SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim: Kathleen

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Kathleen	Victim	White British
Louise	Offender	Daughter of Kathleen (19 years) White British
Address 1		Home of Kathleen & LOUISE

1.2 At 09.46 one day in early 2014 Louise rang the Emergency 999 system and spoke to North West Ambulance Service (NWAS). She reported that '*she had just returned home and had found her mum on the floor'*. Ambulance crews arrived at address 1 at 09.54. They were admitted by Louise and found Kathleen in a bedroom which appeared to have been the scene of a disturbance. Kathleen was lying on the floor on her back and was deceased. Death had occurred some hours before and a post mortem determined the cause as manual asphyxiation. An inquest into her death was opened and adjourned by HM Coroner.

1.3 Louise was arrested on suspicion of the murder of Kathleen and later charged with the offence. She admitted killing her mother although she pleaded not guilty to her murder when she appeared before a Crown Court. The jury returned a verdict of not guilty on the count of murder and instead found Louise guilty of the manslaughter of Kathleen.

1.4 Louise was sentenced to four years and eight months imprisonment. The judge rejected her account that she had lost control and that she had no murderous intent. He took into account her age and previous good character, although he said she did attempt to lay a false trail for the police, specifically in relation to whether a door had been left unlocked.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Sefton Safer Communities Partnership [SSCP] decided that the death of Kathleen met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion was delayed awaiting information from Louise's GP, the family and arranging to see Louise in prison. The Home Office was informed.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. Five panel meetings were held and attendance was good with all members freely contributing to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The Panel comprised of:

➢ David Hunter	Independent Chair
➢ Paul Cheeseman	Author
➢ Sue Coombs	Detective Chief Inspector Merseyside Police
➢ Helen Smith	Deputy Chief Nurse South Sefton CCG
➢ Andrew Rawlins	Clinical Governance Lead Lifeline Project
➢ Gill Ward	Chief Executive Sefton Women and Children's Aid (SWACA)
➢ Gill Kelly	Director of HR Southport College
➢ Christina Jones	Sefton Metropolitan Borough Council
➢ Andrea Watts	Head of Commissioning Sefton Metropolitan Borough Council

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- Southport College (SC)
- Lifeline Project (LP)
- Sefton Supported Lodgings (SSL)
- North West Ambulance Service (NWAS)

2.3.2 Other agencies provided chronologies and supplied relevant information when requested. When this material is used within the body of this report it is attributed accordingly.

2.4 Notifications and Involvement of families

2.4.1 David Hunter wrote to the family and saw her sister [sister1], brother and brother-in-law on 02.03.2015. Correspondence was received from sister2.

2.4.2 A number of people known to Kathleen and Louise as friends, colleagues and associates have been spoken to and provided relevant information for the homicide investigation which is included in the body of the report and attributed where appropriate.

2.4.3 Letters were sent to HM Coroner Christopher Sumner and the Crown Prosecution Service informing them of the DHR and offering a briefing if needed.

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.5.2 Timeframe under Review

The DHR covers the period 01.01.2012 to the homicide. This date was chosen as 2012 was the year in which Kathleen first disclosed to her GP that she was drinking excessively and was the year in which Louise commenced her studies at College. It was felt that choosing 01.01 as a start date would provide a broad enough period to enable all relevant information to be captured.

2.5.3 Case Specific Terms

1. Were the risk indicators for domestic abuse present in this case recognised, appropriately assessed and responded to in providing services to Kathleen, and were the services provided to her timely, proportionate and 'fit for purpose' in relation to the levels of risk and identified needs?

2. How did agencies ascertain the wishes and feelings of Kathleen and were her views taken into account when providing services or support?

3. What barriers were identified that may have prevented Kathleen from making disclosures of her victimisation?

4. How effective was inter-agency information sharing and cooperation in response to Kathleen and Louise's needs?

5. How did agencies deal with information they were given in confidence by Kathleen, Louise and other people, and in deciding what to do with such information, did they consider the risks to Kathleen and Louise?

6. How were the racial, cultural, linguistic, faith and other diversity matters taken into account during assessments and provision of services to Kathleen and Louise?

7. What opportunities existed to assess and address Louise's abuse behaviour?

8. Were single and multi-agency policies and procedures, including the MARAC protocols followed and were they embedded in practice? Were any gaps in policy or procedures identified?

9. How effective was the supervision and management of practitioners who responded to Kathleen and Louise's needs and did managers have effective oversight and control of the case?

10. Were there any issues in relation to capacity or resources within the Partnership or its agencies that meant effective services were not provided to the victim and/or offender?

3. DEFINITIONS

3.1 The experiences of Kathleen and Louise fell within the Government definition of domestic violence which can be found at Appendix A. (Hereinafter referred to as domestic abuse)

4. BACKGROUND KATHLEEN AND LOUISE

4.1 Kathleen

4.1.1 Kathleen's family believe that her voice as a victim of domestic abuse was not heard or listened to when she was alive and that the DHR provides an opportunity for redress.

4.1.2 Louise's father left the family home when she was about six months old. Kathleen brought up Louise as a single parent and thereafter was in an abusive relationship with another man until she found the strength to terminate it. Her family describe Kathleen as a caring and loving mother and that Louise wanted for nothing. Kathleen met all her demands.

4.1.3 Her brother said that Kathleen was a warm and generous person who would never turn anyone away who was in need of help. She provided food and accommodation without judgement and would never make you feel embarrassed or that you had imposed on her. The family said that Kathleen had a strong character but felt she hid too much of her personal life from them.

4.1.4 The family said that Kathleen was very well respected, even adored, by her work colleagues at the hospital where she was employed as a cleaner. After her death they planted a tree and placed a plaque in front of the hospital in her memory.

4.1.5 They recognised she misused alcohol but did not know the extent. Kathleen's death has left a void in the lives of her family.

4.2 Louise

4.2.1 Louise contributed to the DHR and provided her account of the relationship with Kathleen (Section 4.4).

4.3 Kathleen and Louise Relationship

4.3.1 Although very little information is recorded by services in relation to Kathleen and Louise prior to the last few weeks of Kathleen's life, background enquiries by MSP revealed at times they had a difficult relationship. At the time of the events Louise was a college student and also employed part time as a care assistant.

4.3.2 Kathleen worked as a hospital cleaner and was employed by a local NHS Trust. A representative from the Trust said there was no indication from a work perspective of any concerns. The Trust knew there were minor arguments with her daughter but nothing they described that was out of the ordinary. Kathleen's attendance was good and she always appeared happy in work, so much so patients would comment that she cheered them up. Kathleen told her sister that when at work she kept her mobile switched on, against the rules, because Louise would ring and text her constantly and became irate and angry if she did not answer.

4.3.3 Kathleen lived alone with her daughter. Louise disclosed in a number of conversations with friends and to staff from agencies that Kathleen drank heavily. There is independent evidence to support that view. A colleague from Southport and Ormskirk NHS Trust visited Kathleen at home whilst she was off sick during late 2013 and was concerned regarding the seriousness of her depression.

4.3.4 Louise also told agency staff and friends that they argued frequently and Louise attributed this to Kathleen's alcohol consumption. Merseyside Police only have one record of attendance at the address in relation to an incident between Kathleen and a partner on 02.12.2004 and have nothing recorded that is of relevance to this DHR.

4.3.5 Kathleen's sister described a telephone conversation with Kathleen in which she said that Louise had tried to smother her with a pillow shortly before Christmas 2013. Kathleen said she found it very difficult to fight Louise off. She explained that Louise then got a second pillow and was using the two pillows to smother her and then attempted to push her into a cupboard. Kathleen told sister1 that she was frightened to death of Louise who constantly berated her.

4.3.6 A friend of Louise explained that she was with her during the day before the homicide and witnessed a verbal altercation between mother and daughter.

4.3.7 The family dispute Louise's portrayal of Kathleen during the trial as an abusive alcoholic mother. They believe that Louise portrayed a false picture of Kathleen in order to protect herself. The family believe that until fairly recently, the pair had a close and loving relationship.

4.4 Meeting with Louise

4.4.1 David Hunter saw Louise in prison in the presence of her Offender Manager. Louise disclosed a fairly difficult and sometimes traumatic relationship with her mother. Louise said she witnessed domestic abuse between her mother and boyfriend.

4.4.2 Louise said her mother and boyfriend were dependent on alcohol. However, her mother disguised her dependency from her family and friends. Louise was sworn to secrecy by her mother about the domestic abuse and drinking. Louise kept silent for fear of social services removing her from the family home. Louise just wanted her mum to stop drinking and be normal.

4.4.3 Louise said she disclosed to her GP what was happening in her life and was given anti-depressants. Louise told the College she decided to stay with her mother and not in the home for supported accommodation as planned. On reflection Louise believed she should have been stronger and gone into supported accommodation but recognised that her mother might have deteriorated.

4.4.4 Louise said that when her mother was not under the influence of drink she "was proper lovely" and they had some very good times together. Some weeks before her mother's death she was abstinent following an episode of self-harm. Louise said her mum was lovey while she was in hospital and not drinking. Louise expressed remorse for her actions and hoped that her family could forgive her.

THE FACTS BY AGENCY

5.1 Introduction

5.1.1 The agencies who submitted IMRs are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

5.2 Events Pre-01.01.2012

5.2.1 There is very little relevant information concerning Kathleen or Louise outside the timescale of this DHR report. Kathleen was a tenant at address 1 since 29.05.2000. One Vision Housing Ltd describe Kathleen as a *'model tenant'*. The only issue of relevance is a report made about 27.06.2000 or 2001 from a third party that they heard a domestic argument/disturbance and called the police as Kathleen had been fighting with her partner whilst Louise was present.

5.2.2 The same third party also reported that tablets belonging to Kathleen had been thrown onto their property by her partner. Merseyside Police did not have a corresponding record of attendance around that time. However there is a later record of police attendance at address one on 02.12.2004 when a male person, believed to be a partner of Kathleen, was dealt with for assault. There is no further information available on this incident because of the length of time since it occurred.

5.2.3 The only record of any involvement with Children's Social Care is an electronic reference dated 07.02.2005 which refers to *'parental alcohol misuse'.* As the records were migrated from paper documents some years ago it is not possible to determine any further detail other than to say that an assessment was carried out and no further action taken.

