A DOMESTIC HOMICIDE REVIEW (DHR)

'Leonard'

MARCH 2022

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Contents

Introduction ... 3
Timescales ... 4
Confidentiality ... 4
Involvement of family, friends, work colleagues, neighbours and the wider community ... 4
Methodology, scope and terms of reference ... 5
Contributors to the review ... 7
The review panel membership ... 11
The author of the overview report and chair of the review panel and the statement of independence ... 12
Parallel reviews ... 12
Equality and diversity ... 12
Dissemination ... 15
Background information and chronology ... 16
Overview ... 23
Analysis ... 25
Opportunities for the disclosure or detection of domestic abuse before November 2021 ... 29
Information about Leonard's history with a previous partner that could have caused any different action before November 2021 ... 30
Information about Leonard's mental health history including evidence of self-harm known to services. Did psycho-social assessments and inquiries explore the potential for domestic abuse and or self-harm? ... 31
Follow-up provided to Leonard and/or Lilly after Leonard's overdose in August 2021 ... 32
What were the concerns and risks identified at MARAC and did they result in effective planning and action? ... 33
Are there appropriate services for men who are perpetrators of domestic abuse and were they used in this case? ... 35
Is there appropriate service for men who report being victims of domestic abuse and were they used in this case? ... 35
Conclusions ... 36
Lessons to be learnt ... 40
Recommendations ... 43
Issues for National Policy ... 45
Recommendations by individual agency reviewers ... 46
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust ... 46
Doncaster Suicide Prevention Group ... 46
Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH ... 46
Glossary ... 48

Introduction

1. Sincere condolences and sympathy go to the family of 58-year-old Leonard[1] on behalf of the Safer Stronger Doncaster Partnership which commissioned this review as well as the people and organisations who contributed to it.

2. Government guidance[2] requires that when an adult dies, including death by suicide, and the circumstances give rise to concern regarding evidence of domestic abuse, a statutory review should be completed. The circumstances of Leonard's death are within the scope of the law and guidance that require a domestic homicide review (DHR) to be completed. It is, however, inappropriate to talk about Leonard's death as a domestic homicide. The review complies with guidance for a DHR and was commissioned as a fatal incident review. Since This report refers simply to the review. As the review was being completed national guidance was being revised including changing the name of the reviews to Domestic Abuse Related Death Reviews. (DARDR).

3. The review examines the response of organisations and the appropriateness of professional support given before Leonard's death. These services are described in paragraph 18.

4. In addition to looking for any recent agency involvement, the review also examines the past to identify any relevant background or history; 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.

5. For lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand as far as possible what happened, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

6. The review considers the contact and involvement by different professionals and organisations with Leonard and his 25-year-old estranged wife Lilly from August 2021 (when Leonard was first treated for an overdose at the hospital) until the date that Leonard was found deceased at his home. A police investigation confirmed there was no third-party involvement in Leonard's death and subject to the coroner's verdict Leonard's death is treated as a suicide for

[1] This and all the other names used in the report are pseudonyms.
[2] The circumstances under which a domestic homicide review must be carried out are described in the Domestic Violence Crime and Victims Act 2004 and associated national guidance described in multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).

the review. Information was sought where it was known before August 2021 as relevant to the purpose of learning lessons.

Timescales

7. The Chair of the Doncaster Safer Stronger Partnership commissioned the review in June 2022 although the scoping panel did not meet until September 2022. Substantial work on the review was initially delayed to ensure all agencies were able to identify suitably independent people to participate in the review and for efforts to be made to contact Leonard's family none of whom lived locally or were known to services in Doncaster. Contact with Lilly was postponed until Leonard's family had been informed of the review and had an opportunity to determine what involvement they wished to have. The report was completed in July 2023. The report was signed off by the Community Safety Partnership in January 2024. This followed the completion of actions and sign off by agencies involved in the review and agreement with family members.

Confidentiality

8. The findings of the review are confidential as far as identifying the subjects, their families or professionals. Information is available only to officers/professionals and their line managers who participated in the review. The names used in the report are all pseudonyms to protect their identity and provide privacy for the respective families.

Involvement of family, friends, work colleagues, neighbours and the wider community

9. Leonard and Lilly were separated at the time of his death the circumstances of which are described later in the report. Lilly was informed of the review and provided with details about the review, and contact details for the independent reviewer and was offered information about advocacy and support services including AAFDA[3]. Although Lilly had a long discussion with the reviewer in December 2022 she did not respond to subsequent contacts by email, telephone and text messaging. Lilly was kept informed about the review including the completion of the draft report.

10. The review initially had incomplete information about Leonard's family and initially sought contact with a brother who was given as the point of contact who at the time of the police investigation and the start of the review was unwell. The reviewer subsequently had further information about Leonard's family.

[3] Advocacy After Fatal Domestic Abuse

11. Leonard was married twice. He had no contact with his first wife. They had two daughters who are now adults living in the midlands and spoke with the reviewer; further information is included later in the report.

12. Leonard subsequently met and shared a home with another woman in South Yorkshire with whom he had two children. The relationship ended after she disclosed domestic abuse which is discussed later in the report. They have not spoken with the reviewer.

13. Leonard had two sisters and two brothers and they had grown up in a mining community in the midlands. Leonard was the youngest sibling. The reviewer subsequently spoke to another of Leonard's brothers. He had not been in regular contact with Leonard and was unaware of the difficulties he had with his mental health or his relationship with Lilly. He described Leonard as a younger brother who found it difficult to ask for help and felt Leonard perhaps had to live up to certain expectations. He thought Leonard might have been embarrassed to ask for help from his brother who would have wanted to assist and give him support. Leonard had found it difficult to accept the breakdown in his earlier marriage which Leonard's brother believed had been undermined by other people some of whom he described as controlling. The death of Leonard's mother had been difficult and Leonard's brother felt that the relationship with Lilly gave him a new purpose. He had been besotted with Lilly and idolized her. Leonard's sibling believed that Leonard was a victim of abuse rather than a perpetrator.

Methodology, scope and terms of reference

14. The circumstances of Leonard's death were reported to the chair of the Safer Stronger Doncaster Partnership (the responsible authority for the review) shortly after Leonard's death. The formal scoping discussion was incorporated within the first meeting of the panel in September 2022 to identify the lessons to be learnt from Leonard's death.

15. The methodology of the review complies with national guidance. This includes identifying a suitably experienced and qualified independent person to chair and provide an overview report for publication.

16. The initial scoping panel agreed on the list of services that would be asked to provide information to the review and be represented on the panel and included a range of domestic abuse and suicide prevention specialists.

17. The timeline for the review is from August 2021 when Leonard was taken to the hospital following an overdose until the date of Leonard's death in March 2022 taking account of relevant history where it is known. Although there was a record of Lilly consulting the GP for anxiety in December 2019 there was no

other record or information about the circumstances. Apart from routine contact with GP services, there was no other contact with services until August 2021.

18. The review considered how local services responded to Leonard as a perpetrator as well as how his counter-allegations were dealt with and the follow-up when he was treated as a victim as well.

19. Agencies contributing reports or information to the review used the terms of reference set out in national guidance with additional general areas arising from the particular circumstances of this review as described in the following scope. This included;

    a) Opportunities for the disclosure or detection of domestic abuse before November 2021; this included whether for example there was any disability or other difficulty as well as whether control and/or coercion and/or economic or social dependency were factors;
    b) What prompted or assisted the disclosure of domestic abuse in November 2021?
    c) Was there information about Leonard's history with a previous partner that should have caused any different action before November 2021;
    d) What mental health history including evidence of self-harm was known? Did psycho-social assessments and inquiries explore the potential for domestic abuse and or self-harm?
    e) What follow-up was provided to Leonard and/or Lilly after Leonard's overdose in August 2021?
    f) What were the concerns and risks identified at MARAC and did they result in effective planning and action that addressed the risk and safety?
    g) Are there appropriate local services for men who are perpetrators of domestic abuse and were they used in this case?
    h) Are there appropriate services for men who report being victims of domestic abuse and were they used in this case?

20. The panel were mindful that the Covid national lockdown between March 2020 and March 2021 had unintended consequences on domestic abuse victimisation. It changed the nature of reporting domestic abuse and severely limited the opportunity for face-to-face contact with services such as health. Research is providing evidence that domestic abuse increased during lockdown[4]. The impact of Covid was discussed by the panel and comments were made in the report where there are specific points to be made about contact with Leonard or Lilly.

[4] Ivandic, Ria and Kirchmaier, Tom and Linton, Ben, The Role of Exposure in Domestic Abuse Victimization: Evidence from the COVID-19 Lockdown (May 27, 2021). Available at SSRN: https://ssrn.com/abstract=3686873 or http://dx.doi.org/10.2139/ssrn.3686873
Ivandic, R., Kirchmaier, T. and Linton, B., 2020. Changing patterns of domestic abuse during Covid-19 lockdown. https://eprints.lse.ac.uk/108483/

Contributors to the review

21. Twelve organisations in Doncaster and South Yorkshire responded to the initial scoping inquiry for the review about any contact and knowledge they had about Leonard or Lilly. The following services confirmed having information relevant to the review and provided an individual management review (IMR) that was written by authors who were independent of any contact or decision-making and had appropriate experience and expertise.
    a) Crown Prosecution Service (CPS); authorised the police to immediately charge Leonard with threats to kill and controlling and coercive behaviour; CPS provided an action plan for the police on further investigatory enquiries to be completed; the magistrate's court hearing on the 8th March 2022 sent the case to Sheffield Crown Court for a hearing on the 5th April 2022; the judge accepted the interim death certificate without a requirement for the police to perform any additional duties; the indictment was declared to have no legal effect and the case was stopped;
    b) Creative Support; responded to a referral from St Leger Homes to provide support after moving out of the marital home; had no information about domestic abuse except what Leonard disclosed during a discussion with a support worker when he asked for support for a court hearing which Leonard presented as malicious allegations by his estranged wife;
    c) Department for Work and Pensions (DWP); administered benefit claims for Leonard and Lilly (employment and support allowance), personal independence payments (PIP) for Leonard from 2015 and universal credit. They claimed as a couple initially in Wales where they were living before moving to Doncaster in 2019. Leonard was not required to look for work or engage with the DWP due to his health conditions[5]; in January 2020 Lilly was assessed as having limited capability for work and continued to engage with DWP declaring caring responsibilities for Leonard; she received a carer's allowance until the separation in November 2021 when DWP was notified of their separation;
    d) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBHT); Leonard had four emergency department attendances and two outpatient department attendances during the scoping period; Leonard suffered from a condition that he said caused him pain (details of which are not included as not being relevant to the review) and for which Leonard attended the emergency department on two of the four occasions. Both outpatient appointments were about his diagnosis (redacted as being unrelated to the learning for the review). He also attended

[5] The health conditions were anxiety and depression, osteoarthritis, morbidly obese, hypertension and high cholesterol, vibration white finger and memory issues.

