma can affect how a person perceives and responds to their environment in the present.

[16] Jones & Wessely, 2007; Scottish Government, 2012; Becker-Blease, 2017

Aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma survivor. Research[17] into female perpetrators of intimate partner violence (IPV) found that adverse childhood experiences (ACEs) are often found within the developmental histories of both male and female IPV perpetrators:

"These experiences of abuse during childhood can generate feelings of distrust and fear of others in adulthood. Moreover, it was suggested that some IPV behaviours, such as controlling and coercive behaviours, can be a way that people who have experienced childhood trauma cope with their distress in adulthood"

4.42 NHS England and NHS Improvement ['NHSE/I'] published guidance on commissioning effective trauma informed care for women, which includes examples of commissioned services,[18] recommending services are commissioned to enable flexibility for practitioners, so they adapt their 'usual offer' to take into account the prevalence of trauma and likely long-term effects on survivors. In particular, services should be aware that survivors of childhood trauma and multiple adversities are at greatly increased risk of substance misuse and poor mental health (including self-harming and suicide). It is also much more likely that their ability to form healthy, supported relationships will have been damaged.[19]

4.43 When Penny ended her relationship with Michael after being subjected to a number of very serious incidents of domestic violence that were referred to MARAC, she lost her accommodation and had to move into her father's one-bedroom home. This created a 'pressure-cooker' situation, and as Penny's alcohol use escalated, so did the number and frequency of incidents of violence, primarily with Penny as a perpetrator.

[17] Female IPV perpetrators report (natcen.ac.uk)
[18] See 'Engaging with Complexity: Providing effective trauma-informed care for women' by the Centre for Mental Health available at: https://www.mentalhealth.org.uk/sites/default/files/Engaging_With_Complexity..pdf
[19] Lewis, S.J.; Arseneault, L.; Caspi, A.; Fisher, H.L.; Matthews, T.; Mott, T.E.; Odgers, C.L.; Stahl, D.; Teng, J.Y. Danese, A. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. Lancet Psychiatry 2019, 6, 247–256.

This was a particular safeguarding risk for Kieron as an adult with care and support needs. However, this was a Catch-22 as Kieron was aware that her behaviours were dangerous and was extremely distressed by this to the point of suicidal ideation but was unwilling or unable to obtain an exclusion order to remove Penny from his home as this would render her homeless which could then risk her resuming her relationship Michael as Matt lived with his parents.

However, Penny would not be a priority for housing under s189 of the Housing Act 1996 unless she was physically homeless. Further, although the Domestic Abuse Act 2021 amended the Housing Act to explicitly include homeless victims of domestic abuse as being a priority need, this does not extend to perpetrators, so the fact that Penny posed a risk of abuse to her father would not result in her being a priority for accommodation. Although the house was statutorily overcrowded, this would only place Penny on Priority Band B for rehousing, which could take years. IDVA showed good practice in their efforts to resolve this, not only referring Kieron to adult safeguarding and the police, but getting Penny registered on the Council's housing site, however Penny needed to proactively bid for properties and wasn't engaging.

4.44 The Domestic Abuse Act 2021 requires local authority to appoint a local Domestic Abuse Partnership Board (DAPB), including the police, local authority, health services and charities and voluntary sector organisations and members who can represent the interests of victims (including children). The main purpose of the board is to conduct assessment of need for accommodation-based support in its area, publish a strategy for this and monitor the implementation of that strategy.[20] In compliance with the 2021 Act the Liverpool Domestic Abuse Strategy Group transitioned into the Liverpool Domestic Abuse Partnership Board, which must oversee the delivery of the Domestic Abuse Strategic Plan.

[20] The NICE quality standards remain a useful tool for planning and delivering multi-agency services and developing a domestic abuse strategy. Importantly, a draft statutory framework for domestic abuse has been issued, under section 84 of the Domestic Abuse Act 2021, in order to set standards and promote best practice, including 'improving performance to drive consistency and better performance in the response to domestic abuse.'