5.2.4 Louise was seen for assessments by the Primary Care Trust speech and language therapist during 2005 after having been referred by her primary school because of poor progress and concentration. She was assessed as being in the low to average range, had difficulty listening and putting words into sentences. The assessment concluded she did not require regular input from the therapist and an action plan was put in place to support her learning as she moved to a high school.

5.3 GP Services

Services Provided to Kathleen

5.3.1 GP records show that Kathleen attended her surgery regularly. She had a history of depression and received repeat prescriptions of an anti-depressant drug Citalopram. The first mention in relation to excessive use of alcohol is recorded on 11.12.2012 when she disclosed that she drank 70 units per week of spirits and had done so for many years. The GP made a referral to the community alcohol team and an entry dated 04.01.2013 shows that blood tests reflected excessive alcohol use. The GP did not make a referral to social services when Kathleen's alcoholism became apparent.

5.3.2 On 28.8.2013 Kathleen is recorded as having seen the Practice Nurse for a health screening appointment which indicated alcohol consumption of 42 units per week. Lifestyle and brief intervention advice was given. On 26.11.2013 Kathleen was seen by her GP following a multiple overdose that had resulted in her admission to Southport and Ormskirk Hospital on 24.11.2013.

5.3.3 The GP records show that Kathleen had taken a number of drugs, including prescribed ones, together with one litre of Vodka. She stated that she '*knows it's stupid/no intention of suicide or self-harm'.* The record also states that she usually drinks ½ a bottle of vodka each night, is on a hospital detox programme and that she *'feels fine at work but not at* home'. There appears to have been no exploration of why she felt that way nor of why she drank excessively. The only mention of Louise is that she *'lives with 19 year old daughter who supports her'.*

5.3.4 On 03.12.2013 Kathleen saw her GP again and the record shows that she was continuing with the hospital detox programme and that her mood was improving. She told her GP that she had more money since she stopped drinking and was planning to attend bingo sessions with her daughter. She was certified as unfit for work for a further two weeks and offered support as required.

5.3.5 On 13.12.2013 Kathleen again saw her GP. By this time she had successfully completed the alcohol detox programme at the hospital and told her GP that she was motivated to stop. She was continuing with counselling and said that she was *'going out more with her daughter'.* The record shows that she was still not fit for work particularly as it was the festive season and friends would want to go out for a drink.

5.3.6 The final entry in the GP records relate to a visit Kathleen made there on 03.01.2014. This time she did not see her normal GP. She disclosed that she was; feeling low, avoiding social situations; tearful and tired; had poor appetite and interrupted sleep and was not talking to anyone about problems. There is nothing in the record to indicate what these problems might have been nor whether the doctor sought to explore them. She disclosed that she had started drinking again and had consumed ¾ of a bottle of vodka in the last 11 days and was still waiting for a counselling appointment. The doctor gave her a sick note for a further two weeks.

GP Services Provided to Louise

5.3.7 There are a number of relevant episodes relating to Louise's access to GP services. On 08.01.13 she was recorded as having visited the surgery with low mood which she had suffered for two years. She was recorded as living with her mother.

5.3.8 On 3.10.13 she visited the surgery stating that she had problems at work, was missing College and had been referred to counselling with regard to her low mood. The record showed she had '*suicidal ideation'* and, although she had sent a text to Kathleen saying she was thinking of committing suicide, she had no true intentions. Her mood was said to be up and down.

5.3.9 The GP records show that comprehensive information was shared with the surgery by other agencies following Louise's overdose on 24.10.2013. Louise next saw her GP on 11.11.2013. She disclosed that she may move out of address one although Kathleen did know this at the time. She described Kathleen as *'like two different people when she drinks and provides no support for her. Mum almost encourages patient to kill herself when she drinks which is every night'.* She said she had felt down since she was a young child and lacked motivation.

5.3.10 Louise visited the GP surgery on 25.11.2013 when she described Kathleen's recent overdose. She said she told Kathleen that she was moving out. Kathleen then took a large overdose of her own medicines, painkillers and Fluoxetine (anti-depressant) prescribed to her.

5.3.11 Louise's final presentation to the GP surgery was on 30.12.2013 when she stated she had a stressful life as Kathleen had started drinking again and this time more than usual. Louise said Kathleen consumed about one litre of alcohol a day and that she was always arguing with Louise. Louise said the Fluoxetine she was being prescribed helped keep her mood under control and helped her deal with the stresses in her life. Louise said she had no other support mechanisms in place.

5.4 North West Ambulance Service (NWAS)

5.4.1 On 24.10.2013 Kathleen made a 999 emergency call to NWAS stating that Louise had taken an overdose of over-the-counter sleeping tablets. On the ambulance's arrival, Louise disclosed she was feeling suicidal and had taken an overdose. She said this was the first time she had attempted suicide and was on anti-depressant tablets, although she had no medical history documented. The ambulance crew transported Louise to Accident and Emergency (A&E) at Southport and Ormskirk hospital.

5.4.2 On 24.11.2013 a 999 call was made by Louise stating Kathleen had taken an overdose of tablets and was going to go to the beach. Louise was at work and

made the emergency call without seeing Kathleen. Louise told the call taker that Kathleen could be violent due to suffering from depression, but would not be violent to the ambulance crew.

5.4.3 When the ambulance crew arrived they found Kathleen sitting on a chair outside the house, she was conscious, alert and crying. She told the paramedic who attended her that she had taken more than the approved dose of a prescribed drug. She had been drinking and was sitting with a glass in her hand. The paramedic advised her that she would have to attend the hospital and asked if there was anyone he could contact for her as she was alone and upset. Kathleen said that she had an ex-partner or husband and a daughter but she did not want her ex-partner contacting. The paramedic asked Kathleen if her daughter was at work and she told him she worked at a care home but that she didn't want her contacted either.

5.4.4 Kathleen then said to the paramedic *"my daughter's threatened to kill me"*. He formed the impression that she had a volatile relationship with her daughter from her reaction to him asking if she wanted Louise contacting. The paramedic formed a view that her statement to him about her daughter threatening to kill her seemed to be referring to the past and not an immediate threat. Kathleen was distressed and upset and did not make any further reference to Louise or the comment she had just made. The paramedic did not probe any further as he did not believe he had reason to do so. Kathleen was transported to hospital and handed over to nursing staff. The comment made by Kathleen about the threat to kill her was not documented in any of the ambulance or hospital records. However when the paramedic became aware of the death of Kathleen from a colleague he contacted the police and provided a statement.

5.4.5 The final involvement of NWAS related to the homicide of Kathleen.

5.5 Southport and Ormskirk Hospital NHS Trust (Acute Services)

5.5.1 Records from Acute Services show Louise was admitted to A&E on 24.10.2013 having taken an overdose of sleeping tablets and vodka. She was detained overnight for observation and referred to the hospital alcohol liaison team (HALT). She was seen the following day by a member of the mental health review team and stated that her '*depression was due to deterioration of long standing depression. Lives with alcoholic mother who is emotionally abusive'.*

5.5.2 Louise was discharged home on anti-depressants with community follow up on 30.10.2013 and advised to ring the mental health team support line if she felt like this again. She told the team member who saw her that she would be returning to College and work and regretted the overdose. There is no indication that any questions were asked in order to obtain more information as to the nature of the abusive relationship.

5.5.3 At 23.48 on 24.11.2013 Kathleen was admitted to A&E following an overdose of antidepressants and alcohol with a past medical history of depression. She told the doctor who saw her that she '*had an argument with her daughter. Took an overdose with suicidal intent and wanted to walk into the sea and end it all'*.

5.5.4 She was detained in hospital and saw an alcohol specialist nurse later that night. Their record shows that Kathleen was a high risk drinker consuming 22 units per day seven days a week. It was noted that her '*daughter will offer full support to*

community withdrawal'. When seen by the specialist nurse the following day it is recorded that *'protective factors are daughter and her relationship with her'.* Kathleen was discharged at 13.30 on 25.11.2013 following a mental health assessment.

5.5.5 Kathleen remained engaged with acute services and attended the detox clinic on a number of occasions between 26.11.2013 and 11.12.2013. The notes show that she remained abstinent and that she *'is ready to give up alcohol and has the support of her daughter'.* Louise is shown as being present with Kathleen when she attended the clinic on 26.11.2013.

5.5.6 Kathleen failed to attend an appointment at the detox clinic on 18.12.2013 and called to rearrange this for 27.12.2013. However she again failed to attend and an appointment letter was sent out. This was the last contact between the clinic and Kathleen.

5.6 Mersey Care NHS Trust (Mental Health Services)

5.6.1 There is only one recorded contact between Kathleen and mental health services and this was on 25.11.2013 when she was seen at Southport General Hospital by the mental health liaison team following an overdose. The record shows that she took prescribed medication *'due to a disagreement with her daughter'.*

5.6.2 A full mental health assessment was completed. There was no mental health history, she was not previously known to secondary mental health services and the assessment stated there was no evidence of mental health issues. She disclosed this was an *'impulsive overdose whilst intoxicated, expressed regret'*. She was discharged and it is recorded that she was attending a community alcohol detox programme and that her GP would review any developments in relation to mental health difficulties. There is no indication from the records that any discussions or exploration took place to identify the nature or cause of the disagreement with Louise.

5.7 Lifeline Project

5.7.1 Lifeline is a registered Charity managing drug and alcohol services that include recovery, peer mentoring, harm minimization, day programmes, prescribing and shared care, community detoxification services, criminal justice and prison initiatives, family work and services for young people. Their services are spread across Yorkshire, the North East, the North West, London and the Midlands. (Source: www.lifeline.org.uk/about)

5.7.2 On 28.11.2013 the Hospital Alcohol Liaison Team from Southport Hospital referred Kathleen to Lifeline after she had undergone an alcohol detoxification in hospital having been admitted with an overdose. Kathleen attended an assessment appointment with a member of the Lifeline Team on 10.12.2013. Here a plan was put in place to support her to remain abstinent from alcohol and this included interventions and actions she could complete herself. During the assessment Kathleen talked about the impact her drinking had on her daughter Louise which was one of the key factors underlying her motivation to change.