the emergency department on 8th August 2021 after taking an overdose; he disclosed he did this following an argument with his wife (Lilly) and on this attendance, he was referred for a Crisis Team review lastly on 24th September 2021 following a fall;

e) Doncaster Domestic Abuse Service; processed referrals from the police following disclosures of domestic abuse and provided an IDVA (independent domestic violence advisor) for Lilly from November 2021; when Leonard self-referred In December 2021, he was referred to Phoenix another local specialist domestic abuse service and Creative Support;
f) Phoenix WoMens Aid; Leonard was referred in January 2022; at the initial assessment Leonard reported that his wife had made false allegations of domestic abuse causing him to become homeless and live in temporary accommodation; he attended two peer support group sessions as well as had five one-to-one counselling support before his death;
g) Riverside Domestic Abuse Service; had contact with Lilly from 14th December 2021 until February 2022 closing their involvement on the 25th February 2022; they declined a referral through the Hub for Leonard due to already providing a service to Lilly;
h) Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH); had eight contacts with Leonard between June 2020 and March 2022 via the Single Point of Access (SPA) to the Crisis Team seven of which was via a third-party referral and one was a self-referral; none of the contacts proceeded to a secondary level of support; the Crisis Team first responded to a referral in June 2020 from a hospital emergency department when Leonard presented with thoughts about suicide; the triage assessment by phone included a history of depression since 15 years old and anger management issues. Leonard was already on sertraline from his GP; Leonard was signposted to the DRASAC[6] (as the remit of the Crisis Team) improving access to psychological therapies (IAPT) and a local helpline; the OT service had contact in September 2020 to help fit a settee raising device. In August 2021 the Crisis Team had a second referral from the hospital emergency department following Leonard taking an overdose of mirtazapine combined with alcoholic spirits; the triage assessment recorded history of stress relating to his marital relationship and regular arguments; Leonard described “unresolved relationship problems” but said that his wife avoided discussion; he was discharged on the basis his difficulties related to his relationship rather than a mental health condition; no DASH domestic abuse, stalking, harassment and honour-based

[6] Doncaster Rape & Sexual Abuse Counselling Service

violence assessment) or routine inquiry was recorded about domestic abuse; a police alert (DASH) in December 2021 about a vulnerable adult requiring mental health support was discussed at a multi-disciplinary team meeting which concluded he did not meet the threshold for service; a letter was sent to Leonard informing him and advising him to contact the RDaSH SPA (single point of access) if he wanted further help; two days later Leonard contacted the SPA saying that he was in temporary accommodation due to "current domestic abuse issues" and wanted to know what support he could access. Leonard was signposted to Samaritans, Rethink, GP and Safe Space[7]. During the discussion he did not disclose any thoughts or plans about self-harm or suicide; no advice or information was discussed about domestic abuse; on the 26th of January 2022 a referral was made from Safe Space who reported that Leonard had thoughts about suicide but was not talking to Safe Space; the Crisis Team triage by phone recorded that Leonard denied having thoughts about suicide but had low mood and poor sleep; Leonard was referred back to Safe Space and the referral was closed and a text message was sent to Leonard about the Phoenix Domestic Abuse Service; three weeks later in February 2022 Phoenix phoned the SPA to say that Leonard had been attending support groups and had disclosed he "would be charged" with controlling and coercive behaviour which he was denying stating that it was his wife and was the reason for his suicidal thoughts; the Crisis Team worker phoned Leonard and discussed the "relationship issues and impact on his mental health" although the call was prematurely terminated when Leonard took another call; the Crisis practitioner made a follow up call later that evening when Leonard denied any suicidal intent but felt he could not "go through with this anymore". Leonard described having support from Creative Support, Phoenix and a food bank. A letter was sent to the GP adding a review of Leonard's medication (and self-medication); on the 10th of March 2022 the SPA was contacted by Leonard and the police who were at his property with concerns about his safety given he had suicidal thoughts; the Crisis Team worker talked with Leonard following which Leonard said he felt better;

i) South Yorkshire Integrated Care System; GP primary health care services; Leonard had more frequent contact with the GP than

[7]Safe Space is operated by primary health, RDaSH and the People Focussed Group, Mind and Open Minds provide out of hours support for people experiencing mental health crisis and avoid them having to attend the local emergency department using peer and voluntary support to empathise with people experiencing a mental health crisis building wrap around support and a living well plan for each individual which links with local neighbourhood assets and services which can help further.

the average[8]; he suffered with pain in the knees, anxiety and depression and was on long term repeat medication that included sertraline and co-codamol; the overdose in August 2021 involved mirtazapine which was not a medication currently prescribed by the GP; a second presentation to the Crisis Team in February 2022 was notified to the GP although details recorded on the patient system were not clear about the circumstances; he had run out of sertraline having been taking three times his prescribed dose and he requested three prescriptions of co-codamol on the 12th, 14th and 15th February 2022; this was picked up by the GP and practice pharmacist who advised Leonard that no more should be ordered before the due date and highlighting the risk associated with an overuse of co-codamol; on the 28th February 2022 Leonard was able to acquire three separate prescriptions of zopiclone from an online pharmacy which was not a usual prescription for him; the GP practice followed this up with the online pharmacy ensuring only one lot of 28 tablets were issued; Leonard registered with a new GP practice on the 28th February 2022 in the area where he had been housed; Lilly had regular contact with the GP for routine health advice; in early December 2021 Lilly consulted the GP for "depressive adjustment disorder" during which Lilly mentioned separation from her husband who was currently on bail; she was having trouble sleeping but did not have any thought of harming herself and she was not depressed; she was given a one-off sleeping tablet prescription (zopiclone); there is no further recorded inquiry about the circumstances of Leonard being on bail or the separation; the GP had no information about the MARAC referral and discussion;

j) South Yorkshire Police (SYP); in November 2021 Lilly disclosed being the victim of controlling and coercive domestic abuse and threats to kill by Leonard; assessed at high risk and referred to the IDVA service; Lilly was subsequently given information about Leonard's previous history under the disclosure of domestic abuse which detailed threats to his previous partner and breaching court orders which are discussed later in the report; Leonard was interviewed under caution who denied Lilly's allegations; he was bailed until the 13th December 2021 having been charged with the offences described by CPS; Leonard made counter allegations against Lilly in December 2021;

k) Yorkshire Ambulance Service (YAS); had six contacts with Leonard between December 2019 and March 2022 when they attended at Leonard's home after he had died; four of the contacts

[8] In 2018/19 there was an average of 3.3 face-to-face consultations per patient per year with GPs. However. the number rose to 8.7 consultations with GPs, including non-face-to-face, like telephone and online. https://www.manchester.ac.uk/discover/news/four-in-ten-consultations-at-gp-clinics-were-with-frequent-attenders/ accessed 20th December 2022

were via the 111 services for 'medically appropriate reasons' unconnected with the scope of the review; in August 2021 Lilly phoned 999 after Leonard had taken an overdose which is discussed in the report; Lilly contacted the 111 services in December 2019 with anxiety and she was referred to the GP.

22. The following services also provided information. The Railway Housing Association (RHA) was the landlord for Leonard after he moved out of the marital home as a condition of police bail.

The review panel membership

23. The panel was chaired by the author of this report. The first meeting of the panel was in September 2022 and agreed on the scope of the review. There were seven further panels. All of the panel members were independent of involvement with or decision-making about any of the contacts or information examined by the review and had relevant experience and expertise.

Organisation and name of the panel member	**Job title or role**
Adult Social Care Services, Doncaster Council Jackie Cooke	Team Leader, Quality and Safeguarding.
Creative Support Nickie Christie	Senior support worker
CPS Chris Hartley	Deputy Chief Crown Prosecutor Crown Court Unit Yorkshire & Humberside Area Crown Prosecution Service
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBHT) Amanda Timms	Lead Nurse Safeguarding Adults
Doncaster Domestic Abuse Service Tim Staniforth Saffiyah Khan	 Domestic Abuse and Sexual Abuse Theme Manager Domestic Abuse Caseworker and Hub Team Manager
Phoenix Women's Aid Vesta Ryng	CEO
Riverside Domestic Abuse Service Andrea Parkinson	Project Manager
Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Kim Goddard Rebecca Sansom	Lead Professional Safeguarding Adults

South Yorkshire and Bassetlaw Integrated Care System (ICS) Dr Rao Kolusu	GP Clinical Lead, Doncaster Place
South Yorkshire Police DI Roberta Beasley Gary Thompson D Sgt Laura Jones Abigail Acres	 Detective Inspector Case Review and Policy Officer[9] Detective Sergeant Intelligence Research Officer
Yorkshire Ambulance Service (YAS) Catherine Holliday	Named Professional for Safeguarding
Doncaster Council Sarah Smith	Public Health Improvement Co-Ordinator (Public Mental Health & Suicide Prevention),
Doncaster Council Laura Bunting	Senior Survivor Liaison Worker

The author of the overview report and chair of the review panel and the statement of independence

24. Peter Maddocks is the independent author of this report and chaired the panel. He has worked in local authority, voluntary and national services in senior and practitioner roles. These have included working with families and children harmed by domestic abuse including work on policy and service development as well as direct work. He is a qualified and registered social worker who continues to participate in regular professional training and development that includes domestic abuse. He has completed domestic homicide reviews with other community safety partnerships in England. He never worked for any of the organisations that contributed to this review and has not held any elected position in Doncaster or South Yorkshire. He is not related to any individual who either works or holds an elected office in Doncaster or South Yorkshire. This was his first DHR in Doncaster.

Parallel reviews

25. A coroner's inquest was opened and adjourned. The review is grateful for the assistance of the coroner's office in contact with Leonard's family.

Equality and diversity

26. Doncaster is the 48th most deprived district in England and the second most deprived district in South Yorkshire and the Sheffield City Region. The area

[9] Following the death of Gary Thompson representation at the panel was covered by other members of the SYP team. Sincere condolences are offered to Gary's family and friends.

where Leonard and Lilly lived before their separation is located in the 8 per cent most deprived districts in England[10].

27. Leonard had long-term health conditions but was not registered as disabled. There is no information to suggest he had a physical or mental disability or disorder. He suffered from depression and low mood and had some contact with mental health services but did not have a mental disorder. He was not in paid employment.

28. Lilly has no long-term health needs or difficulties. She had no contact with mental health services but had one consultation with the GP about low mood.

29. Leonard and Lilly are white British and English-speaking. There is no record of religious affiliation. They were married to each other. They had no children together. There was a 33-year age difference between Leonard (58) and Lilly (25). Lilly was barely an adult when the relationship began. The panel were aware of research evidence and the work of domestic abuse services that highlight the correlation between partner age difference and power and intimate partner abuse[11]. Younger women (and in particular adolescent females) who are in relationships with older men have low relationship power and are often economically and socially disadvantaged. During the one discussion with the reviewer, Lilly described how Leonard did not want her working or signing on. The move to Wales early on in the relationship removed Lilly from potential support.

30. The Equality Act 2010 defines nine protected characteristics prohibiting discrimination in accessing services.

31. Sex is one of the protected characteristics. The panel explored whether Leonard experienced any discrimination as a man alleging domestic abuse and if so, was this was a factor in the responses that were made by local services. The review found no evidence of discrimination in how services responded to him.

32. Sex is a factor in death by suicide. Leonard lived in an area of England where more men die by suicide compared to other parts of England. The Yorkshire and Humber region has the third-highest rates of death by suicide in the country (12.3 per 100,000 compared to the highest region of 12.8 per 100,000). Men are more likely than women to die from suicide; around three-quarters of registered deaths by suicide in England and Wales in 2020 were among men

[10] ONS Postcode Database shows 92 per cent of English postcodes are less deprived. Leonard's flat was located in a less deprived area (83.9 per cent English postcodes less deprived).

