Domestic Homicide Review

Executive Summary

Report into death of ‘Dawn’

Died October 2021

Report Author and DHR Chair: Stephen McGilvray

Date: February 2025

Trigger warning – this report discusses issues regarding self-harm and suicide.

Contents

Glossary

CMHT	Community Mental Health Team
CPA	Care Program Approach. A process which provides support for patients who have a long enduring mental health condition or those who have a range of complex needs which require the support from secondary mental health services to support and co-ordinate their care.
DASH	Domestic Abuse Stalking and Harassment risk assessment checklist.
DVPO	Domestic Violence Protection Order.
Housing First	Developed to provide accommodation for homeless people.
IDVA	Independent Domestic Violence Advocate.
ISVA	Independent Sexual Violence Advocate provides support to victims of sexual violence.
IRISi	A social enterprise established to promote and improve the healthcare response to domestic violence and abuse.
LUFHT	Liverpool University Hospitals Foundation Trust NHS
MARAC	Multi-Agency Risk Assessment Conference
MARAM	Multi-Agency Risk Management. The MARM Framework is designed to support anyone working with an adult where there is a high level of risk and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial.
MeRIT	Domestic abuse risk assessment checklist developed and used by Merseyside Police.

Ruby Project	A domestic abuse service for victims living in Liverpool, Sefton, Knowsley and St Helens. It offers practical and emotional support to victims from a highly skilled and trained team of domestic abuse practitioners.
SDGH/Mersey & West Lancashire Teaching Hospitals NHS Trust.	Formerly Southport and Ormskirk Hospital NHS Trust on1st July 2023 this Trust combined with St Helens and Knowsley Teaching Hospitals NHS Trust and now operates under its new name
Section 2 Notice	Section 2 of the Care Act 2014 facilitates a planned discharge of patients currently admitted to hospital who have care and support needs.
Section 5(2) Order	Made under the Mental Health Act 1983 is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensures their immediate safety whilst the assessment is arranged.
SWACA	Sefton Women and Children's Aid whose aim is to safeguard women, young people and children. Our dedicated team supports them in surviving the impact of domestic abuse by giving free, practical and emotional help.
VPRF1	Merseyside Police Vulnerable Persons Referral Form completed at the scene of a domestic abuse incident by Police Officers which includes a risk assessment checklist.

1. The Review Process

1.1. This summary outlines the process undertaken by Safer Sefton Together Domestic Homicide Review Panel in reviewing the death of Dawn who was resident in their area. Pseudonyms have been used in this Review to protect their identities and those of their family members.

1.2. The following pseudonyms were agreed by the family of Dawn and the Panel and are used throughout this report to protect the identity of the individual(s) involved.

- Dawn Deceased Aged 46 years
- Ewan Perpetrator Aged 44 years
- Francis Ex Partner

1.3. There are no criminal charges arising from Dawn's death.

1.4. In November 2020 Merseyside Police notified Safer Sefton Together about the death of Dawn. Members of the Safer Sefton Together Partnership then met and agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within the Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016.

1.5. Dawn had died from an overdose of prescription drugs together with traces of illegal substances in a flat owned by her friend in Cheshire. Dawn had been housed in a hotel in Cheshire which had been provided as a temporary place of safety for Dawn following an incident of domestic abuse. Because of the long history of domestic abuse and agency involvement with Dawn in the Sefton area of Merseyside the Safer Sefton Together Partnership agreed to complete the Domestic Homicide Review and advised Cheshire Police and H.M. Coroner in Widnes of this decision.

2. Contributors to the Review

2.1. The following agencies submitted Individual Management Reviews (IMR):

Adult Social Care, Sefton Council

Change Grow Live

HMPPS. (Probation)

Housing Options, Sefton Council

Housing First

Sefton IDVA Service, Sefton Council

Liverpool University Hospitals NHS Foundation Trust

Sefton MARAC, Sefton Council

Mersey Care NHS Foundation Trust

Merseyside Police

One Vision Housing

NHS Cheshire and Merseyside Integrated Care Board.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Sefton Women and Children's Aid

Liverpool MARAC, Liverpool Council

Venus

PSS Ruby Project

2.2 The authors of the IMR's had no prior involvement with Dawn or her family nor had they had direct supervisory responsibility for those engaged with the family.

3. The Review Panel Members

3.1. The DHR Panel established by Safer Sefton Together comprised the following agency representatives:

Louise O'Rourke	Sefton MARAC, Sefton MBC
Nat Hendry-Torrance	NHS Cheshire and Merseyside
Sue Platt	Sefton Women and Children's Aid
Cherry Collison	NHS Cheshire and Merseyside ICB
Holly Chance	Merseyside Police
Carla Whittaker	Mersey Care NHS Foundation Trust.
Sharon Seton	Mersey and West Lancashire Teaching Hospitals NHS Trust
Felicity Shepley	Adult Social Care Service, Sefton MBC
Michelle Dean/Johnathon Platt	HMPPS. (Probation)
Claire Mumford	Liverpool University Foundation Trust Hospital
Rita Chambers	The Ruby Project
Kelly Miller	Change Grow Live
Allan Glennon	Housing Options, Sefton MBC
Suzanne Meylan	One Vision Housing
Ellie Moss	Housing First
Janette Maxwell	Sefton IDVA Service, Sefton MBC

3.2 No member of the Panel had any contact with Dawn and her family prior to this review nor did they have direct supervisory responsibility for staff within their agency who had contact with the family. The Panel met a total of six times.

4. Chair of the Review Panel and Author of the Report

4.1 Safer Sefton Together commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in September 2022. Stephen McGilvray is also the author of this Overview Report.

4.2 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 18 years ago that Stephen retired from Merseyside Police.

4.3 On retirement from the Police Stephen was appointed as Head of Community Safety in a different Local Authority area where he worked for nine years. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children. During the period this unit was under Stephen's management the team achieved CAADA/SafeLives Leading Lights accreditation for the quality of its systems and risk management processes.

4.4 Whilst Head of Community Safety Stephen also had management responsibility for the Integrated Offender Management Unit, a multi-agency collocated team of Police, Probation, and Substance Misuse workers whose role was to reduce the level of threat and risk posed by offenders, including perpetrators of domestic abuse.

4.5 Stephen has successfully completed the Home Office training course for Chairs of DHR's and has Chaired and authored Overview Reports for several Domestic Homicide Reviews as well as taking part in a number of Serious Case Reviews.

4.6 Before undertaking this Review Stephen McGilvray has not had any involvement with the individual's subject of this Review, nor is he employed by any of the participating agencies.

5. Terms of Reference for the Review

5.1 In accordance with the statutory guidance for the conduct of Domestic Homicide Reviews (DHRs), the Panel agreed that the purpose of this DHR was to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked 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 upon, and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working.

5.2 Following the first meeting of the Panel, members were asked to secure all documents relating to their agency's involvement with Dawn and her family and to utilise those documents to complete chronologies of their involvement and contact with the family. Following agreement between the family and the Panel the following key lines of enquiry were agreed.

1. Do the actions of agencies and of MARAC show a co-ordinated and planned approach to the interconnected issues impacting upon Dawn?
2. Were powers which are available to agencies, and which may have provided support and protection to Dawn used effectively?
3. What is the strategy to overcome difficulties in making contact with victims of abuse for the purpose of safety planning and did it work effectively in this case?
4. Is the strategy to support victims who are repeatedly assessed as being at high risk of further abuse robust enough to protect them?
5. The banks expressed concern over access to and use of Dawns account. Were those concerns investigated effectively?
6. How effective was the management of risk and safeguarding by and between agencies.