5.7.3 At that point a full risk assessment was carried out in line with Lifeline's assessment procedures. There was no evidence to indicate that Kathleen was at risk of domestic abuse from Louise. During the process Kathleen disclosed that she had

been a victim of domestic abuse from a former partner 18 years previously. The risk to Kathleen of domestic or physical abuse was assessed as *'past and high'*. The risk of attempted suicide was similarly assessed and the only two *'present'* risks identified were *'deterioration in mental health'* and *'recent stressful life events/losses'*.

5.7.4 On 18.12.2013 Kathleen attended Lifeline for a Health Care Assessment and it was felt that she was doing well and continuing to abstain from alcohol. There is no record from that meeting of any discussion about her family relationships or other risk factors.

5.7.5 On 02.01.2014 Kathleen telephoned Lifeline to say she was unable to attend an appointment and disclosed to a member of staff that she had been drinking since Christmas Eve after her daughter Louise had tried to smother her. She was advised to call the police to report any incidents of threatening behaviour and an appointment was arranged for the following morning. The case was then raised in that morning's full team meeting so that the whole Lifeline Team were aware of the change of risk levels related to Kathleen.

5.7.6 On 03.01.2014 Kathleen attended Lifeline as arranged and spoke to a member of staff. She was again advised to report future incidents to the police but clearly stated that she did not want to do this and would deny that an incident had taken place if the police contacted her. A discussion then took place in relation to Kathleen moving to a place of safety and it was suggested this might be with her sister. She was not comfortable with this suggestion and it was not progressed. However she was advised that she could contact Lifeline at any time for support. One of Kathleen's sisters felt that, as Kathleen was the victim, Lifeline should have considered the possibility of Louise finding alternative accommodation, but that there was no evidence they explored that option.

5.7.7 The information Kathleen disclosed about Louise was not passed on as Kathleen had made her wishes clear. Kathleen told sister1 shortly after the meeting about the conversation she had with Lifeline. She also told her sister that she would deny anything had happened if the police were involved. Lifeline believe their decision to respect Kathleen's wishes was consistent with the organisations understanding of the appropriate response to a disclosure of domestic abuse. The case worker dealing with Kathleen approached a manager within Lifeline to seek support and confirm their actions had been the correct ones. The manager recommended that she take additional advice from Sefton Women's and Children's Aid Centre (SWACA).

5.7.8 Within one hour of the meeting with Kathleen the case worker held a discussion with a member of SWACA on their help desk. The facts were outlined but Kathleen's details anonymised. SWACA offered to speak with Kathleen by telephone when she attended her next appointment at Lifeline on 08.01.2014. The purpose of this call being to explain what support SWACA could offer Kathleen.

5.7.9 Enquiries have been made with SWACA. Their records confirm that an Assessment Officer working there received a telephone call from a member of staff from Lifeline querying if SWACA would provide support to a woman suffering family violence from her daughter. The caller would not give details as she had not spoken to the woman. The caller from Lifeline told the Assessment Worker at SWACA that the woman left an abusive partner 18 years ago with her daughter. The woman took an

overdose on 24.11.2013 and Lifeline became involved; she had since detoxed but resumed drinking over the Christmas period.

5.7.10 The caller from Lifeline said the woman had stated that her daughter was verbally abusive toward her and tried to smother her with a pillow but both women had fallen off the bed. The caller said the woman would not report the incident to the police and stated that if asked, she would deny it. The caller from Lifeline said the woman had an appointment on 08.01.2014 and she would discuss SWACA with her then, gain her consent and pass over the referral.

5.7.11 Lifeline had no further contact with Kathleen and became aware of her death from media reports. The agency has no records of any contact with Louise. SWACA never had any direct contact with Kathleen or Louise and only leant of who Kathleen actually was, and of her death, when they were contacted by a member of staff from Lifeline.

5.8 Southport College

5.8.1 Louise applied for a place at the College and started a course in Health and Social Care on 04.09.2012. Her progress in the first year was described as good, her attendance was average (84%) and there were no concerns about her during that year. The first issue of relevance was on 27.09.2013 when her progress tutor became aware from other students that her mother could be violent towards her and may have a drink issue. It was the intention of the tutor to speak to Louise about this the next time they met as Louise was absent that afternoon from College.

5.8.2 The next possible occasion the Progress Tutor could have asked Louise was Monday 30.09.2013 however the events described in paragraph 5.8.3 meant this was not possible. It was for this reason that no direct opportunity was presented for the Progress Tutor to raise the other students comments with Louise during the period Friday 27.09.2013 to Monday 30.09.2013. The Progress Tutor did, as is normal College practice, correctly pass on the information about the students' comments to Student Services immediately Louise was referred to them.

5.8.3 On the morning of 30.09.2013 staff at the College noted that Louise appeared to be under the influence of alcohol. The Advice and Guidance Coordinator from the College met with Louise who was accompanied by a friend and a conversation took place. During this Louise stated she had been drinking the night before and that she was unhappy and had a difficult home life. The coordinator assessed the risk to Louise and the College and advised Louise she could not remain there under the influence of alcohol. As nobody else was at home to look after Louise, her friend agreed that she could return home with her and she would ensure her safety.

5.8.4 The following day Louise and the same friend came into College and met the Advice and Guidance Coordinator. Louise was described as quiet and subdued and the friend led most of the conversation. The friend explained that Louise did not normally drink that she had lost weight and she was concerned about her. The friend explained that Louise's parents did not live together and that Louise lived with Kathleen who drank every night and would direct nasty comments at Louise. She described Louise as having been bullied all her life, felt worn down and not able to live with her father.

5.8.5 The College has a safeguarding policy in respect of Children and Vulnerable Adults. Louise was over 18 and not a vulnerable adult therefore the referral processes in the policy did not apply. Neither did the College believe information provided about Louise reach the threshold to trigger a referral to SWACA. The view the College took was their responsibility only extended to signposting her to available support services, on this occasion student counselling services. As this was the first time Louise behaved in this way, and there were no other concerns about her behaviour, a decision was made within the College not to invoke their conduct procedures.

5.8.6 On Friday 04.10.2013 the Advice and Guidance Coordinator received information that Louise had been drinking again, and was not in College that day because she was hung over. Apparently Louise had told Kathleen she was receiving counselling at the College and this caused Kathleen to *'go mad'* and say that she was going to *'kick Louise out'.* The informant also told the coordinator that because it had been Louise's birthday the day before Kathleen had been out with her in Southport during which time Kathleen had punched Louise on the arm. The coordinator clarified that Louise was OK and advised her friend that, as an adult, it was Louise's responsibility to report the matter to the police. No report was received by Merseyside Police concerning this incident.

5.8.7 Later that day Louise attended student services and disclosed to the Advice and Guidance Coordinator how unhappy she was and told her that Kathleen blamed her for everything since her maternal grandparents died when she was six. During the conversation Louise disclosed she was under her GP and was taking medication. A decision was made that no further action was needed because Louise said she was receiving support from her GP and had agreed to engage with the College's counsellor. However the coordinator did make enquiries with the Family Centre following information Louise provided that there had been engagement with her family some years before. No relevant information was disclosed through this enquiry. Following this meeting Louise then held two meetings with the student counsellor during which no information of relevance to this review was disclosed.

5.8.8 On 28.10.2013 the College received information that Louise had taken an overdose during the half-term break and as a result the Advice and Guidance Coordinator from the College met with her. Louise explained that she *'felt forgetful, her head was in the clouds, that Kathleen hated her and that she had slept on her grand-parents grave the night before'.* Louise informed the coordinator that she had taken 50mg of sleeping tablets, consumed vodka and alleged that Kathleen had told her she wanted Louise to '*take an overdose again'.*

5.8.9 The College's Advice and Guidance Co-ordinator met with Louise after being told that Louise had allegedly taken an overdose during the College's October half term. When she met with Louise, Louise explained to her that she was receiving support from the Acute Care Team (ACT). This information was followed up by the Advice and Guidance Co-ordinator who contacted the ACT. They advised that Louise was being discharged by them because no risk had been found and Louise should continue with the counselling she was receiving at the College and that the root cause was her housing. At this same meeting, Louise asked the Advice and Guidance Co-ordinator what her options were to move out of address one. The Co-ordinator then explained about the support that Sefton Supported Lodging (SSL) could provide. This was the first occasion that Louise had raised this with the Advice and Guidance Co-ordinator.

5.8.10 The College continued to provide counselling services to Louise and they assisted Louise to engage with SSL to coordinate her move to alternative accommodation. A number of further meetings took place between Louise and the College counsellor and Louise also had further conversations with the Advice and Guidance Co-ordinator concerning her potential move of accommodation including issues she had with moving her pets. During a conversation on 21.11.2013 Louise disclosed that Kathleen's drinking had become worse.

5.8.11 On 27.11.2013 and again on 29.11.2013 Louise provided information to staff at the College that Kathleen had taken an overdose and that she (Louise) had been tasked with keeping a 24 hour suicide watch over her. As a result of these conversations Louise attended College by appointment on 05.12.2013 and met with the Advice and Guidance Coordinator. She repeated the information she had provided before and said Kathleen was being supported by an alcohol agency, was taking tablets to help her come off alcohol and had now been abstinent for one week. The College believed there were no factors that gave rise to a change of support or the need to involve other agencies.

5.8.12 At 08.15hrs on the day after the homicide, a member of staff working on the College switchboard listened to an answerphone message which had been left some time since the College closed at 17.30hrs the previous day. The caller stated; *'I am Louise's mum I am worried about my safety, she tried to smother me the other week. I think the advice you are giving her is wrong. I want to speak to you'*. The Advice and Guidance Co-ordinator made attempts to telephone Kathleen. When these were not successful they escalated the matter and the Head of Student Services contacted Merseyside Police. Kathleen died between leaving the message and it being picked up.

5.9 Sefton Supported Lodgings (SSL)

5.9.1 SSL are accommodation providers who place young people with registered householders in their homes within the community. Following discussions between Louise and the Advice and Guidance Coordinator at Southport College a referral was received from them on 29.10.2013. On 01.11.2013 two members of staff from SSL interviewed Louise there to assess her needs and risk. The needs/risk assessment used by SSL covers 11 different areas of a young person's life.