As part of development of the strategic plan, partners will need to consider how to approach the accommodation needs of perpetrators of abuse, in circumstances where rehousing them will reduce the risk to their victims, but without those victims being disadvantaged by being forced to move home. This will need to be very carefully considered, to ensure that perpetrators are not afforded an unfair advantage in the context of the housing crisis.

4.45 Despite Penny's history of depression and self-harm and diagnosis of neurofibromatosis, it does not appear that she was consider in the context of her rights under the Care Act 2014, either when safeguarding issues arose or with a view to assessing whether she have any care and support needs. While it is not clear that there is any direct link between these needs and Matt's death, proper consideration of these issues may have enabled practitioners to make reasonable adjustments to ensure that Penny had the support she needed to access treatment programmes for her alcohol use at an earlier stage, or in respect of her housing needs.

4.46 Further, although Penny was recorded as having a learning difficulty related to her health diagnosis, within the information from agencies submitted to this review, there was no reference to professionals exploring this to establish the nature of the learning difficulty she asserted and how this may have impacted on her functioning.

A learning difficulty may have referred to a wide range of issues such as a cognitive impairment, or a learning need such as dyslexia or dyspraxia, and the reasonable adjustments required to support those needs could vary accordingly. The only occasion where there is evidence Penny's mental capacity was considered was in relation to her hospital attendance in September 2021 after she had self-harmed after being arrested for criminal damage during an incident when she was violent to Matt, when she told staff that she was in a violent relationship. Mersey Care's IMR noted that when they contacted Liverpool's adult safeguarding team to consider whether further safeguarding enquiries should be made under s42 of the Care Act 2014, Penny

was “deemed to have capacity to make unwise decisions relating to her relationships.”

4.47 There is no other indication that assessments were carried out of Penny’s ability to protect herself or her capacity to engage with necessary care or treatment. The subjective nature of capacity assessments, particularly in respect to a person’s perceived reluctance to accept (or sustain engagement with) support, can obscure statutory welfare responsibilities including under the Care Act 2014. Where there is a suspicion of coercion and/or addiction, this can add significant layers of complexity because the person’s ability to weigh up and act on information affects relevant legal powers to respond to identified safeguarding concerns. For example, had Penny been assessed as lacking capacity in respect of her application for housing, this would have frustrated the Council’s legal powers under the Housing Act 1996, but not their safeguarding responsibilities. Similarly, offers to support someone to reduce harm associated with alcohol use or for rehabilitation are predicated on their ability (and willingness) to engage with treatment programmes. There is, however, still an expectation, in national and local policy, for practitioners to recognise and respond to safeguarding concerns for those in contact or known to their services.

4.48 The wellbeing principle and safeguarding obligation to adults with care and support needs was deliberately widely defined in the Care Act 2014 by Parliament. Since April 2015, s1 Care Act requires local authorities to promote an individual’s wellbeing whenever it is carrying out any care and support function. The Care and Support Guidance, which accompanies the Care Act, dictates an early response to emerging harm is essential to stop risks from escalating. It also clarifies that local authorities have duties when the adult’s needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. This includes *‘physical, mental, sensory, learning or cognitive disabilities or*

illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of the adult and a formal diagnosis of the condition should not be required.' [21]

4.49 Liverpool Adult Safeguarding Service's IMR recognised that support was not offered to support Penny despite there being a rationale that she should have been considered as an adult at risk as defined by Care Act 2014. This is both at the front door and then within the neighbourhood team who were co-ordinating a safeguarding enquiry where Penny was considered to be the persona alleged to have caused harm. Adult safeguarding received a referral in respect of Penny as a victim of domestic abuse in February 2019, which could have triggered an assessment under section 11 Care Act 2014. Information does not appear to have been shared with Penny's GP, the mental health team nor did adult social care reach out to Penny in the form of a phone call or letter to signpost her and share information with her about agencies who could support her with her mental health. The IMR recognised that this siloed to domestic abuse hindered a multi-agency response that could have reduced risk.

