Overview Report

Domestic Homicide Review

'Georgia'

Died April 2021

Chair and Author: Dan Bettison
Supported by: Ged McManus and Carol Ellwood-Clarke QPM

Date: March 2024

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Georgia[1], a resident of Sefton, prior to her death. The panel would like to offer their condolences to Georgia's family on their tragic loss.

1.2 Georgia was a single woman, with no children, who lived with her parents in Sefton. She was 49 years old when she took her own life.

1.3 All subjects of the review are known by pseudonyms to protect their identity and that of their family.

1.4 Margaret[2] and Harold[3], Georgia's parents, are also subjects of the review. Both were originally from the Portuguese island of Madeira and were married more than fifty years ago, whilst still living on the island. Margaret was 16 and Harold was 24 when they got married. They honeymooned in Jersey and whilst there, Harold was offered employment. They lived in Jersey for a time before eventually moving to Liverpool a few years later. They settled in Liverpool and Margaret had all four of their children in the city.

1.5 In 2020, Harold was diagnosed with dementia. This coincided with a disclosure by Margaret to her GP that Harold had hit her with a belt. Subsequently, Margaret disclosed to support services a long history of domestic abuse and controlling behaviour.

1.6 Georgia was often used as an intermediary for services to contact Margaret. This was because Margaret was concerned about Harold's controlling behaviour and that it wasn't safe for services to contact her directly. Although there were no reported incidents of domestic abuse with Georgia as the victim, it was known by professionals that she was affected by the abuse her mother suffered and sought medical help and counselling.

1.7 In addition to agency involvement, this Domestic Homicide Review also examines: the past to identify any relevant background or trail of abuse before Georgia sadly took her own life; whether support was accessed within the community; and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.8 The review considers agencies contact and involvement with Georgia, Margaret, and Harold from 1 January 2020, until Georgia's death in April 2021. This time period

[1] A pseudonym agreed with the victim's sibling.
[2] A pseudonym agreed with the victim's sibling.
[3] A pseudonym agreed with the victim's sibling.

was chosen as it encompassed the Covid-19 lockdown and a disclosure of domestic abuse by Margaret. Although the couple had been married for many years, the panel thought that focussing on the chosen time period maximised the opportunity for contemporary learning in Sefton. Background information prior to 1 January 2020 is used in the report for context.

1.9 The panel agreed that the unique circumstances presented by the UK government response to the Covid-19 pandemic should be considered throughout the review. Rather than consider the impact of Covid-19 as an individual term of reference, it was agreed that the impact of lockdown periods and restrictions to mainstream local service provision would be addressed within each term, where appropriate.

1.10 The panel referred to guidance provided by the Institute for Government[4] and considered the following timeline:

- 23 March 2020 – The Prime Minister announces the first lockdown in the UK, ordering people to "stay at home"
- 25 March 2020 – Coronavirus Act 2020 gets Royal Assent
- 26 March 2020 – Lockdown measures legally come into force
- 10 May 2020 – The Prime Minister announces a conditional plan for lifting lockdown, and says that people who cannot work from home should return to the workplace but avoid public transport
- 15 June 2020 – Non-essential shops reopen in England
- 23 June 2020 – The Prime Minister announces relaxing of restrictions and 2m social distancing rule
- 4 July 2020 – More restrictions are eased in England, including reopening of pubs, restaurants, hairdressers
- 14 August 2020 – Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play
- 22 September 2020 – The Prime Minister announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector
- 5 November 2020 – Second national lockdown comes into force in England
- 2 December 2020 – Second lockdown ends
- 6 January 2021 – England enters third national lockdown
- 8 March 2021 – lockdown restrictions start to be eased, with students returning to school

1.11 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate

[4] https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.12 **Note:**
It is not the purpose of this DHR to enquire into how Georgia died. The Coroner's Office has informed the Chair that they will await the outcome of this review, prior to progressing further.

2 Timescales

2.1 This review began on 22 November 2021 and was concluded on 5 August 2022, following consultation with the family. More detailed information on timescales and decision-making is shown at paragraph 5.2

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process. Reports are marked as 'official sensitive 'until publication.

3.2 Pseudonyms were agreed with the victim's sibling to protect Georgia's identity and that of her family.

4 Terms of Reference

4.1 '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 inform national and

local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice'.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe Under Review

The DHR covers the period 1 January 2020 to 8 April 2021

4.3 Case Specific Terms

Subjects of the DHR

Victim: Georgia, aged 49 years

Georgia's mother: Margaret, aged 69 years

Georgia's father: Harold, aged 78 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Georgia?

2. What knowledge did your agency have that indicated Georgia could be at risk of suicide as a result of coercive and controlling behaviour or domestic abuse?

3. How did your agency assess the level of risk faced by Georgia, and which risk assessment model did you use?

4. Did your agency consider that Georgia could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult concern and request or hold a strategy meeting?

5. What consideration did your agency give to any mental health issues when identifying, assessing, and managing risks around domestic abuse?

6. What services did your agency provide for Georgia; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

7. How did your agency ascertain the wishes and feelings of Georgia, Margaret, and Harold? Were their views considered when providing services or support?

8. How effective was inter-agency information sharing and cooperation on this case? Was information shared with those agencies who needed it?

9. Was there sufficient focus on reducing the impact of Harold's alleged abusive behaviour towards Margaret by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

10. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice, and were any gaps identified?

11. What knowledge did family, friends and employers have that Margaret was in an abusive relationship or of the effect it had on Georgia, and did they know what to do with that knowledge?

12. Were there any examples of outstanding or innovative practice?

13. What training did your agency provide to staff around domestic abuse, coercive and controlling behaviour and mental health, specifically dementia? Had staff who interacted with the family, completed the training and when?

14. What learning did your agency identify in this case?

15. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Georgia, Margaret, or Harold?

16. Does the learning on this case feature in any previous DHRs commissioned by Sefton Safer Community Safety Partnership?

5 Methodology

5.1 Following Georgia's death, a referral for consideration of a DHR was made to Sefton Community Safety Partnership by Merseyside Police on 20 April 2021. On 16 September 2021, Sefton Communities agreed the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review (para 18 Statutory Home Office Guidance)[5]. The decision to conduct a review was taken because it was apparent that Georgia had taken her own life, had been affected by the domestic abuse in her parents' relationship, and lived at home with them. The Home Office was informed on 3 November 2021.

5.2 Georgia, Margaret, and Harold were made subjects of the review. This approach was taken by the panel in order to ensure that as full a picture as possible of the family dynamics would emerge. The panel was clear that the main focus of the review was Georgia.

5.3 The first meeting of the DHR panel took place on 22 November 2021. Meetings took place in person and using Microsoft Teams video conferencing. The panel met four times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final panel meeting took place on 9 June 2022, after which, minor amendments were made to the report: these were agreed with the panel by email.

5.4 The report was shared with one of Georgia's siblings on 5 August 2022. The Chair met with them and discussed the content at length.

Minor amendments were made to the report to clarify some matters.

Georgia's sibling articulated that their overriding observation from reading the report, and circumstances leading to Georgia's death, was one of disappointment and frustration. Not with any particular individual or agency, but with the continued approach of treating Harold as a victim throughout and not addressing the underlying abuse he was directing towards both Margaret and Georgia.

They stated that this still continues – with Margaret not receiving the support she needs from healthcare professionals, and Harold still being treated as the victim.

[5] Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it merges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

6 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 Family

6.1.1 Margaret

The Chair of the review wrote to Margaret, enclosing the Home Office DHR leaflet for families and a leaflet from AAFDA. Margaret agreed to speak to the Chair but declined support from AAFDA or any other agency. Her contribution is referenced appropriately throughout the review.

6.1.2 During the course of the review, Margaret became unwell and was unable to continue her involvement.

6.2 Siblings

6.2.1 The Chair of the review wrote to Georgia's siblings, enclosing the Home Office DHR leaflet for families and a leaflet from AAFDA[6]. Some of Georgia's siblings agreed to contribute to the review and met with the Chair on several occasions. Although one sibling engaged with AAFDA by email, they did not receive advocacy support. Their contributions are referenced appropriately throughout the review.

6.2.2 Georgia's siblings were asked if they would like to meet with some, or all, panel members to discuss the review in person. They decided not to do so.

6.3 Friends

6.3.1 The Chair of the review wrote to two of Georgia's friends. They both agreed to contribute to the review.

6.4 Employer

6.4.1 Georgia worked in the local branch of a national department store. She loved her job and her family described it as 'her life'.

6.4.2 The Chair of the review wrote to the manager of the store, asking if they wished to contribute to the review. They agreed to contribute to the review and provided background information.

[6] Advocacy After Fatal Domestic Abuse, a charity which supports the families of domestic homicide victims.

6.5 Harold

6.5.1 Harold's medical condition has progressed and it is now assessed by health professionals that he does not have capacity to take part in the review, or consent to access to his medical records. The review has been unable to gain access to Harold's medical records and therefore only brief information relating to his diagnosis is contained within the review.

6.5.2 The panel considered asking specific questions of Harold, supported by appropriate healthcare professionals. However, when balanced against the impact this may have on his health and the challenges it would present for his children and Margaret, it was not considered proportionate.

7 Contributors to the Review / Agencies Submitting IMRs[7]

7.1.1	**Agency**	**Contribution**
	Mersey Care NHS Foundation Trust	IMR
	CCG – on behalf of Primary Care	IMR
	Southport and Ormskirk Hospital NHS Trust	IMR
	Sefton Adult Social Care	IMR
	Talking Matters Sefton	IMR
	Sefton Women and Children's Aid (SWACA)	IMR
	Sefton IDVA Service	IMR
	Sefton MARAC	IMR
	SWAN Women's Centre	IMR
	Merseyside Police	IMR

7.1.2 In addition to the IMRs, some agencies provided a chronology of interaction with Georgia, Margaret, and Harold, including what decisions were made and what

[7] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Georgia, Margaret, and Harold.

actions were taken. The IMRs considered the Terms of Reference (TOR), whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Georgia, Margaret, or Harold, nor had any involvement in the provision of services to them.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the subjects of the review over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Georgia, Margaret, and Harold; and any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 The IMRs in this case were of good quality and focussed on the issues facing Georgia. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and cooperation. Where an IMR did not contain sufficient detail, additional information and clarity was sought during panel meetings and checked against chronology documents.

7.2 Information About Agencies Contributing to the Review

Mersey Care NHS Foundation Trust

The Trust provides specialist in-patient and community services that support mental health, learning disabilities, addictions, brain injuries and physical health in the community.

South Sefton and NHS Southport and Formby CCG

Responsible for planning and buying, or 'commissioning', the majority of local health services that South Sefton and Southport and Formby residents may need.

Responsible for commissioning the following services:

- Nearly all hospital services – such as routine operations, maternity services and outpatient clinics

- Nearly all mental health services – apart from specialist and secure mental health services

- Community services – like blood testing, district nursing, podiatry and community clinics for conditions such as diabetes and dermatology

- GP out of hours service – this service ensures that people can get treatment from a doctor if they need to when their surgery is closed for the evening, at weekends or Bank Holidays.

Support member GP practices to be actively involved in the work of the CCG. Much of its work is carried out in GP practice 'localities', covering four geographical areas, so practices can really focus on addressing the health needs of their individual communities.

Each locality is chaired by a GP and provides an opportunity for other professionals in practices, such as nurses and support staff to get involved in our work. Localities also gain commissioning support from its small team of experienced CCG managers to give practical help and advice.

Southport and Ormskirk NHS Trust

Southport & Ormskirk Hospital NHS Trust provides healthcare in hospital and the community to 258,000 people across Southport, Formby and West Lancashire.

Acute care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital. This includes adults' and children's accident and emergency services, intensive care and a range of medical and surgical specialities. Women's and children's services, including maternity, are provided at Ormskirk Hospital.

Sefton Adult Social Care

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils and providers of services to make sure that people who need care and support have the choice, flexibility and control to live their lives as they wish.

Talking Matters Sefton

Talking Matters Sefton (TMS), is part of the national Improving Access to Psychological Therapies (IAPT) programme and provides access to psychological therapies, often known as talking therapies.
Talking Matters Sefton is a free, confidential service designed to help residents of South Sefton, Southport and Formby, aged over 16, to deal with common mental health difficulties. These may include depression, anxiety, panic, phobia, obsessive compulsive disorder (OCD) or post-traumatic stress disorder.

Sefton Women and Children's Aid (SWACA)

SWACA is a charity that provides a professional, holistic service to more than 1,500 families each year. The service includes advocacy, advice, structured programmes of work, parenting support and therapeutic support on a one-to-one, family or group basis.

Women are encouraged to develop emotional resilience, identify and manage risk, understand the impact domestic abuse may have upon themselves and their children and improve self-esteem.

Children's Caseworkers aim to help children explore wishes, worries and feelings in order to recover from their experiences of domestic abuse.

A residential support service (or refuge) accommodates up to three families at any one time.

Sefton IDVA Service

The Sefton IDVA (Independent Domestic Violence Advisors) service provides specialist crisis support, including safety planning and advocacy to high-risk adult victims of domestic abuse. IDVAs do not have any direct contact with perpetrators of domestic abuse.

Sefton Multi Agency Risk Assessment Conference (MARAC)

MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where very high risk has been identified, a multi-agency action plan is developed to support all those at risk. MARAC in Sefton is coordinated by Sefton council.

SWAN Women's Centre

SWAN Women's Centre works with women and girls aged 13+ years, who are affected by or experience anxiety, depression, stress, isolation or other mental health issues. The centre provides a range of services such as Counselling, as well as an Outreach Service for those who struggle to leave their home, a Befriending Service, as well as a number of Women's Support Groups.