6. Summary chronology

6.1 At age 19 years whilst living in a part of Lancashire Dawn had given birth to a child however Dawn had substance misuse issues which increased her vulnerability' and 'despite her protective efforts, the child remained a risk from his (the perpetrator's) behaviour' as a result the child was taken into care and later adopted. The child remained living in Lancashire. Ewan was not the father of this child, and the father of Dawn's child took no part in this review. It is not believed that Dawn maintained any form of contact with her child though grandparents did maintain contact for several years on occasions of birthdays and Christmas.

6.2 Dawn, her parents and her younger brother then moved to live in Sefton where she met and began a relationship with Ewan. At the time of her death Dawn had been in a relationship with Ewan for 26 years.

6.3 Incidents of domestic abuse involving Dawn in which her long-time partner Ewan was named as the perpetrator had been discussed at Sefton MARAC first in 2015 and in total 10 times before her death in 2021 and three times at Liverpool MARAC in 2015, 2018 and a third time in 2021 just one month before her death. Dawn declined to work with support agencies including hospitals and the Police throughout the period reviewed which she disclosed was because of her fear of repercussions had she done so.

6.4 In August 2015 Dawn called Police she alleged Ewan sexually assaulted her but later withdrew that allegation, she stated that Ewan was not her partner just a friend.

6.5 On 29 October 2015 a MARAC meeting discussed an incident involving Dawn and Ewan. Notes of the meeting revealed that there had been no domestic abuse incidents reported to Police and no callouts to Dawn's address. Ewan was open to and actively engaging with Lifeline (Drugs Service). IDVA reported that Dawn was now in refuge in St Helens and intended to remain in the area. The action from the meeting was for a MARAC-to-MARAC transfer to be completed to St Helens.

6.7 As an inpatient on a Mental Health Ward in July 2016 Dawn during assessment by a Doctor reported feeling very distressed with a number of issues. She has thoughts to self-harm, thoughts she cannot go on, guilty feelings towards her mum about how her self-harm may affect her mum, grief for a broken relationship and a child that was placed into care some years earlier.

6.8 In May 2017 the hospital Mental Health Liaison Team received a referral for Dawn from the hospital Critical Care Unit where she was receiving treatment following an overdose. It was the plan for Dawn to be allocated a mental health assessment. Four days later Dawn was discharged prior to mental health assessment taking place.

6.9 On 21st July 2017 Police received an abandoned 999 call. A male and female were heard arguing in the background, the male calling her a '*scumbag*' and she asks why he was spitting in her face. Police Officers traced the call and attended Dawn's home address where Dawn was seen safe and well, and Ewan arrested for Common Assault on Dawn and the unlawful Abstraction of Electricity. Dawn did not support a Police prosecution for the assault. Police officers did consider issuing Ewan with a DVPN but decided it was not necessary as Ewan was charged with assault. A VPRF 1 was completed and assessed the risk of future violence as low.

6.10 In July 2017 Dawn received treatment as an in-patient on a Mental Health Ward. She was seen by a Doctor but there is limited documentation to evidence what the reasons were which were causing her distress. However, Dawn kept returning to topics of harming herself and advised that she had every intention of killing herself if she left the ward. The next day a ward review including a Consultant Psychiatrist examined Dawn. A diagnosis recorded that Dawn was suffering mental and behavioural disorders due to multiple drug use, and Emotionally Unstable Personality Disorder. Staff at the hospital were to continue to support Dawn in finding safe accommodation. There is no indication within records that Adult Care Services were involved in this care plan.

6.11 After receiving treatment for one week as an inpatient on the mental health ward Dawn signed a Discharge against Medical Advice form, she was provided with

seven days medication and agreed to work with the CMHT and drug team. The issue regarding accommodation had still not been resolved and Dawn reported that she is going to stay with her friend in until a refuge place is found.

6.12 Following an assessment by the Mental Health Liaison Team at Aintree Hospital also in July 2017 Dawn was diagnosed as suffering Emotionally Unstable Personality Disorder and also suffers from substance misuse which may impact upon her ability to safeguard herself.

6.13 On 16th August 2017 a Section 2 Notice was sent by Aintree Hospital to Adult Social Care. Dawn had been admitted to hospital due to a complaint of epigastric pain where she disclosed that Ewan had assaulted her. Adult Social Care recorded that this Section 2 Notice was not progressed to a safeguarding review due to Dawn having capacity and no care/support needs and that she has been sign posted to agencies which support victims of domestic abuse.

6.14 In terms of this incident there was no completion of a MERIT assessment and a referral to MARAC or completion of a VPRF 1 by officers speaking to Dawn. Aintree Hospital did complete a risk assessment of Dawn which assessed her as being at high risk of future violence or homicide, but this assessment was not referred to either the MARAC or IDVA service.

6.15 In a follow up to this incident the Ruby Project after meeting Dawn did assess the risk, she faced which showed the level of risk to be high and a MARAC referral was made. The perpetrator in this risk assessment was identified as Ewan and the Ruby project continued to provide Dawn with ongoing support around a sexual assault.

6.16 In October 2017 Dawn was being supported by staff at the Venus Project. Dawn disclosed to them that she has been taking opiate based drugs. Additionally, she has been to 5 different G.P.'s in 5 weeks and there were concerns about why she is doing this.

6.17 One month later Venus again spoke to Dawn. She admitted to smoking heroin. She also said that Ewan has been coming to see her at the flat but

not staying over. Dawn also said her benefit is being paid in to his bank account which is a worry as he has control over her finances.

6.18 In January 2018 Dawn attended the Accident and Emergency Department with her mum having been advised to do so by her pain management consultant at Broadgreen Hospital Liverpool. She was seen at the hospital by the Mental Health Liaison Team and during her appointment she had become very distressed and divulged significant information regarding abuse towards her by her partner and also information her partner had given to her regarding serious criminal activity. Dawn reported that she had been the victim of domestic abuse for some 20 plus years by her current partner. Dawn reported that her partner has told her he has committed murder at an earlier time and that he was expecting her to take items into one of the Liverpool prisons that evening which she said she was not going to do as this would put herself at risk.

6.19 There is no record of any action being taken in response to the disclosures Dawn made. There is no record of a DASH risk assessment being completed, nor a referral to MARAC or Adult Safeguarding being made nor had the information been shared with Police.

6.20 On 2nd July 2018 DAWN contacted Merseyside Police to report being threatened earlier that day by Ewan and his new girlfriend. She had called at his home to get her benefit money which was still being paid into his bank account. Ewan threatened to shoot her. A VPRF 1 completed by officers attending this incident assessed Dawn as being at high risk of future violence. Police arrested Ewan but he denied all allegations. CPS did not approve any charges and no further action was taken.

6.21 Two days later this incident was discussed at MARAC who agreed actions for Police to ensure a ‘test on arrest’ marker be placed on the PNC for Ewan and a Trace and Locate marker be placed on the PNC for Dawn whose whereabouts were unknown at the time of the meeting.

6.22 One month after her first warning from the Police for being a sex worker Dawn received a second warning. Police Officers referred Dawn to Changing Lives a

charity who provided support to sex workers who had been assaulted but Dawn did not engage with when they contacted her.