[11] Volpe, E. M., Hardie, T. L., Cerulli, C., Sommers, M. S., & Morrison-Beedy, D. (2013). What's Age Got to Do With It? Partner Age Difference, Power, Intimate Partner Violence, and Sexual Risk in Urban Adolescents. *Journal of Interpersonal Violence*, *28*(10), 2068-2087. https://doi.org/10.1177/0886260512471082

(4719)[12]. This is a consistent trend since the mid-1990s. Self-harm[13] is a public health problem in many countries. It is a major risk factor for death by suicide and is associated with elevated all-cause mortality. Unlike Leonard, two out of every three people who died by suicide had no contact with mental health services.

33. In the last published audit of deaths by suicide in Doncaster, 84 per cent were men, they were all white, and within that group recent marital breakdown, being subject to serious allegations, and unemployment or retirement were significant factors[14]. This data informs discussion later in the report for how risk-based discussions for example at MARACs need to include consideration about ensuring GPs are aware of potential stressors for both perpetrators and victims of domestic abuse.

34. Relationship breakdown constitutes a major risk factor for suicide ideation and completion. Although no definitive conclusion can be reached about a gender differential in susceptibility to this factor, several studies have identified that there is an elevated risk factor in men following a relationship breakdown including divorce and separation[15] and are reflected in some of the thoughts Leonard wrote about before his death.

35. Intersectionality describes the interconnection of factors including race, class, and gender among an individual or group. It is often related to an experience of discrimination or a disadvantage. Not all victims experience domestic abuse in similar circumstances. Issues of culture, language and immigration status for example influence how individuals will seek advice and help and feel able to use services.

36. Sex is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subject to abuse. Poverty or lack of access to financial or social resources contributes to dependency on a violent partner as a risk factor. Women in exploited labour or seeking asylum are additionally at risk of abusive controlling relationships.

37. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[16]. On average, two women are killed each week by their current or former partner in England and Wales, a figure that has changed

[12] Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
[13] Intentional self-poisoning or self-injury, irrespective of type of motivation
[14] Doncaster Suicide Prevention Strategy Action Plan.pdf (moderngov.co.uk)
[15] Scourfield J, Evans R. Why Might Men Be More at Risk of Suicide After a Relationship Breakdown? Sociological Insights. Am J Men's Health. 2015 Sep;9(5):380-4. doi: 10.1177/1557988314546395. Epub 2014 Aug 26. PMID: 25164123.
[16] Office for National Statistics. 'Domestic Abuse in England and Wales'. 2018. Crown Prosecution Service 'Violence against women and girls report.' 2018.

relatively little in recent years[17]. It impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence and susceptibility to economic abuse as defined by the Domestic Abuse Act 2021. Women's inequality limits their ability to escape from relationships with abusive partners; it can make it more difficult for them to enforce their rights and are more likely to experience sexual harassment and violence.

38. Domestic abuse is a very significant although all too often an unrecognised issue for mental health care services. Some research studies put the number of women mental health patients being subjected to domestic abuse as high as 69 per cent[18].

39. Depression and self-harm/suicide are significant health problems, particularly for women. Notably, in studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders and suicide. In 2013 researchers published a systematic review of longitudinal studies to explore intimate partner violence (IPV), incident depressive symptoms and attempted suicide[19].

40. Mental illness associated with being a perpetrator of domestic abuse can be a significant risk factor not restricted to a specific condition. Threats or attempts to die by suicide, far-reaching dependency on their victim and fear of abandonment are factors to be considered in risk assessment and management.[20] Leonard was dependent on Lilly which combined with his history of self-harm was not recognised by relevant professionals at the time.

Dissemination

41. Leonard's brother, two of his daughters and Lilly will have a copy of the published report. All the organisations and people who participated in the review will receive a copy of the published report. The report will be sent to the Domestic Abuse Commissioner, the South Yorkshire Police Crime and Police Commissioner, the chief officers of the Safer Stronger Partnership authorities who are the City of Doncaster Council, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, South Yorkshire Police, the Integrated Care Board (ICB), South Yorkshire Fire and Rescue Service and the Probation Service.

[17] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March 2016, Chapter 2: Homicide'. 2016

[18] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015, pp. 875-886

[19] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. (2013) Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies. PLoS Med 10(5): e1001439. https://doi.org/10.1371/journal.pmed.1001439

[20] Monkton-Smith, J, Williams, A and Mullane, F, 2014 Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave Macmillan p55.

Additionally, the report will be sent to the Doncaster Strategic Suicide Prevention Group and the Doncaster Health and Wellbeing Board. Copies will also be provided to Doncaster Mind and Voluntary Action Doncaster.

Background information and chronology

42. Leonard had been married before he met Lilly. His daughters from that marriage described their dad as having a problem with alcohol which adversely impacted his behaviour and relationships. Leonard's brother told the reviewer that he was not aware of his brother having a problem with alcohol although mentioned he had completed various courses when he had served a prison sentence (not related to intimate or family relationships). Both daughters described their father as quick to "fly off the handle", paranoid with mood swings that could happen with no warning or trigger, being capable of extreme anger during which he could be abusive and threatening and cause damage to their home and afterwards be very contrite. In 2020 when Leonard had contact with the Crisis Team via SPA, he talked about his difficulties with anger management although his brother was unaware of this aspect of Leonard's difficulties. Neither of the daughters had a close relationship with their father. Domestic abuse was not reported to the police and the daughters felt their mother avoided confrontation as a strategy for dealing with his behaviour. The marriage ended in divorce.

43. Leonard subsequently met and lived with another woman and it was during this relationship which had ended by the time Leonard met Lilly that he was convicted of domestic abuse offences. In 2007 the police attended four incidents in April 2007, January 2008, February 2010 and July 2010. Little detail is recorded on the police system over and above the incidents were "verbal disputes".

44. The police national database (PND) has information about Leonard being convicted of two counts of battery where the victims were Leonard's ex-partner and her father. He was given a 24-month community order with a supervision requirement and ordered to pay compensation and costs. In late 2012 Leonard was charged with two counts of breaching a non-molestation order regarding his ex-partner and was given a further 12-month community order with unpaid work and an activity requirement.

45. Leonard and Lilly met in 2014 whilst working for the same employer and began living together in August or September 2014 and subsequently married in June 2016. They moved to Wales in 2015 where they were both unemployed. They moved to Doncaster in November 2019 because Lilly wanted to be nearer to her family. In June 2021 Lilly told Leonard that she wanted a divorce and were separated at the time of Leonard's death in March 2022. They had no children together. The separation followed Lilly's disclosure in November 2021 of domestic abuse over most of the time that they were married. This, along with

the counter allegations that Leonard subsequently made against Lilly are described and analysed later in the report.

46. In December 2019 Lilly contacted the 111 services on the 10th of December for anxiety. No further detail was recorded about the circumstances other than Lilly was referred to her GP.

47. On the 9th of August 2021, Leonard took an overdose of mirtazapine with a bottle of spirits. This was not a medication prescribed by the GP and there is no record of enquiry or knowledge about how and where Leonard had procured this medication.

48. The telephone triage assessment by the Crisis Team recorded information from Leonard that he was stressed about his relationship with his wife 32 years his junior and "unresolved issues" were the significant factors. No DASH was completed by any health professional. The Crisis Team referral was closed (in the absence of acute mental health needs). The later disclosures by Lilly of controlling and coercive behaviour by Leonard and the evidence of thoughts about suicide are significant factors for risk assessing safety from domestic abuse and fatalities. This is discussed in the learning later in the report. There is no record of response by the GP practice to the notifications sent by the hospital or the Crisis Team of the intentional overdose of non-prescribed mirtazapine.

49. The first record of domestic abuse is when Lilly went to a city centre police station in mid-November 2021 having become very frightened due to escalating threats from Leonard. A DASH recorded a history of coercive and controlling domestic abuse throughout the relationship. The DASH completed as part of Lilly's initial disclosures recorded the level of risk as high which was confirmed by a secondary assessment by the DARA[21] team.

50. Lilly was given written information about Leonard's history under the domestic violence disclosure scheme (DVDS) in December 2021. This confirmed that Leonard was already known by the police to have an extensive history of violence against an ex-partner and the ex-partner's father and had also breached court orders and used weapons. The information was "sufficient to cause the police significant concern" for Lilly's safety. The disclosure also advised Lilly about the associated risk of escalating violence when a relationship ends and encouraged Lilly to seek support from domestic abuse services. By the time of the DVDS Lilly was already in contact with the IDVA service.

51. The IDVA contacted Lilly on the day of the police referral in November 2021 and completed an initial assessment. Lilly was informed that Leonard was in

[21] Domestic abuse risk assessment team.

police custody having been arrested. Lilly reported being constantly monitored by Leonard via her telephone whenever out of his company and she was not allowed to work. Lilly reported being assaulted several times during the marriage. Lilly said that she had attempted to leave the relationship. Lilly described Leonard as having mental health problems and had taken an overdose although believed this had been more "to mess with Lilly's head"[22]. Lilly was referred the same day to the NCDV[23] for help with applying for a non-molestation order providing details of local legal representation for Lilly.

52. A safety plan was developed which included the IDVA delivering four stick-on window alarms, a door chain and a personal alarm. Lilly already had CCTV fitted at the address. The IDVA was due to go on scheduled leave and advised Lilly to contact the DA Hub if she needed help when the IDVA was away. The arrangements for IDVA cover have already been changed to ensure a named IDVA is briefed and will cover an absent colleague through a buddy system.

53. When Leonard was arrested and interviewed in mid-November 2021, he denied the allegations made by Lilly. The police had requested a charging decision from CPS on the day they had interviewed Lilly. The police file included information about Leonard's history with a previous partner for domestic abuse as well as offences of affray, assault, possession of offensive weapons and breaching non-molestation orders. The police reported that Leonard had stated that if released on bail he would return to the marital home.

54. The CPS noted that the police investigation had not yet been completed but based on the information provided by the police agreed that it was appropriate to charge and produce Leonard at the next available court. CPS also agreed for bail to be opposed. CPS provided an action plan for the police concerning outstanding information.

55. In the event, the police did not charge Leonard until mid-December 2021 and he was released on police bail with conditions that included not contacting Lilly or going to the marital home where Lilly remained. Further information and analysis are provided later in the report.

56. The high-risk DASH assessment completed by the police when Lilly had made her initial disclosure meant that the case was referred to the MARAC which discussed it at a scheduled meeting two weeks later on the 1st of December 2021. The MARAC was attended by the IDVA service, SYP, children's services,

[22] Research has shown a link between gender, violence, and suicide. This relationship is complex, and few empirical studies have explored suicide and family and interpersonal violence perpetrated by men. Fitzpatrick, S. J., Brew, B. K., Handley, T., & Perkins, D. (2022). Men, suicide, and family and interpersonal violence: A mixed methods exploratory study. Sociology of Health & Illness, 44(6), 991–1008. https://doi.org/10.1111/1467-9566.13476

[23] National centre for domestic violence.

probation service, safeguarding adults service, Complex Lives[24], Aspire (drug and alcohol service), the 0-19 service and St Leger Homes.

57. Lilly consulted her GP on the 3rd of December 2021 for what is recorded as a "depressive adjustment disorder"; this can describe a range of stress-related conditions including anxiety, depressed mood, disturbed emotions or any combination. It is a response to psychosocial stressors which can include domestic abuse for example. Lilly "mentioned" that her husband had left her two weeks before that, he was currently on bail and that the house was in both of their names.