5.9.2 The referral from the College mentioned Louise was having difficulties at home due to her mother's bouts of depression and alcoholism and these were making her vulnerable. The coordinator had previously helped Louise complete a risk assessment for SSL which contained reference to the fact that, if Louise changed her living arrangements, then the risks posed to her would be reduced. Louise confirmed these facts during the interview and that home life was not good. During the interview Louise also disclosed that she had taken an overdose during 10.2013, had been admitted to Accident and Emergency and had then been referred to the Hesketh Centre. [Acute Care Team, Mersey Care NHS Trust]

5.9.3 During the meeting with SSL, Louise said Kathleen had been verbally abusive towards her. She also said she was unhappy and down due to her home life and that she very rarely drank alcohol as she did not like it. However it is known that Louise did drink as on 30.09.13 she attended College under the influence of alcohol and was drinking whilst celebrating her recent birthday.

5.9.4 Following this initial meeting with Louise, staff from SSL carried out background work and identified a potential household for her to move into. On 12.11.2013 a member of staff from SSL together with the householder, her partner and son met with Louise at the College to discuss the arrangements for her to move in with them. A further meeting between Louise and the couple took place on 19.11.2013 and a move in date of 27.11.2013 was agreed.

5.9.5 On 27.11.2013, when the member of staff from SSL contacted Louise to confirm the arrangements, Louise informed them she had changed her mind and no longer wished to move. The reason she gave was that her mother had recently taken an overdose and been admitted to hospital. Louise explained that Kathleen had become very upset about her decision to move out and there had been a number of arguments resulting in Louise leaving. She claimed she had stayed with her father but this was not ideal as their relationship was also problematic.

5.9.6 Louise also disclosed that, while stopping at her father's, she had received a call from the hospital to say that Kathleen had taken an overdose. She went to the hospital and Kathleen apologised and said she wanted to stop drinking; now Louise wanted to be there for her. The staff member from SSL stressed to Louise that she should not lose sight of her own goal of attending university. They encouraged her to engage with the support mechanisms available in the College's student services and counselling as well as the support SSL could offer.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one terms and where that happens a best fit approach has been taken.

6.1 Were the risk indicators for domestic abuse present in this case recognised, appropriately assessed and responded to in providing services to Kathleen, and were the services provided to her timely, proportionate and 'fit for purpose' in relation to the levels of risk and identified needs?

6.1.1 Risk indicators for domestic abuse were present in this case. Although domestic abuse is more normally associated with persons in an intimate relationship, the definition (Appendix 'A') clearly covers the circumstances here.

6.1.2 Kathleen misused alcohol and had a relationship with Louise that included frequent exchanges of verbal abuse. Kathleen's misuse of alcohol is well documented in visits she made to her GP, to the hospital and in the counselling she received. The exchanges of verbal abuse had been witnessed first-hand by neighbours and friends of Louise. Louise also described the abuse she claimed to have received from Kathleen to friends and to staff at Southport College and Sefton Supported Lodgings.

6.1.3 As well as the use of verbal abuse, the more serious aspects of this case are the incidents of violence that took place between mother and daughter. Kathleen made a disclosure to a member of staff at Lifeline on 02.01.2014 that Louise had tried to smother her. She also left a telephone message on the answering machine at

Southport College shortly before death making a similar claim although this was not heard by staff until after Kathleen had died.

6.1.4 However, for a number of reasons, the opportunities for agencies to recognise assess and respond to these issues as risk indicators of domestic abuse in relation to Kathleen were limited. There is evidence from sister1 that Louise constantly berated her mother who was in turn frightened of her daughter. Additionally, work colleagues knew there were, what they describe as, minor arguments between mother and daughter.

6.1.5 In respect of misuse of alcohol this, on its own, does not necessarily put a person at risk of domestic abuse. Kathleen's misuse of alcohol was well documented. It was discussed with her GP on a number of occasions and she received referrals and treatment for it, latterly as part of a structured detoxification programme. However there is no reference within the GP records that show any other domestic abuse risk indicators were present. The only reference to Louise within the records was that she supported Kathleen and there was no mention of any verbal or physical abuse having taken place.

6.1.6 When Kathleen presented at A&E on 24.11.2013 she disclosed that she had argued with her daughter and taken an overdose with suicidal intent. Her alcohol consumption was recognised as high risk. However there was no information provided to A&E to suggest that Kathleen was at risk of being abused by Louise. Rather, the presence of Louise was seen as a 'protective factor' and that she could assist her mother in giving up alcohol.

6.1.7 When Kathleen spoke with a member of staff from Lifeline on 10.12.2013 she described having been the victim of abuse from a former partner 18 years ago. She did not disclose any information at that time to suggest she was at risk of abuse from Louise. Rather, Kathleen spoke about the impact her drinking was having on Louise. While a risk assessment was conducted, this looked at the risk of suicide and of abuse to Kathleen from a past partner. There was no consideration of risk from Louise to Kathleen and this was reasonable given that Kathleen had not provided any relevant information. Notwithstanding this, the Lifeline IMR author believes their staff do need to understand where the line should be drawn between 'past' and 'present' risk given that Kathleen had made a suicide attempt within the last month.

6.1.8 The next opportunity presented to Lifeline was on 02.01.2014 when Kathleen made a disclosure to a member of their staff that Louise had tried to smother her. While the confidentiality aspects of this disclosure are covered in detail at 6.5, it is clear that the staff member concerned identified there was a risk and reacted quickly to it by advising Kathleen to make contact with the police. The IMR author concludes that the practitioner receiving the disclosure took steps in line with the organisations understanding of how to respond. This included escalating the issue to a member of the management team and sharing the information with the rest of the team at a morning meeting so that everyone was aware of the raised risk.

6.1.9 The response to the raised risk continued the following day when Kathleen attended for an appointment with Lifeline and she was again advised to contact the police. In addition, discussions took place with her in relation to moving her to a place of safety, although this suggestion drew adverse comment from Kathleen's family when they saw the report. They felt that as the victim, Kathleen was entitled

to remain in her home and that if it was necessary to separate mother and daughter to ensure mother's safety, it was Louise who should have left. Following the meeting further steps were taken through contact that was made with SWACA. An anonymised discussion took place concerning the support they could provide and Lifeline believe this confirmed the steps taken so far were in line with accepted good practice. The panel believe that Lifeline should have given far more serious consideration to foregoing Kathleen's wishes and their rationale for that belief is covered at paragraph 6.8.

6.1.10 In relation to Southport College, the only contact they had with Kathleen was the answering machine message left by her shortly before her death. College staff clearly recognised there was a risk to Kathleen and reacted immediately to this by contacting the police when they failed to be able to return the call to Kathleen. Nobody will ever know what exactly was in Kathleen's mind when she made that call.

6.1.11 The panel does not believe there is any evidence to support the concern Kathleen expressed about the College providing the *'wrong advice'* to Louise. The College IMR documents extensive contact with Louise on a number of occasions in response to concerns about her. The services the College provided to Louise were appropriate to those concerns and included extensive counselling services and referral to SSL in an effort to help her move to alternative accommodation.

6.1.12 Finally the panel discussed whether there might have been a role for Child and Adolescent Mental Health Services (CAMHS). Children and young people can be referred to CAMHS if they are finding it hard to cope with family life. The panel felt that a referral to CAMHS would have been useful if the environment within which Louise was living and the problems she was experiencing had been identified earlier. However they recognise that, because of Louise's age at the time both the College and her GP became aware of her experiences, she fell outside the parameters of the CAMHS service and therefore remained within adult services.

6.2 How did agencies ascertain the wishes and feelings of Kathleen and were her views taken into account when providing services or support?

6.2.1 Kathleen had limited contact with agencies at which there were opportunities to take her views into account. However those that are documented appear to show consideration towards her. Following her admission to hospital on 28.11.2013 she underwent alcohol detoxification and was referred to Lifeline and appeared to want to address her alcohol issues. They responded by putting plans in place that she could follow and a positive relationship was built between the Lifeline practitioner and Kathleen and this allowed her to continue to engage. The issue of Kathleen's wishes in relation to confidentiality and the disclosure to them of domestic abuse are covered in 6.5 below.

6.3 What barriers were identified that may have prevented Kathleen from making disclosures of her victimisation?

6.3.1 There are many reasons why victims of domestic abuse do not disclose their victimisation to professionals. Her Majesty's Inspectorate of Constabulary (HMIC)* carried out a survey as part of a review they conducted into the handling of domestic abuse. Of those victims of domestic abuse who responded to HMIC"s open on-line survey, 46 percent had never reported domestic abuse to the police.

The reasons the victims HMIC surveyed gave for not reporting domestic abuse to the police were: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent)".

*Source: Everyone's business: Improving the police response to domestic abuse 27 March 2014 ISBN: 978-1-78246-381-8 www.hmic.gov.uk

6.3.2 The Crime Survey for England and Wales reported that, while the majority of victims (79 percent) told someone about the abuse, for both women and men this was most likely to be someone they knew personally (76 percent for women and 61 percent for men). Only 27 percent of women and 10 percent of men said they would tell the police

6.3.3 The panel considered whether there were any barriers such as those identified by HMIC which may have prevented Kathleen making a disclosure. While there is evidence that the relationship between mother and daughter involved both physical and verbal abuse there are also indications (as identified by the Trial Judge) of *'good times'*. For example, in conversations with her GP in 12.2013 Kathleen described Louise as supporting her and how they were planning to go out more together including to bingo sessions.

6.3.4 Kathleen disclosed to the paramedic that conveyed her to hospital when she took an overdose on 24.11.2013 that Louise had threatened to kill her. However later that night health care professionals recorded that she had the full support of her daughter and that Louise and her relationship with her mother was '*a protective factor'*.

6.3.5 Although these statements appear somewhat contradictory, the panel believe that a possible underlying barrier to a full disclosure by Kathleen may well have been the fact that Louise '*was all that Kathleen had'*. This was a comment she made to her GP in 1994 since when both mother and daughter had lived together, and survived, a previous abusive and violent relationship.