6.23 Concerns were raised by the Homeless Section of Sefton Council. They record that "*We have some safeguarding concerns regarding Dawn which have been reported to Careline. She was moved to a Hotel, in Anfield last night after a breakdown of her current placement. These concerns are centred on a male partner who has been staying*". The Homeless Section raised the option with Sefton Adult Safeguarding service that if they had any further information/concerns about domestic abuse "*it may be worth meeting up to discuss and ensure safety going forward"*. The Homeless Section also identified that "*hopefully we will have some permanent accommodation for Dawn sorted quite soon*".

6.24 On 12th February 2020 a referral was received by the MARAC administrators from the Probation Service for Dawn with Ewan named as the perpetrator which assessed the level of risk Dawn faced as being high. Dawn stated that she kicked her partner out of the flat yesterday as he has been violent towards her, punching her, threatening her with knives, stopped her going out and has taken control of all her finances. Dawn says that when she told him to leave yesterday, he took all of her shoes and her medication. Dawn has refused to make a statement to the Police as she says he is involved in drugs and gangs, and she would be fearful of the repercussions should she make a report. She admitted to punching Ewan in self-defence.

6.25 On 13th February 2020 Dawn attended SDGH Accident and Emergency Department with abdominal pain, caused by her pancreatitis. Dawn reported that she had been punched in the back by Ewan two days ago however she was discharged following x-rays. There was no professional curiosity shown by staff at the hospital in relation to Dawn reporting an incident of domestic abuse two days previously, and no internal referral made to hospital safeguarding team.

6.26 After attending the hospital and speaking to Dawn the Police made a referral to SWACA regarding this assault. SWACA being unable to contact Dawn by

telephone then sent a letter offering support to Dawn and including SWACA contact details. The letter was sent to the home address Dawn shared with Ewan the perpetrator of the latest assault. The Panel were unable to find a MeRIT or DASH risk assessment completed following this disclosure.

6.27 In April 2020 Dawn disclosed that she had offered violent resistance to Ewan stating that "*if he assaults me, I just batter him back so he isn't doing it so often anymore."* There is no further record of Dawn disclosing her use of violent resistance.

6.28 On 30th April 2020 the Ruby Project and Probation Service held a meeting regarding Dawn. Housing First advised that Locks have been changed on Dawn's house and Ewan was no longer living there. During the Housing First telephone call with Dawn she had disclosed to them that Ewan had begun intravenous drug use and would wake her up during the night and physically assault her by kicking her to the stomach. She reported that he frequently spits at her and is increasingly verbally abusive since his escalation in drug use. She stated that he takes her medication from her. Dawn was asked if she was able to speak freely and she replied that she didn't understand why the Police were called and that Ewan had not hit her or done anything to her. The support worker heard Ewan in the background telling Dawn what to say including tell her "*I haven't hit you or anything*". The support worker then received a text off Dawn saying, "*can't talk I'm ok ta*".

6.29 On 23rd July 2020 the Probation Service held a meeting with Dawn present. The meeting discussed a plan of action regarding her housing needs. Dawn stated that she has been using spice for the past week. She says Ewan has been feeding her the Spice and she does not want to be on it. Dawn states that she has now kicked Ewan out of her home, but he must return to get his stuff. Dawn states she would like to engage with the Ruby Project and counselling. Dawn states she has been diagnosed with a personality disorder and states she has also been hearing voices so would like some support with her mental health.

6.30 This incident was discussed at the CMHT Multi-Disciplinary Team (MDT) meeting. The following issues impacting upon Dawn were raised. Ongoing

issues with neighbours, and problems with her current relationship. She was experiencing stress and anxiety, was the victim of domestic violence, and has not been taking medication as directed. She has a history of self-harm. The outcome of the MDT meeting was for a routine Outpatient Appointment to be made for Dawn. Contact was also made with Dawn by the IDVA service the outcome from which was that Dawn did agree to speak to someone in the team.

6.31 In November 2020 Staff at SDGH contacted Police regarding Dawn. Dawn had told them Ewan threatened to visit the hospital the previous day and also said he would kill her. Dawn said she feared for her mother and other family members. She spoke about old injuries from a catalogue of incidents and asked to be placed in a Refuge and for an Injunction to be obtained against Ewan. She said that she was willing to engage with Police.

6.32 Following this contact from the hospital Merseyside Police took part in an emergency strategy meeting arranged in light of the new information and the increased level of threat from Ewan. At this meeting it was decided that hearsay statements should be taken from those to whom Dawn made the disclosures and attempts should be made to arrest Ewan. Ewan was located and arrested that evening however, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to charge Ewan with any offences and he was released.

6.33 In February 2021 Dawn attended the Accident and Emergency Department of a local hospital, having been brought in by Ambulance, and was reporting abdominal pain and a safeguarding concern. Dawn stated that she was in pain because her partner Ewan has attacked her on Saturday 13th February and Sunday 14the February 2021. Dawn stated that an argument occurred, and she was then kicked in the left leg, this bought her down to the floor where she was kicked repeatedly in the abdomen.

6.34 A Hospital Safeguarding practitioner attended the Accident and Emergency Department to speak with Dawn; however she had called for a taxi stating she now felt safe to return home as the perpetrator had left the property, and she declined any further support.

6.35 On 30th April 2021 Dawn was taken to hospital by ambulance which had been called by her partner Francis after he had found Dawn unconscious following her administering a mixed overdose of diazepam, amitriptyline and diamorphine, she was intubated and transferred to ITU. Liaison took place between the Hospital Safeguarding Team and Adult Care Services Safeguarding Team who shared information that Dawn was reported to be in a new relationship and to be eight weeks pregnant.

6.36 Francis stated to that he and Dawn had argued prior to her taking an overdose and she had left a note. Due to concerns for her safety, she was detained under provisions of Section 5(2) of the Mental Health Act and referred to Mental Health Services for Assessment. Dawn said that this was an unintentional overdose stating that she had not been taking all her medications recently and she wanted to go to sleep but did not want to harm herself. She-reported to be in a new relationship and was very happy with no Domestic Abuse taking place within the relationship.

6.37 On 24th May 2021 the Fire Service contacted Merseyside Police, advising that they were dealing with a fire at Dawn's home, and they believed Dawn may have tried to kill herself. Neighbours who were alerted to the fire saw Dawn at a window with flames visible, but she ignored their calls to exit the flat. One neighbour smashed the window and pulled her out, whereupon she ran screaming down the road. Dawn was located on a road near-by and taken to hospital by Ambulance having taken an overdose of Diazepam and Pregabalin medication and suffering from smoke inhalation. The fire was confirmed as a deliberate ignition and Dawn was arrested for an offence of committing Arson with Intent to Endanger Life.

6.38 Three days following Dawn's admission into hospital she was assessed by a Mental Health Practitioner from the Crisis Resolution and Home Treatment Team for informal admission to mental health ward. Dawn stated that she has been getting threatening text messages on her phone, she couldn't disclose who they were from and exactly what they said as she is fearful of reprisal resulting from any disclosures. Diagnosis following the assessment noted a significant suicide attempt in context of ongoing social stressors, possible substance misuse and

issues with emotional dysregulation. Dawn shows no regret regarding overdose and is still intent on ending her life.

6.39 On 29th May 2021 the Crisis Resolution and Home Treatment Team again assessed Dawn following her admittance to hospital. The Team asked Dawn why she had not engaged with the Crisis Resolution and Home Treatment Team when referred to them at the start of May 2021. Dawn replied, '*because I had the wrong people around me*'. When asked what would be different for involvement this time around and she stated *'those people have gone. I'm struggling I need help'.* As a result of this further assessment, it was considered that Dawn would remain an unpredictable risk to herself which is chronic in nature. Both subjective and objective current needs do not require admission to a mental health acute inpatient ward and that Dawn has the capacity to make decisions regarding her health at this time.