4.50 Senior leaders recognised that the current high levels of newly qualified police officers[22] nationally make it more likely that those responding to urgent calls may not have wider life experiences or expertise to recognise or respond in a way that reflects wider 'think family' and person-centred, trauma-informed approaches now advocated within safeguarding best practice guidance. The probation service discussed how its trauma-informed approach had developed over time. This was particularly important in respect of the services they offered that were not compulsory such as the Ruby Project, which supported female victims of domestic violence, in trying to explore with clients why they found it difficult to engage. Good practice could be noted in response to issues Penny raised, for example, the offer from her Ruby Project keyworker for Penny's

[21] Paragraph 6.104 Care and Support guidance, DHSC

[22] Currently 60% of frontline responding officers have less than 5 years' experience. Basic domestic abuse training is included as part of the initial training programme.

sessions to be moved to telephone based after Penny expressed concern that her violent ex-partner worked near the office location. Initially, Penny appears to have found the support offered by the Women's Turnaround Project (WTP) supportive and would open up to her key worker, but over time she disengaged. Further good practice was observed in the support the probation officer offered to Penny in respect of resolving her housing application.

4.51 Practitioners noted a tension between trauma-informed practice and the requirement to enforce breaches of services which need to be therapeutic to result in meaningful change, such as alcohol recovery. We Are With You, an alcohol treatment service, commented that they were not made aware of the increase in Penny's drinking and that although they would like this to be common practice to improve delivery of change, they rarely received such information.

However, a more informed understanding of trauma-informed practice may also have recognised some of Penny's avoidant strategies in terms of compliance with her alcohol treatment order, a compulsory part of her court ordered sentence, and attendance at regular probation meetings. Probation staff recognised that alcohol recovery is a journey, and that the fact Penny was continuing to drink was not, in itself, a reason to restore the matter to court, but attending meetings as ordered was. Practitioners recognised that early in her sentence, Penny appeared to be testing the boundaries by proffering a variety of excuses for non-attendance, as there continued to be no consequences for this, she simply stopped turning up.

4.52 The probation service's IMR identified that enforcement practice lacked a robust approach, and this, combined with staff absence and limited management oversight resulted in substantial drift occurring in this case. Had enforcement practice adhered more closely to policy in this case, the IMR author noted that Penny might have been reengaged, and aware of clearer and more consistent boundaries in terms of her behaviour and supervision.

This was reinforced by observations in Mersey Care's IMR, which noted that in September 2021, Penny was keen to access support for her alcohol misuse

and presented with insight into the impact alcohol and not taking medication had on her mental health.

5 Conclusions

Lessons: support for male victims

5.1 Research highlights men's inability to recognise and accept their victimisation, so it is vital that criminal justice, domestic abuse and other agencies believe and validate their experience, offering 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 **[see recommendation 1].** Merseyside Police officers were generally empathetic and complied with their procedures in respect of ensuring the victim's immediate safety, providing him with opportunities to disclose abuse and completing referrals and risk assessments. However, there were missed opportunities by both police and DAA/IDVA to engage more intensively with the victim following the most serious report of domestic abuse and in particular, to build a trusted relationship and giving him time to consider whether he wanted to support a prosecution or engage with domestic violence support **[see recommendation 2].** This was also not considered in the context of coercive and controlling behaviour by the perpetrator and alternatives to a criminal justice response were not explored with the victim. In respect of the perpetrator's father, an episodic response to repeated police referrals did not result in a s42 safeguarding enquiry by Liverpool's adult social care, nor a review of his care and support needs or her role as a carer. This was a missed opportunity to explore the risks in a holistic way, utilising a 'think family' approach which could have recognised that the increasing severity and frequency of incidents of violence in the household required a more proactive multi-agency safeguarding response **[see recommendations 3 and 4].**