58. There is no recorded evidence of exploring the circumstances of either the separation or why Leonard was on bail. Lilly said that she was struggling to sleep but was not having thoughts about suicide. She has been prescribed a one-off sleeping tablet (zopiclone). Lilly said that she was in contact with a counselling service and would contact them if necessary.

59. On the 6th of December 2021, Lily contacted the DA hub requesting help with acquiring a court order. Lilly stated that she was the victim of coercive control and threats to kill. The IDVA who was allocated to work with Lilly was away on pre-booked leave and had advised Lilly to call the hub in her absence if and when Lilly needed advice or help. The duty hub worker passed the referral on to Riverside apparently without checking their system and identifying that Lilly was already open to an IDVA and that she was at high risk of domestic abuse.

60. The referral was processed by Riverside on the 10th December 2021 who were unaware that an IDVA was already allocated to Lilly until a phone conversation with the IDVA service in January 2022. Riverside outreach team involved Lilly in a therapeutic programme (loves me loves me not) which was completed over eight weeks. As part of their contact with Lilly, Riverside completed a DASH at a medium level with Lilly. This is discussed later in the report.

61. On the 13th of December 2021 Leonard was released under investigation (RUI) and from this stage was not subject to bail or any restrictions beyond voluntarily agreeing to not contact Lilly or attempt to visit the marital home. The CPS lawyer in March 2022 was told by Lilly that Leonard had continued to contact her although none of the services was told about this by Lilly.

62. On the 15th of December 2021, the IDVA phoned Lilly who was updated about the MARAC and said that she was being supported by family and friends though no other detail was recorded. Improvements to recording are being addressed through training for all domestic abuse staff in Doncaster. Lilly told the IDVA that Leonard had been charged with coercive and controlling behaviour; the IDVA had not been given this information by the police. Lilly had acquired a job.

[24] An integrated care service focussed on the needs of people without homes involving statutory, community and voluntary organisations.

She had set up a separate bank account. Lilly said that the solicitors had been unable to help with the non-molestation order due to a conflict of interest given they had been instructed by Leonard. Lilly was given details of a firm in Sheffield. The police had informed Lilly (but not the IDVA) that Leonard had been released from bail conditions.

63. On the 17th of December 2021, the safeguarding adult's Hub was notified of Leonard's contact with the police and mental health services.

64. On the 20th December 2021, the police DASH risk assessment of Leonard was discussed at the SPA multi-disciplinary team (MDT) meeting which resulted in a letter being sent to Leonard advising him to contact the SPA if he required help with his mental health. Leonard responded to this on the 22nd of December 2021 when he phoned the Crisis Team and in the absence of acute mental health needs, was signposted to local services. Although Leonard discussed "the relationship problems with his wife" there is no further recorded inquiry about this or of a DASH being considered or completed. There is no evidence of this SPA contact in the GP practice patient records.

65. On the 21st of December 2021, the IDVA service was notified by the police that Leonard had reported being the victim of domestic abuse from Lilly. No action was taken by the IDVA service to allocate an IDVA given they were already supporting Lilly. Regarding action in considering the significance of the counter-allegations, the police DASH risk Assessment was assessed as standard risk and there was no consent given to contact Leonard. Consent is required to contact standard and medium-risk victims to offer support and to share information with other agencies. This would not have in itself prevented discussion between relevant professionals.

66. On the 22nd of December 2021, Leonard contacted Safe Space. He described that he had moved out of the marital home and the police were involved. Leonard described having thoughts about suicide but had no plan. Leonard said that he was the subject of a non-molestation order (although an order had not been made at this stage). Leonard described having debt problems.

67. At a follow-up telephone appointment with Safe Space on the 27th of December 2021 Leonard talked about his "relationship breakup" and that his brother had a heart attack on Christmas Eve. He disclosed testing positive for Covid. He said that he was due back in court on the 29th of December 2021 and that his partner had been saying he was very controlling.

68. A week later on the 29th of December 2021, Leonard self-referred to the DA hub. The referral was sent on the following day to the Riverside domestic abuse service to respond. It was re-directed to Phoenix as Riverside was already working with Lilly (as a result of the misdirected telephone contact from Lilly).

69. During a third telephone appointment with Safe Space on the 30th of December 2021, Leonard said that a domestic abuse worker was now involved and that he had a solicitor. He was advised that Safe Space would not be able to advise or help with the court process but would provide him with emotional support.

70. The fourth Safe Space telephone contact with Leonard on the 3rd of January 2022 is recorded as Leonard talking a lot about his ex-partner and what she had done to him. A follow-up call on the 6th of January 2022 was postponed to the following day when Leonard took another call. Leonard was moving to "supported living" and was feeling better. A sixth telephone appointment on the 10th of January 2022 confirmed that Leonard had moved into his new tenancy; he was still speaking about his ex-partner but said he was taking positive steps to move on with his life. A seventh call on the 14th of January 2022 found Leonard feeling better but reported a "breakdown with police, solicitors and DWP". He requested a food bag to be delivered. The eighth call on the 17th of January 2022 found Leonard sounding "really bad and feeling very low". A food parcel was to be delivered later that day. A ninth call on the 19th of January 2022 found Leonard more upbeat feeling "very good and positive". Leonard wanted the support calls to continue which he said helped him. He said that he would probably just need a couple more calls.

71. The tenth call on the 26th of January 2022 found Leonard very tearful. He said that he had not had any medication for three months (which was not correct as evidenced by the GP and pharmacy information). He blamed his ex-wife who he said had changed various passwords. Leonard was preparing a list of things he wanted to recover from the property. He said that he was due in court on the 11th of March 2022 and was struggling to pay for his solicitor. Safe Space referred Leonard to the SPA who declined the referral from Safe Space which was raising concerns about Leonard's thoughts about suicide. The telephone triage by the Crisis Team recorded that Leonard had no active thoughts about suicide. He was signposted to Phoenix domestic abuse service.

72. The first face-to-face appointment was not until the 27th of January 2022 when Leonard reported that he had been made homeless when his wife made allegations against him of perpetrating domestic abuse which he denied. He described struggling with his mental health since an attempt to die by suicide in August 2021. He discussed the options of counselling, a support group, food parcels and having access to the 24/7 helpline. A food parcel was delivered the following day. Leonard attended the first counselling session on the 2nd February 2022 where he discussed concern about his wife's actions and was described as making valuable contributions. He attended a drop-in on the 9th of February 2022 and a further counselling session on the 11th of February 2022. He attended a men's domestic abuse peer support group on the 16th of February 2022.

73. Leonard registered with a new GP practice after being given a tenancy in a different part of Doncaster. During a consultation with the GP on the 8th of February 2022 Leonard mentioned that he had recently separated from his wife who he reported had caused “significant domestic abuse and taken possession of his house”. No further information is recorded and no indication of any action to explore his mood and state of mind or to consider potential support needs. Information about Leonard’s low mood and overdose the previous year would have been on the electronic patient record system.

74. On the 14th of February 2022, Creative Support contacted the DA hub asking for support for Leonard who was going to court for financial abuse. At a counselling session on the 18th of February 2022, Leonard disclosed suicidal ideation. They arranged contact with the SPA and Crisis Team. Leonard did not want to discuss the charges he was facing in court.

75. On the 18th of February 2022, the SPA was phoned by Phoenix where Leonard had been attending support groups and had disclosed he was facing charges of controlling and coercive behaviour which he denied and said it was his wife who was controlling and was a factor in his suicidal thoughts. The Crisis Team contacted Leonard who spoke about his situation and talked about being the victim of financial abuse by Lilly. He was advised to work with the services and legal system to “resolve the situation with his wife”. A letter was sent to his GP regarding the “self-medication” and reviewing his antidepressants; there is nothing recorded in the GP patient record about this letter. Leonard was advised to contact SPA if he needed support with his mental health.

76. On the 25th of February 2022, Leonard asked Phoenix's counsellor for a letter of support to use in court to say he was a victim of abuse. This was the first time that Phoenix became aware of domestic abuse allegations against Leonard or court proceedings.

77. A welfare check by Phoenix on the 7th of March 2022 followed the magistrate's court hearing on the 6th of March 2022. Leonard said that he was not coping and felt in need of more emotional support. Phoenix called the Crisis Team who in the absence of a mental health emergency referred them back to the police who in turn referred them back to The Crisis Team. Leonard cancelled the counselling session on the 10th of March 2022 needing a little to “rest and collect” himself. In a follow-up call, Leonard said he felt tired and emotionally drained but did not want additional support at that time. He was offered a counselling appointment the following week which he did not keep.

78. On the 10th March 2022, the SPA was phoned by Leonard and the police who were concerned for his safety due to thoughts about suicide. During the discussion with the Crisis Team, Leonard said that he felt safe and that he could contact the Crisis Team at any time. There is nothing in the GP records about this contact with SPA.

79. On the 14th of March 2022, Lilly phoned the IDVA to say that she doing fine and that the non-molestation and occupancy order had been granted. She also said that Leonard was due in court on the 5th of April 2022.

80. Leonard did not attend a scheduled counselling session with Phoenix. An attempted welfare check got no answer. The Creative Support worker phoned Phoenix to say Leonard had not kept a scheduled appointment with them and subsequently checked with Leonard's solicitor who said they had not heard from him at all to take instruction.

Overview

81. Lilly first reported being the victim of domestic abuse from Leonard in November 2021. Lilly described that the abuse began early in the relationship describing Leonard as seeking to control Lilly. She said he prohibited her from working and therefore she had no independent source of income. The Domestic Abuse Act 2021 implemented a legal definition of economic abuse from June 2022 which is discussed later in the report.

82. Lilly says that while they were in North Wales Leonard insisted on Lilly going to the GP to be signed off work with depression and to have her name removed from job seekers. Lilly says that the trigger for going to the police station in November 2021 was when she had endured prolonged behaviour from Leonard who had seen her being helped by another man to load the equipment into her vehicle. Leonard had made veiled threats such as coming into the bathroom when she was in the bath and commenting about how easy it would be to push her head under the water. Lilly described it as "the straw that broke the camel's back".

83. Lilly told the reviewer and author of this report that she was frightened of what Leonard might do after she had made her disclosures. Lilly did not know the details of Leonard's history with his previous wife until after she contacted the police in November 2021. She was worried that he would not keep to his bail conditions given he had a history of ignoring previous court orders with his earlier partner. Lilly says that she was shocked when she was phoned by the police in December 2021 to be told that the bail had been lifted and that Leonard was not under any conditions or controls. Recording in DAS on the 2nd February 2022 indicates there was a misunderstanding about the bail status of Leonard who the IDVA thought was still under conditions of bail. This is discussed later in the report.

84. The CPS decision to authorise the police to charge Leonard with two crimes of engaging in controlling/coercive behaviour and making threats to kill was on the basis that the police would be charging Leonard and would be requesting the court to remand him into custody to continue an active investigation guided by

the CPS action plan which included analysis of phone data, enquiries with Lilly's family, review body cam footage and taking a further statement from Lilly. The circumstances under which Leonard was released under investigation (RUI) a month later are discussed in the next section of the report.