6.40 On 9th June 2021 Santander Bank made a Safeguarding referral to Adult Care Services expressing concerns of financial abuse. Dawn's account transactions did not fit her recent circumstance with regards to her being in hospital. This information was transferred by Adult Care Services to Mental Health Services North for their safeguarding staff to follow up.

6.41 On the 14th July 2021 Dawn reported to the Mental Health Liaison Team taking an impulsive overdose of medication with suicidal intent at her friend's house and denied being under the influence of illicit substances when making that decision. There was no degree of planning to her overdose, she didn't write a suicide note. She reported taking the overdose secondary to psychological trauma/feeling overwhelmed mainly in relation to her traumatic relationships with ex-partner Ewan with whom she had a history domestic violence. Dawn was regretful and she was pleased to have survived the overdose. The Consultant Psychiatrist considered Dawn to be vulnerable to acts of deliberate self-harm as a component of maladaptive coping strategies and separate from any suicidality, she denied any suicidal plans, and that the risks were mitigated by engagement with services and seeking support. The Consultant noted that this may change especially when she is under the influence of alcohol or due to unstable accommodation. There are no records available to the Panel which indicates that a domestic abuse risk

assessment or safeguarding referral was completed, nor that Dawn was referred to a trauma support service.

6.42 On 9th August 2021 Dawn took an overdose of medication requiring admission to the Intensive Care Unit. Mental Health Services were informed and Dawn disclosed to them that she had taken an overdose of all her prescribed medication, as she felt it was not working and because she had her Oxycodone medication reduced from 40mls to 10mls. Dawn informed the Mental Health Care Practitioner that since the reduction she has reverted to using heroin as a replacement. Dawn now needed methadone to prevent symptoms of opiate withdrawal.

6.43 On 16th August 2021 Adult Care Services received a Section 2 notice which detailed that the referral was made at the request of social workers with the reason given being that Dawn was being mistreated or neglected. The Notice stated that Dawn discharge date was 16th August. She lives with her partner and is a victim of domestic violence and does not have a residence which it is safe to move to on discharge. The hospital was now awaiting input regarding safe space and residence on discharge. Adult Social Care followed up the Section 2 notice and discovered that Dawn had been discharged the day before the planned date recorded on the Section 2 notice. Further enquiries showed that Dawn had been referred to the hospital social work team at University Hospital Aintree, but her discharge took place before contact was made with Dawn by the hospital social work team to offer assessment of need. The hospital social work team had not been notified of discharge.

6.44 On 24th August 2021 the Probation Service spoke with Dawn via telephone. Dawn informed them that she took another overdose at the weekend and the last two night's Ewan had assaulted her. She reported that she was in a friend's house would not give friends name or address and stated she had to be quiet because Ewan was asleep upstairs. Dawn reported that she had, had seizures in the previous days and wanted to know how they had come about. Dawn reported that she had been assaulted the previous evening by her partner, punching her in the head three times Dawn stressed that she didn't want any Police involvement. Dawn said she was vulnerable from her partner and was

going to go to the Accident and Emergency Department. The Ruby Project later provided an update following contact they had with Dawn. She has had a CT scan, and this confirmed she had suffered bruising to the brain. There is no record of a domestic abuse risk assessment being completed following receipt of this information and no referral to safeguarding services or MARAC.

6.45 On 25th August 2021 the Ruby Project spoke with Dawn at the Hospital. A record of that contact states that Dawn is not willing to assist the Police with a statement, she simply wants an injunction and safe accommodation. Dawn stated that she gets paid this evening and Ewan wants £300 off her, and it is more than likely that he will be seeking her out. Ruby referred to Dawn to the NCDV to obtain a non-molestation order and discussed safety planning with her.

6.46 On 23rd September 2021 Merseyside Police were contacted by a British Transport Police officer reporting a domestic incident at Fazakerley train station between Dawn and Ewan. He accused her of stealing one hundred and fifty pounds from him but later retracted his allegation saying he found his money. Dawn told the officer she had been kept in a shed by her partner who had punched her in the head eight times causing her to lose consciousness. She showed him a lock knife saying she would use it if necessary. Merseyside Police attended Southport Hospital later that day, following a call from a member of their staff about further disclosures Dawn had made, showing them a lighter burn on her hip, threats he made to her family if she tried to leave the shed, and naked videos he had made of her, she said she was homeless. A VPRF 1 was completed and graded high risk/Gold and a referral to MARAC made.

6.47 The Hospital ISVA attempted to source a refuge place for Dawn which was explored with IDVA Teams, the Ruby Project and the Liberty Centre but they were unable to find a space due to Dawn's complex needs. Staff arranged temporary accommodation once Dawn was fit to be discharged at a Travel Lodge Hotel in Widnes.

6.48 On 7th October 2021 a MARAC meeting discussed the referral of Dawn to MARAC following the latest incident. Police reported that Dawn had provided an initial statement in relation to Common Assault but had then made further

allegations before later denying them. The "*Police will take no further action in this case as the victim refused to provide a further statement"* Dawn was open to Adult Social Care who were looking at holding a multi-agency meeting to discuss concerns. The Mental Health representative advised that Dawn's mental health was assessed two weeks ago, and she did not require sectioning. Actions at the meeting were for Adult Care Services to consider if a multi-agency meeting was still necessary as Dawn is now out of area.

6.49 On 9th October 2021 Dawn was found dead in a room at a friend's flat in Widnes. Police enquiries showed that Dawn had visited a friend at his house in Widnes. Dawn went to the address after an argument with Ewan. The friend said Dawn was distressed after phoning the ex-partner and consumed a bag of Heroin and he later found her dead in a room at the flat.

7. Key Issues Arising from the Review

7.1 There were several interconnected issues which impacted upon Dawn. These issues included:

- Substance Misuse
- Criminal Behaviour
- Self-neglect
- Mental Illness
- Housing Issues
- Victim of domestic abuse

7.2 When faced with a crisis event affecting Dawn there are a number of good examples of a single agency initiating action. Communication and engagement with a wide range of other partners necessary to resolve the existing situation was good during these times of crisis.

7.3 Being an adult with care and support needs, due to all of the above, this impacted upon her ability to safeguard herself. However, a safeguarding referral leading to a Safeguarding Strategy meeting was never completed for Dawn.

7.4 However, away from the crisis situations which occurred a number of Panel members observe that multi-agency engagement and good communication was ad hoc, rather than a continuation of collaborative and proactive working between agencies which would have aided in reducing risk. An outcome of this failure was that not all agencies had full oversight of the interconnected issues that were impacting upon Dawn. Agencies feel they would have benefitted from more multi-disciplinary team meetings, MARAM's or professionals' meetings held more frequently as opposed to separate communication sent to all agencies. It would have been more productive to have agencies together in more regular meetings to have discussed safety management solutions together.

7.5 Panel members observed that agencies appeared to work in silo, with a lack of escalation to greater partnership/agency involvement when required, which impacted upon the multi-agency response to the management of risks associated with Dawn.

7.6 There is little evidence of MARAC or any single agency looking beyond the immediate situation and taking a coordinated approach to address the causal and contributory issues impacting upon Dawn. The outcome of this is evidence that the same issues were causing a crisis to reoccur and leading to further crisis interventions having to be made making the response to the issues faced by Dawn reactionary rather than planned.