Lessons: use of protective measures

5.2 This case demonstrates that systems across Merseyside are currently not well embedded to enable repeated incidents of domestic abuse involving the same perpetrator that are graded bronze or silver to be analysed to determine whether risk is increasing [see recommendation 5]. Inconsistent information sharing between agencies (particularly with probation) and across borders further limited the ability of agencies to analyse escalation of risk **[see recommendations 6-7].** It is likely that this is impacted by the fact Liverpool does not now have an Adult Multi-Agency Safeguarding Hub, although this is currently being reviewed and will require full representation of relevant safeguarding partners to function effectively if re-established **[see recommendations 8-10].** To address these issues, a Merseyside-wide strategic group led by Merseyside Police is looking to establish a Multi-Agency Task and Co-ordination pathway to coordinate the response to repeat and high-risk perpetrators who fall outside other statutory frameworks. Merseyside Police have also initiated a Domestic Homicide Prevention tool research project to improve data analysis and analysis of trends in respect of domestic abuse, support victims through data-driven, targeted interventions and hopefully, to allow for the identification of those most likely to become the victim of domestic homicides before cases escalate to murder **[see recommendation 11].**

Lessons: response to female perpetrators

5.3 Data from Merseyside Police indicates that gender bias may play a role in the agency response to female perpetrators, although this needs to be explored for conflating factors **[see recommendation 12].** Known risks associated with female perpetrators through national and local reviews were not well understood by professionals, including increased incidence of emotionally abusive behaviour, coercive and controlling behaviour and risk of more severe violence to partners by women who are also violent towards non-partners **[see recommendation 13].**

Although Merseyside probation service's specialist services for female perpetrators offer a quality service, these are at risk due to funding issues **[see recommendation 14].** Risk assessments carried out by the probation service

were not completed or generic and impacted by poor information sharing, and non-compliance with court-imposed conditions was not enforced. These deficiencies meant that substance misuse, one of the most acute areas of risk in the case, and one that the perpetrator had requested help with on several occasions, was never adequately addressed. **[see recommendation 15-16]**

Lessons: trauma-informed response to victims/perpetrators with additional needs

5.4 Knowledge across partner agencies of the perpetrator's adverse childhood experiences and traumas as an adult, including experience as a victim of serious domestic abuse herself could have been used to ensure support was delivered to her in a more trauma-informed way **[see recommendation 4].** Further, her identified physical and mental health needs did not result in an assessment of her care and support needs or a safeguarding response under the Care Act 2014 in respect of referrals identifying her as the victim of domestic abuse, which may have enabled reasonable adjustments to be made to support her access to support services, in particular in respect of her substance misuse **[see recommendations 17].** As part of development of the Domestic Abuse Strategic Plan, partners will need to consider how to approach the accommodation needs of perpetrators of abuse, in circumstances where rehousing them will reduce the risk to their victims, in particular those with care and support needs **[see recommendation 18].**

6 Recommendations

Recommendation 1: Citysafe should undertake an analysis, utilising experts by experience, to establish the barriers to male victims accessing domestic abuse services and consider how, as a partnership, specialist services for male victims of domestic abuse can be improved. Citysafe and KCSP should seek additional funding from the Home Office to support this programme.

Recommendation 2: Citysafe and KCSP should promote awareness of male victims across frontline services to facilitate identification of male victims and the wider community, to 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 3: ASC should evidence the impact of changes which have been introduced as a consequence of previous learning, to ensure that where VPRFs are received in respect of domestic abuse by a carer to an adult with care and support needs, this triggers a review of the care and support plan pursuant to s27 of the Care Act 2014.

Recommendation 4: Merseycare should share the package it is developing in respect of trauma-informed practice with Citysafe and KCSP, to enable partners to tailor a shared approach to trauma-informed risk assessment and support for victims and perpetrators of domestic abuse.

Recommendation 5: Merseyside partners (police and domestic abuse services) should review the MeRIT form in line with the Domestic Abuse Act 2021 and clarify what constitutes an escalation to MARAC when the MeRIT score is bronze/silver, when the incident involved use of a weapon. Knowsley CSP should also carry out an audit to determine whether VPRFs involving weapons are being consistently referred through to its MARAC in accordance with its procedures.