There are craft and activity groups such as card making, flower arranging, knitting as well as courses such as Creative Writing. We provide a range of services that promote mental well-being such as a Walking Group, Yoga and Complementary Therapies such as Reflexology, Thai Yoga, Reiki, Tui Na, Body Massage, Indian Head Massage, Hopi Candles etc. There is also a Therapeutic Allotment that women can get involved in, support each other, build friendships as well as their confidence.

Merseyside Police

Merseyside Police is the territorial police force responsible for law enforcement across the boroughs of Merseyside: Wirral, Sefton, Knowsley, St Helens, and the city of Liverpool. It serves a population of around 1.5 million people, covering an area of 647 square kilometres. Each area has a combination of community policing teams, response teams and criminal investigation units.

8 The Review Panel Members

8.1	Dan Bettison	Independent Chair and Author
	Ged McManus	Support to Chair

Carol Ellwood-Clarke	Support to Chair
Janette Maxwell	Locality Team Manager, Communities Sefton Council
Neil Frackleton	Chief Executive, SWACA
Paul Grounds	Detective Chief Inspector, Merseyside Police
Lorraine Rock	Safeguarding Lead for Vulnerable Communities, Mersey Care NHS Foundation Trust
Natalie Hendry-Torrance	Designated Safeguarding Adults Manager, NHS South Sefton CCG and NHS Southport and Formby CCG
Mal Williams	Principal Social Worker, Sefton Adult Social Care, Sefton Council
Amanda Comer	Service Lead, Talking Matters Sefton
Gemma Kehoe	Interim Named Nurse Safeguarding Adults, Southport and Ormskirk Hospital NHS Trust
Maria Joao Melo Nogueira	Operations, Partnerships and Client Support Director. Respeito [cultural advisor to the panel]

8.2 The review panel agreed the need to ensure that expertise and advice was available in relation to Portuguese culture. The Chair approached Maria Joao Melo Nogueira, Partnerships and Client Support Director of Respeito[8], who agreed to support the DHR process and be a panel member. Respeito is a charity and a company limited by guaranty. It was founded in November 2016 and is based in London (the borough of Lambeth), where an estimated 50,000 Portuguese speakers live. Respeito is dedicated to reducing domestic abuse in the Portuguese speaking community by raising awareness of its negative impact and by providing training, support, and information to empower people to become agents for change. Respeito

[8] http://www.respeito.org.uk/

is based on the principles of equality, human rights, and social integration. The panel was satisfied that Maria was appropriately qualified and experienced to provide expert advice on Portuguese culture and attitudes.

8.3 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review chairs and authors.

9.2 Dan Bettison was chosen as the Independent Chair and Author of the review. Following a career in policing (not Merseyside), he is now an independent practitioner and consults within mental health services, education, and children's social care. He is an Associate Trainer for the College of Policing and an Associate Inspector for Her Majesty's Inspectorate of Constabulary. He has completed accredited training for DHR chairs, provided by AAFDA, and has supported colleagues on numerous DHRs.

9.3 He was supported by two other independent practitioners.
Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside or an adjoining authority) and has chaired and written previous DHRs and Safeguarding Adults Reviews. He has completed accredited training for DHR chairs, provided by AAFDA.

9.4 Carol Ellwood-Clarke retired from public service (British policing – not in Merseyside), during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for Safe Lives[9]. Carol has completed accredited training for DHR chairs, provided by AAFDA.

9.5 None of them has previously worked for any agency involved in this review.

[9] https://safelives.org.uk/

10 Parallel Reviews

10.1 It is not the purpose of this DHR to enquire into how Georgia died. The Coroner's Office has informed the Chair that they will await the outcome of this review, prior to progressing further.

10.2 Mersey Care undertook a concise review at the request of the CCG following Georgia's death. The review was submitted to the CCG in December 2021 and identified learning in respect of internal electronic communication. This is also included within this review as a single agency recommendation, with appropriate action already taken by Mersey Care.

No other agency has undertaken any form of internal review separate to the DHR process.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He

starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].

- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Georgia was a single woman of Portuguese/Madeiran heritage who was born in Merseyside. She was 49 years old at the time of her death and lived with her parents, as she had done all her life. She had recovered from anxiety and low mood in 2018, through high intensity cognitive behavioural therapy (CBT) and medication. Georgia suffered from anxiety and depression again during the timeframe of the review and was prescribed appropriate medication by her GP. She did not misuse alcohol or any other drug. There is no evidence that Georgia's medical conditions affected her ability to carry out day-to-day activities to the extent that she was disabled within the meaning of the Equality Act. For around 25 years, Georgia worked full time in a department store.

11.3 As described in section 1, Margaret was born in Madeira and moved to live in Merseyside as a married woman in her twenties. All four of her children were born in Merseyside. Margaret lived with her husband of more than fifty years, Harold, and their daughter Georgia. During the timeframe of the review, Margaret suffered from anxiety and was prescribed appropriate medication. She did not misuse alcohol or any other drug. There is no evidence that Margaret's medical condition affected her ability to carry out day-to-day activities to the extent that she was disabled within the meaning to of the Equality Act. Margaret worked part-time in a supermarket.

11.4 As described in section 1, Harold was also born in Madeira and moved to Merseyside after he and Margaret were married. At the time of his daughter Georgia's death, he was 79 years old and had been diagnosed with dementia. He was prescribed appropriate medication and was visited regularly by a Community Psychiatric Nurse. The review does not have other detailed health information for Harold. The panel was unable to come to a conclusion as to whether Harold's medical condition would have affected his ability to carry out day-to-day activities to the extent that he was disabled within the meaning of the Equality Act. It is known that he continued some activities. For example, he regularly drove Margaret to medical and other appointments.

11.5 The panel considered whether Harold's age had an impact on the way that services were delivered. The panel noted that agencies were in possession of information that Harold was a perpetrator of domestic abuse and that this was not addressed with him. The panel was told that at the time of the events under review, Harold was considered to have the capacity to make his own decisions. There is no evidence that enforcement options were considered, and the panel concluded that Harold's age must have been a factor in this. This is further discussed in section 14 of the report. The panel sought the membership of an individual to advise around the impact of age for this case. No suitable individual was identified, but the final

report was shared with the Director of Operations for Age Concern (Liverpool and Sefton) and their feedback considered accordingly.

11.6 Margaret and Harold were Portuguese citizens – they applied for, and were granted, settled status when the United Kingdom left the European Union.

11.7 All three subjects of the review were fluent in English, both orally and in writing. They were able to access services freely and had many medical appointments. The family were well integrated into the local community and there is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.8 The panel agreed that despite Margaret and Georgia's siblings stating that Madeiran culture was similar to the UK, further advice should be sought. This was done through engaging the Operations, Partnerships and Client Support Director of a charity, Respeito, to act as an expert in Portuguese/Madeiran culture to the panel. Respeito is a London-based charity, the aim of which is to:

"To empower and support Portuguese speaking families and individuals in the UK to build safer and happier lives, one person at a time".

The charity's mission is:

"To reduce and prevent domestic abuse in the Portuguese speaking community living in the UK".

11.9 Domestic homicide, and domestic abuse in particular, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

Whilst Georgia's death was not as a result of homicide, the above statistics show the prevalence of domestic abuse linked to domestic homicide.

12 Dissemination

Georgia's family
Home Office
Sefton Community Safety Partnership
Merseyside Police and Crime Commissioner
Domestic Abuse Commissioner
All Agencies Contributing to this Review

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, discussions with Georgia's family, and material gathered by the police during their investigation following her death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1 Relevant History

13.1.1 Margaret told the Chair of the review that both she and Harold quickly learned to speak English on coming to the UK, and that Madeiran culture was, and is, very similar to British. Prior to moving to the UK, Harold had served in the army and always retained a very military-like, controlling manner with Margaret and all the children. He was the boss. He always seemed to live in fear that something would happen to his family and wanted to keep them close, not allowing the children to go to parties or college.

13.1.2 Whilst honeymooning in Jersey, Harold accepted a job as a waiter in a restaurant: the couple remained there for a short time, before moving to the UK mainland, where they settled in Liverpool. On arrival in Liverpool, Margaret worked as a

chambermaid and Harold as a steward on British Rail trains. He then began working for a brewery, managing pubs and restaurants.

13.1.3 Margaret did not work for a long time after having children, although by the mid-1980s, Harold had bought a restaurant and she helped out with various roles such as cleaning and administration. Harold didn't allow her to be 'front-facing' in the restaurant. Harold is described by his family as always controlling Margaret and all their children. He always wanted to know where they were, keep them away from other people, and seemed fearful of losing them. They believe this was due to his own mother dying when he was four years old and his father being unable to look after him due to alcoholism. He was brought up by his uncle.

13.1.4 The children had little freedom. Harold did not allow them to socialise much or go to college, and they were all expected to help out with the family business. The restaurant was successful for a number of years, but by the early 1990s, Harold had also bought a pub attached to the restaurant and this did not work out financially. He sold the restaurant and the family moved to mainland Portugal for a few years. By this point, two siblings were both adults and returned to the UK and began their own lives. A couple of years later, Margaret and Harold also returned to the UK with Georgia and the youngest sibling, settling in Southport. They initially rented a property, but Harold quickly bought a large, terraced house, which he also had extended.

13.1.5 When they returned from Portugal, Georgia initially lived with her sibling in a flat. She considered renting her own property but decided against it and moved in with her parents. She was very close to both and worried about her mum. She wanted to be around Margaret to make sure she was ok. Georgia had a small section of the house to herself, consisting of a bedroom, bathroom, and spare room. By this stage, Harold had passed his HGV driving test and was working as a driver for a supermarket. He did this until around 2018, when he retired following a number of workplace road traffic collisions and accidents within the warehouse. Although not diagnosed by that stage, the family believe these were due to the onset of dementia.

13.1.6 The panel was informed by the cultural advisor that Portuguese-speaking culture is very family orientated. It is commonplace for any conflict or friction to radiate through a whole family network. It is often the case that if an individual does not marry, they remain within the family home and care for their parents.

As with many Western European countries, domestic abuse is common within Portuguese-speaking culture. However, coercive and controlling behaviour is not generally recognised as a form of domestic abuse.

13.1.7 Georgia left school with one GCSE qualification. As an adult, she began working for a national department store. She performed many roles, from the shopfloor to HR, and advising on new store openings. She loved her job and loved the close friends she made there. Her family say that Georgia had the potential to be promoted into more senior roles but chose not to do so as she did not want to leave the area. Following her death, her colleagues arranged a number of events to remember Georgia. They scattered flowers in a river in one of her favourite places, planted shrubs, and dedicated a room to her within the workplace named 'The Peony Room' (her favourite flower). The room is for staff to use as a quiet place where they can relax and be peaceful.

13.1.8 Georgia was described by family and friends as a caring individual who 'always put others before herself.' She was always the one who would offer help, go the extra mile, and remember birthdays and anniversaries. She wanted to make everyone happy. They also acknowledged that this sometimes caused her unnecessary stress as she would not think twice about working longer hours, doing more work than required, or 'running around to help people'.

13.1.9 Georgia also had good friends outside of work. She stayed in touch with friends from school and was still close to them. Although Georgia spent much of her time at home where she could keep an eye on her mum, she still enjoyed seeing her friends and loved going on holidays abroad with them, which she did three to four times each year. She never formed an intimate relationship with anyone and said that she enjoyed her own space. Some family and friends believe that part of the reason, however, was her fear of how Harold would react to her bringing someone home. Harold was always very protective and controlling of his children.

13.1.10 Georgia loved spending time with her nephew who she treated like the child she never had. The two were very close and loved each other's company. She would pick him up from school a couple of times each week and spoil him: letting him get away with things that his parents wouldn't. They had great fun together and loved going out for a pub lunch. They were best friends. Georgia loved listening to George Michael.

13.1.11 Georgia's sibling told the Chair of the review that throughout their childhood, the children heard arguments and verbal abuse, which they suspected escalated to physical violence. Harold would, on occasions, hit the children if they had

misbehaved or had not done as he told them, although this was not a regular occurrence. The exception was Georgia, as she never did anything wrong.

13.1.12 Prior to the time frame of the review, there were no reports to any agency of domestic abuse in the family and Harold has no criminal record.

13.1.13 Georgia had been registered with the same local GP surgery for over 20 years. She had longstanding anxiety symptoms dating back to at least 2016. Some of her family described Georgia as a worrier, who had always been anxious of what others would think of her and how she looked. She lacked self-confidence and hated confrontation.

13.1.14 The family believe that Covid-19 restrictions were a significant factor in Georgia's death. Harold's mental health deteriorated at a time when he, Margaret and Georgia were unable to socialise outside of their household. Family feel that the restrictions concentrated the abuse within Harold and Margaret's relationship and made it more difficult for Georgia to cope. Some of the family feel that Georgia, Margaret, and Harold did not receive an acceptable service from healthcare professionals, as a result of Covid-19 restrictions.

13.2 Events within Timeframe of Review

13.2.1 Within the timeframe of the DHR Terms of Reference, the following paragraphs summarise those issues affecting the family that the panel felt were most relevant.

13.2.2 In March 2020, Georgia saw her GP with increased anxiety attributed to issues at work.

13.2.3 On 1 April 2020, Georgia had a GP appointment for anxiety, which now also related to her father's behaviour. She was worried that he was not adhering to social distancing guidance. She was referred to psychology services and signed off work for the next two months.

13.2.4 Access Sefton was the local Improving Access to Psychological Therapy (IAPT service) and provided Georgia with nine sessions of cognitive behaviour therapy, resulting in some improvement in her symptoms. At the point of discharge in December 2020, Access Sefton conducted a risk assessment by telephone (due to Covid-19 restrictions). The assessment included the standard IAPT measures

including the PHQ9[10] and GAD7[11]. No risks were identified or recorded within Georgia's patient notes.