7.7 Dawn suffered several traumas during her life, the removal into care of her child, ongoing incidents of physical and emotional abuse from a coercive and controlling partner. Sexual abuse by three different perpetrators and the witnessing of a man taking his own life.

7.8 Agency's recognised that Dawn did have complex needs and it was difficult to support her as she kept returning to Ewan. The Panel also acknowledge a lack

of resources being in place to support a trauma informed approach during the period of this review.

7.9 However, the Panel agreed that there is doubt that details of Dawn's traumatic past consistently remained front and central in the decision making of practitioners and that the need to reinforce the awareness of practitioners that working in a trauma informed manner is critical.

7.10 Hospital's in Liverpool and Sefton Accident and Emergency Departments made a number of referrals of Dawn to Mental Health Services following admissions due to self-harming or expressed suicidal ideation.

7.11 On one occasion Dawn was seen by a member of a University Hospital Aintree Mental Health Liaison team and during that assessment Dawn refused to go home, after being told she could now be discharged, due to her fear of suffering further domestic abuse and physical violence. Dawn reported thoughts of self-harm and harming or stabbing others when threatened. Dawn said that she feels 'madness' when she thinks of her partner, she explained that madness is when she has visions of herself stabbing her partner, then she feels ok, then becomes tearful and then wants to harm herself. The assessment concluded that there was no indication of a need for an inpatient admission to a mental health ward at this time. At the conclusion of the assessment neither a MeRIT or DASH risk assessment nor a referral to MARAC was completed.

7.12 Additionally Dawn had a diagnosis of Emotionally Unstable Personality Disorder (EUPD), with a Substance Misuse dependence which clinicians noted may impact upon her ability to safeguard herself yet there was no safeguarding referral to Adult Social Care made at this time nor any referral made to substance misuse services.

7.13 The National Institute for Health and Care Excellence (NICE) produces guidance for the NHS and other organisations responsible for people's health and care. They say that "*people who have a severe mental illness and drug or alcohol problem should get help under the Care Programme Approach (CPA)*

[1]. Though Dawn was referred to the CMHT following assessment by mental health clinicians in hospital there is no record of Dawn ever being referred to an MDT for assessment of her need for a Care Programmed Approach to be followed.

7.14 Mental Health Services note that Trust Risk Assessments completed for Dawn were "very focused" on her mental health rather than taking into consideration her interconnecting factors and the risk management of the safeguarding concerns.

7.15 Actions agreed at the conclusion of each MARAC meeting in the case of Dawn did not include interventions which considered the history of Dawn's abuse by Ewan and did not seek to provide a longer-term solution to prevent further abuse and increased safety for Dawn. Several actions were not requiring of a multi-agency meeting to resolve they could have been achieved via telephone call or email between agencies.

7.16 The Tackling Domestic Abuse Plan published by H.M. Government in 2022 states. "*We are clear that perpetrators are the ones who need to change their behaviour and stop offending. By relentlessly pursuing them we can make this happen. We can drive down the prevalence of domestic abuse and reduce the number of domestic homicides*" [2]

7.17 Apart from one MARAC at which an action was agreed to "consider domestic abuse work with Ewan" there were no other MARAC meetings or meetings of professionals which concluded with actions which focus upon changing Ewan's behaviour. Therefore, the risk to Dawn remained unchallenged and ever present throughout the 26 years of their relationship.

7.18 Whilst Dawn made numerous visits to Hospital's in Liverpool and Sefton for treatment of injuries following domestic abuse or following an overdose of prescribed medication and at times illegal substances, on occasions Dawn would discharge herself or be discharged by the hospital prior to assessment

[1] Coexisting severe mental illness and substance misuse: community health and social care services. NICE guideline [NG58] Published: 30 November 2016

[2] Tackling Domestic Abuse Plan - Command paper 639 (accessible) Updated 1 September 2022

of her mental health. Therefore, the opportunity for safeguarding interventions was lost.

7.19 However, on two occasions Doctors in the Accident and Emergency Departments treating Dawn applied provisions contained within Section 5(2) of the Mental Health Act 1983. This facilitated a temporary holding of Dawn on a mental health ward for a mental health assessment to be arranged and ensured her immediate safety whilst the assessment is arranged. This the Panel believe is a positive example of powers available to agencies used to provide support and protection to Dawn.

7.20 A further example of an agency's ability to provide support and protection is Housing First's use of a personalisation budget to support Dawn at times of crisis which facilitated safety measures for her.

7.21 Merseyside Police received a total of 65 calls during the period of this review either from Dawn herself or from agencies treating or supporting her. On only one occasion did the Police consider using the powers contained within the Crime and Security Act 2010 to issue a Domestic Violence Protection Notice (DVPN). On this occasion MARAC records show that issuing Ewan with a DVPN was considered but felt "not necessary as Ewan was charged with assault".

7.22 In 2017 Ewan was arrested for assaulting Dawn. The Police supported a prosecution with the use of hearsay evidence and evidence led policing. Tenacity was demonstrated when dealing with this incident but unfortunately the charge was dismissed at court. In November 2020 Ewan was arrested on suspicion of making threats to kill Dawn and an assault and battery of her. An evidence led prosecution was considered but without the key evidence from Dawn, required by the Police Decision Maker, the investigation did not progress.

7.23 In September 2021 whilst receiving treatment at SDGH following physical abuse from Ewan Dawn reported to hospital staff and Police Officers that she believed Ewan had sexually assaulted her. No evidence to support a Police prosecution for these alleged offences was secured neither was consideration

given here for the Police to make application to the Court for the grant of a Sexual Risk Order.

7.24 Reference is made within the chronology to Dawn being assessed by Mental Health Clinicians over the need for her to be admitted to a mental health ward as an in-patient. There was no evidence within the clinical records that mental capacity assessments were completed for Dawn, and Panel members note that the notion of Dawn having capacity appears to have been used to justify not intervening. There was no evidence that Dawn's executive capacity for example in response to her discharge from hospital and ability to maintain her own safety was ever considered.

7.25 If, a clinical practitioner has a concern that a patient under their care with care and support needs as defined within the Care Act 2014 is at risk or is being abused there is an expectation included within the Mental Health Trust policy that the practitioner raises a safeguarding concern with the local authority Adult Social Care after establishing the views of the patient.

7.26 The chronology clearly identifies multiple concerns which should have been shared by Mental Health Clinicians with Adult Social Care via the raising of a safeguarding concern in accordance with the Care Act 2014, and Mersey Care Trust Policy but which were not. There is no information available to the Panel to indicate that the raising of a safeguarding concern to obtain her views was ever discussed with Dawn.

7.27 Given the complexity and significant issues and risks associated with Dawn if professionals had come together in the form of a safeguarding strategy meeting, and/or a MARAM group meeting legal representation could have attended those meetings and consideration be given for an Inherent Jurisdiction to be made by the High Court to protect Dawn due to a possible compromising of her decision-making ability caused by the abuse she was being subjected to by her partner. Inherent Jurisdiction entitles the court to decide, where there is no existing law available, and where it is clear that the decision of a court is required. This could have been considered after other legislation and action had

been considered and discussed at a safeguarding strategy meeting or MARAM meeting.