Recommendation 6: Partners should consider how to strengthen the multi-agency team supporting the individual and to ensure that multi agency meetings are used consistently to share information and develop effective risk management strategies as risk and harm start to escalate. This should include consideration of dynamics and risk to all family members and intimate partners (a Think Family approach). When MARAC actions have not mitigated the identified risks, this should be fed back to both the multi-agency team and the Domestic Abuse Strategic Partnership as this may suggest a strategic need.

Recommendation 7: VPRFs and MARAC decisions in respect of offenders who are subject of a community order (irrespective of the nature of the offence that has led to

the sentence) should automatically be sent to the offender's probation officer, to inform their offender management and risk assessment processes.

Recommendation 8: Liverpool adult social care should consider how to ensure that key partners such as probation, domestic abuse specialists and IDVAs support decision making in respect of relevant s42 safeguarding referrals to Liverpool adult safeguarding.

Recommendation 9: Citysafe and KCSP should liaise with neighbouring Community Safety Partnerships to identify how to harmonise s42 and MARAC referral processes and enable a joined-up multi-agency approach to identifying and managing risk, including where intimate partners live across different areas.

Recommendation 10: Representatives from key partner agencies such as probation and the ICB should commit to attending the local MARAC.

Recommendation 11: Merseyside Police should provide an update report to Citysafe and KCSP on the progress of its innovative projects (the Multi-Agency Task and Co-ordination pathway and Domestic Homicide Prevention tool research project**),** including analysis of the practicalities or wider roll-out.

Recommendation 12: Merseyside Police should further analyse data in respect of its response to domestic abuse incidents by gender, including the gravity of such incidents and the perpetrator's offending history, to determine whether its decisions in respect of arresting and referring perpetrators to the CPS are influenced by gender bias.

Recommendation 13: All partner agencies should refresh their training offer in respect of domestic abuse and promote accessible resources, to ensure practitioners are equipped to identify and respond to abuse by female perpetrators.

Recommendation 14: Citysafe and KCSP should seek additional funding from the Home Office to develop a specialist domestic abuse programme to reduce reoffending for female perpetrators of abuse, including those outside the criminal justice system and at an early-intervention stage.

Recommendation 15: Probation Services should ensure that frontline staff have clear guidance and training in respect of information governance and the importance of recording information in respect of the victims of incidents of violence, to enable accurate risk assessments to be undertaken and informed judgments to be made in respect of enforcing breaches of probation conditions. Consideration should be given to carrying out an audit to ensure that the strengthened supervision processes introduced since 2021 are consistently identifying cases where breaches should be enforced.

Recommendation 16: Probation services and partner agencies should review whether existing domestic abuse risk assessment tools such as SARA are calibrated to assess female perpetrators of violence.

Recommendation 17: Partner agencies should review referrals forms for support services such as substance misuse or IDVA/DAA services to ensure these require disabilities or known trauma responses that may act as a barrier to accessing services to be identified, so that reasonable adjustments can be made to facilitate access to support for victims and perpetrators.

Recommendation 18: When developing Liverpool's Domestic Abuse Strategic Plan, partners will need to consider how to approach the accommodation needs of perpetrators of abuse, in circumstances where rehousing them will reduce the risk to their victims. This should include consideration of dedicated accommodation providing therapeutic interventions for those with a long history of domestic abuse.

7 Glossary

DAA	Domestic Abuse Advocate
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
FTA	Failure to Attend
Citysafe	Liverpool Citysafe Board
LDAS	Liverpool Domestic Abuse Service
CMHT	Community Mental Health Team
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICB	Integrated Care Board
IPV	Intimate partner violence
KCSP	Knowsley Community Safety Partnership
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
RLUH	Royal Liverpool University Hospital
SARA	Spousal Abuse Reduction Plan
VPRF	Vulnerable Person Referral Form
WTP	Women's Turnaround Project