6.3.6 If Kathleen had made a full disclosure to the police or other agencies about Louise's behaviour, it could have led to serious consequences for Louise. This might ultimately have resulted in the mother/daughter relationship being severed. If, as it seems likely, the relationship with Louise was all that Kathleen did have it would have created a very significant barrier for her to overcome. If Kathleen made a disclosure it could also be that her actions would have been called to account. Kathleen's family recognised that she hid too much about her personal life and this natural proclivity probably added an additional hurdle to disclosure.

6.4 How effective was inter-agency information sharing and cooperation in response to Kathleen and Louise's needs?

6.4.1 The relatively limited contact that Kathleen and Louise had with agencies, except in the last few weeks before Kathleen's death, meant there were few opportunities to share information. However when such opportunities were presented the agencies concerned seemed to have used them.

6.4.2 For example Southport College made enquiries with the Family Centre when Louise disclosed to them that they had been involved with her some years before and

similarly with children's services. They also made contact with the Hesketh Centre to discuss her case when they learnt that Louise had taken an overdose around 28.10.2013. A considerable amount of dialogue also took place between the College and SSL in an attempt to assist Louise to find alternative accommodation.

6.4.3 In relation to Kathleen she was referred by the Southport Alcohol Liaison Team to Lifeline following her admission to hospital. Upon receiving the disclosure from Kathleen about the attempt by Louise to smother her, Lifeline shared information anonymously with SWACA in an effort to provide further support and advice.

6.4.4 While the occasions for information sharing were limited the panel did discuss one opportunity that it believes could have led to greater exploration of the relationship between Kathleen and Louise. On 24.10.2013 Louise was admitted to hospital having taken an overdose. During conversations with the mental health review team the following day it was recorded that '*she lives with her alcoholic mother who is emotionally abusive'*.

6.4.5 However when Kathleen was admitted to the same hospital on 24.11.2013, having taken an overdose, there appears to be no cross reference back to the admission of Louise the month before. The information about Kathleen's emotional abuse of Louise was known to health professionals on 24.11.2013 and contained within records held by acute services. The panel considers this may have made a difference to some of the outcomes they arrived at. For example, that information would have provided them with a reason to explore in more detail the relationship between mother and daughter. This in turn may have led them to reach a different conclusion as to whether Louise and her relationship with Kathleen was indeed a protective factor.

6.4.6 Sister1 makes a persuasive point that the problems of Kathleen and Louise were dealt with in isolation and no one organised a multi-agency meeting or adopted a problem solving approach to the issues. The sister queried whether the route for doing so lay through Adult Safeguarding. The panel considered whether Kathleen and/or LOUISE were vulnerable adults within the "No Secrets" definition.

The Safeguarding Adults Framework for Action relates to responses made to person aged 18 years or over 'who is or may be in need of community care services by reason of mental or other disability, age or illness and is or maybe unable to take care of him or herself, or able to protect him or herself, or able to protect him or herself against significant harm or exploitation'. (No Secrets Dept of Health 2000) See Appendix A for fuller information.

6.4.7 The panel believed that neither Kathleen nor Louise fell within the definition. Having said that, they were vulnerable adults in the ordinary meaning of the term and there was nothing to stop professionals from collaborating to identify the real problems and offer appropriate support. An ideal opportunity arose at the point Louise was organising alternative accommodation. No one appears to have considered the impact on Kathleen of Louise moving out or how Kathleen would react when she was told. The panel thought the move could have been handled in collaboration with Kathleen, thereby removing the element of surprise of a done deal.

6.5 How did agencies deal with information they were given in confidence by Kathleen, Louise and other people, and in deciding what to do with such information, did they consider the risks to Kathleen and Louise?

6.5.1 Kathleen gave one known piece of information in confidence to a member of staff at Lifeline on 02.01.2014 (see paragraph 5.7.5). It seems that Kathleen was very clear that she was providing this in confidence and reinforced this by saying she would deny making this comment if she was contacted by the police. She repeated the conversation she had with Lifeline to sister1 shortly after. Lifeline were therefore in a difficult position; it is clear they recognised there was a risk as they tried to persuade Kathleen to involve the police. However, if they breached the confidence and told the police or another agency, and they were not able to take action because of Kathleen's refusal to cooperate, they believed there was a very real danger that the relationship they were building with Kathleen would be damaged if not severed.

6.5.2 There were two clear choices to make; either, share information and hope that affirmative police action would follow, or maintain the confidence and try alternative protective measures. A plan to follow the latter path was initiated by Lifeline and the IMR sets out the rationale for this. It was based upon Lifeline's understanding of the appropriate response. Which was, in the absence of witnesses or corroboration, the police would be unlikely to take action. Therefore a disclosure that could not be backed up by robust safety planning could significantly increase the short term risk.

6.5.3 Sister1 told Kathleen that Lifeline would probably override Kathleen's objections and report the incident to the police. Her sister felt that while Kathleen did not want to make the report, she would not be too upset if Lifeline did. In that way she could say to Louise it was not me who told the police. However, that was not explicitly said.

6.5.4 Once the decision not to inform the police had been taken by the Lifeline staff member they took further steps to protect Kathleen. These included discussing the matter with all other staff so they were aware of the change in the levels of risk, making an appointment to see Kathleen at the earliest opportunity, involving management in the decisions and seeking support from SWACA.

6.5.5 Lifeline's plan was therefore to try and ensure Kathleen's safety and wellbeing by maintaining regular contact with her, supporting her to think through options for keeping herself safe in the short term and securing additional expertise relating to domestic violence. It appears the agency considered the risks and believed at the time that disclosure could have increased risk.

6.5.6 The panel discussed the actions taken by Lifeline in response to the disclosure of confidential information from Kathleen. In doing so they gave consideration to what was meant by 'smothering'. The panel recognised that the act of 'smothering' has serious consequences. It is, at the very least, an assault by one person on another. At the other end of the scale, if successful, it could lead to the death of a victim. At either end of the scale it is therefore a criminal offence. However, in reaching a view as to the course of action taken by Lifeline the panel have been careful to avoid basing any views upon hindsight and what they now know was the final outcome of the case. Nevertheless, the panel felt that Lifeline should have told

Kathleen they were going to report the matter to the police and devised a safety plan for her.

6.5.7 Clearly when Lifeline received the information from Kathleen they recognised there was a need to involve the police and on two occasions gave this advice to Kathleen. However the panel believes that the member of staff involved did not appreciate the potential gravity of the disclosure that Kathleen had made. When they advised Kathleen to contact the police they referred to '*threatening behaviour'* and this tends to support the belief that the member of staff simply underestimated the gravity of what they had been told. A factor that may be relevant here is that, at the time of these events, there was no detailed guidance to staff within Lifeline about how to deal with disclosures of domestic violence (see paragraph 6.8.2).

6.5.8 In relation to Louise, she made a number of comments to members of staff at Southport College about her unhappy home-life. The comments she made to the College were recorded and are documented in the IMR. The College shared some of this information with other agencies, for example SSL in relation to the risk assessment (29.10.2013) and a member of the Acute Care Team in relation to an overdose (31.10.2013). This information does not appear to have presented any risks to either Kathleen or Louise that would have created a barrier to it being shared.

6.5.9 In relation to friends, the College received information on a number of occasions from a person close to Louise concerning incidents that involved her (e.g. being hung over after her birthday and in relation to the taking of an overdose). This information was recorded by the College and followed up appropriately and in so doing does not appear to have raised any potential risks in relation to either Kathleen or Louise that required consideration.

6.5.10 In relation to the actions of the College in sharing information with third parties this was only done with the express consent of Louise. When Louise sought confidentiality, for example in relation to Kathleen finding out about whether she took up the option of counselling (01.10.2013), this was respected by the College.

6.6 How were the racial, cultural, linguistic, faith and other diversity matters taken into account during assessments and provision of services to Kathleen and Louise?

6.6.1 While there were no matters relating to race, culture or linguistic issues the panel did discuss a reference that was made by the Trial Judge when he said he had taken into account Louise's *'limited mental development'.* While a referral was made to a speech and language therapist during 2005 the assessment concluded she did not require regular input from the therapist and an action plan was put in place to support Louise's learning as she moved to a high school. None of the other information supplied to the panel through IMRs, chronologies or reports indicates that any agencies held information to suggest limited mental development was an issue. Consequently it would not appear to have been reasonable to expect them to take this issue into account when providing services to Louise.

6.7 What opportunities existed to assess and address Louise's abuse behaviour?

6.7.1 The occasions to assess and address Louise's abusive behaviour were limited. Kathleen did not make any disclosures to her GP that might have indicated abuse. Although she made a comment to the paramedic who collected her on 24.11.2013 she does not appear to have repeated that comment when she arrived at the hospital. In fact the notes from both her GP and acute services seem to indicate that she was relying on Louise to support her in addressing her misuse of alcohol. The relationship that Kathleen had with Louise is seen as a 'protective factor' in the notes recorded by the alcohol specialist nurse who saw her on 25.11.2013.

6.7.2 The panel discussed the actions of the paramedic. They felt that it was not clear whether Kathleen was telling the paramedic about a historic incident or something that had happened that night. The paramedic knew that Kathleen was being taken to hospital where suitability checks would be carried out into the background of Louise. The panel felt that the paramedic acted with integrity by contacting the police as soon as they learnt of the death of Kathleen. While the panel felt the explanation the paramedic gave for their actions was reasonable they felt some supplementary questions could have been asked of Kathleen to clarify exactly what she meant.

6.7.3 The only two known occasions the panel have identified when Kathleen directly disclosed that Louise had abused her were when she told a close family relative on 24.12.2013 that Louise had tried to smother her and subsequently Lifeline on 02.01.2014. The disclosure to Lifeline has already been considered at length in paragraph 6.5.

6.7.4 While the panel believe the opportunities for receiving direct referrals from Kathleen were limited, they consider there were opportunities to explore some issues in more depth. For example, GP services had known for a number of years that Kathleen misused alcohol and on occasions drank excessive amounts. However, from the records, there seems to have been no discussions with her as to the reasons why she did this. While the GP records indicate she lived with her 19 year old daughter who supported her it does not appear there were any discussions or exploration of the impact her behaviour might be having on Louise.