7.28 Five of the MARAC meetings discussing incidents of abuse suffered by Dawn took place during Covid-19 national lockdown periods. Due to the nature of the Covid restrictions agencies ways of working and engaging with victims changed and it was no longer possible to complete actions such as home visits or face to face meetings. The only exception to this was Adult Social Care. For some agencies general staffing/resources were also extremely stretched at this time due to impact Covid19 was having on areas of service delivery.

7.29 The majority of crisis events involving Dawn occurred at hospitals across Merseyside and centred on the risk to Dawn's safety by her returning to a home she shared with Ewan and the unwillingness of refuges to accept Dawn due to "her complex needs". One Vision Housing and the Housing Options Team in Sefton were active partners in the task to provide safe living accommodation and reduce the risk of further domestic abuse by Ewan "and ensure safety going forward". However, Dawn and Ewan shared a home together for the majority of their long relationship and this was known to inhibit agency contact with Dawn due to the presence of Ewan in the room.

7.30 A Panel member notes that the strategy to overcome difficulties in contact being made with Dawn to support with safety planning should have been a multi-agency response either coordinated via the MARAC process, Statutory Safeguarding Process, or the Multi-Agency Risk Assessment Meeting [MARAM] process. The importance of multi-agency communication is an important lesson to be learned from this review.

7.31 There is no outreach program in place in Sefton which is utilised to safely engage with survivors of domestic abuse in such cases. Sefton does employ one Complex Needs IDVA who may overcome difficulties agencies have in maintaining contact with survivors but by the intensive nature of their role the number of survivors of domestic abuse that can be engaged and supported by a single complex needs IDVA is limited, and current resources prohibit the recruitment of further posts into this role.

7.32 SafeLives identified that "*a repeated pattern of abuse can be more injurious and harmful than a single incident of violence*"[3]. During the period of this Review MARAC cases involving Dawn as a survivor of domestic abuse and Ewan named as the perpetrator of abuse were held in Sefton a total of ten times and the frequency of MARAC discussions involving Dawn and Ewan increased during the last quarter of 2020 and during 2021 when a total of five MARAC meetings discussed their case. It is clear from this that agency interventions had not been effective or successful in reducing the risks that Dawn faced.

7.33 The Panel could find no evidence that the intensity of re victimisation during 2020 – 2021 was recognised by any agency or MARAC and acted upon.

7.34 There is no strategic overview of high-risk cases of domestic abuse where the survivor is re victimised. There are currently no arrangements in place within Sefton to review the impact of actions previously agreed at MARAC to safeguard re victimised survivors of abuse or to hold MARAC meetings where the cases being discussed are confined to those of survivors who have been re victimised and are again assessed as being at high risk of serious injury or homicide.

7.35 The Panel whilst identifying this weakness do recognise that necessary changes to existing structures and the processes to remedy this do present a significant challenge in the face of budget cuts and restrictions.

7.36 Agencies are also facing the challenge of early intervention work in support of victims of domestic abuse being withdrawn due to financial restrictions and the Panel identified that a number of community based universal services which supported victims of abuse have not reopened or restarted their work following the Covid restrictions.

7.37 There was an example of good practice highlighted by the Panel. Housing Options are responding to this challenging situation by establishing a Complex Needs Panel for those survivors within their client base thus providing extra focus and support to survivors.

[3] Safelives

7.38 On five occasions Dawn herself identified to different agencies, the Venus Project, Merseyside Police, the Ruby Project and Mental Health Services, the financial control that Ewan exerted over her.

7.39 The record of MARAC meetings however makes only one mention of any potential financial abuse. At the meeting in September 2017 the Ruby Project reported that Dawn had disclosed that a friend had taken her benefits money out of her account. There were no actions agreed at the end of this meeting to investigate this matter or offer support to Dawn regarding this abuse.

7.40 In June 2021 a safeguarding referral from Santander Bank was received by Adult Care Service Safeguarding team which highlighted unusual transactions on Dawn's account and transactions which occurred during periods when Dawn was a hospital inpatient. The Bank also raised concerns that Dawn was coming into the bank accompanied by a male 'carer'. Santander put safeguarding measures in place until their investigation into possible financial abuse had been completed. Adult Care Service responded to this referral by "transferring the notification to Mental Health North for Safeguarding follow up." The outcome of this transfer to the Metal Health Safeguarding Team was that closure of the referral was made due to the inability of the Social Worker to contact Dawn. Other agencies were experiencing similar contact issues at this time. .

7.41 The Domestic Abuse Act which came into force only nine days before Dawn's death does not make economic abuse a crime in its own right but does now include economic abuse within the statutory definition of domestic abuse. This change is intended to highlight this form of abuse and make agencies more likely to consider this abuse as constituting an offence of controlling or coercive behaviour contrary to the Serious Crime Act 2015.

7.42 16.75 The Panel's conclusion therefore is that the incidence of financial abuse suffered by Dawn was not investigated effectively. Consideration was not given to prosecution of Ewan for offences of controlling or coercive behaviour nor was effective support provided to Dawn over this issue.

7.43 The Panel believe that weaknesses were present in the management of risk and actions to safeguard Dawn. There is an acknowledgement by MARAC and

the MARAC Steering Group that some actions that may have been requested could not be delivered in practice. This is partly linked to Covid restrictions in place during some of the time period of this Review, but also due to what type of offer agencies could provide and gaps in service provision.

7.44 The chronology of this report indicates that Dawn did disengage from services several times which Dawn later disclosed was because cooperation with agencies may have led to repercussions from Ewan.

7.45 Some Panel members note that not all agencies had full oversight of the interconnected issues that were impacting on Dawn. They highlight the fact that not all agencies were aware of the number of times Dawn had been heard at MARAC or had knowledge of the issues which surrounded both Dawn and Ewan. The General Practice team were not aware that Dawn was discussed at MARAC meetings. There were no communications between the MARAC committee and the surgery, or any communication initiated by the surgery with MARAC, and Dawn did not disclose this information to the practice.

7.46 In 2021, one month after her discharge from hospital with no recognised safe place to go to, Dawn was again admitted to the Accident and Emergency Department of SDGH. During this latest admission Dawn disclosed that she had been locked in shed by Ewan, had burns to her body, and that Ewan had told her that he had made a recording of a sexual assault he had made upon her.

7.47 On another occasion whilst being treated in University Hospital Aintree Dawn was assessed by a mental health professional. At the conclusion of the assessment the Doctor noted, "*Documented risk of death by misadventure due to EUPD and lifestyle. Dawn is aware she is waiting for a refuge. No further input required form the team currently. Informed safeguarding of outcome of assessment.*" Notes available to the Panel indicate that during the assessment the focus of the Doctor was upon the abuse which had led to Dawn's hospital admission on this occasion and that her previous history had not been sought or considered.

7.48 No information has been shared with the Panel to indicate that clinicians had raised these concerns with Adult Social Care via a Safeguarding Adults referral or that any action was taken by Mental Health or Adult Safeguarding services to reduce this documented risk.

7.49 Dawn had a dual diagnosis of mental health needs and substance misuse. However, during the period reviewed the commissioned substance misuse service records only one referral into those services that received from HMPPS in respect of Dawn. There is a poor response by professionals to Dawn's substance misuse despite the threat it presented and documented risk within the psychiatrist report.

7.50 16.91 Prior to conducting the chronology as part of this Review agencies had not recognised that during the latter months of her life Dawn had suffered a significant escalation in the amount and degrees of violence reported to have been caused by Ewan and that additionally there had been an increase in the frequency of episodes of self-harm. No single agency or partnership body in Sefton identified that this escalation was taking place and the increased risk which had emerged surrounding Dawn.