85. Lilly was offered contact with an IDVA when the referral from the police was received. Practical safety measures such as window locks were discussed and delivered quickly. Advice to seek a protective court order was not followed up by effective enough legal advocacy and securing a court order for several weeks. Lilly tried several legal firms but had all been contacted by Leonard who had made counter-allegations to the police. Lilly was eventually put in contact with solicitors based in Sheffield.

86. When the IDVA went off on leave Lilly was required to access support through the hub which proved ineffective in dealing with practical issues such as Lilly's problems in getting legal representation after Leonard had contacted the same firms. The decision to refer Lilly to Riverside was inappropriate given Lilly was already open to an IDVA. The Hub worker is no longer employed by the service and was not available for discussion or an interview.

87. Leonard's claims that Lilly's allegations of domestic abuse and that he was the victim of her controlling behaviour were processed as unrelated behaviour rather than considering whether it could be perpetrator behaviour intended to control and divert investigatory processes. This is an important area of learning in this review. The fact that coercion and control had been identified at the point of the initial disclosure should have been factored into subsequent plans and strategies including when Leonard made his counter-allegations. Coercion and control along with economic abuse is a continuing pattern of behaviour that requires vigilance and the ability of the respective agencies such as police and domestic abuse services to adapt safety plans and responses.

88. The counter-allegations were not referred to a MARAC or discussed by any of the services that processed information about them. The MARAC should be in a position to address the safety needs of a victim of domestic abuse and consider how the behaviour and welfare of the perpetrator are also to be addressed. The psychological impact of a perpetrator losing control represents a heightened risk for the victim and the perpetrator. The significance of this is discussed later in the report.

89. There were opportunities for services to have inquired about domestic abuse before November 2021. The clearest example is when Leonard presented at hospital emergency services following an overdose and the subsequent contact with the mental health Crisis Team. Neither of these services demonstrated sufficient informed curiosity about domestic abuse. Lilly also consulted the GP about depression and was on medication until late 2020.

90. The GP practice had extensive contact with Leonard and he was on repeat prescriptions. There is no evidence of information being sent from services such as the hospital being recorded and followed up. The GP and SPA share a common patient record system. Leonard told the GP in February 2022 about domestic abuse and having left the marital home although presented himself as the victim. The GP had no information about the MARAC but did have information about Leonard's history of overdoses and self-harm. There was little inquiry about the circumstances of the domestic abuse and no self-harm assessment.

Analysis

91. The circumstances of Leonard's death suggest a tragic death by suicide following earlier incidents of intentional self-poisoning. At the time of his death, Leonard faced charges at the Crown Court of threats to kill and coercive and controlling behaviour.

92. A threat to kill, combined with controlling and coercive behaviour and a history of depressive illness and attempts to die by suicide are markers of behaviour that deserve attention in risk assessments associated with domestic abuse highlighted in a study of men and fatal domestic abuse[25]. The study found evidence of far-reaching dependency on the victim and fear of abandonment. Other studies cited by Monckton Smith et al highlight a key source of frustration for perpetrators is the inability to live without the victim, difficulty in coping with severe stress and suffering morbid jealousy[26].

93. Home Office guidance[27] makes clear that coercive and/or controlling behaviour does not relate to a single incident and as such has implications for risk assessment and safety strategies. It is a purposeful pattern of behaviour to exert power, control or coercion over another person. Controlling behaviour is a range of acts designed to make a person subordinate or dependent by isolating them from sources of support and depriving them of the means necessary for independence, resistance and escape. This includes economic abuse such as deprivation of access to independent income or a bank account.

94. It is behaviour that may or may not be accompanied by coercive behaviour involving threats, humiliation and intimidation to harm, punish or frighten a victim.

[25] Liem, M. and Roberts, DW (2009) Intimate Partner Homicide by Presence or Absence of a Self-Destructive Act Homicide Studies 13 :399

[26] Monckton Smith, J. Williams, A. with Mullane, F. (2014) Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave and MacMillan pp55-56

[27] https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

95. Interference with legal and other processes is one of a range of strategies that can be deployed as part of coercion or control of a victim. This can include for example making counter-allegations to confuse, divert or disrupt investigatory processes. It can be a way of gaining access to local services as a way of building strategic alliances to discredit or question the integrity or veracity of allegations and can delay or block access to specialist support and advocacy for the victim.

96. When Leonard made his counter-allegations the case was allocated to another police officer who was aware of the allegations that Lilly had made against Leonard. The officer did not arrest Lilly which would have been the usual process for a person who is subject to allegations of domestic abuse.

97. There are various reasons why an arrest was not done immediately including the fact there was already an investigation of allegations of Leonard as a perpetrator with bail conditions in place and evidence needed to be gathered to either support or negate the allegation being made by him. This could be done without arresting Lilly at that stage and reduced potential distress and trauma to her as a victim.

98. Consideration about whether Leonard's counter-allegations could be symptomatic of the coercive and controlling abuse that Lilly had disclosed would be expected practice alongside the police investigating the veracity of Leonard's complaint of being a victim of abuse from Lilly. It has important implications for how civil and criminal proceedings are managed; the Family Court for example becomes involved in cases involving children when for example Judges will make findings of fact[28]. The Home Office guidance and HHJ Jayden make clear the importance of understanding the behaviour as "an appreciation of a pattern or series of acts the impact of which must be assessed cumulatively".

99. Perpetrators making counter-allegations is not uncommon according to SafeLives who report that MARAC meetings regularly see cases where there is conflicting information.

100. Counter-allegations must be identified and resolved to assist in an effective understanding of risk and working to ensure that victim and perpetrator get access to appropriate services. This is an issue that has been addressed in the daily management briefing that includes specifically identifying perpetrators presenting as victims.

[28] The case of F v M [2021] EWFC 4 examined allegations of coercive and controlling behaviour and provided guidance for dealing with this issue in the Family Courts. Mr Justice Hayden sought to "highlight the insidious reach of this facet of domestic abuse".

101. Douglas[29] describes how legal engagement can be an opportunity to exercise coercive control over a former intimate partner. Drawing on interviews with 65 women who engaged with the (Australian) legal system as a result of violence in their intimate relationships, she explored how women's engagement with the legal system was frequently experienced as an extension of an intimate partner's coercive control. Building on existing research Douglas illustrates how legal processes provide an opportunity for perpetrators to continue and even expand their repertoire of coercive and controlling behaviours post-separation referring to these as legal systems abuse.

102. The expectation of equality of access to justice and fair hearings that underpin legal processes need to be reconciled with legal engagements that seek to end coercive and controlling behaviours. In other words, the police had a duty to record Leonard's allegations but not in isolation from whether this represented an attempt to control the outcome of the investigation into Lilly's disclosures.

103. MARACs and the constituent services have to be vigilant about perpetrators who present as victims. This can be motivated by seeing themselves as the aggrieved party or because they seek to control and isolate their victim by using agencies (and in particular the criminal justice system) to further abuse. Individual people and services may not have all the relevant information as happened in this case, and are not in a position to identify this behaviour; in this case, this included specialist domestic abuse services and health professionals.

104. An important learning point from this review is that nobody discussed and resolved the counter-allegations by Leonard who did not consent to having information shared. The daily DA service management meeting includes a specific check to ensure this is addressed in future. The self-referral from Leonard sent to Riverside at the end of December 2021 and subsequently to Phoenix stated that the referral related to a high-risk victim who had an IDVA. This had implications in the mindset of how aspects of protection for Lilly were handled and meant that much of the work with Leonard was done without a proper understanding of his behaviour and history to offer better-targeted help to address the alleged perpetrator's behaviour and the potential risk from self-harm.

105. Treating Leonard as a victim whilst subject to the charges reinforced his sense of being an aggrieved party and disrupted how advice and help were given to both Lilly and Leonard. It also meant that the scale of the psychological and mental crisis triggered by the disclosures and the collapse of the relationship was not properly understood.

[29] Douglas, H. (2018). Legal systems abuse and coercive control. Criminology & Criminal Justice, 18(1), 84–99. https://doi.org/10.1177/1748895817728380

106. There were shortcomings in how Lilly's safety was assured after she made her disclosure in November 2021. The initial arrest, interview and bail of Leonard meant that Lilly was initially left with insufficient measures of protection given the initial decision to charge and seek custody. She was left without the direct support of a named IDVA at a critical stage when civil protective court orders were required. Lilly faced multiple difficulties finding a solicitor who had not already been approached by Leonard. The police released Leonard from bail under investigation without any updated safety planning with Lilly or consultation with other services.

107. Leonard's history of poor mental health and self-poisoning deserved closer attention when he was facing criminal charges. People like the GP were unaware of the domestic abuse that was disclosed to the police, hospital and mental health services; none of the GPs made routine inquiries about domestic abuse and other stressors when Leonard was presenting with low mood or after his self-poisoning that included reference to his relationship with Lilly.

108. The MARAC is often the only joint agency discussion about victim and perpetrator. The focus of the MARAC is how to keep the victim safe and reduce the risk presented by the perpetrator. Emotional and psychological stress will be an issue for a victim or perpetrator and therefore the MARAC action plan can be a mechanism for alerting people such as GPs about their respective patients' needs. Disclosure and investigation can trigger an escalation of risk to both the victim and perpetrator.

109. The only MARAC discussion occurred after the initial disclosure by Lilly but did not consider any information about the subsequent counter-allegations. The role of MARAC is to consider and make informed judgments about the potential risks; in this case, ensuring the GP was properly informed about the information would have been valuable. The MARAC should also ensure that actions taken by different services do not conflict. Two different domestic abuse services were working with both parties as victims. The DA Hub/MARAC and performance manager, who is part of the daily domestic abuse management briefing meeting, now has additional responsibility for the MARAC.

110. Resolving the counter-allegations would have opened up a clearer strategy of encouraging Leonard to access a voluntary perpetrator programme along with other services to address his stress and anxiety. He had lost a relationship, his home and his routine as well as having his control challenged.

111. The lack of a named IDVA (the system has since changed)[30] to cover during planned leave and reliance on the Hub to respond to Lilly contributed to Lilly being inappropriately referred to another domestic abuse service that was not aware of the full history which coincided with Lilly having difficulty finding a

[30] Since the start of the review the IDVAs now have allocated buddies who cover cases for them while they are on leave or unavailable. Details are shared with the staff on the DA Hub

solicitor to act for her and before a court order (occupancy or a non-molestation order) had been secured. The DASH completed by Riverside which downgraded the level of risk to the medium was done without full knowledge and understanding of the circumstances.

112. The misunderstanding by the IDVA that Leonard was still on bail in February 2022 indicates fundamental miscommunication between the police and the IDVA service. This is a basic part of providing effective protection to victims and managing a perpetrator.

Opportunities for the disclosure or detection of domestic abuse before November 2021

113. Lilly told the reviewer that although she and Leonard met whilst, at work, he was unhappy about her having a job after they were married. It was Leonard who wanted to move to north Wales and therefore further away from Lilly's family and social network.

114. This was highly indicative of a power imbalance in the relationship. Having less experience (of life and relationships), being reliant or made to be more reliant through lack of independent earning, and Leonard's mental health were all factors that could have contributed to the absence of disclosures about abuse before November 2021. It is why professionals must be alert to the potential of a relationship involving very significant age differences not just at the point of disclosure but during routine contacts such as health appointments.

115. Lilly had continued with her interest in participating in events with her animals although Leonard accompanied her to these activities. Lily told the reviewer that it had been Leonard's reaction to seeing Lilly being helped move some equipment by another male that had contributed to her visiting the police station in November 2021.