6.7.5 Similarly when acute services treated Kathleen on 24.11.2013 she told the doctor who saw her that she had had an argument with her daughter. The panel has considered whether the nature of that argument should have been explored in more depth during the course of her treatment there. However the panel believes that, because Kathleen then went on to tell the mental health team about Louise being a protective factor, it was not reasonable to have expected them to probe the disagreement further.

6.8 Were single and multi-agency policies and procedures, including the MARAC protocols followed and were they embedded in practice? Were any gaps in policy or procedures identified?

6.8.1 In relation to Lifeline, policies are in place for domestic abuse, information sharing, safeguarding of children and adults at risk. Records are kept that staff are trained in, and know about, these policies. Their safeguarding policy has been significantly rewritten since this incident to provide clearer guidance for staff.

6.8.2 The IMR author has checked the policy that was in place within Lifeline at the time of these events. They conclude it did not provide detailed guidance about how to

respond to disclosures of domestic violence. They therefore believe the actions of the practitioner at Lifeline in relation to Kathleen's disclosure was based upon custom and practice rather than a clear written policy. The policy in use at the time stated that "*High-risk domestic violence issues can be referred to a multi-agency risk assessment conference (MARAC*)." This requires an accurate assessment of risk, and it is clear from the policy that consideration of a MARAC is a "can" rather than a "must" or a "should". The author therefore concludes that the practitioner was not acting against the policy by not referring the disclosure Kathleen made to a MARAC. The absence of a clear policy about violence supports the panel's belief that the practitioner did not appreciate the gravity of the disclosure made by Kathleen.

6.8.3 The panel discussed the role of Lifeline in relation to Kathleen and whether their actions were compliant with the multi-agency policies then in place. The Lifeline IMR author believes the actions of their agency were consistent with the general principles of the Sefton Safeguarding Adults Policy and Procedural Framework Action 2011. In doing so he highlights page 11 of that policy which sets out the need for consent to share information.

6.8.4 The panel has considered the circumstances as to when confidentiality can be breached and has considered page 12 of that policy. This outlines a range of circumstances were consent is not necessary, which include *inter alia*;

- *In order to protect the vital interest of the service user (i.e. in matters of life of death) and they are not able to provide consent and it is not reasonably expected to be obtained;*
- *If it is in the substantial public interest;*
- *If necessary to prevent or detect unlawful acts and seeking consent would prejudice these protective aims.*

6.8.5 The panel accepts that, in making the decision not to disclose, staff at Lifeline acted professionally and honestly believed they were working in the best interests of Kathleen. As outlined earlier smothering is a serious crime which could lead to death. Therefore the Sefton Safeguarding Policy did in fact provide an avenue for the confidential nature of Kathleen's disclosure to be breached had Lifeline chosen to do so.

6.8.6 However the Panel felt it was important to complete the analysis of this case based on what was known at the time and against the contemporary policies and operating framework, as opposed to hindsight. It therefore believes that, while the Sefton Safeguarding Policy did provide an avenue for disclosure, the decision not to make one was flawed. This is because they feel the Lifeline practitioner did not appreciate the potential magnitude of what they had been told and genuinely believed they were acting in the best interests of Kathleen. The Lifeline manager who was consulted also did not understand the gravity of what Kathleen said and appears not to have considered disclosure against the Sefton Safeguarding Adults Policy.

6.8.7 Southport College has policies and procedures in place including Safeguarding, Maintaining Student Responsibility and Codes of Conduct. The College reports on Safeguarding as part of its annual Self-Assessment Reporting process. This annual

report is then submitted to OFSTED. Separately like all schools and Colleges, the College is routinely visited by OFSTED and when this last inspection visit took place in March 2013 the College's overall inspection grade was good. There is a programme of staff development in place in relation to safeguarding and a committee that reports to the Executive Team and Governors. The IMR author concludes the College's safeguarding policy and procedure was used as a guide to determine the decisions made by the Advice and Guidance Coordinator along with her relevant knowledge and experience.

6.8.8 The College does not have a specific domestic abuse policy in place although it does have a clear definition of a vulnerable adult which is;

"A person aged 18 or over who may be in need of community care services by reason of mental or other disability, age or illness and who is, or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation".

6.8.9 Neither Kathleen or Louise were subject of a MARAC referral and the key issue in relation to this case is whether the agencies involved had sufficient grounds to report their concerns which might have led to a MARAC being held. This section of the report therefore considers to what extent policies and procedures were interpreted.

6.8.10 In relation to Louise, Southport College are clear that they are a provider of further education and because she was over 18 the disclosure from Louise did not trigger a safeguarding referral. Consequently they regarded their responsibilities as extending to signposting. There is no doubt they put considerable effort into this by providing counselling and working with SSL to try and obtain accommodation for her away from Kathleen.

6.8.11 The College had a number of direct dealings with Louise and received information from others concerning her relationship with her mother. For example information had been provided to the College on 27.09.2013 that Kathleen had been violent towards her. On 01.10.2013 in a conversation with College staff, in which a friend of Louise spoke for her, they were told Kathleen drank every night and that she shouted at and directed *'nasty comments'* at Louise. She also agreed that she had been bullied by Kathleen all her life and felt worn down. The friend also expressed concern about her because Louise was losing weight and drinking.

6.8.12 On 02.10.2013 the same friend disclosed to the College that Louise had been drinking again and on this occasion had been punched on the arm by Kathleen. Clearly the member of staff involved realised this could have amounted to a crime as she advised the friend it was Louise's responsibility to report the matter to the police. During a conversation with a member of College staff two days later Louise talked about Kathleen's drinking and how she blamed Louise for everything since her maternal grandparents died.

6.8.13 Such behaviour by Kathleen, together with what Louise had already told them about bullying, could be said to fall within the definition of psychological abuse. Similarly the comments Louise made to staff at the College on 28.10.2013 following the overdose she took contained reference to behaviour by Kathleen that amounted to similar abuse. The key issue the panel has considered at length has been

whether it was reasonable to expect Southport College to have made a domestic abuse referral concerning Louise.

6.8.14 Again the Panel felt it was important to complete the analysis of this case based on what was known at the time and against the contemporary policies and operating framework, as opposed to hindsight. Clearly the College did recognise that Louise had needs. They had safeguarding policies and procedures in place and responded appropriately to both direct and indirect information concerning Louise by signposting her to other agencies such as SSL.

6.8.15 However the College did not have a domestic abuse policy in place and were not part of the multi-agency arrangements within the Sefton area for tackling domestic abuse. This limited their knowledge of the subject and the options and pathways that were available, such as carrying out a DASH risk assessment. They were aware of the services available from SWACA although they did not consider that in this case it would have met the threshold for a referral.

6.8.16 The issue of a threshold for disclosures to domestic abuse services has been raised with the Chief Executive of SWACA. She advised there is no threshold and the belief in the existence of such a policy is a misunderstanding. Domestic abuse services are available to provide advice and guidance on any case involving domestic abuse and there is not a policy of setting thresholds. SWACA would have provided advice in relation to Louise's experiences if asked. The panel believe it may therefore be timely to issue information to agencies who provide or use domestic abuse services or signpost others to them to reinforce this point.

6.8.17 The panel sought views from CAADA (Coordinated Action Against Domestic Abuse) about the role of Colleges such as Southport. Their advice is that, whilst agencies such as Colleges can complete risk assessments in their own right, it is not reasonable that every establishment has the capacity to provide risk assessment training to allow this to happen. The realistic expectation of a College is that they nominate a safeguarding single point of contact who is aware of the need to refer any cases of domestic abuse to the local domestic abuse services. Based upon this and all that was known about Louise at the time by the College the panel therefore believes they acted reasonably and followed the policies and procedures in place.

6.9 How effective was the supervision and management of practitioners who responded to Kathleen and Louise's needs and did managers have effective oversight and control of the case?

6.9.1 In relation to Kathleen, it was clear that management were involved in the very limited dealings that Lifeline had with her. The staff member who acted as the key worker for Kathleen immediately sought advice from the internal safeguarding lead about the disclosure she had received. The worker was a qualified social worker and had a level of expertise in safeguarding that would not necessarily be expected of all front line staff in drug and alcohol recovery services. However the IMR author does believe that the levels of knowledge and competency of other members of their team should be reviewed and has made two agency recommendations which appear in appendix 'B'. Sister1 is disappointed that the Lifeline worker and manager will not face further action over their handling of Kathleen's disclosure.

6.9.2 The case of Louise was handled within the Southport College Student Services section by the senior case leader and she and the team meet to discuss cases and

review decisions together. Some case are escalated up to the Head of Student Services however this did not happen in the case of Louise as it was considered that all support measures were in place. All the staff who were involved in dealing with Louise's case within the College were experienced and held level 2 safeguarding qualifications and had completed safeguarding training.

6.9.3 The panel therefore concludes that none of the issues arising in this case have their roots in a failure to effectively manage or supervise practitioners and rather are issues of interpretation of policy.

6.10 Were there any issues in relation to capacity or resources within the Partnership or its agencies that meant effective services were not provided to the victim and/or offender?

6.10.1 There was only one issue of capacity that came to light during this review and that related to Southport College and the Student Services Team who were already reviewing the significant number of students directed to them for academic and welfare issues rather than safeguarding issues. This had no bearing on the support in place for Louise. An action has been raised within plan at Appendix 'B' by the College which covers this issue.

7. LESSONS IDENTIFIED

7.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix 'B'.

7.2 The DHR Lessons Identified are listed below. Each lesson is preceded by a narrative.

1. **Narrative:** Kathleen was an adult with vulnerabilities because she was in receipt of services. There was a failure to recognise that the disclosures she made to staff at Lifeline concerning the attempt to smother her by her daughter Louise (02.01.2013) amounted to a serious criminal offence and was therefore both an instance of domestic abuse and of abuse of a vulnerable person within the terms of the Sefton Safeguarding Adults Policy and Procedural Framework for Action 2011.

   Lesson

   Failure to recognise when the serious nature of a crime committed or suspected overrides the confidentiality wishes of a vulnerable person means that policies on abuse are not correctly applied thereby denying agencies the opportunity to assess and address abuse.