13.2.5 On 8 June 2020, Harold had an in-person GP appointment. He was not in the surgery when his turn came, and the GP went into the car park to look for him. The GP found Margaret and Georgia waiting in their car. Margaret was distressed and told the GP that Harold had assaulted her earlier that day, hitting her multiple times with a belt. She showed the GP the injuries, which were belt mark bruising to her trunk and legs. She had not contacted the police following the assault and she was advised to contact the police if there was any further violence. Margaret did not want anything further to be done that day for herself but agreed to a follow-up telephone call.

13.2.6 On 10 June 2020, the GP phoned Margaret, however it was apparent she didn't feel safe to speak over the phone as she said that Harold had been screening her phone calls. She agreed to a safeguarding adult referral and arranged a face-to-face appointment at the surgery for the next day. The GP raised a safeguarding concern with Adult Social Care.

Margaret attended the appointment on 11 June, where she discussed the difficulties at home with Harold and how best to ensure her safety. She did not want any police involvement.

13.2.7 On 12 June 2020, Adult Social Care called Georgia as her number had been given in order to make contact with Margaret. Georgia agreed to speak to Margaret regarding her desired outcomes for the safeguarding and the potential for a lifeline pendant (alarm) to be allocated to Margaret. The duty safeguarding social worker was to make contact again on the following Monday.

The case was not progressed to a safeguarding enquiry under section 42 of the Care Act 2014 as Margaret did not have any care and support needs – she was mobile, self-caring, and was employed.

13.2.8 On 15 June 2020, the duty social worker spoke to Georgia who said that Margaret did not want a lifeline pendant or SWACA referral; therefore, the case was closed. Margaret's GP was informed.

[10] The Patient Health Questionnaire (PHQ-9) - is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
[11] Generalised Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder.

13.2.9 On 15 June 2020, Harold attended a face-to-face appointment with a Consultant Psychiatrist and Community Mental Health Nurse. He was diagnosed with mixed dementia. Margaret was seen separately and discussed the incident of assault that had previously been reported to her GP. Margaret said that there had been no further incidents of aggression towards her or other family members and Harold did not remember the incident. Margaret told of a history of physical, emotional, sexual and psychological abuse from Harold, including regular non-consensual intercourse throughout their marriage (the panel considered the wording used within medical records, but were clear that non-consensual intercourse is rape).

13.2.10 On 22 June 2020, Mersey Care made a referral to SWACA for Margaret.

13.2.11 On 26 June 2020, SWACA called Georgia as her number had been given in order to make contact with Margaret. An initial assessment was arranged for Margaret on 7 July 2020.

13.2.12 On 29 June 2020, after obtaining consent from Margaret, Mersey Care made a referral to MARAC. A DASH[12] risk assessment was completed that showed the risk as high. The referral was shared with the Independent Domestic Violence Advocate (IDVA)[13] team.

13.2.13 On 2 July 2020, after previous unsuccessful attempts, an IDVA called Georgia as her number had been given in order to make contact with Margaret. Georgia asked for the IDVA phone number and stated that she would get Margaret to call the IDVA when it was safe. Margaret returned the call later the same day. Safety planning was completed and access to a refuge was discussed. Margaret said that she was not ready to do anything immediately. Margaret asked for no further contact from the IDVA at that time and stated that she would contact the team when safe to do so.

13.2.14 On 7 July 2020, Margaret had her first appointment with SWACA. Georgia was the 'go between' for arranging appointments and updates with her mother.

Margaret said that Harold had been controlling throughout their marriage but until the assault in June, she had always been able to predict when he would be

[12] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

[13] Independent Domestic Violence Advocates (IDVAs) are specialists who are Safe Lives accredited. IDVAs provide high-risk victims of domestic abuse with a tailored and person-centered safety and support plan so that victims and their families are protected from abusive behaviour.

physically confrontational with her. On that occasion, the assault was without warning. She explained that Harold's behaviour had deteriorated over the previous 12 months and that it coincided with his memory loss.

13.2.15 On 8 July 2020, Margaret had a face-to-face GP appointment. She said that she was fearful of Harold but did not want to leave the family home. She confirmed that she had spoken to a domestic violence support worker, and she agreed to trial an antidepressant medication, citalopram[14] (10mg) alongside an as-and-when anxiety medication, diazepam[15].

13.2.16 On 23 July 2020, Margaret and Harold were discussed at MARAC. At the meeting, actions were set as follows:

- SWACA to speak to victim about engaging with RASA for counselling.
- SWACA to speak to victim about wishes and feelings in relation to reporting incidents to police and feedback to police.
- Merseyside Police to record disclosures made by victim as a crime for investigation, when further information received from SWACA. [Further information was not provided to Merseyside Police until after Georgia's death – a crime was recorded after her death].

13.2.17 On 5 August 2020, Margaret had a face-to-face GP appointment. She said that Harold had become angry and told her that she couldn't attend today's appointment, but there had been no further physical violence. She stated that she would not leave the family home as she didn't want to leave Georgia alone at home with Harold. The GP recommended that she leave the family home, with Georgia, and go to a women's refuge, but she declined this advice.

13.2.18 On 9 September 2020, Margaret had a face-to-face GP appointment. She remained hypervigilant and scared of Harold, although she said that he had been more passive in the last few weeks. She was resolved to remain at home. She agreed to increase her citalopram to 40mg.

13.2.19 On 16 September 2020, Margaret attended a routine appointment at Southport and Ormskirk Hospital. Margaret stated that Harold had hit her three weeks earlier and

[14] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat low mood (depression) and also sometimes for panic attacks. It helps many people recover from depression, and has fewer side effects than older antidepressants.

[15] Diazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety, muscle spasms and seizures or fits.

that she had not reported this incident. She told the nurse that she was a victim of domestic abuse and that she was working with agencies following a MARAC in July. Margaret left the hospital prior to review from the Trust Safeguarding Team; therefore, SWACA was contacted, and information was shared with Margaret's case worker.

13.2.20 On 29 September 2020, Georgia told her SWACA case worker that Harold had become increasingly verbally abusive towards Margaret. Georgia said that she did not believe he would act on the abusive statements made – safety arrangements were made, should the abuse escalate further.

13.2.21 On 29 September 2020, Harold's Community Psychiatric Nurse contacted Adult Social Care requesting a Care Act Assessment for him, due to concerns of breakdown of care and support.

13.2.22 On 7 October 2020, Adult Social Care called Georgia. It was established that following a recent change in Harold's medication, his health and mobility had improved. During the contact, the social worker was also informed that Georgia did not believe a Care Act Assessment was required at the time, as the family were coping and were able to support Harold. Discussions took place regarding community activities that may benefit Harold and also provide some respite for Georgia and Margaret, as opposed to formalised respite within a care setting. It was agreed, however, that more formal support may be required in the future and Georgia was informed that a further referral could be made. The case was closed.

13.2.23 On 15 October 2020, Harold's Community Psychiatric Nurse contacted Adult Social Care. The CPN said that Margaret was experiencing domestic abuse: taking the form of emotional intimidation and threatening violence. The Community Psychiatric Nurse or Georgia were to be points of contact. Adult Social Care called Georgia who said that a lifeline referral (alarm) had been made and confirmed that Margaret was engaging with SWACA. The social worker recorded that there was no further role for them and closed the case.

From 15 October 2020 to 20 October 2020, a series of discussions took place between Harold's Community Psychiatric Nurse and Adult Social Care about obtaining a day centre place for him.

13.2.24 On 29 October 2020, Adult Social Care contacted Georgia to discuss arranging a care and support assessment for Harold. Georgia said that Harold was now attending the day centre. She did not believe that a Care Act Assessment would be

beneficial and could potentially make things worse at home. Georgia said that she had Power of Attorney (POA) for Harold over his finances, health and welfare.

On the same day, Sefton Carers Centre contacted Georgia to discuss a carer's assessment for Margaret. Georgia said that Margaret did not want to go ahead with the assessment. Information and advice were given, and the case was closed.

13.2.25 On 25 November 2020, Margaret had a GP telephone appointment. She disclosed that Harold had grabbed her against the wall at home following an argument about Margaret continuing to work after the new year, as Harold did not want her to continue. The information was given to the Community Mental Health Team treating Harold.

13.2.26 On 19 January 2021, Georgia informed SWACA that Margaret had become close to using her lifeline over the previous weekend. She explained that Harold's behaviour was becoming worse, and he was asking Margaret for sex on almost a daily basis. She explained that in an attempt to reduce his libido, his Community Psychiatric Nurse had increased his medication.

Georgia also explained that on 17 January 2021, Harold had pulled Margaret's hair and threatened that if she ever left him, "she would be in trouble." Georgia did not witness this but was told by Margaret. SWACA acknowledged that Georgia had a limited support network and made a referral to SWAN Women's Centre for counselling.

13.2.27 On 20 January 2021, Margaret informed SWACA that on Christmas Day, Harold had woken at 6 am and asked if she had cooked the turkey for that day. When she stated not, he pushed her out of bed, on to the floor. Margaret stated that she offered to make him breakfast, but he said that he did not want anything from her. She explained that when Georgia woke around 8 am, she was able to persuade Harold to have some breakfast and open presents with them.

Margaret also told SWACA that in mid-January, there had been another incident when Harold had pulled her hair and been verbally abusive towards her. She said it was following an appointment Harold had with his Community Psychiatric Nurse and her colleague. Harold accused Margaret of telling them that she was not having sex with him. She tried to leave the room to get away from him, but he restrained her by pulling her hair. She managed to text one of her children, who rang Harold and tried to diffuse the situation. Harold did, however, continue to be 'in a bad mood.'

SWACA discussed safety plans with Margaret, including the use of her lifeline. She stated that although she had considered using this option, she had decided not to as she was fearful of repercussions from Harold.

13.2.28 On 22 January 2021, Georgia had her first counselling session with SWAN Women's Centre. She said that she had had a breakdown two years ago. Georgia discussed what felt most important to her at the moment: her mum and dad's health. She was worried about her dad's dementia. She did not mention domestic abuse although it was known that the referral was via SWACA. Georgia thought that she was doing ok as she worked full time so felt like she was managing that.

Georgia had weekly online counselling sessions via Zoom; her last appointment was on 2 April 2021. She discussed feeling anxious and depressed.

13.2.29 On 25 January, Margaret had a GP telephone appointment. It was agreed that she would have a weekly appointment with a psychologist from the Community Mental Health Team at the GP surgery, to support her and allow her some respite from the home situation.

13.2.30 On 2 February 2021, Georgia called SWACA. She was feeling very low with the current situation with her dad. Georgia said that on Wednesday 27th January, she was at rock bottom as she had received a letter from the hospital asking her to come for a bladder scan following a referral from her GP. Georgia was Googling bladder cancer from this and was becoming increasingly anxious. Georgia stated that her dad was in a very paranoid mood and her mum was unable to leave his side and was very anxious as a result.

13.2.31 On 5 February 2021, Georgia had a GP telephone appointment with symptoms of insomnia due to the volatile situation at home. She was noted to be in contact with SWACA. Georgia was issued a short course of zopiclone sleeping tablets and diazepam tablets for anxiety.

13.2.32 On 8 February 2021, Georgia had a face-to-face GP appointment. Her anxiety had increased. She was concerned that urinary symptoms that she had, could be an underlying cancer, but also admitted that she was living in fear that something terrible would happen at home. She said that she had been looking up her symptoms, and also her father's behaviour, on YouTube, and the sites she had accessed had left her distressed and traumatised. She agreed to trial an antidepressant medication citalopram. The GP made an urgent referral to the Community Mental Health Team and agreed to follow up later that week.

13.2.33 On 11 February 2021, Georgia had a telephone appointment with a GP and then went on to see the GP in person. She was very worried that the police would investigate her for viewing the websites she had accessed. During this consultation, she admitted that she had thought about taking an overdose of tablets the previous night. She then produced a small handful of unidentifiable tablets from her pocket, which the GP took from her. The GP recommended an immediate mental health team assessment by way of an admission to the local designated place of safety at Southport Hospital A & E. However, having discussed it, Georgia calmed down considerably and declined this. The GP assessed that she had capacity to do so. The GP agreed to contact the Community Mental Health Team (CMHT) to ask for them to assess Georgia as soon as possible, as an alternative approach.

13.2.34 On 12 February 2021, Georgia had a telephone appointment with a GP. She said that things had calmed down and she would never undertake an act of self-harm.

13.2.35 On 12 February 2021, following a referral from her GP, the Mersey Care Single Point of Access (SPA) telephoned Georgia to assess the risk to her. She had no suicidal thoughts or plans identified. She was offered an SPA appointment for further assessment of her mental health.

13.2.36 On 13 February 2021, Margaret had a telephone appointment with a GP. She said that she was struggling with anxiety and insomnia, as since Christmas, Harold had been saying he wanted sex again, and she was afraid of what he might do. She felt unable to use her panic alarm or ring the police, and again said that she would not leave the family home.

13.2.37 On 17 February 2021, Georgia had a telephone appointment with a GP and then went on to see the GP in person. Georgia reported heightened anxiety and that she was feeling constantly on edge. She said that she was having counselling with SWACA and that she was not suicidal, as she was too scared to harm herself. The GP discussed the possibility of leaving the family home to escape the situation there, but Georgia declined this. She was prescribed propranolol for anxiety, and promethazine to help her sleep.

13.2.38 On 22 February 2021, Georgia had a face-to-face appointment with a GP and was noted to be brighter in person. She admitted that she was worried she may 'do something stupid' but again reiterated that she was too scared to undertake an act of self-harm.

13.2.39 On 28 February 2021, Georgia had a telephone assessment with the Mersey Care SPA team. No plans or intent to harm herself were identified during the assessment.