116. It is known that health professionals are people who are likely to encounter people who are either being subjected to domestic abuse or are perpetrators and therefore have a critical role in providing immediate advice and support and opening pathways to help.

117. The initial consultation with the Crisis Team in June 2020 during which he disclosed having anger management issues did not explore for example the impact and implications for his relationships or the triggers for the anger. There was an expectation that this would be explored by other non-crisis services as part of longer-term involvement and the Crisis Team made referrals.

118. Leonard's overdose in August 2021 was known to have been triggered by psycho-social stress that included his marriage. There is no recorded evidence by any of the various health professionals of enquiries about this. Leonard's

use of non-prescribed mirtazapine was not followed up by any of the health professionals. His later behaviour of over-ordering medication in 2022 also displayed a degree of prior planning and a flag for the potential of Leonard's self-harming. The overordering was identified by the pharmacy and the GP advised Leonard although it is not evident that the underlying risk or the psycho-social stressors were explored.

119. In two earlier and separate consultations with the GP in late July 2020 and mid-August 2020, Leonard insisted that he phone Lilly during the consultation so that she could hear what was being said. The GP noted that Leonard appeared to be ever more reliant on Lilly. The notes do not clarify whether the GP was querying whether there was some form of difficulty, disability or capacity issue to consider. The GP was unaware that Leonard had a history of domestic abuse from his first marriage.

120. When Leonard registered with his new GP practice in February 2022, he mentioned he had separated from his wife due to domestic abuse although did not mention that he was the subject of allegations of domestic abuse against Lilly.

121. Lilly's contact with the GP in early December 2021 about poor sleep and stress did not elicit a recorded enquiry about domestic abuse or the circumstances under which Leonard was no longer living at the house. An earlier contact with the YAS in 2019 for depressive mood disorder was an opportunity by ambulance and GP practice to ask questions about psycho-social stressors such as domestic abuse and relationships.

Information about Leonard's history with a previous partner that could have caused any different action before November 2021

122. Lilly told the police in November 2021 that domestic abuse had started early in the relationship with Leonard but had not contacted the police or any other service before November 2021. A delay in reporting is not unusual given the dynamics of domestic abuse. There is no recorded exploration by the police or the IDVA about coercive control (and therefore establishing a longer-term pattern of behaviour and implications for risk management) although the police recognised that coercive control was a potential offence for CPS to consider as a charging decision and therefore reflected an extended pattern of behaviour.

123. The only service that had a record of the earlier history of domestic abuse was the police. As part of the response to Lilly's disclosure in November 2021, the police researched Leonard's history and provided Lilly with a formal disclosure of the information on the 9th of December 2021.

124. The disclosure was within the timescale of 35 days described in national guidance[31]. The police's prompt referral to the CPS for a charging decision reflected their recognition of the potential risk to Lilly. The fact that the charging decision was not acted upon by the police combined with the subsequent decision to release him under investigation is explored in other parts of this report.

125. Leonard's contact with local health services following self–poisoning and overdose were opportunities to explore domestic abuse and could have sought to elicit information from Leonard about his relationship with Lilly and previous relationships. This is explored in other parts of the report.

Information about Leonard's mental health history including evidence of self-harm known to services. Did psycho-social assessments and inquiries explore the potential for domestic abuse and or self-harm?

126. Psycho-social assessments and inquiries immediately following the overdose and presentation at the hospital did not explore the potential for domestic abuse and or self-harm and there was no follow-up by the GP. During the first contact with the Crisis Team in June 2020 Leonard described his difficulties with anger management; there is no further detail about who with or where he was getting angry, the circumstances or detail about whether it was verbal or physical for example.

127. In August 2021, the Crisis Team assessed Leonard after he was referred by the hospital ED doctor following Leonard's presentation following an intentional overdose. The notification to the GP describes the overdose as prescription-only medication although the medication that Leonard used had not been prescribed by the GP. The circumstances under which Leonard had acquired the medication were not explored at the hospital, by the Crisis Team or by the GP practice when it subsequently had the notification about the ED contact and referral to the Crisis Team.

128. During the assessment, Leonard disclosed being stressed in his relationship with Lilly and was having regular arguments. No detail is recorded about the nature of the stress or the arguments; there was no DASH assessment. This was the second time that Leonard had presented following self-harm and disclosing information that indicated domestic abuse. Managers for the service describe the focus of the service to be assessing the patient "at the moment" and to intervene as necessary to reduce and manage immediate risk.

31 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf p9

129. The Royal College of Psychiatrists report in 2020[32] describes the importance of practitioners identifying risks to inform an understanding of stressors but not specifically to predict suicide. The importance of understanding the individual experience of a person to intervene using a bio-psycho-social model to mitigate or decrease risk in the immediate and longer future is discussed. It is why paying attention to domestic abuse as part of a person's experience is required particularly when it is a pattern of ongoing behaviour.

130. The focus of the triage assessment was on Leonard's mental and physical health and whether he was presenting with any diagnosable conditions requiring further assessment and treatment.

131. The Crisis Team ensured that Leonard had contact details of organisations and people to respond to if his mental health deteriorated. There is no recorded evidence about whether a referral to adult social care should have been made to assess Leonard's care and support needs and whether there were safeguarding concerns. The GP information about Leonard's long-term health difficulties and growing dependence on Lilly could have been referred for a Care Act assessment by any of the services.

132. Leonard's physical health was appropriately assessed and managed by regular contact with the GP practice which paid close attention to blood pressure, cholesterol and joint pain. He was also on anti-depressant medication (sertraline). There was less attention given to his emotional and psychological health and no inquiry about his relationship with Lilly over and above recording his apparent dependence on her.

133. In August 2020 a GP appeared to think that Leonard might have some form of learning difficulty. It is the only time that a learning difficulty is mentioned by any service. The reason for the GP's speculation is not recorded. The Equality Act's description of protected characteristics and making reasonable adjustments along with additional considerations under the Care Act in terms of whether Leonard might have care or support needs would have been applicable.

134. When evidence of Leonard over-ordering his regular prescription for sertraline in February 2022 when he had taken three times his prescribed level this was not explored with him beyond the pharmacy and GP warning about potential harm to his health.

Follow-up provided to Leonard and/or Lilly after Leonard's overdose in August 2021

[32] RCPSYCH Self-harm and suicide in adults. Final Report of the Patient Safety Group 2020 p 47 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

135. Although a routine report of Leonard's presentation at the hospital emergency service was sent to the GP there is no record of a follow-up consultation being attempted with Leonard.

136. Leonard's overdose in early August 2021 was described by the A and E staff as deliberate and involved mirtazapine an anti-depressant that had not been prescribed for Leonard. There is no recorded evidence that the source of the prescription medication was clarified in the assessments at the hospital or when the GP practice received the notification. There was no follow-up to provide support or further assessment.

137. The GP practice was not told about the contact that Leonard had with the SPA in January, February and March 2022. In January 2022 Safe Space made a referral reporting that Leonard had experienced thoughts about suicide, was not sleeping and that his brother who had been supporting him had experienced a stroke. The referral was returned to Safe Space.

138. In mid-February 2022 Phoenix contacted SPA to report that Leonard was experiencing poor mental health associated with "relationship issues". Leonard denied having thoughts about suicide when the SPA worker spoke to him; Leonard described significant financial and legal stress. The third contact in March 2022 involved the police who had found Leonard in a very distressed mental state at home. None of this information was reported to the GP and domestic abuse services were not aware of all of the contacts.

139. In February 2022 when Leonard registered with a new GP practice there is no record of a new patient assessment that could have provided an opportunity to take a fuller history taking account of Leonard's poor physical health and record of low mood and self-harm. At his first appointment, he mentioned that he had recently separated from his wife who he described as causing him "significant domestic abuse" and had "taken possession of his house". There is no record of further inquiry about the circumstances or to consider what support he might need.

140. The GP practice was not aware of the MARAC discussion concerning Lilly although it is IDVA standard action to inform GP practices that a client is being discussed at MARAC. If the GP practice is not identified health representatives are contacted for the information. It is standard practice for this action to be completed before the MARAC meeting.

What were the concerns and risks identified at MARAC and did they result in effective planning and action?

141. The MARAC discussion of Lilly's allegations of domestic abuse at a meeting on the 1st of December 2021 was before Leonard made his counter-allegations. The MARAC should have been informed of the decision by CPS to authorise

Leonard to be charged with engaging in controlling and coercive behaviour and threatening to kill Lilly. The MARAC should have been told that the police had been so concerned about Leonard's history of offending and ignoring bail and community orders in the past that the police had consulted CPS based on Leonard being charged and remanded into custody.

142. There is no recorded evidence that the MARAC was made aware of Leonard's history of overdose and did not include any actions about alerting relevant services that Leonard might be in a psychologically and emotionally vulnerable condition following the enforced separation from Lilly as a condition of his bail.

143. When Leonard made his counter-allegations against Lilly in December 2021 the information was sent to the IDVA and the DA Hub "for information". Although the fact of the counter-allegation was recorded and also forwarded to other services the allegations were not resolved. Action has been taken to address this through the daily domestic abuse management meeting. The self-referral from Leonard sent to Riverside and then to Phoenix said that the referral was related to a high-risk victim (Lilly) who was with an IDVA and was the named perpetrator. It was not referred to the MARAC because it was not assessed as a high-risk assessment and took no account of the context in which the counter-allegations were made.

144. The MARAC's workload is such that a strict threshold operates in determining which cases are referred. There is no evidence that anybody considered the counter-allegations within the context of a potential pattern and evidence of coercive control. The implication and significance of the counter-allegations to helping a perpetrator of domestic abuse gain access to services and inadvertently helping to isolate and further control a victim was not recognised. In this case, Lilly faced difficulty finding a solicitor to act for her in securing a civil order such as an occupancy order because Leonard had already been to those solicitors. In his contact with domestic abuse services, he presented himself as a victim and wanted advocacy and support in court proceedings.

145. Although there is recorded evidence that the police recognised that they fell within the principles of a MARAC repeat referral a decision was taken by the police not to refer given the recent discussion at the MARAC unless there were any further high-risk incidents. The implications of the counter-allegations being a strategy of control and coercion by a person already identified as presenting a high risk did not get factored into the decision-making. The workload of the MARAC has increased substantially and was exacerbated by the Covid lockdown and was probably a significant factor in decision-making about which cases to refer. In 2019/2020 there were 900 referrals which had grown to 1461 the following year (56.22 per cent).

146. Leonard was released from bail on the 14th of December 2021. This was the date that Leonard was charged. At that stage, Lilly had not secured a non-

molestation or any other court order. There were no legal sanctions or controls in place.

147. The DASH assessment completed by Riverside at the medium level represented a lower risk concern than the assessments completed in November 2021. Factors that influenced the Riverside DASH assessment were the fact that Leonard had been arrested and was subject to bail conditions although these ended shortly afterwards. It also noted that Lilly had been signposted to local solicitors (although had still to secure the occupancy or non-molestation order). Some of this information was incorrect and may have been presented by Lilly as part of the assessment.

Are there appropriate services for men who are perpetrators of domestic abuse and were they used in this case?

148. Apart from the police and CPS who processed the information that resulted in criminal charges being made, Leonard was not referred to any service as a perpetrator of domestic abuse. The referrals to local domestic abuse services about Leonard were after he made counter allegations of domestic abuse. Referrals to a programme are voluntary and would have required Leonard's consent.