2. **Narrative:** Kathleen and Louise both had contact with agencies for issues that were either caused by their relationship as mother and daughter or impacted upon that relationship. Some of the behaviours displayed by both Kathleen and Louise amounted to domestic abuse as defined at Appendix A. However agencies did not recognise that indicators of domestic abuse were present.

   Lesson

Had the relationship between Kathleen and Louise been an intimate one as opposed to mother/daughter, organisations may have responded differently. This case highlights that professionals need to understand there are different aspects to domestic abuse. These include controlling behaviour that does not always present in the context of an intimate relationship between a male and a female.

3. **Narrative:** Kathleen misused alcohol and this was known to health agencies including her GP and primary care who referred her to support services. However no agency appeared to adequately explore the root causes of her misuse of alcohol nor the consequences of it, which was the impact it was having upon her relationship with Louise.

   Lesson

   Agencies providing support to patients such as Kathleen who misuse alcohol should not view the issue in isolation and need to explore the impact such behaviour is having, not just on the patient, but also on the their relationships with others. Where there is felt to be an impact, as well as treating the root cause, interventions which address the harm their addiction is causing should be considered such as, for example family therapy or mediation.

8. CONCLUSIONS

8.1 Kathleen had misused alcohol for a number of years and when she had been in relationships with partners these are reported to have been volatile. Louise had been exposed to these behaviours from a young age and found them distressing. There is evidence that Kathleen's drinking was known to children's services in 2005 although it does not appear to have triggered any action. Louise had expressed these concerns to friends and gave evidence about her mother's behaviour during her trial.

8.2 Kathleen's misuse of alcohol was known to her GP and attempts made to address it although there appears to have been no exploration with her as to the reasons why she drank excessively. Neither was there any exploration of the impact her misuse of alcohol was having on her daughter Louise. However Louise's behaviour from her enrolment at Southport College in 09.2012 until 30.09.2013 did not raise any concerns which would suggest there were significant issues between her and Kathleen during this time.

8.3 During the autumn of 2013 the relationship between Kathleen and Louise seemed to deteriorate and Louise disclosed to friends and to staff at the College that her mother was drinking heavily, and that she had an unhappy home life. Information was also received within the College that Kathleen had struck Louise on the arm.

8.4 Louise claimed she did not drink but there were two episodes when she became intoxicated and a single occasion when she took an overdose. She was clearly unhappy. In addition Louise took one documented overdose on 24.10.2013 which she claimed her mother had encouraged her to repeat. This panel concluded on the information given by Louise that she was the victim of domestic abuse at the hands of Kathleen. Equally, the same information reveals that Louise was perpetrating

domestic abuse on her mother. No formal domestic abuse risk assessments were undertaken, and no co-responsive violence screening took place to determine whether Kathleen or Louise was the prime aggressor. Therefore is not possible to say objectively what the exact nature of the relationship was and whether one person was dominant over the other. However, it is a fact that Louise was responsible for her mother's death, so at that point she was the antagonist.

8.5 Southport College staff engaged with Louise, provided counselling services, signposted her to other services and believed that, as she was 18, this was the action that was necessary. They shared information with SSL, with the Hesketh Centre, with children's services and with the Family Centre in an attempt to understand Kathleen's situation. The panel believe that was good practice.

8.6 On 28.11.2013 Kathleen took an overdose following which she was admitted to hospital. During that process she disclosed to the paramedic attending her that Louise had threatened to kill her. The paramedic did not believe this to be a recent or immediate threat and did not explore it further. The panel believe this was a reasonable belief.

8.7 While at the hospital Kathleen saw an alcohol specialist nurse who identified that Louise was a protective factor for Kathleen. Had the specialist nurse been aware of the admission of Louise a month earlier, after taking an overdose herself, that information may have led them to probe deeper into the relationship between Kathleen and Louise. This might have led to a different conclusion in relation to the suitability of Louise as a protective factor.

8.8 This event seems to have coincided with the period when Louise was trying to find alternative accommodation so as to escape from Kathleen's drinking and abuse. As a result of that incident Kathleen engaged with Lifeline stating that she wanted to address her habit. A risk assessment was carried out although this considered the risk to Kathleen from her former partner, but not to Louise. Given Lifeline had no information at that time to suggest there was any risk to Kathleen from Louise that was a reasonable step to take. At the same time Louise made a decision not to leave home and instead told the College that she was staying to look after her mother. The panel believes this suicide attempt by Kathleen was controlling behaviour and may have been an attempt to stop Louise leaving.

8.9 The panel discussed these events and whether, had the relationship between Kathleen and Louise been an intimate one as opposed to mother/daughter, organisations may have responded differently. They believe this case highlights that professionals need to understand there are different aspects to domestic abuse. These include controlling behaviour that does not always present in the context of an intimate relationship between opposite or same sex partners.

8.10 Despite Kathleen's attempts to remain abstinent, which were partially successful, it appears she engaged in a significant bout of drinking over the Christmas period. On 02.01.2014 she contacted Lifeline and told them about her drinking together with the fact that Louise had tried to smother her. Staff at Lifeline dealt with the disclosure by advising her to report the matter to the police but she declined and insisted it remain confidential. Lifeline staff and management took a conscious decision not to breach this confidentiality believing instead they could put measures in place to protect Kathleen.

8.11 The panel believe this case presented grounds upon which Lifeline should have breached the right of Kathleen to confidentiality. However they felt it was important to complete the analysis based on what was known at the time and against the contemporary policies and operating framework, as opposed to hindsight. The "reasonableness test" was applied and they believe that the member of staff at Lifeline who received the information from Kathleen did not appreciate the potential magnitude of what they were being told and neither did the manager who was consulted.

8.12 Matters escalated during the following days and there is evidence that Kathleen and Louise argued and that Louise told friends about the behaviour of her mother. Evidence from these friends reveal that the mobile telephone numbers for Kathleen and Louise had the same very derogatory label.

8.13 Kathleen left a message on Southport College answering machine disclosing that Louise had attempted to smother her and during that same evening Louise actually carried through that act and killed her mother. It is absolutely clear the College had no opportunities to respond to that call, nor did they have any evidence or indication during their conversations and dealings with Louise that she had attempted or was contemplating such an act. The panel also believe there is no evidence to support Kathleen's claim they were giving Louise the wrong advice. All the evidence appears to confirm Southport College were trying to signpost Kathleen towards what they believed were the right services.

9. PREDICTABILITY/PREVENTABILITY

9.1 In coming to a conclusion on these issues the panel once again felt it was important to complete the analysis based on what was known at the time. They applied the "reasonableness test" and were careful to ensure the magnitude of the events did not prejudice their thinking. The panel concluded that, while there were missed opportunities to assess risk, the death of Kathleen was neither predictable nor preventable.

10. RECOMMENDATIONS

10.1 The Agencies recommendations appear in the Action Plan at Appendix 'B'.

10.2 The DHR panel recommendations appear below and also in the Action Plan;

i. That Sefton CSP reviews its domestic abuse policies, and works with its partners to review their policies, so as to ensure it is clear when confidentiality can be breached and how suspicions of crime should be reported;

ii. That Sefton CSP reviews its domestic abuse policies, and works with its partners to review their policies so as to ensure that the circumstances in which behaviour amounts to abuse is clear and how it should be reported;

iii. That Sefton CSP works with partners to review their domestic abuse policies so as to ensure that direct questions are asked of those who abuse alcohol to establish if they present a risk of being a perpetrator or victim of domestic abuse;

iv. In delivering these recommendations Sefton CSP should reinforce to partner agencies the complexities of family violence within a domestic abuse framework. In doing so they should consider using the death of Kathleen as a case study. It illustrates well that domestic abuse occurs in many different relationships between family members and not just between those who are, or have been, in an intimate relationship.

v. That agencies who are commissioned to provide services should be required to inform their Commissioners when they become engaged in a DHR and of any recommendations arising.

Appendix 'A'

Definitions

Domestic Violence and Abuse

1. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 and is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

   Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

   Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

2. Therefore, the experiences of Kathleen and Louise fell within the various descriptions of domestic violence and abuse.

Risk Assessment Terms

Merseyside Risk Identification Toolkit (MeRIT)

3. MeRIT is the risk assessment model currently by Merseyside Police and partner agencies. MeRIT is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference [MARAC].

4. Police officers who attend domestic abuse incidents use the MeRIT tool to identify the level of risk faced by the victim. Information gathered, together with any additional comments by the officer are submitted to the Family Crime Investigation Unit (FCIU) using a Vulnerable Person Referral Form 1.

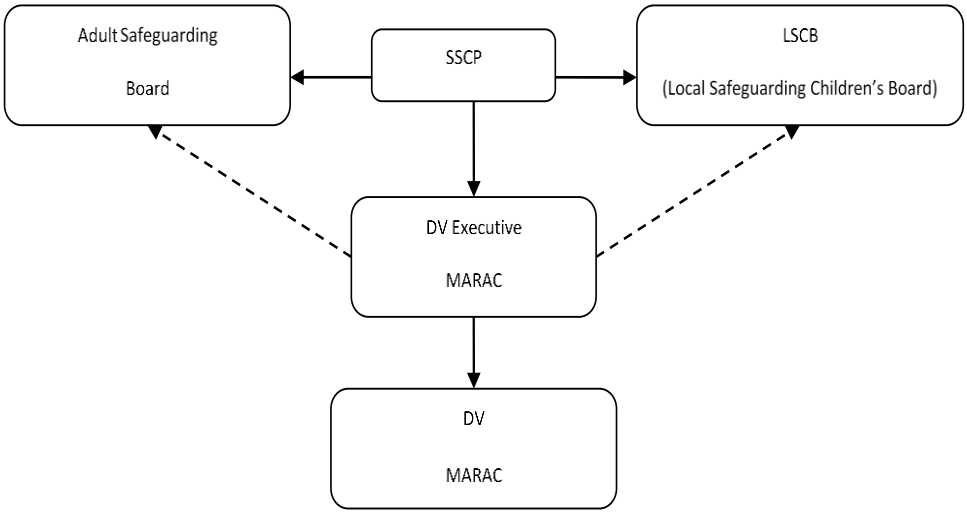
5. A trained assessor in the FCIU reviews and categorises the risk to the victim of abuse. The FCIU risk assesses victims of domestic abuse and categorise them as Gold, Silver or Bronze. Gold victims suffer the highest risk of further abuse which could amount to serious harm.