She was referred to the Mersey Care Community Mental Health Team and additional support was requested from the Mersey Care Complex Care Team in relation to Harold's diagnosis and psychoeducation for the family.

13.2.40 On 1 March 2021, Georgia had a telephone appointment with a GP. She remained anxious and paranoid. She also raised concerns about a letter from the Community Mental Health Team about an assessment on 28 February 2021, and what effect this might have on her in the future.

13.2.41 On 3 March 2021, at a psychology session, Margaret disclosed that she was struggling with the impact that Harold's behaviour was having on her and Georgia. She said that if Harold assaulted her again, she "would kill him" and could do this by giving him all his medication.

13.2.42 On 5 March 2021, as a result of Margaret's disclosure at the psychology session, a safeguarding concern was raised to Adult Social Care by Mersey Care.

13.2.43 On 5 March 2021, Georgia saw a GP in person. She said that she felt close to harming herself but that she had no active plans for this. There was again a discussion about attending the local designated place of safety at Southport Hospital A & E but Georgia declined and had the capacity to do so. The GP spoke to the Community Mental Health Team to ensure that they were aware of the situation.

13.2.44 On 8 March 2021, Georgia saw a GP in person and again had fears that she would come to harm in the future because of her contact with the Community Mental Health Team. She said that she still had suicidal thoughts but reiterated that she would not do anything and wouldn't go through with it.

13.2.45 On 11 March 2021, Margaret saw a GP in person. She said that she was upset about the impact the situation at home was having on Georgia. She was having to cuddle and console Georgia, and that if Harold ever did anything to harm Georgia, this could drive her to take matters into her own hands. She admitted that she had been thinking if those events occurred, she would intentionally overdose her husband to kill him.

She had already disclosed similar thoughts to her psychologist: this had triggered further safeguarding input and a planned MDT meeting, the next day, with Community Mental Health Team, social worker, psychology, and the safeguarding team, to discuss the whole family.

13.2.46 On 11 March 2021, Georgia attended a face-to-face appointment with a Community Mental Health Nurse. Georgia said that she had fleeting suicidal thoughts, she denied any current plan or intent to act on these thoughts, and stated that she would never harm herself as she knew what this would do to her family, particularly her mother.

13.2.47 On 12 March 2021, Georgia saw a GP in person. She was noted to be significantly better. Although she had ongoing anxiety, she had no thoughts of self-harm or suicide.

13.2.48 On 12 March 2021, arising from the safeguarding concern, a virtual MDT meeting took place to discuss the whole family: the outcome of which, was a strategy meeting was to be arranged involving the police, as well as to plan the safest intervention. The police were requested to place a 'treat as urgent' marker on the home address. [Present were Mersey Care, GP, SWACA, and Adult Social Care].

13.2.49 On 17 March 2021, Georgia had a telephone appointment with a GP. She sounded much calmer. She was still anxious but did not have suicidal ideation. She said that she had self-referred to psychology services.

13.2.50 On 19 March 2021, a second virtual MDT meeting took place. The outcome was that the GP was to reduce the family's repeat medications to weekly prescriptions to minimise the risks of an intentional overdose of Harold by Margaret. The meeting heard that Margaret was due to return to work in a week's time, which was thought to be positive. [Present were Mersey Care, GP, and Adult Social Care].

13.2.51 On 21 March 2021, during a telephone call with the Community Mental Health Team about Harold, Margaret asked that they speak to Georgia as she was struggling with anxiety. Georgia denied any thoughts, plans or intent to harm herself. She was advised to contact her GP and was signposted to anxiety apps. An appointment was arranged with a Consultant Psychiatrist for 15 April 2021.

13.2.52 On 22 March 2021, a strategy meeting took place arising from Margaret's disclosure to her psychologist on 11 March 2021.
[Present were Merseyside Police, Mersey Care and Adult Social Care].

Actions:

- Police to add a flag to their records indicating that there was a safeguarding enquiry under S42 of the Care Act ongoing.
- A referral to be made for an urgent Care Act assessment for Harold.

13.2.53 On 23 March 2021, Georgia had a telephone appointment with a GP. She was concerned that the 20mg dose of citalopram was making her anxiety worse. She agreed to reduce the dose to 10mg and undertake a blood test to look for any systemic cause for her symptoms and to help clarify if the citalopram was making things worse. Blood tests were shown to be normal.

13.2.54 On 26 March 2021 at a counselling session with SWAN Women's Centre, Georgia said that she was feeling fearful and anxious still, especially in the morning. She was still experiencing trauma associated with family issues.

13.2.55 On 29 March 2021, Georgia saw a GP in person. She appeared much calmer than on a previous assessment. She had much greater insight into her anxiety and discussed the imminent easing of Covid-19 lockdown restrictions that might improve the situation at home, by allowing her father to resume swimming regularly. She also discussed her hopes to return to work in a month's time. Georgia said that she was mortified that she had even considered harming herself and had no current thoughts of self-harm. She remained concerned about the letter from the Community Mental Health Team on her notes and the future implications of this – worrying it might affect her employment at some point in the future.

The GP discussed this in detail with her and she was reassured that this was confidential to her medical records and the GP was confident it would have no future implications. Georgia discussed her feelings that her previous suicidal thoughts had been due to the citalopram medication, as she felt they only started to occur after initiating this. She was keen to stop this treatment completely, however she was persuaded to continue, and only reduce further the following week to half a tablet a day (doing so after the Easter bank holiday weekend to ensure that if she had any problems, the surgery was open and available for contact).

13.2.56 On 31 March 2021, following a self-referral, Georgia had a telephone appointment with Talking Matters and an assessment was completed. Georgia disclosed that she had an appointment for a psychiatric assessment on 15 April 2021. This was felt to be unusual, given Georgia's presentation, and caused Talking Matters to follow up about the psychiatric assessment before arranging further appointments with Georgia. This was not resolved before her death.

Later the same day, Georgia had a prearranged telephone appointment with a GP. She said that she had had a telephone consultation with psychology services that morning, with further intervention planned from them – she seemed hopeful about this, as their interventions had helped in the past.

13.2.57 On 1 April 2021, Georgia spoke with SWACA and described improvements at home. She said that Margaret had started back at work and Harold seemed settled with this. She also said that she felt that counselling had helped her and she had 'turned a corner' in terms of her own mental health: she planned to return to work at the end of April.

Georgia asked SWACA to act as a conduit between Margaret and Harold's Community Psychiatric Nurse as she was sharing information which made her feel uncomfortable. She also asked that Margaret not be informed that she had requested this. SWACA agreed to this.

13.2.58 On 1 April 2021, Georgia had a telephone appointment with a GP. She requested the cancellation of the planned follow-up from the Community Mental Health Team, as she felt she no longer needed their input. She further discussed the plan to gradually reduce citalopram. This was Georgia's last contact with her GPs.

13.2.59 On 7 April 2021, Adult Social Care called Georgia and a conversation took place with Georgia and Margaret. Georgia now thought that a Care Act Assessment for Harold would be beneficial. Arrangements were made to meet with Margaret at SWACA later in April.

Georgia said that she was able to go out and that Harold's behaviour did not impact upon her lifestyle, although she did suffer from anxiety. She also said that the Covid-19 lockdown had exacerbated things between her mother and father.

13.2.60 Georgia was found deceased at home in her bedroom on a day later in April. A police investigation ruled out any third-party involvement and Georgia appeared to have taken her own life.

14 ANALYSIS

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Georgia?

14.1.1 The panel has not seen any evidence that Georgia was a victim of physical domestic abuse. There were no reports or disclosures from her to any agency of domestic abuse.

14.1.2 It is clear from the disclosures made by Margaret that she was the victim of domestic abuse from Harold. There were no reports to agencies of any abuse until Margaret's disclosure on 8 June 2020 to her GP that Harold had struck her with a belt. Georgia was present when Margaret made the disclosure. Margaret later

disclosed a long history of domestic abuse and controlling behaviour to SWACA. The abuse had become more frequent over the previous 12 months and this appeared to coincide with a deterioration in Harold's mental health.

14.1.3 Georgia had always lived with her parents apart from a short spell living separately with a sibling. The family lived in large, terraced house and Georgia had a bedroom and two other rooms to herself. She was present when her mother made a disclosure to the GP about an assault by Harold, and the panel felt it inconceivable that she was not aware of the abuse that had happened for many years.

14.1.4 The panel considered whether there was evidence that Harold had subjected Georgia to coercion and control. In doing so, the panel referred to the Crown Prosecution Service's policy guidance.

14.1.5 The Crown Prosecution Service's policy guidance on coercive control states:[16]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study

[16] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.1.6 The Serious Crime Act 2015 received royal assent on 3 March 2015. The Act created the offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both. The offence, which does not have retrospective effect, came into force on 29 December 2015. The panel acknowledged that although Margaret and Georgia may have been affected by Harold's behaviour for many years, only actions after 29 December 2015 could be considered to be unlawful.

14.1.7 Given the extensive information provided by her family at section 13 of the report, for example not being allowed to go to parties or college and being kept away from

others, the panel agreed that, with hindsight, Georgia had been subjected to controlling and coercive behaviour by Harold.

The panel also agreed that considering the disclosures made by Margaret to SWACA, she too had been subjected to controlling and coercive behaviour by Harold.

14.1.8 From March 2013, the cross-government definition of domestic abuse was:

'Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass but is not limited to:

Physical, psychological, 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.

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group'.

14.1.9 The previous cross-government definition of domestic abuse also included emotional abuse.

14.1.10 The Domestic Abuse Act 2021[17], which was not in place at the time of the events analysed, defines domestic abuse as:

'(1)This section defines "domestic abuse" for the purposes of this Act.
(2)Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a)A and B are each aged 16 or over and are personally connected to each other, and

[17] https://www.legislation.gov.uk/ukpga/2021/17/section/1/enacted

(b)the behaviour is abusive.

(3)Behaviour is "abusive" if it consists of any of the following—

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

(d)economic abuse (see subsection (4));

(e)psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct'.

14.1.11 The charity, Relate provides the following information on emotional abuse:[18]

What constitutes emotional abuse?

There are a variety of types of behaviour that could be classed as emotional abuse. These include:

- **Intimidation and threats.** This could be things like shouting, acting aggressively or just generally making you feel scared. This is often done as a way of making a person feel small and stopping them from standing up for themselves.
- **Criticism.** This could be things like name calling or making lots of unpleasant or sarcastic comments. This can really lower a person's self-esteem and self-confidence.
- **Undermining.** This might include things like dismissing your opinion. It can also involve making you doubt your own opinion by acting as if you're being oversensitive if you do complain, disputing your version of events or by suddenly being really nice to you after being cruel.
- **Being made to feel guilty.** This can range from outright emotional blackmail (threats to kill oneself or lots of emotional outbursts) to sulking all the time or giving you the silent treatment as a way of manipulating you.
- **Economic abuse.** This can be withholding money, not involving you in finances or even preventing you from getting a job. This could be done as a

[18] https://www.relate.org.uk/relationship-help/help-relationships/arguing-and-conflict/what-emotional-abuse?gclid=Cj0KCQjwgMqSBhDCARIsAIIVN1XR9cKJJpr6z-voIrjNNn-haPl1kgdulXSzMwJ_o9-eLQ-QSMfUpe8aAuTjEALw_wcB

way of stopping you from feeling independent and that you're able to make your own choices.

- **Telling you what you can and can't do.** As the examples above make clear, emotional abuse is generally about control. Sometimes this is explicit. Does your partner tell you when and where you can go out, or even stop you from seeing certain people? Do they try to control how you dress or how you style your hair?

14.1.12 The panel also thought that Georgia would have been affected by the emotional abuse of living in a home where her mother was the victim of domestic abuse. Although the Domestic Abuse Act 2021 did not receive Royal Assent until after Georgia's death, previous cross-government definitions of domestic abuse included emotional abuse. The possibility of Georgia being affected by emotional abuse and therefore being a victim of domestic abuse in her own right, was not recognised by agencies during the timeframe of the review.

This is a learning point which leads to panel recommendation 1.

14.1.13 The panel considered whether Harold's behaviour in preventing his children from going to college and expecting them and Margaret to work in the family restaurant may amount to economic abuse. No evidence suggested that this was the case.

14.2 **What knowledge did your agency have that indicated Georgia could be at risk of suicide as a result of coercive and controlling behaviour or domestic abuse?**

14.2.1 Throughout February and March 2021, Georgia exhibited signs of increased anxiety and depression that may have had several contributing factors. She was concerned that symptoms of a physical health condition may have been cancer and was made more anxious by research that she did on the internet. This may have combined with the anxiety that she was feeling around the domestic abuse in her parents' relationship.

14.2.2 During February and March 2021, Georgia disclosed suicidal ideation to her GP and Mersey Care staff. On 11 February 2021, her GP took a small amount of unknown tablets from her when she said that she had considered taking them. The GP recommended an immediate mental health team assessment by way of an admission to the local designated place of safety at Southport Hospital A & E. However, having discussed it, Georgia calmed down considerably and declined this. The GP assessed that she had capacity to do so. This episode led to a mental health assessment with the Mersey Care SPA team later in the month, when no plans or

intent to harm herself were identified. On 5 March 2021, there was another discussion about attending the local designated place of safety at Southport Hospital A & E – when Georgia told a GP that she felt close to harming herself but that she had no active plans. She again declined this, and the GP spoke to the Community Mental Health Team to ensure that they were aware of the situation. The panel thought that this was an appropriate response.

14.2.3 Georgia's siblings told the Chair of the review that Georgia had a number of periods of poor mental health in her life. Her siblings recall a handful of occasions when, as an adult, Georgia had been low – most recently after an operation on her foot which resulted in her suffering with depression. That was around 10 years before the events discussed here, and her depression became so bad that she attended A & E and asked for help. Georgia's sibling said that on that occasion, Georgia was admitted briefly to hospital but placed on a ward with elderly dementia patients. Margaret told the Chair of the review that this experience prevented her from fully engaging with mental health services.