149. Phoenix was not aware of the criminal proceedings until Leonard disclosed them in late February 2022 when he asked Phoenix to provide a letter for the court identifying him as a victim of domestic abuse. At this stage, the staff working with Leonard recognised that Leonard was trying to develop a defence strategy and took the decision to continue supporting him but to withdraw him from peer support groups for victims with immediate effect. Phoenix also attempted to find out further information from the Hub.

150. Phoenix does not provide perpetrator support and interventions. Cranstoun Inspire to Change is a service for perpetrators of domestic abuse in South Yorkshire[33] and was not offered at any stage.

Is there appropriate service for men who report being victims of domestic abuse and were they used in this case?

151. Phoenix is a non-commissioned service to assist men and women who are victims of domestic abuse. Phoenix provided a service initially to Leonard as a victim of domestic abuse until information about criminal proceedings against him as a perpetrator was revealed in February 2022. Phoenix provided counselling sessions which Leonard was using before and after the disclosures and also participated in male victim peer support group sessions. He also had practical and emotional help in the form of food parcels and welfare checks and

[33] https://cranstoun.org/help-and-advice/domestic-abuse/inspire-to-change/

used the helpline and drop-in centre. Leonard was signposted to other support including Samaritans and Crisis Team and was helped to find a solicitor.

Conclusions

152. The premature death of any individual is a tragedy, especially for family members. From the information that was available to the review, it seems clear that Leonard had suffered trauma that began early in his life. At the time of his death, he was under significant levels of stress associated with the loss of a relationship and living at his marital home.

153. His history of domestic abuse and breaching orders in a previous relationship and the allegations about his behaviour toward Lilly were indicative of coercive control. The loss of control would have exacerbated his stress. Leonard should have been offered clearer support to address his behaviour and there should have been a more informed appreciation of the anxiety and stress that he was suffering over a long period which no doubt was exacerbated by the prospect of going to court.

154. The Royal College of Psychiatrists report in 2020[34] highlighted that the long-term treatment of self-harm is affected by the lack of an accurate assessment tool and expresses caution in relying on tools and questionnaires that use terms such as low risk or reducing risk. When somebody like Leonard is in a deep psychological crisis over several months, what is required is an in-depth conversation and a detailed appreciation of circumstances and background.

155. Leonard's move to a new GP practice in February 2022 occurred as the UK was gradually relaxing Covid-related restrictions although primary health services were still providing a significant proportion of consultation by remote contact.

156. Lilly told the police and IDVA that she had been a victim of domestic abuse from very early in the relationship. The isolation from family and keeping Lilly dependent by not working or having independent finances including a bank account were behaviours that contributed to keeping the abuse from being disclosed for many years. The strategy was deployed after Lilly went to the police when Leonard sought to prevent Lilly from securing local legal advocacy. Developing relationships with much younger partners, financial dependence and threats to self-harm are common perpetrator traits.

157. Although there was an effective initial police response and risk assessment when Lilly made her initial disclosures of domestic abuse the subsequent follow-up did not provide effective support to Lilly. She struggled to find legal

[34] RCPSYCH Self-harm and suicide in adults. Final Report of the Patient Safety Group 2020 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

representation to secure protective orders and the decision to release Leonard under investigation without bail conditions left her vulnerable.

158. The rules under which bail decisions were made in 2021 were introduced in 2017. The way the rules were understood and implemented by local police forces raised significant concerns, particularly in cases of domestic abuse. The inspectorate[35] acknowledged that the rules were introduced extremely quickly and without enough consideration for victims. RUI left too many victims without the reassurance and protection that bail conditions can provide, police services were not seeking the views of victims, and did not tell CPS when a suspect had been RUI. These factors applied in this case.

159. Concerns that the RUI system was being deployed inappropriately and overused often resulting in the unconditional release of suspects in violent and sexual offences when conditions of bail should be used led the government to reform the pre-charge bail rules in November 2022 following a public consultation. The presumption was shifted towards using pre-charge bail as opposed to the earlier presumption introduced under the Police and Crime Act (PCA) 2017.

160. The revised rules introduced after the events described in this review provide a focus on a risk-based approach to bail decisions and a duty to inform victims. Custody officers have delegated decision-making authority (rather than an inspector or above previously) and are expected to ensure that victims are involved in the pre-charge bail decision process and to seek their views about any proposed conditions. It also requires custody officers to consider a specific list of risk factors[36] that include the need to safeguard victims[37] of crimes and witnesses.

161. The revised rules allow the custody officer to authorise bail for up to three months with extensions at six by an inspector and at nine months by a superintendent. Nine months and beyond can only be granted in a magistrate's court.

162. The decision to release Leonard under investigation (RUI) was not adequately explained given the previously identified high risk he presented to Lilly. There may have been an assumption that Lilly was being helped to find legal advice and advocacy to seek protective court orders. It is inappropriate to place responsibility on a victim to protect themselves particularly when the perpetrator has a history and there is current evidence of coercion and/or control. Without bail conditions or a court order, it can be difficult to control the behaviour of the

[35] Pre-charge bail and released under investigation Striking a balance HM Crown Prosecution Service and HMICFRS 2020
[36] Section 38(1B) of PACE 1984
[37] A category defined at section 30CA (6) of PACE 1984

perpetrator. An RUI decision can also undermine the legal argument in court for some form of a protective order.

163. Two parallel investigations were opened but no account has been given about how the counter-allegations were considered over and above ensuring the relevant OIC was made aware. The allegation made by Lilly against Leonard on the 15th of November 2021 was assessed as HIGH risk from the DASH and therefore was allocated to the DA Team for investigation. The counter allegation by Leonard against Lilly on 17th December 2021 was assessed as medium risk and therefore remained with the Local Policing Team (LPT) to investigate.

164. The failure to resolve the issue of Leonard's counter-allegations is a significant area of learning along with how evidence of self-harm was dealt with. Controlling and coercive behaviour is a pattern of behaviour that precedes the detection or disclosure and is likely to continue and possibly escalate as a result of a victim disclosing information and leaving the relationship and control of the perpetrator. Risk assessment and mitigation strategies need to take this into account alongside the criminal investigation.

165. Security equipment was delivered to Lilly's home; she had to arrange the fitting of all the equipment which was common practice at the time and some of which did not require any tools or DIY skill.

166. As a result of funding from the Department for Levelling Up Housing and Communities together with City of Doncaster Council funding, money has been released to pay for the equipment and fitting costs for any person living in Doncaster who is threatened with homelessness as a result of domestic abuse and/or is at risk of further harm from the perpetrator.

167. The Doncaster Safe at Home service was set up in March 2023 to help victims remain safely in their homes, reduce the fear of crime, improve their safety while in the home and prevent them from having to leave their homes, work and support networks.

168. The equipment that can be fitted under the scheme includes

a) Changing door locks
b) Door chains
c) External letterboxes and plating up door letterboxes (especially for any threat of arson)
d) Door jammers
e) Window locks
f) Dummy CCTV and actual CCTV
g) SmartWater
h) Window shock alarms
i) Patio door locks.

169. The scheme covers private landlords whose permission must be sought before equipment is fitted and the property must be in a “good state of repair to allow target hardening to be installed and for the measures to be fully effective”

170. The workload associated with domestic abuse has increased. Detectives, including detective sergeants, are qualified to complete PIP Level 2 (Serious and Complex Investigations) The investigations within the DA Team are PIP Level 1 therefore non-detective trained officers are qualified to deal with them with the additional over-sight of a detective supervisor who completes as a standard 1 monthly investigation reviews. There is no specific training for DA Team officers other than the DA Matters training that is delivered to all officers regardless of their location.

171. The police did not comment specifically on whether there were resource issues in terms of the availability of investigatory capacity or specialist knowledge and expertise that had an impact on any aspect of this particular case. The officer dealing with Lilly’s disclosures was a member of the domestic abuse team; which is a mix of DCs and PCs. At the time the OIC was on track to become a DC.

172. There are resourcing issues within DA teams which are monitored through the monthly PVP performance meetings. There is a national shortage of detectives and SYP is also impacted by this. All officers within the domestic abuse teams carry high workloads; this is monitored to ensure officers are not pushed beyond capacity.

173. The DA service manager has additional responsibility for the MARAC and the service. A gatekeeping process was introduced, in conjunction with South Yorkshire Police, to help manage an ever-increasing workload that involves consistent agencies. Some of the implications are seen in how for example the issue of counter-allegations was not referred to despite being potentially symptomatic of an escalating pattern of behaviour and how they should be addressed through the lens of perpetrator behaviour rather than a victim. The quality of discussion in terms of identifying risks as a result of domestic abuse needs to take into account potential welfare risks for the victim and perpetrator. A fundamental part of that is ensuring GP practices are alerted to information.

174. The referrals to the IDVA service are far more than Safelife's recommendations which are for 100 referrals per IDVA FTE post; in 2021/2022 the number is more than double running at 229. This is despite increases in funding. Additionally, IDVAs need to have access to good-quality support and supervision and to ensure for example that risk assessments, plans and recordings meet required standards. The manager regularly supports individual clients with a caseload of their own and administers the MARAC. This is not

sustainable or safe and has been changed under the reorganisation of the service in 2024.

175. The City of Doncaster Council Domestic Abuse Strategic Board authorised the commissioning of an independent MARAC review in July 2022. The process lasted nine months and concluded with 14 recommendations. The review focussed on five thematic areas; organisational culture, volume of referrals, training, operational support, governance and resource allocation. Staffing and the organisation of work within the domestic abuse service is an area of focus. The Domestic Abuse and Sexual Abuse Theme Manager is responsible for the implementation of recommendations.