6. The FCIU use the information contained in the VPRF 1 document to populate a database entitled 'PROTECT' where all incidents of domestic abuse are held.

During the risk assessment process the FCIU identify actions designed to reduce known risks to the victims and this can include referrals to other agencies or a multi-agency risk assessment conference (MARAC).

7. MARACs are meeting where information about high risk domestic abuse victims is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim.

Governance arrangements in Sefton



8. Sefton Safer Communities Partnership (SSCP) and Local Safeguarding Children's Board (LSCB) have identified Domestic Violence as a core priority recognising the significant impact upon Communities.

9. SSCP has responsibility for all crime and community safety issues in Sefton. The CSP is chaired by the Cabinet Member Safer Communities and Neighbourhoods.

10. DV Exec is a specific group to look in detail at the top level repeat cases and identify specific MARAC actions to address what is causing the repeats.

11. DV MARACs are meetings where information about high risk domestic abuse victims is shared between local agencies and appropriate actions defined.

12. LSCB (Local Safeguarding Children's Board) is the key statutory mechanism for agreeing how organisations will cooperate to safeguard and promote the welfare of children and young people.

Support to Victims

13. Currently those individuals experiencing domestic violence have access to a range of support services provided through the Council and voluntary sector these include the following.

14. VVAT Support high risk domestic violence victims and all high risk sexual violence victims and all MARAC cases; provide crisis interventions, undertake full needs and risk assessment and sanctuary assessments; assist with safety

and support plans and act as an advocate on behalf of the victim in dealing with other agencies.

15. SWACA Offer long term specialist support for women who experience domestic abuse, Refuge accommodation and children's service for children and young people who have experienced or lived with domestic violence.

16. Venus Women's organisation offering info & support (on issues such as housing, benefits, etc.), volunteering, day trips, residential.

17. Voice4Change. An Independent support and counselling service for male and female victims of Domestic Violence.

18. RASA Sefton provides essential crisis and therapeutic support to survivors of sexual violence by offering support and counselling. RASA works with all individuals who have been victims of sexual violence at any time in their lives.

19. Aspire (Sefton) Female offenders access supervision appointments within SWACA. Packages of support are developed by Offender managers and SWAN centre.

20. Probation perpetrator programmes. For male offenders who are convicted of any offence related to violence against their partner or ex-partner.

21. NoXcuses: Approx 30 week Voluntary Perpetrator Programme facilitated by Sefton Family Support Workers. Referrals made by Social Workers. Partner support offered by SWACA. Currently a pilot programme.

Review of Domestic Abuse

22. A sub group of the LSCB agreed a review of domestic violence should be carried out to provide an up to date picture of the key issues facing Sefton, what services are currently on offer, identify any gaps, and actions that need to be developed to start addressing these. A report was completed in 03.2014 incorporating learning from two domestic homicides and a plan has been produced which identifies areas for improvement.

23. A Domestic and Sexual Violence Strategy is currently under development that will incorporate lessons to be learned from this and two other Domestic Homicide Reviews.

Action Plan **Appendix B**

Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Review domestic abuse policies, and work with partners to review their policies, so as to ensure it is clear when confidentiality can be breached and how suspicions of crime should be reported;	As part of Sefton's Domestic and Sexual Violence Strategy – work with key partners to review policies and procedures around safeguarding procedures and sharing information Started as part of mapping work September 2105 - ongoing	Updated policies and procedures	Consistent approach to information sharing when confidentiality must be breached for safeguarding reasons	Sefton CSP	March 2016
2	Review domestic abuse policies, and work with partners to review their policies so as to ensure that the circumstances in which behaviour amounts to abuse is clear and how it should be reported;	As part of Sefton's Domestic and Sexual Violence Strategy – support to partners about what domestic violence can involve: offer of training, staff briefing sessions Partners to review policies and procedures so training outcomes reflected in these Started as part of mapping work September 2105 - ongoing	Updated policies and procedures	Clear and Consistent referral pathways Clear and readily accessible information about services available in Sefton	Sefton CSP	March 2016
3	Work with partners to review their domestic abuse policies so as to ensure that direct questions are asked of those who abuse alcohol to establish if they present a risk of being a perpetrator or victim of domestic abuse;	As part of Sefton's Domestic and Sexual Violence Strategy – work with partners to highlight need for routine questioning Started as part of mapping work	Updated policies and procedures	Clear identification of domestic violence risk factors associated with alcohol misuse	Sefton CSP	March 2016

		September 2105 - ongoing				
4	In delivering these recommendations reinforce to partner agencies the complexities of family violence within a domestic abuse framework. In doing so they should consider using the death of Kathleen as a case study. It illustrates well that domestic abuse occurs in many different relationships between family members and not just between those who are, or have been, in an intimate relationship.	As part of Sefton's Domestic and Sexual Violence Strategy – development of 'Sefton offer' promotional info on domestic violence services; updated webpage on Council website – available www.sefton.gov.uk/behindcloseddoors Review of existing training opportunities available for partners across Sefton – to ensure highlights different forms of domestic abuse. Work started on this September 2015 – ongoing	Updated DV training programme Updated promotional information	Clear and readily accessible information about services available in Sefton Promotional information highlights the different forms of domestic abuse	Sefton CSP	Promotional Info completed Dec 15 March 2016
5	That agencies who are commissioned to provide services should be required to inform their Commissioners when they become engaged in a DHR and of any recommendations arising.	As part of Sefton's Domestic and Sexual Violence Strategy – Nhoods & Partnerships to work with Commissioning and contracts teams to consider how this could be done Initial conversations started and ongoing, particularly in relation to Public Health contracts.	Dependent on outcomes of discussions	Consistent approach to DHR involvement and learning	Commissioned Services within Sefton CSP area.	April 2017

Agency Recommendations- NWAS						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	To review Domestic Violence content for mandatory training.	Review Induction Training for all new staff and for bi annual mandatory training. Include indicators of domestic abuse and professional curiosity.	Updated mandatory training	Increase awareness of domestic violence and early intervention or support for patients at risk.	Vivienne Forster.	31/1/2015
2	Publish learning lessons from this review in the 'Clear Vision' Bulletin.	Write an article highlighting the importance of risk assessment and information sharing in relation to domestic abuse.	'Clear Vision' article	Increased staff awareness in relation to risks associated with domestic abuse and support guidance and supervision available to staff	Vivienne Forster	31/01/2015
3	Debrief and reflective learning with staff involved with Kathleen and Louise.	Arrange meeting to de-brief the staff in relation to this case with a focus on practice and lessons learned.	Evidence from Advanced Paramedic this has taken place.	Support to staff in a safe learning environment while learning and increased awareness of the issues occurs.	Vivienne Forster and Andrew woods (Advanced Paramedic)	31/01/2015
Agency Recommendations- Lifeline						

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	Recommendation (internal and external) Lifeline to approach SWACA to see whether they can provide a training session to the team in Sefton – to (i) confirm the team's understanding of appropriate responses to disclosures of domestic violence, (ii) describe the support that they can offer and in the circumstances in which they can provide support, and (iii) support us to reflect on whether our usual responses to disclosures of domestic violence should be any different if the perpetrator is the victim's child, sibling, etc.	Within six months, approach SWACA to see whether they can provide a training session to the Lifeline Sefton staff team covering the three areas detailed in the recommendation. Organise staff availability and rotas to ensure the maximum number of members of the team are available for this briefing. Sefton Safeguarding and Governance lead to feed back any areas relevant to Lifeline's organizational understanding of domestic abuse to operational managers and Clinical Governance Lead	Within six months – either (a) notes and attendance records from SWACA training session, or (b) correspondence showing that SWACA were unable to provide training If there are any areas relevant to Lifeline's organizational understanding of domestic abuse, these will be incorporated into Lifeline's Safeguarding policy,	Increased awareness of appropriate responses to disclosures of safeguarding amongst the Lifeline Sefton Team. If identified, an improved organizational understanding of effective responses to domestic abuse cases that do not follow a male-female partners category	Lifeline Sefton Safeguarding and Governance Lead Lifeline Sefton Safeguarding and Governance Lead and Lifeline Clinical Governance Lead	16/12/14 31/12/14
2.	Review staff awareness of their role in responding to disclosures of domestic abuse, and confidence in fulfilling these roles – with individual development plans to address any identified needs	Within three months, undertake a review of staff awareness and competency in responding to disclosures of domestic abuse within the Lifeline Sefton team.	Completed domestic abuse competency audit. Examples of	Assurance that all current staff are aware of their roles in responding to disclosures of domestic abuse	Lifeline Sefton Safeguarding and Governance Lead	16/9/14

		Identified developmental areas to be incorporated into personal development plans	personal development plans including developmental needs identified through this audit			

Agency Recommendations- Southport College

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	To have one central tracking document per student.	Develop and implement a new single tracking document for each student receiving support.	Tracking document will be held in each file.	The tracking document will provide an overview to anyone reviewing the student. It can be used to check and cross reference that all notes, messages etc listed are held on the file and identify gaps and/or any delays in follow up action.	Director of Quality and Support	October 2014
2.	Advice should be sought from the LCSB as to the appropriateness of key College staff having a Level 3 Safeguarding qualification.	Level 3 Safeguarding training to be completed by staff if it is considered appropriate and	Course completed	College staff are trained above the minimum requirements.	Director of Quality and Support	June 2015

		available from LCSB				
3.	External supervision should be available to staff with safeguarding responsibilities.	College to source appropriate external supervisor.	Records of supervision meetings.	Staff feel supported and have an opportunity to off-load, discuss and review cases, share good practice and identify improvements/changes to existing practices and systems.	Director of Quality and Support	March 2015
4.	Implement a new model of delivering conduct, welfare and support in College. Review Student Services staff roles and functions and ensure roles are more clearly defined.	Review roles, responsibilities and delivery models for conduct, welfare and support and make appropriate structural changes.	Review completed.	Student Services roles more clearly defined. The priority of key staff with Student Services remains safeguarding cases. Welfare and conduct matters are managed at source within curriculum	Director of Quality and Support	March 2015

				departments.		

End of Report for Publication