14.2.4 Although she disclosed suicidal ideation on a number of occasions during the review period, Georgia also told professionals that she would never act on this as she was too scared to harm herself or was worried about the impact on her family. It was known that one of the factors in Georgia's anxiety and depression was Harold's abusive behaviour towards Margaret, which impacted on her. Georgia was also clear that she personally was not a victim of physical domestic abuse. The panel reflected that Georgia and professionals may not have recognised that what she was experiencing could be domestic abuse in the context of emotional or psychological abuse.

14.2.5 On 29 March 2021, at a GP appointment, Georgia said she was mortified that she had even considered harming herself and had no current thoughts of self-harm. A plan was put in place to reduce her medication, and on 1 April, she asked the GP to cancel her involvement with the Community Mental health Team as she no longer needed it.

14.2.6 Georgia was not seen as a victim of domestic abuse or a victim of controlling and coercive behaviour by any professional, and although she had expressed suicidal ideation, she did not disclose developed plans to act upon it.

14.2.7 The panel was made aware of research indicating that a significant number of domestic abuse victims suffer from suicidal ideation. A study[19] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation.

This is a learning point which leads to panel recommendation 2.

14.3 How did your agency assess the level of risk faced by Georgia, and which risk assessment model did you use?

14.3.1 Two agencies completed formal risk assessments for Georgia.

14.3.2 Mersey Care completed a Care Programme Approach (CPA) risk assessment (the CPA is a framework used by mental health services to assess need and ensure support is in place to meet those needs. This document highlights indications of risk, including domestic abuse).

A CPA Statement of Care (SoC) was also completed in line with Mersey Care's Covid-19 guidance of non-face-to-face contact. This document replaced a CPA Core Assessment and is a shorter version of assessment of need that was utilised to inform telephone assessments by SPA during the restricted contact period of Covid-19 regulations.

14.3.3 Talking Matters Sefton assessed the level of risk using a standardised service risk assessment within the IAPT framework. This includes assessing risk to self or others, thoughts, and intents and plans of self-harm or suicide.

Georgia also completed the standardised questionnaires in line with IAPT requirements – the PHQ-9 for depression and GAD-7 for anxiety.

Item 9 on the depression questionnaire is a standard measure for risk. Scoring on this will prompt further exploration of risk – using additional risk assessment tools. As Georgia scored zero on this item, there was no evidence to support further questioning.

14.3.4 Neither risk assessment prompted immediate concern for Georgia, although her anxiety and depression, which was impacted on by Harold's abusive behaviour towards Margaret, were acknowledged in these assessments as well as by other

[19] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse [*Vanessa E. Munro & Ruth Aitken]*

services that interacted with Georgia, for example, her GP and the counselling service at Swan Women's Centre.

14.4 **Did your agency consider that Georgia could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?**

14.4.1 The definition of an adult at risk is found within section 42 of the Care Act 2014. This states:

'This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a)has needs for care and support (whether or not the authority is meeting any of those needs),

(b)is experiencing, or is at risk of, abuse or neglect, and

(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

(a)having money or other property stolen,

(b)being defrauded,

(c)being put under pressure in relation to money or other property, and

(d)having money or other property misused'.

14.4.2 Georgia was subject to ongoing assessment of her care and support needs by Mersey Care. It had not been fully established during the assessment period what her diagnosis was. Her previous history with mental health services, states that she had moderate anxiety that did not render her to be considered as an adult at risk within the terms of the Care Act 2014.

14.4.3 No agency contributing to the review considered that Georgia was an adult at risk. The safeguarding risks highlighted, were to her parents, not her. Also, Georgia indicated to Adult Social Care that her lifestyle was not impacted by her father's behaviour.

14.5 **What consideration did your agency give to any mental health issues when identifying, assessing, and managing risks around domestic abuse?**

14.5.1 The doctors at Georgia's GP surgery were aware of Georgia's mental health history and that she had recovered from anxiety and low mood in 2018, with high intensity cognitive behavioural therapy (CBT) and medication.

14.5.2 During 2019, she had six contacts with the practice (none with anxiety), yet within weeks of the first Covid-19 lockdown, she presented with anxiety symptoms. This was in part due to the impact of the lockdown and her father's medical diagnosis.

Extract from medical notes states:

"she is struggling at home with her dad's behaviour as he isn't observing the social distancing advice despite repeated warnings".

She was given time off work and referred for counselling, which had worked well previously. Following this, she presented the surgery with a bouquet of flowers, and received a thank you letter: "the flowers are beautiful, and they really cheered us all up". She presented to the surgery during the rest of the year with medical symptoms as appropriate. She had nine sessions of high intensity CBT from the local provider (Access Sefton) and was discharged from that service in December 2020.

14.5.3 As set out in previous paragraphs, although the GPs were aware of Harold's behaviour, Georgia did not make any disclosure that referred to herself as a victim, and she was not perceived to be a victim of domestic abuse.

14.5.4 Mersey Care's involvement with Georgia was primarily as a result of her own anxiety and depression. Following a referral from her GP, further information was sought to ensure the correct service and support was offered. An SPA telephone triage took place to review Georgia's risk to self and urgent care contact numbers were provided. An SPA appointment was expedited at her GP's request.

14.5.5 A Community Mental Health Team referral was made to review the requirement for secondary mental health care, and a Community Mental Health Nurse followed up to ensure that Georgia had made a self-referral to Talking Matters Sefton. When Georgia completed a telephone assessment with Talking Matters, the fact that she had an upcoming appointment for a psychiatric assessment caused them to make enquiries to establish the purpose of the appointment. It was decided to await the outcome of the psychiatric assessment before offering further appointments with Talking Matters. This was an appropriate course of action given the low risk

identified [see paragraph 14.3.3]. The issue was not resolved prior to Georgia's death.

14.5.6 Mersey Care staff were aware of Harold's diagnosis and were involved in assessing and treating him. Although Margaret was acknowledged as a victim of domestic abuse, Georgia was not, and she did not make any disclosure of domestic abuse to Mersey Care or any other agency.

14.5.7 The panel agreed that Georgia was a victim of controlling and coercive behaviour by Harold and could have been referred for assessment and support in her own right. It was felt that as she was an adult without any obvious vulnerabilities, the risks to her were not identified, and as such, neither was the increased risk of suicide.

This is a learning point linked to panel recommendation 1.

14.6 What services did your agency provide for Georgia; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

14.6.1 Agencies that provided services directly to Georgia were her GP, Mersey Care, Talking Matters Sefton, and SWAN Women's Centre. Georgia was sometimes in touch with SWACA but was not a client – the SWACA client was Margaret.

14.6.2 Georgia's GP surgery provided primary care services. There were no barriers to Georgia's access to general practice due to the Covid-19 pandemic, and Georgia had several contacts during lockdown periods, including being seen face to face. There is clear evidence of GP's knowledge of the need to assess those people with anxiety and depression for suicidal ideation and risk, and she was able to access support freely. She was seen in person and had telephone and text message contacts with the practice. An appropriate referral was made to Mersey Care that was followed by a request to expedite an assessment.

14.6.3 On 23 March 2021, Georgia had a telephone appointment with a GP. She was concerned that the 20mg dose of citalopram was making her anxiety worse. She agreed to reduce the dose to 10mg and undertake a blood test to look for any systemic cause for her symptoms and to help clarify if the citalopram was making things worse. The panel considered the possibility that Georgia may have stopped taking her medication against the advice of her GP but had no evidence on which to come to a conclusion.

14.6.4 Mersey Care noted positive and timely practice in relation to a prompt assessment and contact to review Georgia's risk to self by the SPA team. There was also positive

collaboration with other mental health services and the GP practice to inform health needs. The initial assessment by SPA was not face to face due to Covid-19 guidance: this did not affect further referral or services for ongoing assessment of need.

14.6.5 Talking Matters Sefton carried out an assessment appointment 20 days after receiving Georgia's self-referral. NHS England guidance is that an assessment should be conducted within six weeks. At the appointment, using the recognised risk assessment tools PHQ-9 and GAD7, there was no risk identified. Covid-19 did not affect the service provision to Georgia. Talking Matters Sefton routinely deliver telephone assessments, irrespective of the pandemic, with approximately 95% of cases being delivered in this way.

14.6.6 Although Georgia was not their primary client, SWACA made a referral for counselling for her to SWAN Women's Centre on 19 January 2021. This was quickly followed up with a first appointment on 22 January and weekly appointments thereafter. Georgia discussed her anxiety and depression as well as her medical appointment during counselling sessions but did not disclose suicidal ideation.

14.7 **How did your agency ascertain the wishes and feelings of Georgia, Margaret, and Harold? Were their views considered when providing services or support?**

14.7.1 SWACA met Margaret for appointments and also had conversations with Georgia to ascertain her views. As noted at paragraph 14.6.4, contact with Georgia led to a referral for counselling for her. SWACA also acknowledged that Georgia was finding it difficult to act as a conduit between Margaret and Harold's Community Psychiatric Nurse and agreed to support her with this.

14.7.2 Georgia was given time to talk in GP consultations and express herself, with a very responsive service balanced around her clinical needs. She attended alone, possibly due to Covid-19 restrictions. There is a 'task' system within the GP computer system to enable communication between professionals, and there is evidence of rapid transfer of information between practice teams relating to referrals, expediting of appointments, and queries.

14.7.3 Georgia was offered the opportunity to discuss her views and wishes within Mersey Care SPA and Community Mental Health Team assessments. Georgia's wishes were considered, particularly in relation to information sharing with family and a request for an assessment to be at a Mersey Care site and not at her home address.

14.7.4 In June 2020, following a safeguarding concern from Margaret's GP, Adult Social Care spoke to Georgia as she was the nominated point of contact. Margaret was offered a lifeline pendant alarm but did not want this. The case was closed as it was assessed that she was not a person at risk within the terms of the Care Act 2014.

14.7.5 On 12 August 2020, Harold's GP undertook a capacity assessment over the telephone – regarding him wanting his house to be left to Georgia in the event of his and his wife's death. The assessment was specific to that particular issue and at that time, the GP felt that Harold did have capacity to make that decision.

14.7.6 In early October 2020, Adult Social Care spoke to Georgia about a Care Act Assessment for Harold, following a referral from his Community Psychiatric Nurse. Georgia said that things were more settled following a change of medication and did not think a Care Act Assessment was needed: this was not progressed. The panel do not know what Georgia's knowledge of Care Act Assessments had been, but thought that the referring Community Psychiatric Nurse would have had more experience than a lay person. The panel thought that there may have been an opportunity for Adult Social Care to be more proactive on this occasion.

14.7.7 On 29 October 2020, after further concerns about his behaviour were raised by Harold's Community Psychiatric Nurse, Adult Social Care again spoke to Georgia. On this occasion, Georgia said that Harold was now attending a day centre and she thought that a Care Act Assessment would make things worse at home. Georgia also declined a carer's assessment on behalf of her mother. The panel noted that Georgia should also have been offered a carer's assessment but thought it unlikely that she would have accepted. The case was again closed. Georgia said that she had 'Power of Attorney' (POA) for Harold over his finances, health and welfare. However, the Power of Attorney for health and welfare can only be used when a person is unable to make their own decisions. At that time, there is no evidence that Harold was considered to not have the capacity to make his own decisions. Although it was appropriate to consult Georgia, repeated concerns were being raised by Mersey Care, and it may have been appropriate for Adult Social Care to have considered other options to explore an assessment. For example, visiting Harold at the day centre. The panel acknowledged that best practice for a Care Act Assessment is to see someone in their usual environment; however, the panel thought that the issues being raised warranted a more urgent and creative response.

14.7.8 Adult Social Care then had no involvement with the family until April 2021, following a further request for a Care Act Assessment made as a result of a strategy meeting. On this occasion, Georgia thought that an assessment would be beneficial, and an

arrangement was made to meet at a neutral location to discuss an assessment. Georgia said that she was able to go out and that Harold's behaviour did not impact upon her lifestyle, although she did suffer from anxiety. She also stated that the Covid-19 Lockdown had exacerbated things between her parents. The consultation with Georgia was appropriate as she was the named family contact – the meeting was to be used to plan how to conduct an assessment of Harold's care needs. Georgia died before the meeting took place.

14.8 **How effective was inter-agency information sharing and cooperation on this case? Was information shared with those agencies who needed it?**

14.8.1 There is good evidence of information sharing and cooperation across the agencies involved in the review. Referrals were made between agencies and information was available to professionals who needed it.

14.8.2 Two multi-disciplinary meetings and a strategy meeting took place. The first multi-disciplinary meeting involved Mersey Care, GP, SWACA, and Adult Social Care. The second included the same agencies with the exception of SWACA. Arising from those meetings, a strategy meeting was arranged as it was felt that police involvement may be required. Merseyside Police, Mersey Care and Adult Social Care were involved in the strategy meeting. Information was shared freely and discussed in all three meetings. The effectiveness of the meetings is discussed at paragraph 9.

14.9 **Was there sufficient focus on reducing the impact of Harold's alleged abusive behaviour towards Margaret by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**

14.9.1 There had never been a report of domestic abuse to the police, or any other agency, arising from Harold and Margaret's relationship until Margaret's disclosure to her GP in June 2020. The GP's safeguarding concern raised with Adult Social Care, did not result in any action to deal with domestic abuse. The GP or Adult Social Care could have conducted a domestic abuse risk assessment or ensured that one was conducted by another agency.

This is a learning point in relation to domestic abuse support pathways and links to panel recommendation 3.