7.51 During August 2021 there was a total of seven separate incidents of physical abuse reported by Dawn including two separate occasions when Dawn disclosed that she had been burnt by cigarettes and a lighter applied to her body by Ewan. During 2021 Dawn self-harmed by taking an overdose and was self-harming with a frequency which had not before been experienced. Individual events were dealt with but there is no evidence that agencies identified or responded to this escalating situation.

7.52 During the period of this review there are 11 occasions when Dawn disclosed domestic abuse and yet no DASH or MeRIT risk assessment was completed. This was not confined to one agency as risk assessments were not completed following disclosures of abuse to Mental Health Services, Hospital's, and the Police. Failure to assess risk in this way inhibits agencies response to the management of risk and safeguarding.

8. Conclusions

8.1 Family and friends of Dawn commented upon the high standard of work and the sensitivity and compassion which front line staff from a number of agencies showed when working with Dawn for which they are grateful. However, following that initial contact the Panel feel that there are lessons to be learnt.

8.2 The role of multi-agency meetings in safeguarding Dawn and ending the risks she faced from domestic abuse plays a large part in this review. The decision to do this is based upon a number of issues.

- Dawn as a survivor of domestic abuse was discussed at MARAC a total of ten times in Sefton and on three occasions in Liverpool including a MARAC one month before her death. In the last quarter of 2020 up to her death in 2021 Sefton MARAC alone discussed the risks faced by Dawn a total of five times. Dawn's repeat victimisation was never examined and escalation of need never identified or responded to. Dawn's appearance at the Liverpool MARAC did not because of the time between being heard at MARAC constitute repeat victimisation. There is no evidence of information sharing between Liverpool and Sefton MARAC despite in the latter months of her life an escalation of MARAC discussions regarding Dawn.

- A number of agencies identify and record that Dawn presented with complex needs. Resolution of those needs would require intervention and support from more than a single agency. Therefore, the coordination which can be provided by MARAC, or by a MARAM or a Safeguarding Strategy Meeting were the right vehicles to take this forward however, there is no evidence of this coordination or ownership for a long term resolution of the issues affecting Dawn ever happening.

- Two key challenges faced by Dawn, mental health illness and substance misuse were not supported by taking a Care Program Approach to Dawn's mental health or by her referral to and support from substance misuse services.

8.3 There are several examples outside of MARAC of strong multi-agency working and communication initiated by agencies dealing with a crisis situation involving Dawn. However, once that situation had been resolved there was no evidence a, MARAC, MARAM, Safeguarding Strategy Meeting, or professionals meeting, follow up or of a joint agency plan to address the causal and contributory factors and trauma causing risk to Dawn and prevent such a situation from reoccurring, which on a number of occasions it did. Good communication links, following crisis situations, did not exist across all agencies and service providers.

8.4 Opportunities to provide support for Dawn through the effective use of powers available to agencies was poor and weaknesses in the adherence to safeguarding procedures added to those opportunities being lost. There is an almost total absence of effective action to address the perpetrators behaviour through management, disruption, diversion or proactive prosecution.

8.5 There are lessons within this review for all agencies in Sefton who failed to identify the significant escalation in risks to Dawn's safety and wellbeing. Evidenced by frequent assessment that Dawn was at a high risk of further serious physical harm or homicide, her attendance at MARAC, and the number of incidents of self-harm three of which required treatment within the ITU of local hospital's all occurring in the months prior to her death.

8.6 The management of risk was also impacted upon by the multiple failure of agencies to complete domestic abuse risk assessment forms, DASH or MeRIT and to make referrals to MARAC or Safeguarding Strategy Meetings.

9. Lessons learnt

9.1 There are several lessons which Panel members have identified as arising from this Review and the tragic death of Dawn.

9.2 Regarding the issue of Dawn not being able to access a place at a refuge because of her complex needs work is now underway in Sefton to resolve this. In terms of accommodation for survivors of domestic abuse who also have complex needs Sefton's Domestic Abuse Strategy and expected standards outlined within the Domestic Abuse Act 2021, work is already underway to commission a specialist offer locally. This will provide crisis beds and a mixture of short-medium stay accommodation in a woman only provision. It will be specifically for women experiencing domestic abuse who also have complex needs. It will include 24 hours staffing available for immediate support with links into local substance misuse and mental health provision, as well as access to a therapist.

9.3 Alongside this work, there are also multi-agency discussions across Merseyside in which Sefton plays a part about developing more focused perpetrator management within high repeat/high harm cases. In Sefton a pilot piece of work is currently being developed and planned to commence in early 2024 which will focus on high repeat/high risk of harm perpetrators of domestic abuse. This will take the form of a disruption panel/ MATAC (Multi-Agency Task and Coordination) approach which is being led by Merseyside Police within a multi-agency framework. The aim of this will be to provide a coordinated approach to discussing serial /high risk of harm perpetrators and with a view to agreeing a practical action plan to take forward to address their actions. It will also provide real time learning to understand in more detail opportunities for action that could be developed further as well as gaps in services/support to inform future commissioning need linked to Sefton's Domestic and Sexual Abuse Strategy. This work will be linked to other local multi-agency working developments, such as the new Complex Lives MDT referenced below in 9.4, to ensure learning is jointly utilised and to avoid duplication of effort.

9.4 Sefton have recently introduced a Complex Lives MDT meeting. This was developed following a recognition that agencies/services respond well to immediate crisis situations, but often are not able to pull together the relevant agencies and services within the required timescales to provide long-term,

joined up care for the client. Complex lives are defined as people who are experiencing the following needs: Either one or more physical health condition Plus One or more mental health condition Plus- one of the following Homelessness, Substance use/dependence, History or current offending, High intensity user of Accident and Emergency Departments, History of being a looked after child, Domestic abuse. Dawn would have met the criteria for support from a Complex Lives MDT.

9.5 The MDT for people with Complex Lives is non-Primary Care Network Specific accepting referrals according to need and complexity rather than geographical boundaries and amongst its key aims are. To bring together all the relevant people and agencies in order to assess, plan and co-ordinate the best way to meet the needs of people with complex lives. To work collaboratively to provide a joined up single plan for service delivery for each person, their family and carers. To share information to increase the safety, health and well-being of people with complex needs whose needs prevent them from accessing appropriate accommodation, support and care services.

9.5 In September 2021 One Vision Housing reviewed it's then combined policy covering Domestic Abuse, Anti-Social Behaviour, Hate Crime and Harassment. The review concluded that domestic abuse should have its own policy due to the specific complex nature of issues which surround domestic abuse, this work was undertaken, and One Vision Housing now has a Domestic Abuse Policy. In line with this change OVH also introduced a Domestic Abuse awareness course, this was written to develop a deeper understanding of the complex nature of domestic abuse, as a further development OVH wrote an awareness course covering Professional Curiosity, this course aims to ask all our teams to look deeper into situations, the course adopts good practice, taking themes and learning from serious case and domestic homicide reviews undertaken and One Vision Housing now has a domestic abuse policy.

9.6 The G.P. practice is implementing regular searches on their register of patients for all patients who are coded with Domestic Abuse, these patients will be

added to their important person register and would be reviewed at regular clinical meetings.

9.7 The structure of the Probation Service Women's Team specifically the female practitioners, links to local female specific service provision underpinned by the Female Offender Strategy and National Women's strategy, has facilitated a model of good practice which enabled the Probation Practitioner to provide specialist management/support underpinned by a relational approach to supervision by that service.