Lessons to be learnt

176. The lessons for making a difference include;

a) Loss of control and leaving a relationship escalates the risk to a victim and can trigger a major psychological crisis for a perpetrator; the emotional and psychological welfare of both has to be considered alongside any strategies for addressing abusive behaviour;
b) Understanding the lived experiences and stressors contributing to poor mental health and self-harm and not relying on tools and questionnaires that use terms such as low risk or reducing risk is recommended practice by the Royal College of Psychiatrists and applies to other professional disciplines involved in risk assessment. An in-depth conversation and a detailed appreciation of a person's circumstances and background that encourages disclosure of domestic abuse and relationship breakdown is clinically and therapeutically valid and creates an opportunity to address domestic abuse more effectively; it is remarkable how little is recorded or known about Leonard (or Lilly); there are additional vulnerabilities associated with men who are losing control over an intimate partner or family member;
c) MARAC action plans need to include addressing potential mental health and welfare risks and ensuring primary health and mental health services are notified of MARAC referral and discussion[38]; A safety plan can help the person to focus on keeping themselves safe at that moment; according to the Royal College of Psychiatrists, safety planning should be seen as part of the overall care, crisis and contingency planning and can be simple in format. Safety planning should ideally be done by the patient with the support of a professional and is a stepped proactive approach to

[38] All NHS services in the locality are represented at the MARAC. Information is shared at the MARAC. Case summaries and meeting records and actions are circulated as part of the MARAC process with these services.

help those with suicidal ideation to plan using a range of sources and activities;

d) All health providers should be encouraged to routinely inquire about domestic abuse as part of psycho-social assessments with patients presenting with low mood or concerns about self-harm, especially with evidence of relationship breakdown and any additional factors that suggest coercive control has been a factor and therefore implications for psychological crisis and escalation; encouraging GPs to routinely follow up notifications about contact with other services following self-harm and or mental health concerns; attention to the use of non-prescribed medication associated with self-harm/self-poisoning;
e) Resolving counter-allegations as part of criminal investigation and safety strategies is essential to minimise the potential for manipulation and address the needs of a victim and perpetrator; using and manipulating legal processes and institutions/systems to threaten, harm, impoverish or discredit a victim is a recognised tactic of coercive control occurring before and after separation; manipulation of victims and professionals is another well-recognised symptom;
f) Recognising and responding to coercive control along with economic abuse as a pattern of cumulative behaviours and ensuring that incidents are assessed and dealt with in that context; this includes DASH and criminal investigatory processes and how discussion at MARAC is framed and recorded; it is behaviour that is likely to continue and escalate; manipulation and interfering with legal and investigatory processes can be part of a repertoire of perpetrator behaviours; the introduction of economic abuse as a further defined form of abuse from June 2022 postdates the events examined on this review but will require future risk assessments to consider this behaviour which represents behaviour intended to control and isolate victims;
g) A high-risk DASH needs to be followed up by concerted action by the police and specialist domestic abuse services that are focussed on securing the immediate and long-term safety of the victim; this includes ensuring the security of premises and being provided with effective legal advice and advocacy;
h) Ensuring the physical safety of victims of high-risk domestic abuse has to include effective measures to provide their physical security that should not be delayed; this means working with private landlords to ensure urgent action is taken to upgrade safety measures for domestic abuse victims; the Domestic Abuse Housing Alliance (DAHA) had developed good practice guidance in consultation with Standing Together[39];

[39] http://www.privaterentedservice.co.uk/wp-content/uploads/2019/12/PRS-Landlord-Guidance-around-domestic-abuse.pdf

i) Communication between police and IDVA about charging and bail decisions and use of court orders; there was no direct contact when the initial referral was processed by the police; neither IDVA nor police had any effective follow-up to the progress on Lilly securing court orders; the IDVA was not told about the decision by the police to release Leonard under investigation;
j) The practice of releasing under investigation (RUI) an accused perpetrator of high-risk domestic abuse is inappropriate and does not reflect national guidance that has been subsequently introduced since November 2022;
k) The importance of a named IDVA covering absences of colleagues supporting a victim of high-risk domestic abuse; there was no IDVA actively progress chasing at a critical time for Lilly getting legal advocacy and when Lilly contacted the Hub in early December 2021 to ask for help she was redirected to Riverside but the issue of court action remained unresolved; changes to the IDVA working arrangements for named cover have been introduced although this is within the context of what is already a service operating at over twice its capacity; additional changes from September 2024 includes a daily management briefing that includes identifying and reviewing cases where perpetrators have presented as victims to agree on the specific action and follow up.
l) Quality of recording and supervision by IDVA service; a DASH was completed although there was little detail recorded about Lilly's support network and is being addressed through training; the IDVA was uncertain for example about whether Lilly was in contact with friends or family and had little detail recorded about whether she was working and what support she had; Lilly was not recognised as a high-risk victim open to an IDVA when she contacted the Hub;
m) Understanding that domestic abuse is hidden when euphemisms are used such as relationship breakdown and without proper enquiry; the significance of dependency and self-harm (threatened or otherwise) being recognised as risk factors for a perpetrator's safety and potential escalation in abuse.
n) Power imbalances can occur in many different forms including age, finances and authority; not all power imbalances are abusive.

177. A learning brief that summarises learning from the review produced locally would widen the learning beyond the more limited readership of this report. This learning will be shared by the DA and SA Theme Manager with the DA Service, MARAC Steering Group, DA and SA Theme Group (Multi-Agency/Discipline

http://www.privaterentedservice.co.uk/wp-content/uploads/2019/12/PRS-Landlord-Guidance-around-domestic-abuse.pdf

across Doncaster), DA Strategic Board and Safer Stronger Doncaster Partnership Board (CSP). Action created.

Recommendations

1. The Safer Stronger Doncaster Partnership should develop a clear policy and protocol for the processing of counter-allegations of domestic abuse.

   Action taken. Referrals involving counter allegations into the Doncaster Domestic Abuse service are routinely reviewed by the allocated IDVAs or Domestic Abuse Caseworkers with their team managers. The Team Managers review with the Domestic Abuse and Sexual Abuse Theme Manager following the initial review with staff.

   Action taken. The Doncaster Domestic Abuse Service has undertaken a restructuring in September 2024. All operational staff supporting people currently suffering abuse are now IDVAs. IDVAs now support clients of all risk levels. Daily management meetings take place. Counter-allegations are discussed at the meetings. IDVAs also discuss these cases with their respective team manager,

2. The Safer Stronger Doncaster Partnership should consider what further measures can be taken to promote domestic abuse guidance for private rented sector landlords in Doncaster developed by the Domestic Abuse Housing Alliance (DAHA)[40] cross-referenced to local schemes such as Safe at Home.

   Action taken. The City of Doncaster Council Domestic Abuse and Sexual Abuse Theme Manager has met with the Housing Safeguarding Partnership Manager and the Strategic Housing Programme Manager from St Leger Homes. Communication with private rental sector landlords about domestic abuse and support services available is being developed for circulation. The City of Doncaster Council started producing and delivering a quarterly newsletter for private landlords in December 2023. An article about domestic abuse and support services available is to be included in the March 2024 newsletter. Periodic communication will follow via the newsletter. A Domestic Abuse Service update article is scheduled for September 2025.

[40] http://www.privaterentedservice.co.uk/wp-content/uploads/2019/12/PRS-Landlord-Guidance-around-domestic-abuse.pdf

3. A review of IDVA arrangements for covering high-risk cases in the absence of the allocated IDVA should be completed as a matter of urgency.

   Action taken. All IDVAs working for the City of Doncaster Council have dedicated “work buddies” and they provide cover and backup for each other when one is not at work. The details of the individuals involved have been shared with staff in other areas of the DA Service. A named deputy is available when colleagues are not at work.

4. The workload of IDVA service should be reviewed and include the support, supervision and oversight of case recording and risk assessments.

   Action taken. An independent MARAC review was commissioned by the City of Doncaster Council. The review was completed in 2023. Following the review, consultation on a restructuring of the Council Domestic Abuse Service has started. The restructuring process commenced in January 2024. It is the intention to increase the number of IDVAs by amalgamating with DA Caseworkers in the service. The changes will introduce a new way of working with staff holding clients assessed at all risk levels. An additional management post and a restructuring of the administration and MARAC processes are also part of the activity. The consultation will end in February and plans to implement the recommended changes and relevant time scales will be agreed following on from that point. It is expected that the restructuring will be completed by autumn 2024. The restructure was completed in September 2024.

5. RDaSH should review whether any action is required from this review on the use of medication in self-harm following the recent audit on concordance with Nice Guidance for self-harm assessment and preventing recurrence.

   Action taken. Any patient referred to services will have a medication review, however, not all patients will disclose what if any, non-prescribed medication they are taking.

   GP practices undertake medication reviews on an annual basis.

   The audit is quarterly and is at 92% showing continued improvement.

6. MARAC should ensure that action plans include highlighting any potential safeguarding or welfare concerns for the victim and perpetrator and that GP practices and RDaSH (SPA) are routinely advised of MARAC's discussion and plan.

Action taken. Doncaster IDVAs inform GP Practices for their clients about the MARAC. This is a standing action for staff to complete. (SPA) Single Point of Access information sharing takes place when appropriate. RDASH are part of the MARAC cohort and attend meetings. Actions and minutes are shared with RDASH.

7. The SYP ensure that current arrangements for managing the bail of perpetrators of domestic abuse are compliant with national guidance that discourages the use of RUI in cases of domestic abuse and where there is an ongoing risk to victims.

   Action taken. Measures have been put in place to ensure officers are aware of the legislation and any actions are compliant with national guidance. Training has been delivered via Wednesday Webinar (force-wide online training) and within online training available through SYPTV. Clear bail guidance is also included within Trainee Investigator training. As a direct result of this case, a centralised email inbox has been created within the Doncaster district for officers to address any bail matters. This inbox is monitored by district Superintendents which is the rank required for authorisations.

8. The SYP should confirm an action plan has addressed any learning about the decision-making by the OIC and custody officers following the CPS advice to immediately charge Leonard.

   Action taken. The issues regarding the OIC were addressed by the district supervision. An action plan was recorded and completed to address the issues raised. Additionally, the officer is no longer working within a PIP 2 investigatory role, although this is not specifically due to this matter. Specific details of the action plan, delivery and implementation have not been provided as this level of detail is not deemed to be relevant to this recommendation.

Issues for National Policy

1. The Home Office to determine if further research and collation of information about counter-allegations of domestic are required.
2. The Home Office should consult with the Association of Chief Police Officers as to whether further national guidance for the handling and processing of counter-allegations in domestic abuse cases involving evidence of coercion and/or control is required.

Recommendations by individual agency reviewers

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

1. Increase awareness of professional curiosity within the clinical setting.

Action taken.

A “seven-minute briefing” document about professional curiosity has been circulated to the Trust. Professional curiosity is included in the Trust's safeguarding training modules. Safeguarding and domestic abuse staff continue to raise awareness when present in the wards and departments.

Doncaster Suicide Prevention Group

1. Promote and encourage more collaborative safety planning with those expressing suicidal ideation.

   Action taken.

   This has been discussed at the Doncaster Suicide Prevention Group meetings. Work to produce a coordinated campaign with colleagues across South Yorkshire is scheduled for 2024/25. The intention is to promote more safety planning and raise awareness at a population level.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH

1. To ensure that all staff are aware of the need to be Professionally curious when receiving information which may indicate domestic abuse is present in a relationship.

   Action taken. All RDASH safeguarding training (including domestic abuse) includes professional curiosity and “asking the question” around relationships at each contact.

2. To ensure that the relevant learning and recommendations from this review are embedded into practice within the Trust.

   Action taken. Any learning from the review will be included in training and domestic abuse is part of the RDASH Audit programme.

Glossary

Court Bail	Bail granted by magistrate/judge at court post-charge and in advance of trial or hearing.
CPR	Cardiopulmonary Resuscitation
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DA Hub	Domestic Abuse Hub
DAC	Domestic Abuse Caseworker
DARA	Domestic abuse risk assessment (domestic abuse risk assessment team at SYP)
DASH / DASH RIC	Domestic Abuse, Stalking, Harassment and Honour-Based Abuse Risk Indicator Checklist
DBTH	Doncaster Bassetlaw Teaching Hospital
DHR	Domestic Homicide Review
FLO	Family Liaison Officer
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advocate/Advisor
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tasking and Coordination
MDT	Multidisciplinary Team
NFA	No Further Action
OIC	Officer in the Case
OT	Occupational Therapist
Police Bail	Bail granted by Police pre-charge, to allow for further enquiries to be made or CPS advice to be sought.
RDaSH	Rotherham Doncaster and South Humber NHS Trust
RUI	Released Under Investigation
SIO	Senior Investigating Officer (Insp or above)
SPA	Single Point of Access
SSDP	Safer Stronger Doncaster Partnership
SW / SCW	Social Worker / Social Care Worker
SYP	South Yorkshire Police