There is an additional learning point here for Adult Social Care in relation to the need for an Adult Social Care process to ensure that all adult safeguarding referrals involving domestic abuse, or where it is suspected, should trigger a further referral

to the appropriate specialist domestic abuse support service as standard, even if the original safeguarding referral is not progressed by ASC.

The panel acknowledged that similar points have been raised in a previous Sefton DHRs and wished to restate the need for action to make changes.

14.9.2 Mersey Care then made a MARAC referral, having conducted a domestic abuse risk assessment, and the case was discussed at MARAC. Mersey Care's actions were independent and not prompted by the GP or Adult Social Care. At the meeting, actions were set as follows:

- SWACA to speak to victim about engaging with RASA for counselling.
- SWACA to speak to victim about wishes and feelings in relation to reporting incidents to police and feedback to police.
- Merseyside Police to record disclosures made by victim as a crime for investigation, when further information received from SWACA. [Further information was not provided to Merseyside Police until after Georgia's death – a crime was recorded after her death].

14.9.3 MARAC actions are recorded and disseminated to all member agencies following the meeting. Agencies are expected to complete the actions and provide feedback to the MARAC Coordinator: this is then kept as a record. If agencies do not submit any feedback as to the progress of the action, they are recorded as incomplete.

Currently, there is no formal process in place for sharing MARAC information with the GP.

This is a learning point. The panel was told that discussions have been underway for some time between the Council, on behalf of MARAC, and the CCG and GP safeguarding leads, and a draft process has been agreed. However, this still needs formal agreement by the CCGS/GP network about how this will be implemented on a practical level. This is being progressed as a priority. This action has also been highlighted in DHR10, which is nearing completion. As this action is already underway, the panel chose not to make a further recommendation on this point.

None of the actions at the MARAC meeting led to any action to deal with Harold's alleged abusive behaviour.

14.9.4 On 25 November 2020, during a telephone appointment with a GP, Margaret made a new disclosure that Harold had grabbed her against the wall at home following an argument about Margaret continuing to work after the new year, as Harold did not want her to continue. The information was given to the Community Mental Health Team treating Harold. The GP or the Community Mental Health Team could have

conducted a domestic abuse risk assessment or ensured that another agency did so. There is no evidence that a domestic abuse risk assessment was conducted following this disclosure. The absence of a risk assessment meant that risks were not fully understood and potential mitigating action not considered. An outcome from a risk assessment could have been a further referral to MARAC. This is a second learning point in relation to domestic abuse support pathways and leads to panel recommendation 3.

14.9.5 In early March 2021, Margaret disclosed in a psychology appointment that she was struggling with the impact that Harold's behaviour was having on her and Georgia. She said that if Harold assaulted her again, she "would kill him" and could do this by giving him all his medication. A safeguarding concern was raised with Adult Social Care.

14.9.6 On 12 March 2021, arising from the safeguarding concern, a virtual multi-disciplinary team meeting took place to discuss the whole family: the outcome of which, was a strategy meeting was to be arranged involving the police to plan the safest intervention. The police were requested to place a 'treat as urgent' marker on the home address.
[Present were Mersey Care, GP, SWACA, and Adult Social Care].

Whilst the action for the police to treat any call as urgent was prudent, nothing was done to address Harold's alleged abusive behaviour.

14.9.7 On 19 March 2021, a second virtual MDT meeting took place. The outcome was that the GP was to reduce the family's repeat medications to weekly prescriptions to minimise the risks of an intentional overdose of Harold by Margaret. The meeting heard that Margaret was due to return to work in a week's time, which was thought to be positive.
[Present were Mersey Care, GP, and Adult Social Care].

The action from the meeting to reduce the availability of medication was prudent. However, nothing was done to address Harold's abusive behaviour.

14.9.8 On 22 March 2021, a strategy meeting took place arising from Margaret's disclosure to her psychologist on 11 March 2021.
[Present were Merseyside Police, Mersey Care and Adult Social Care].

Actions:

- Police to add a flag to their records indicating that there was a safeguarding enquiry under S42 of the Care Act ongoing.
- A referral to be made for an urgent Care Act Assessment for Harold.

Both actions were prudent. An urgent Care Act Assessment could have led to actions that may have mitigated Harold's behaviour. It then took until 7 April 2021 for Adult Social Care to contact Georgia, who was the nominated point of contact, about the Care Act Assessment. The panel thought that an urgent assessment arising from a strategy meeting should have been addressed more quickly than this.

14.9.9 None of the meetings produced actions that could have stopped or mitigated Harold's alleged abusive behaviour. These meetings arose from a safeguarding concern in which Harold was perceived to be the potential victim. However, all of the available information is clear that the situation arose as a result of his behaviour. Margaret had previously declined to move out of the family home. The panel has seen no evidence of any discussion with Harold about his behaviour or the possibility of him moving out of the family home. This was certainly complicated by his dementia diagnosis; however, it was clear that his alleged abusive behaviour significantly predated that diagnosis.

14.9.10 The panel thought that the strategy meeting could have considered options available to encourage Harold to move out of the family home. It is possible that an option arising from a Care Act Assessment could have been a move to other accommodation.

14.9.11 Another option would have been to consider whether Harold could have been moved out of the family home, either with or without his consent.

14.9.12 One potential option in such circumstances could be consideration of a Domestic Violence Protection Notice.

14.9.13 The College of Policing Authorised Professional Practice on such notices, states[20]:

Domestic Violence Protection Notices and Domestic Violence Protection Orders (DVPN/DVPO) can provide short-term protection for a victim following a domestic incident involving a perpetrator over the age of 18. A DVPN issued by the police prohibits the perpetrator from molesting the victim, as a minimum. It gives the victim a respite from their abuser and an opportunity to engage with services without the perpetrator being on the scene. The DVPN is followed up with an application for a DVPO in the magistrates' court within 48 hours of service (not

[20] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/#domestic-violence-protection-notices-and-domestic-violence-protection-orders

including Sundays, bank holidays, Christmas Day or Good Friday). The resulting DVPO, if granted, lasts for between 14 and 28 days.

In order for it to be an option, the officer should conclude that there are reasonable grounds to believe that:

- *the suspect has used or threatened violence against the victim, and*
- *the DVPN is necessary to protect the victim from violence or threat of violence by the suspect.*

It is appropriate to consider issuing a DVPN at incidents when an arrest has not been made and positive action is required, a charge is not possible, an investigation is continuing or results in a caution or no further action (NFA), or a suspect is bailed without conditions restricting their contact with the victim.

14.9.14 Whilst it would have been unusual to apply for a DVPN in the circumstances of this case, and it is not certain that a DVPN would have been authorised by a police superintendent, it should have been an option. If a DVPN had been served, it would certainly have posed a new problem of accommodating Harold that may have presented challenges. The panel acknowledged those challenges and that the service of such a notice would have been highly intrusive.

14.9.15 A number of other legal options were open to Margaret. For example, an application for a non-molestation order or an occupation order. There is no evidence that Margaret was given information about services to help her with this or advised to seek legal help. Due to Margaret's ill health, the Chair of the review has been unable to speak to her about this.

14.9.16 The panel thought that, in hindsight, the three meetings did not have sufficient clarity of purpose. They had been called because of a perceived risk to Harold; however, all the evidence pointed to the core problem being his abusive behaviour, which pre-existed his medical condition. His behaviour was not addressed via any of the actions taken.

The absence of action to address Harold's abusive behaviour is a learning point, which leads to panel recommendation 4.

14.10 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice, and were any gaps identified?**

14.10.1 All agencies have indicated that their single agency policies and procedures were followed. The relevant multi-agency policy is the Northwest Safeguarding Adults policy[21]. The panel thought that agencies had in general followed the policy and appropriate safeguarding concerns had been raised.

14.10.2 The case was referred to MARAC by Mersey Care on 29 June 2020. This followed Margaret's initial disclosure to her GP of domestic abuse on 8 June 2020. The GP raised a safeguarding concern with Adult Social Care who closed the case after consultation with Georgia. Both the GP and Adult Social Care could have made a referral to MARAC. In the GP's case, the choice was to raise a safeguarding concern: the panel thought that whilst this may not have been the best pathway given the specifics of the case, the GP acted promptly and in good faith. Having received a safeguarding concern that they did not progress because Margaret did not have care and support needs, Adult Social Care should not have closed the case without ensuring that some action was being taken in relation to the allegations of domestic abuse. It would have been appropriate for them to refer to MARAC.

This is a learning point, which links to panel recommendation 3.

14.10.3 The case was referred into MARAC by Mersey Care on 29 June 2020. They were already actively engaging with Harold and had completed the Sefton domestic abuse risk tool (an adaptation of DASH) due to disclosures made by Margaret.

14.10.4 During the MARAC discussion, Georgia was briefly mentioned as a point of contact for Margaret, but there was no specific information shared in relation to her. The referral to MARAC did include details relating to Georgia living in the same household as Margaret and Harold, though this information was not included in the MARAC papers and so some agencies may not have been aware of this.

14.10.5 Georgia was not identified as a potential victim of domestic abuse in her own right. The MARAC team have stated that, on reflection, this could have been a missed opportunity to gain a greater understanding of what Georgia was experiencing. The fact that Georgia lived in the household where the abuse was taking place could have been highlighted at MARAC – either by agencies who already knew this information prior to the meeting, but also via the MARAC process directly, by including Georgia's details in the MARAC papers.

[21] https://www.sefton.gov.uk/media/3104/north_west_safeguarding_adults_policy_v52.pdf

14.10.6 None of the subjects of the review were eligible for MAPPA management.

14.11 What knowledge did family, friends and employers have that Margaret was in an abusive relationship or of the effect it had on Georgia, and did they know what to do with that knowledge?

14.11.1 Georgia's siblings told the Chair of the review that Harold had always been controlling; however, they did not, at the time, realise that his behaviour was domestic abuse. Siblings stated that although they never actually witnessed physical abuse in his relationship with Margaret until 2021, they always suspected that it was taking place.

14.11.2 A few months before her death, Georgia told one of her siblings of a recent occasion when Harold had assaulted Margaret, which was reported to the police. She also said that Margaret had confided in her about other incidents but would not go into further detail. Georgia's sibling suspects that these were further incidents of physical violence.

14.11.3 Georgia's sibling describes the final months of Georgia's life as being really difficult. Her physical appearance had deteriorated to the point where she would not even facetime her nephew because she didn't want him to see her. She was absent from work due to her mental health and although her sibling tried to talk to her, Georgia did not want to open up. Her sibling knew from Margaret that Georgia was receiving some help through her GP. On no occasion had they ever heard Georgia allude to any suicidal ideation, nor ever suspected it.

14.11.4 Georgia's friends were unaware that Margaret was in an abusive relationship. They regularly saw her and Harold together and believed they were very happy. Following Georgia's death, they were surprised to learn that the relationship had been abusive and agreed that this would have had a significant effect on Georgia's mental health.

14.11.5 Georgia's friends described her as a private person, who was very reluctant to open up to them. However, in the few months prior to her death, she would acknowledge how unhappy she was and how upset she was to see her father's health deteriorate. She admitted that she had, on occasions, hoped 'she wouldn't wake up'. Friends were reassured by her that she was receiving help from her GP and other healthcare professionals.

14.11.6 Georgia's employer was also unaware that Margaret was in an abusive relationship. They noticed a distinct change in Georgia's mental and physical health from the beginning of 2021; however, she never elaborated on the root cause, other than to

explain that her father's mental health had deteriorated, and this was causing her worry at home.

14.11.7 Georgia's employer recognised that the change in circumstances at home, was beginning to affect her performance at work. Their primary concern was her health, and as such, when her manager spoke with her at the beginning of February 2021, she was encouraged to seek medical help. Georgia did not wish to be absent through sickness and negotiated with her manager to be absent through a period of furlough. Her employer agreed to this and signposted her to internal psychological support services. There is no evidence that she accessed these services.

14.12 **Were there any examples of outstanding or innovative practice?**

14.12.1 The panel acknowledged the significant work that the GP practice had done to ensure that Georgia was able to access appointments quickly and face to face where necessary even throughout lockdown.

14.12.2 The panel thought that Mersey Care's referral to MARAC was good practice. Both the GP and Adult Social Care previously had similar information but did not proceed with action on the domestic abuse. Mersey Care undertook a domestic abuse risk assessment and made the MARAC referral appropriately.

14.12.3 The panel did not identify any examples of outstanding or innovative practice that it wished to highlight.

14.13 **What training did your agency provide to staff around domestic abuse, coercive and controlling behaviour and mental health, specifically dementia? Had staff who interacted with the family, completed the training, and when?**

14.13.1 **IDVA Service:**

IDVAs support high risk victims of domestic abuse and receive specialist training on domestic abuse for this role, including coercive and controlling behaviour. The IDVA working on this case had completed the Safe Lives accredited IDVA training. Staff also have access to mental health training via the Council's Corporate Learning Development Unit, although this is not specific to dementia.

14.13.2 **SWACA:**

SWACA did not provide any information to the panel in respect of training in this area.

14.13.3 **MARAC:**

MARAC is a multi-agency setting, including representatives from police, health agencies and both adult and children's safeguarding teams. Therefore, there were a number of trained and knowledgeable professionals present at each meeting who were able to identify safeguarding concerns, including potential indicators of abuse, and who were able to suggest actions that could be taken to safeguard any vulnerable adults or children identified.

Training specifically related to MARAC and its processes is offered to all agencies signed up to the MARAC process by the MARAC Coordinator on an ongoing basis. The MARAC also holds development days with MARAC partners in order to refresh working practices within the MARAC process.

14.13.4 **Talking Matters Sefton:**

All Talking Matters Sefton employees are required to complete adult and child safeguarding mandatory training. The employee concerned, completed both modules on 7th January 2021.

All staff working as practitioners are either qualified in an IAPT compliant therapy modality, or on a training course for the same. The practitioner concerned, qualified in March 2019.