9.8 Since October 2020 the Mental Health Trust have had a Mental Capacity Act Lead Practitioner and now a Mental Capacity Act Team who provide advice and support to the workforce including training on Mental Capacity. With the initial proposed implementation of the Lead Practitioner Service over the past 12 months the Mental Capacity Team have provided support to operational clinical services and completed quality and assurance audits of Mental Capacity practice within the workforce.

9.9 The G.P. Practice already have full robust procedures around controlled drugs; however, they will review this process to see if there is any gaps in that service. The surgery has also introduced a new patient process which includes that the practice will not be prescribing certain drugs (benzodiazepines etc.) and if the patient wishes to register at the practice the patients will be given an appointment with one of the GPs with a view to a reducing regime for those medications.

9.10 The G.P. Practice made a decision based upon what it believed to be the best way to safeguard Dawn, over the issue of prescribed medication, that despite moving outside the practice boundaries she would remain a patient registered with that practice. Lessons learned from this is that the practice have identified the need to strictly adhere to their geographic patient boundaries. Whilst at the time the practice believed it was better for Dawn to keep her registration with that practice so she at least had one agency that knew her and was aware of her personality, in retrospect this could have caused more inconvenience

to her as if she needed any care from the District Nursing teams then that surgery would not have been able to arrange this as she was out of the area.

9.11 The Panel supported the view that the Complex IDVA which is in post in Sefton has made a positive difference to other complex and challenging cases and should be accepted as good practice.

9.12 During the period reviewed several changes have occurred within the Mental Health Trust which includes changes in structures of the leadership team, and alignment of service lines and this has resulted in the alignment of processes and pathways to enhance the patient journey and to ensure a more consistent approach to care. Furthermore, the safeguarding offer within the division has increased, with proactive support being provided to the workforce to ensure that the workforce are responding appropriately to safeguarding concerns by developing knowledge and confidence within operational teams.

9.13 Liverpool University Foundation Hospital Trust identified a need to work alongside statutory and 3rd sector colleagues regarding high-risk MARAC cases to ensure monitoring of the survivors compliance and engagement with other services once discharged from hospital

10. Recommendations from the review

10.1 The recommendations include one made by the entire Panel and a number of recommendations made by individual agencies making up the Panel membership.

DHR Panel

1. Develop and embed a coordinated pathway within Sefton for tackling serial /high risk of harm perpetrators of domestic abuse above what is provided via MARAC.

Housing Options, Sefton MBC

1. Appoint a new Domestic Abuse Housing Options Advisor.
2. Develop a new Domestic Abuse Complex Lives Women's Service.

Liverpool University Foundation Hospital Trust

1. LUHFT to have better understanding of agencies available in community to support high risk cases who have complex lives.

Adult Social Care Sefton MBC

1. Conduct a deep dive audit into safeguarding episodes where there are multiple referrals for an individual over a specified period.
2. Identify if LAS capability could flag individuals more effectively with repeated referrals and how this could be incorporated into risk assessment and practice.
3. Training department within Adult Services to develop a more advanced/bespoke training package in relation to the functionality of LAS system outside of current basic training content.
4. Implementation of new safeguarding documentation
5. Review of outcomes from the safeguarding audits and benchmarking to ensure consistent standards.
6. Design and deliver trauma informed practice training for all frontline practitioners.
7. Adult Social Care to review current training offer for Liquid Logic to ensure that all staff receive training on use of and interrogation of the Safeguarding episode.
8. Adult Social Care to review and update as required current Safeguarding practice guidance for frontline practitioners.
9. Adult Social Care to design new safeguarding episode documentation within Liquid Logic including a risk management document.
10. Adult Social Care workforce to have increased confidence in supporting individuals who self-neglect.
11. Sefton Council Adult Social Care staff to have increased confidence in routine enquiry, professional curiosity, identification and responding to domestic abuse.

12. Adult Social Care staff to ensure multi-agency communication is maintained.
13. Adult Social Care to implement regular safeguarding audits to be completed to ensure consistent standard of practice across Adult Social Care.
14. Adult Social care to design and deliver trauma informed practice training for all frontline practitioners.

General Practice

1. MARAC information sharing process to be developed between general practice and MARAC.
2. Confirmation of commissioned pathways around patients dependent on prescription medication.
3. All general practice staff in index surgery to complete mandatory Domestic Abuse training.
4. Index surgery to identify and discuss patients who are experiencing DA at practice safeguarding meetings.

Housing First

1. Arrangement of more frequent Multi-Disciplinary Teams with all agencies.

Sefton IDVA, Sefton MBC

1. Explore options for continuation funding of the Complex Lives IDVA to ensure this additional support remains in place beyond the current temporary funding arrangements (currently March 2025)
2. IDVA team continues to support the development and implementation of the Domestic Abuse Complex Needs Supported accommodation service.

Liverpool MARAC

1. Address inconsistencies in attendance at Liverpool MARAC.
2. Strengthen the ability to share information between partners within the Liverpool MARAC, ensure detailed updates are shared on actions set and establish the impact of actions completed.

Mersey Care NHS Foundation Trust

1. Mersey Care NHS Foundation Trust workforce to have increased confidence in routine enquiry, professional curiosity, identification and responding to domestic abuse.
2. Mersey Care NHS Foundation Trust workforce to adhere to Trust policy when there is a concern that an adult under there care is being or is at risk of being abused.
3. Mersey Care NHS Foundation Trust workforce to ensure multi-agency communication is maintained.
4. Mersey Care NHS Foundation Trust workforce to ensure that carers of patients open to the Trust are provided with appropriate carer support.
5. Mersey Care NHS Foundation Trust workforce to have increased confidence in responding to patients who self-neglect.
6. For Trust staff to access relevant safeguarding information easily
7. Ensure that the workforce are aware of Carer Support services available within the locality and who to signpost family members who may be carers too.
8. Reflective supervision sessions to be provided to Trust staff upon publication of this report.

One Vision Housing

1. Strengthen OVH's risk assessment when supporting high-risk customers / families.
2. Put into place oversight from the Safeguarding Team.
3. Provide a second Professional Curiosity (PC) course.

Probation Service

1. Improve the assessment of cases where domestic abuse is a feature.
2. Improve the management of cases where domestic abuse is a feature, both in respect of male and female perpetrators including when the victim is male.
3. Reinforce the necessity for Probation Practitioners to use Professional Curiosity in domestic abuse and child safeguarding cases.

4. The OASys Risk Management Plan should contain relevant actions to reduce and manage the risks from Domestic abuse.
5. Delius Case recording to contain appropriate comments that conform to the CHRIS model to enable appropriate risk management of cases.

Mersey and West Lancashire Teaching Hospitals NHS Trust (Southport and Ormskirk Sites)

1. To continue to ensure staff use professional curiosity and complete routine enquiry for patients attending with indicators of domestic, and sexual abuse and in the event of a disclosure undertake the required risk assessment and referral to the Safeguarding Team.
2. To seek available funding for Health IDVA's and if successful the recruitment and ongoing funding for HIDVAs.
3. To review the process for adding domestic abuse alerts to the patient's electronic patient record even when criteria for MARAC not met.
4. Review the development of a BI report for patients with a Domestic Abuse alert attending the AED, to identify missed opportunity and any subsequent actions that could be undertaken.

SWACA

1. To ensure joined up working between all services is effective and all avenues of contact/engagement are discussed.