14.13.5 **Police:**

In June 2021, the force established a Multi-Agency Domestic Abuse Suicide Prevention working group. The meeting is attended by local domestic abuse services, local authority representatives and Health. The objectives are to work in partnership to understand and prevent suicide in domestic abuse and to formulate an action plan to achieve the objectives pan Merseyside.

During Nov and Dec 2021, Merseyside Police held a domestic abuse intensification period, during which 1069 continuous professional development events and briefings were delivered, with 6844 members of staff in attendance. The learning covered several domestic abuse topics, providing an in depth and powerful insight as to the

issues faced by victims. Coercive and controlling behaviours and the links between domestic abuse and suicide were included in that learning.

14.13.6 **Adult Social Care:**

The following training courses have been delivered by Adult Social Care:

Domestic Abuse Training – 10/10/17 and 02/09/20
Mental Health Awareness – 07/07/15 and 30/09/19
Dementia Awareness – 16/09/16 and 18/02/18
Dementia and Communicating Well – 14/10/16 and 16/02/18

A member of staff who had interacted with Georgia, Margaret and Harold had not attended any of the training.

Sefton Adult Social Care do not provide staff with any training into coercive and controlling behaviour.

14.13.7 **Mersey Care:**

Safeguarding training is a mandatory requirement for all staff employed by Mersey Care. Staff involved with this family were subject to mandatory 3 yearly Level 3 safeguarding training: the content includes domestic abuse, and coercive and controlling behaviour.

14.13.8 **Southport and Ormskirk Hospital NHS Trust:**

All staff employed by Southport and Ormskirk Hospital NHS Trust complete Dementia Awareness Tier One training via ESR. Staff who are likely to have regular contact with dementia patients complete Tier 2 e-learning. In addition to this, clinical staff are also able to access the face-to-face Frailty study day, where the correlation between safeguarding and frailty are explored with specific reference to the links between domestic abuse and dementia.

Safeguarding adults and children training is a mandatory requirement for all staff employed by Southport & Ormskirk NHS Trust.

14.13.9 **SWAN Women's Centre:**

SWAN did not provide any information to the panel in respect of training in this area.

14.14 **What learning did your agency identify in this case?**

Taken directly from IMRs.

14.14.1 **IDVA Service:**

That adult family members living in a household where there is partner domestic abuse are 'seen', with consideration being given to what they are experiencing, what risks they are facing, and whether they have any direct support needs themselves.

14.14.2 **SWACA:**

This case was particularly unusual as SWACA was not formally supporting Georgia. When/if this situation arises again, SWACA will ensure the appropriate services are in place for all parties.

14.14.3 **MARAC:**

Georgia was not considered as a potential victim of domestic abuse in her own right. What can be taken from the review of this case is the need to consider the impact of domestic abuse on anyone living within a household and the potential risk, and needs associated with this, even where the abuse is partner related between other individuals.

14.14.4 **Talking Matters Sefton:**

Next-of-kin/emergency contact details should be obtained at the first contact with client whenever possible. If the client declines to provide this, this should be recorded.
Practitioners need to be alert for any indication of safeguarding issues and, where identified, explore further.

Improved awareness of impact from dementia on family and carers would be beneficial.

14.14.5 **Police:**

Merseyside Police did not provide any information to the panel in respect of learning from this case.

14.14.6 **Adult Social Care:**

Although policies and procedures appear to have been followed by staff, case record recordings indicate that there was a lack of professional curiosity demonstrated by staff.

If this had been demonstrated, staff would have explored the circumstances more thoroughly and engaged with wider family members and friends to build a clearer picture and a more accurate reflection of the issues faced by the service users concerned.

The panel was aware that learning had been identified previously in DHR8. It would appear that actions from that review have not been progressed, or if they have, without effective outcomes. The areas that the panel still felt should be considered were:

- Need for staff awareness/training
- Staff knowledge and understanding of DA support pathways in Sefton
- Need for an ASC process that all adult safeguarding referrals involving domestic abuse, or where it is suspected, should then trigger a further referral to the appropriate specialist DA support service as standard, even the original safeguarding referral, if it is not progressed by ASC.

14.14.7 **Mersey Care:**

On reviewing the information, including contacts with services and clinical decisions made, it has been identified that the impact of domestic abuse can have a negative effect on a victim's mental health, particularly if a victim has a pre-existing mental health condition. The need to ensure that staff are professionally curious where victims of domestic abuse may have additional support needs. The Department of Health's definition of domestic abuse outlines that victims of domestic abuse include family members. In this case, it is important to ensure that staff are able to recognise victims within households and ensure that they have access to support where abuse is taking place.

14.14.8 **Southport and Ormskirk Hospital NHS Trust:**

Southport and Ormskirk Hospital NHS Trust did not provide any information to the panel in respect of learning from this case.

14.14.9 **SWAN Women's Centre:**

SWAN Women's Centre did not provide any information to the panel in respect of learning from this case.

14.15 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Georgia, Margaret, or Harold?**

14.15.1 Agencies followed their own processes and protocols when considering support to all parties but did not identify any needs or issues requiring specific attention.

14.15.2 The panel acknowledged that agencies knew that Harold was a perpetrator of domestic abuse, yet there was no enforcement action taken to address this. At the time of the events under review, Harold was considered to have the capacity to make his own decisions, therefore the panel felt that his age may have been a factor in this.

14.16 **Does the learning on this case feature in any previous DHRs commissioned by Sefton Safer Community Safety Partnership?**

14.16.1 Learning around the understanding and recognition of domestic abuse within the context of family relationships has appeared in DHRs 4, 5, 6 & 8. Following the first DHR, significant work was done to highlight the definition and wider context of domestic abuse, to include family related violence and abuse, and ensuring this was included in new promotional materials and the Sefton Domestic Abuse Protocol. Building on learning from further reviews, this is also clearly highlighted in any Sefton multi-agency domestic abuse training.

14.16.2 It is acknowledged that there is a continuous and ongoing need for ensuring agencies, particularly front-line practitioners, have appropriate domestic abuse training available, and agency attendance is regularly reviewed due to the changes in services and staffing. This will be a key priority area within Sefton's Domestic Abuse Strategy currently underway, which will be overseen by the Sefton Domestic Abuse Partnership Board. The learning in this review is specifically around making sure professionals see, acknowledge, and respond to any other adult victims, connected to a domestic abuse case, as potential victims requiring support outside of the initial concern or referral(s). This will be incorporated into Sefton's multi-agency training offer and the learning shared with the Domestic Abuse Board

agencies for them to consider this within their single agency training offer, if not already.

14.16.3 DHR8 identified learning related to Adult Safeguarding and their role in responding to domestic abuse. Similar learning has been identified in this review showing there is still some work to do. Recommendations will be overseen by the Domestic Abuse Board to ensure that there is strategic oversight on making sure these are priorities and implemented across the department.

14.16.4 DHR10 (which has been underway at the same time as this review and has not yet been submitted to the Home Office for quality assurance) identified learning for MARAC around highlighting known risk information, such as suicidal ideation within the information shared with agencies and the discussions at MARAC meetings. There is some similarity in learning in relation to ensuring known information about individuals is shared and specifically highlighted in multi-agency safeguarding forums – such as suicide concerns as a risk factor identified in DHR10, and information about other adults present in a household who may also have their own needs identified in this review. Actions related to this are being considered and addressed together by the MARAC steering group.

15 CONCLUSIONS

15.1 Harold subjected Margaret to domestic abuse for many years, and prior to him exhibiting signs of dementia. Incidents were not reported to the police and the abuse went unnoticed by friends and family, who may not have identified Harold's behaviour as being coercive and controlling.

15.2 The panel was grateful for the advice provided by Respeito. An awareness of Portuguese and Madeiran culture added context to the dynamic within the household. Georgia remained in the family home and was committed to caring for both parents. She was unreservedly loyal to both and worried about her mum, not wishing to leave her alone with her dad for very long. The support Georgia gave to her mum also presented a moral dilemma for her. The panel felt that hiding things from her dad and acting as a conduit for professionals to speak with Margaret would have made Georgia feel very uncomfortable and increased the significant emotional pressure she was already under.

15.3 When Margaret reported physical abuse to her GP in June 2020, Georgia was already suffering with poor mental health. She was worrying about Harold's behaviour and was finding social distancing difficult. That incident began a chain of

events by professionals, all intended to support Margaret as a victim. However, such was Georgia's role as supporter and organiser for both her parents, those same events placed additional pressure on her, which contributed to her becoming unwell. The 'lockdown' restrictions may have increased the frequency and nature of the abuse Margaret received, which in turn exacerbated the impact on Georgia.

15.4 The panel felt that professionals may not have recognised that Georgia was experiencing domestic abuse in the context of emotional or psychological abuse. It was felt that she was a victim of controlling and coercive behaviour by Harold and could have been referred for assessment and support in her own right. The panel felt that because Georgia was an adult without any obvious vulnerabilities, the risks to her were not considered, and as such, neither was the increased risk of suicide.

15.5 Professionals offered and provided support to both Margaret and Georgia, but the panel felt that more could have been done to support the family within the remit of the Care Act. That may have relieved some of the pressure Georgia placed on herself to fulfil her duties as daughter – caring for her parents in emotionally challenging circumstances.

15.6 After disclosing physical abuse in June 2020, Margaret's GP raised a safeguarding concern with Adult Social Care. Neither the GP nor Adult Social Care conducted a domestic abuse risk assessment or ensured that one was conducted by another agency. The absence of a risk assessment resulted in risks not being fully understood and a lack of action to address Harold's behaviour. The case was eventually referred to MARAC; however, Georgia was not identified as a potential victim. This was a missed opportunity for all agencies involved to better understand the impact on Georgia and take appropriate action.

15.7 In March 2021, two multi-disciplinary meetings and a strategy meeting took place after Margaret stated that she would harm Harold, if anything happened to Georgia. Nothing was done to address Harold's alleged abusive behaviour in terms of enforcement or preventing future harm. Harold's dementia complicated matters, but the panel did not feel that other options had been considered. Those meetings lacked clarity of purpose.

15.8 Agencies were in possession of information that Harold was a perpetrator of domestic abuse and no enforcement action was taken to address this. The panel was told that at the time of the events under review, Harold was considered to have the capacity to make his own decisions. The panel concluded that Harold's age must have been a factor in this.

16 LEARNING

This multi-agency learning arises following debate within the DHR panel.

16.1 Narrative

The possibility of Georgia being affected by emotional abuse and therefore being a victim of domestic abuse in her own right was not recognised by agencies during the timeframe of the review.

Learning

Further work is needed by agencies involved in the review to enable their staff to recognise all aspects of domestic abuse.

Recommendation 1 applies.

16.2 Narrative

The panel thought that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

Learning

Knowledge of the link between domestic abuse and suicide will enable professionals to formulate appropriate risk assessments and risk management plans.

Recommendation 2 applies.

16.3 Narrative

Professionals in three agencies did not follow existing domestic abuse pathways.

Learning

Knowledge of and adherence to agreed domestic abuse referral pathways maximises the ability of agencies to understand risk and provide appropriate services to victims.

Recommendation 3 applies.

16.4 **Narrative**

Agencies had information which pointed to Harold's continuing abusive behaviour that pre-existed a medical diagnosis of dementia.

Learning

The absence of effective action to address domestic abuse perpetrated by older people means that there is continuing risk for victims. Domestic abuse involving older people needs to be acknowledged as domestic abuse and dealt with according to established policies and processes for domestic abuse.

Recommendation 4 applies.

17 RECOMMENDATIONS

17.1 DHR Panel

17.1.1 All agencies involved in the review should provide the Domestic Abuse Board with assurance that training has been provided to staff to enable them to recognise and act upon all aspects of domestic abuse within the definition contained in the Domestic Abuse act 2021.

17.1.2 All agencies involved in the review should provide the Domestic Abuse Board with evidence that information has been provided to staff on the links between domestic abuse and suicide.

17.1.3 All agencies involved in the review should provide the Domestic Abuse Board with evidence that staff in their organisation have been provided with information on Sefton domestic abuse referral pathways, including implementation processes.

17.1.4 The Community Safety Partnership should produce a briefing summarising the learning from this review in relation to domestic abuse in older people.

17.1.5 All agencies involved in the review should provide the Domestic Abuse Board with evidence of their approach to dealing with domestic abuse affecting older people as victims or perpetrators.

17.2 Single Agency Recommendations

17.2.1 All single agency recommendations are shown in the action plan at appendix A.

Appendix A
Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	All agencies involved in the review should provide the Domestic Abuse Board with assurance that training has been provided to staff to enable them to recognise and act upon all aspects of domestic abuse within the definition contained in the Domestic Abuse act 2021.	Local	All DAPB agency members are asked to submit information and evidence Outcomes from this are fed into a training and development sub group – linked with Safeguarding Adults Board and Sefton Children's Safeguarding Board sub groups Additional multi agency training developed if gaps identified	Domestic Abuse Partnership Board	Questionnaire devised to enable consistent capturing and analysis of information Questionnaire sent out to all agencies Analysis of information collected shared with DAPB and training and development sub group(s) Additional multi agency training and DA resources in place	January 2024 March 2024	Audit of current agency training completed Feb 2024.Additional multi agency training offer available as part of the new integrated Sefton Domestic Abuse Service offer. Info from audit has fed into this. As part of this, DA awareness e- learning package has been produced to be made available to all agencies across Sefton, launched November 2024 Multi Agency DA Protocol is being updated and refreshed. Resources and information available on new DA website, including 7

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							minute briefings and DHR Learning briefings www.sefton.gov.uk/domesticabuse which will be added to as and when more info is available. Multi agency DHR Learning event held October 2024 – 160+ people attended. Training offer is regularly reviewed
2	All agencies involved in the review should provide the Domestic Abuse Board with evidence that information has been provided to staff on the links between domestic abuse and suicide.	Local	Linked to the above recommendation and actions Also development of specific DA & Suicide Prevention training	Domestic Abuse Partnership Board	As above DA & suicide training specification agreed DA & Suicide training rolled out Numbers completing training in Sefton	January 2024 for audit work February 2024 To be agreed once specification ready	Links between suicide and DA are being regularly discussed at DAPB. Key priority within Sefton DA Strategy. Ongoing work with Merseyside DA & Suicide Prevention group to develop and roll out DA & Suicide Prevention training to professionals in collaboration with

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							CHAMPS (public health). Procurement exercise underway March 2024
3	All agencies involved in the review should provide the Domestic Abuse Board with evidence that staff in their organisation have been provided with information on Sefton domestic abuse referral pathways, including implementation processes.	Local	Linked to the above recommendation and actions New SDAS service developed and in place and all agencies aware of the offer and pathways	Domestic Abuse Partnership Board	As above SDAS contract Regular report to DAPB on progress and learning outcomes Evidence of information shared across the partnership	January 2024 for audit work November 2023 for SDAS service	New Sefton Domestic Abuse Service (SDAS) contract in place from November 2023, providing 'one front door' approach to offering victim support services. This includes a new Helpline number for victims. Friends and family and professionals. Information has been shared across DAPB and SST partners and within local community based organisations Over the next 6-12 months this will be developed further across a range of wider organisations,

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							including local VCF groups and businesses
4	The Community Safety Partnership should produce a briefing summarising the learning from this review in relation to domestic abuse in older people	Local	Produce and share briefing with DAPB, SST, SSCP (children's safeguarding), and SSAB (adult safeguarding)	Safer Sefton Together	Briefing produced	April 2024	Complete. DHR12 Learning Briefing and DA & Older People 7 Minute Briefing produced. Shared at DHR Learning Event October 2024 and across partnerships. Also available on DA webpage www.sefton.gov.uk/domesticabuse
5.	All agencies involved in the review should provide the Domestic Abuse Board with evidence of their approach to dealing with domestic abuse affecting older people as victims or perpetrator	Local	Linked to actions 1 – 3. Outcomes shared with SSAB	Domestic Abuse Partnership Board	As above in Action 1 -3	April 2024	To be progressed

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
Mersey Care NHS Foundation Trust							
1	Raise awareness of victims of domestic abuse within non intimate relationships.	Local	Discuss the training need within MCFT safeguarding team training assurance group and agree how to include in bespoke DA training packages.	Mersey Care		September 2022 Expected outcome: Raise awareness of victims.	Completed Sept 2022.Domestic Abuse training packages reviewed and updated. Mersey Care has a training pool of specialist safeguarding leads delivering modular training on key issues with Domestic Abuse
2	Raise awareness of victims of domestic abuse with additional support needs.	Local	Discuss the training need within MCFT safeguarding team training assurance group and agree how to include in bespoke training packages.	Mersey Care	Not provided	September 2022 Expected outcome: Raise awareness of victims with additional support needs.	Domestic Abuse risk screening across the Trust is under review with an expected relaunch of routine questioning and bespoke training packages to assist the different service lines in their engagement with patients.
3	To share the learning from this review with the Trust's Suicide Prevention Leads.	Local	Meet with the Trust's Suicide Prevention Leads to highlight the	Mersey Care	Not provided	With immediate effect.	Action complete. Safeguarding leads also sit on the Suicide Prevention Group to share learning from

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			learning themes from this review.			Expected outcome: Ensure that the learning from this review is shared and the themes are highlighted as part of the Trust's suicide prevention initiatives.	reviews and link into the safety plan awareness across the Trust. Themes of the current reviews are reported against on a quarterly basis by the Assistant Director of Safeguarding at the Trust Strategic Patient Safety Improvement Group. All reviews are also highlighted at the quarterly Safeguarding Assurance Group chaired by the Divisional Deputy Director of Nursing & Governance.
CCG – on behalf of Primary Care							
1	Reinforcing link between suicide and DA.	Local	Share learning from local DHRs and links between suicide and DA at clinical practitioner learning event.	Named GP for safeguarding adults Sefton CCGs	Linked with SDHR13, audit undertaken reviewing self-harm disclosures and holistic review of GP records.	30.06.22	Completed 15.06.22 Presentation at learning event as well as sharing of research

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							6. 15.10 to 15.25 - Dr Anna Hunter.ppt
2	Highlight knowledge of DA and the new Act to GPs and surgery staff.	National	Create a Rapid Read in collaboration with NHS England.	Named GP for safeguarding adults Sefton CCGs	Written by Named GP in collaboration with Sefton GPs involved in DHRs.	31.05.22	Completed and disseminated nationally 24.05.22 **Rapid Read for GPs and surgery staff on**
Sefton Adult Social Care							
1	Reinforce the need to be professionally curious in our interventions with service users, their carers, and wider support systems.	Local	Agenda discussion in professional practice forum with frontline practitioners and devise and distribute a Quality Practice Alert (QPA) across Adult Social Care (ASC), outlining the need for us to practice a degree of	Mal Williams Principal Social Worker (PSW)	Not provided	October 2022 Expected outcome: Increased knowledge of professional curiosity and how this can support practitioners to question and challenge information they receive, identify	

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			professional curiosity, rather than accepting things at face value.			concerns, and make connections to enable a greater understanding of a given situation. Consequently, it is envisaged that this will lead to Adult Social Care professionals becoming more proactive in their care planning and producing comprehensive and holistic Care Act assessments.	
2	For the development of appropriate pathways within the Local Authority.	Local	Sefton MBC (Sefton Adults, communities, and Children's services) to design an agreed appropriate	Joan Coupe, Safeguarding Governance and Board Business Manager,	Not provided	December 2022 Expected outcome: A more integrated	

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			pathway to ensure all contacts made into Sefton Council, are managed effectively, and signposted to appropriate agencies where criteria for access to service is not met.	Sefton Adult Social Care.		pathway is established across all council and partnership services. Thus, ensuring appropriate response where domestic abuse features.	
Talking Matters Sefton							
1	Request NOK/emergency contact details at the point of every referral.	Local	1. Examples, including this case, to be shared with the administration team to demonstrate possible impact from not having this information. 2. To work with Data Lead to carry out audits to monitor compliance.	Administration Managers	Information re. impact of not obtaining emergency contact details shared with administrators, using this case as a 'live' example.	Audit 3 monthly. Emergency contact details are obtained for all clients or alternatively it is clearly documented that client declined to provide.	

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
2	Additional training to be delivered to the PWP team to develop understanding and confidence of when to appropriately explore possible safeguarding issues.	Local	1. Training package to be developed by Learning & Development Team 2. Live examples to be provided and used, anonymised as part of training. 3. Training delivered to PWP team.	Step Lead	Not provided		November 2021 Training delivered by MHM's Learning & Development team. Evidence in case management/ clinical supervision that practitioners are identifying potential adult/child safeguarding, exploring, gathering key information and discussing appropriately
3	Strengthen links with local dementia care services, with a view to improving knowledge for all staff.	Local	1. Link with local Alzheimer's Society. 2. Share information and/or advice received regularly from the Society with the TMS Team.	Service Lead Clinical Lead Step Leads	Establish contact with key individuals in local Alzheimer service provision.	Special interest group practitioner identified – April 2022 Presentation to teams – May 2022	1. Links established, regular emails received from AS. 2. Good examples of working together, e.g., suggestion of a joint piece of work between therapist and 'dementia care expert'

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			3. Consider a nominated practitioner with a special interest in support for carers. 4. Invite AS to present at team meetings.				to support a specific client.
4	To consider all options available to clients who find it challenging to access the service without adaptations.	Local	1. All staff to be aware of the need to flag challenges for any client in accessing the service. 2. Managers to explore all options, thinking innovatively as necessary.	Service lead	Not provided	Complete	Staff aware and flag as appropriate. Evidence of considerations; arrangements made with specific GP practices to meet an individual client's needs; home visit carried out; increasing out of hours activity; use of interpreters; liaising with support workers.
Sefton IDVA Service							
1	Ensure the risks and needs of any other adult family members living in a household where there is domestic abuse	Local	IDVA procedures updated to include a specific point about considering	IDVA Team manager	Procedures updated. Team session held.	March 2022	Complete Discussed as part of a team session held 3 March 2022.

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	are considered as standard practice for all IDVA referrals, even where the abuse is partner related (rather than family abuse) between other individuals.		the risks and needs of any other adults living in the household where the domestic abuse is being perpetrated, even when the referral is in relation to partner abuse associated with other individuals. Hold a reflective learning session with the IDVA team to discuss the findings from this case and the new procedure going forward.				Team have actively taken this on board and considered this as part of new cases. IDVA procedures.
Sefton MARAC							
1	Ensure the risks and needs of any other adult family members living in a household where there is domestic abuse are considered at MARAC meetings, even where the	Local	Review of the MARAC Operating Protocol to ensure it includes a specific point about asking agencies to	MARAC Coordinator	Updated MARAC Operating Protocol in place. All MARAC partners informed of changes.	September 2022	Action plan and proposed changes discussed and agreed at MARAC Steering Group 29 June 2022.

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	abuse is partner related between other individuals.		consider the risks and needs of any other adults living in the household where the domestic abuse is being perpetrated, even if they are not classed as a vulnerable adult, and also when the referral is in relation to partner abuse involving other individuals. Highlight this learning to all MARAC partners. Details of any other adults living in a household named on the MARAC referral to be included in all		MARAC papers include the details of any adults living in the household.		Links to other DHR and child practice review learning re: best use of known information . Additional information about adults in a household added to the MARAC Operating Protocol, wording also changed on MARAC referral form to include all adults in a household. All MARAC members updated and received updated MARAC Protocol

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			future MARAC case paperwork.				

End of Overview Report 'Georgia'

Please note: the action plan is a live document and subject to change as outcomes are delivered.

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Janette Maxwell
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Communities
Sefton Council
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20th September 2023

Dear Janette,

Thank you for submitting the Domestic Homicide Review (DHR) report (Georgia) for Sefton Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 23rd August 2023. I apologise for the delay in responding to you.

The QA Panel commented that this is a well-written report, with appropriate learning and recommendations identified. The report demonstrates good engagement with Georgia's family, friends, and colleagues, and helps the reader understand who Georgia was as a person. As such, there is clear consideration of Georgia as a victim of domestic abuse in her own right throughout the report.

The inclusion of a Portuguese charity advisor helped to give deeper cultural context to the dynamics within Georgia's family. There is a helpful section covering potential equality, diversity and inclusion issues. Discussion of how agencies could have acted to disrupt Harold's abuse is helpful, and the report notes where relevant recommendations from previous DHRs have not been implemented.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Harold is a subject of the review but there is very little information about him and the agencies he interacted with. The author notes his medical notes were requested but not shared.
- There was no specific line of enquiry around the impact of Covid-19, and this feels like a gap. Though the impact of the pandemic is explored and mentioned throughout, a specific question would help to pull out the learning from the case. The report does not clearly show the lockdown dates which

would be useful to look at right from the outset to consider the context of what was happening at home alongside those significant periods.

- Paragraph 3.2.9 mentions ‘non-consensual sex’. Non-consensual sex is rape and should be described as such.
- Harold’s economic abuse towards both Georgia (and his other children) and Margaret is not recognised. This included that he did not allow the children to go to college (13.1.1) and that he did not want Margaret to return to work in 2021 (13.2.25). His behaviours around the family business could also be considered (13.1.3-4) including that he bought the restaurant and expected Margaret and the children to ‘help out’, and that he did not allow Margaret to be ‘front-facing’ in her roles.
- Though Harold’s age is concluded to be a factor in the lack of enforcement against him in the Equality, Diversity and Inclusion section, this is not expanded upon, leaving it less clear what led the panel to come to this conclusion.
- It is not accurate to describe the abuse as ‘domestic abuse in Georgia’s parent’s relationship’, for example in paragraphs 14.2.4, 14.3.4. Harold was abusive to Margaret.
- Not including a public health and/or suicide prevention representative on the panel was a missed opportunity not as they could have added additional perspective.
- Georgia’s sibling raised concerns around Harold’s abuse towards Margaret still continuing, and it’s particularly concerning that Georgia’s sibling shared that Harold is still being ‘treated as the victim’.
- Multi agency risk assessment conference (MARAC) meeting actions and poor follow up could have been considered more. For example, there was an action to provide information to the police for a crime report to be generated which was not completed and subsequently prevented police risk assessments and potential action being taken.
- Although there appeared to be lots of contact with services in the timeframe under review, previous involvement was not clear, which would allow for consideration of whether there was a sharp escalation in contact to services by the whole family. This may have been a clear risk escalation but is difficult to see from the report.
- The action plan does not include the DHR recommendations, and some single agency ones have not been completed (for example, the first agency plans are missing milestones).
- Some panel member roles are missing (for example, Talking Matters).
- Paragraph 14.1.12 could also include that the DA Act 2021 recognised children as victims. Although Georgia was an adult during the review period, her sibling’s account is that they experienced Harold’s abuse growing up.

- The question: ‘Was there sufficient focus on reducing the impact of Harold’s alleged abusive behaviour towards Margaret by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?’ is not sufficiently answered.
- From the information in this review, it is clear that the poor state of mental health that Georgia was experiencing was caused by living in fear of Harold and what he would do. This also raises the question whether Georgia’s pre-existing mental health problem was also likely to have been caused by Harold as she had been living in an abusive environment for most of her life. This is not explored.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

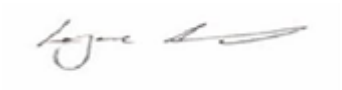
Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,



Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel