Domestic Homicide Review

Overview Report

Report into the death of ‘Dawn’

Died October 2021

Author and Domestic Homicide Review Chair: Stephen McGilvray

Date: February 2025

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

This report is the property of Safer Sefton Together.

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Glossary

ABC	Acceptable Behaviour Contract. Written agreement between a client and a service provider aimed at reducing levels of anti-social behaviour.
CJMH	Criminal Justice Mental Health Team.
CMHT	Community Mental Health Team
CPA	Care Program Approach. A process which provides support for patients who have a long enduring mental health condition or those who have a range of complex needs which require the support from secondary mental health services to support and co-ordinate their care.
CPS	Crown Prosecution Service
CRC	Community Rehabilitation the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales.
DASH	Domestic Abuse Stalking and Harassment risk assessment checklist.
DVDS	Domestic Violence Disclosure Scheme enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.
DVPO	Domestic Violence Protection Order.
EDT	Adult Social Care Emergency Duty Team.
Freedom	Programme that provides group work sessions for victims of domestic abuse. Each week looks at a different aspect of behaviour, looking at what the abuser says and how it is said, what the abuser does and why we believe them. It

	helps to identify the common tactics to gain power and control.
HMPPS	His Majesty's Prison and Probation Service
HOT	Housing Options Team a Gateway system to assess, manage and allocate homelessness and housing related support.
Housing First	Provides people who have experienced homelessness and have support needs the opportunity to sustain a stable home with an open-ended and holistic approach to support provided.
IRISi	A social enterprise established to promote and improve the healthcare response to domestic violence and abuse.
IDVA	Independent Domestic Violence Advocate.
ISVA	Independent Sexual Violence Advocate provides support to victims of sexual violence.
LUFHT	Formerly Royal Liverpool University Hospitals NHS Foundation Trust – now Liverpool University Hospitals NHS Foundation Trust made up of Liverpool Hospital and Broadgreen Hospital
MARAC	Multi-Agency Risk Assessment Committee.
MARAM	Multi-Agency Risk Management. The MARM Framework is designed to support anyone working with an adult where there is a high level of risk and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial.
MDT	Multi-Disciplinary Team based within Community Mental Health Services.
MeRIT	Domestic abuse risk assessment checklist developed and used by Merseyside Police. Gold, Silver Bronze assessed levels of risk following domestic abuse, same as High Medium and Low risk levels.

NCDV	National Centre for Domestic Violence.
OASys	Probation online risk and needs assessment tool.
PNC	Police National Computer
RASA	Rape and Sexual Abuse Support service available to victims of sexual assault.
Ruby Project	A domestic abuse service for victims living in Liverpool, Sefton, Knowsley and St Helens. It offers practical and emotional support to victims from a highly skilled and trained team of domestic abuse practitioners.
SDGH/Mersey & West Lancashire Teaching Hospitals NHS Trust.	Formerly Southport and Ormskirk Hospital NHS Trust on 1st July 2023 this Trust combined with St Helens and Knowsley Teaching Hospitals NHS Trust and now operates under its new name, however this might be easier to read as Southport Hospital in the report.
Section 2 Notice	Section 2 of the Care Act 2014 facilitates a planned discharge of patients currently admitted to hospital who have care and support needs.
Section 5(2) Order	This can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concludes that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act.
SPO	Senior Probation Officer.

SSO	A Suspended Sentence Order is a custodial sentence which should only be imposed if: a. The custodial threshold has been passed. b. A custodial sentence is deemed by the Court as inevitable c. No other sentence can achieve the same aims of sentencing. The custodial sentence is suspended but can be activated in the event of a breach or the commission of a further offence during the suspension period of the Order.
SWACA	Sefton Women and Children's Aid whose aim is to safeguarding women, young people and children. Our dedicated team supports them in surviving the impact of domestic abuse by giving free, practical and emotional help.
VPRF1	Merseyside Police Vulnerable Persons Referral Form completed at the scene of a domestic abuse incident by Police Officers which includes a risk assessment checklist.
Women's Turnaround Programme	A female only service offering a drop in, individual and group work support and counselling to adult female offenders. The project works closely with a number of agencies, such as CAB, drug and alcohol agencies, local training and employment agencies, mental health services, probation and the courts.

Foreword

The Panel wish to record their sadness that Dawn's life should have ended this way, and our sympathies go to Dawn's family and all who knew her. Whilst suffering several traumatic events during her life nevertheless friends describe the intelligent and funny person that she was and the great sadness they feel at her loss. It is clear that Dawn was loved by her family and friends.

1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and the support given to Dawn (pseudonym), a resident of Sefton prior to the point of her death in October 2021

1.2 In addition to agency involvement the Review will also examine the past to identify any relevant background or trail of abuse before Dawn's death, 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.

1.3 The circumstances which led to this Review being undertaken are as follows. In October 2021, Police Officers were called to a flat in Widnes Cheshire were they found Dawn who was deceased. The flat belonged to a friend of Dawn who lived in Widnes. Dawn was staying in Widnes on a temporary basis having been placed in a hotel by agencies in Sefton as a place of safety following an incident of domestic abuse reported to have been perpetrated by her partner Ewan (pseudonym), Dawn at the time of her death had been in a long-term relationship with Ewan, during which she suffered numerous incidents of abuse,

1.4 The Review will consider agencies contact and involvement with Dawn and Ewan from 1st January 2015 until Dawn's death in October 2021. The Panel decided on this time frame because this would capture information about any history of abuse and violence within their relationship, Dawn disclosed to the Ruby Project that domestic violence began in their relationship in 2015, and this also reflects the period during which incidents of abuse against Dawn began to be discussed at MARAC. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included within the agency's individual management review.

1.5 The key purpose for undertaking this DHR is to enable lessons to be learned from incidents where a person dies as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible professionals need to understand fully what happened in this case and most

importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

2. Timescales

2.1 In October 2021 Cheshire Police attended a flat in Widnes belonging to a friend of Dawn in which she had died. Dawn had been temporarily placed in Widnes by agencies in Sefton following an incident of domestic abuse perpetrated by her partner. Due to the reasons for which Dawn had been accommodated in a place of safety Cheshire Police informed Merseyside Police of the death.

2.2 Due to an administrative oversight a delay occurred before Merseyside Police notified the Safer Sefton Together partnership of the death.

2.2 Once notified, because of the history of domestic abuse suffered by Dawn whilst living in the Sefton area of Merseyside members of Safer Sefton Together agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016. The Home Office were notified of this decision.

2.3 As a result of the Safer Sefton Together decision the Chair of the DHR Panel was commissioned in September 2022 and the Review was completed in January 2024

3. Confidentiality

3.1 Prior to Home Office approval for the publication of this Review its findings are confidential and information is available only to the Panel's participating professionals and their line managers.

3.2 The following pseudonyms which had been shared with the parents of Dawn were agreed by the Panel and are used throughout this report to protect the identity of the individual(s) and their families.

Dawn	female partner in relationship. Deceased	Aged 46 years
Ewan	male partner in relationship.	Aged 44 years
Francis	Ex-partner of Dawn.	

The ethnicity of both Dawn and Ewan was white British.

4. Terms of Reference

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

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

4.2 Having reviewed the chronologies gathered from agencies the DHR Panel agreed the focus of this Review should be upon the following Key Lines of Enquiry.

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

4.3 Agencies completed Individual Management Reviews (IMR) and each IMR covered the following areas: A chronology of their interaction with Dawn and Ewan, what was done or agreed following those interactions, whether internal procedures were followed, what learning they took from the review and conclusions and recommendations from the agency's point of view. Whilst completing the IMR Panel Members interviewed colleagues who had direct contact with Dawn or Ewan.

5. Methodology

5.1 Having received notification from Merseyside Police of the fatal incident members of Safer Sefton Together agreed that a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016 was required. The Home Office were notified of this decision.

5.2 At the commencement of the Review and prior to the first Panel meeting the Chair made contact with the family and friends of Dawn and sought their input on what key lines of enquiry the DHR should follow.

5.3 Panel members were asked to provide chronological accounts of their agencies contact with Dawn and Ewan within the agreed timescale of 1st January 2015 and Dawn's death in October 2021 and secure all files relating to such contacts. Where there was no involvement or insignificant involvement, agencies advised accordingly.

5.4 Having reviewed the chronological accounts provided by Panel members the Review Panel agreed the key lines of enquiry the Review should focus upon. Details of the key lines of enquiry were shared with Dawn's parents.

6. Involvement of Family and Friends

6.1 The Panel engaged with both of Dawns parents and discussed her life from her teenage years until her death. Pseudonyms to be used within the report were agreed and discussions held with her parents about what the key lines of enquiry are that the Review should consider. The Home Office leaflet for family and friends was shared with Dawn's parents at this time. Also discussed was information surrounding the provision of advocates for the family during the Review and the support available to them during this tragic time. At this time the family did not feel able to make a decision on the provision of advocates.

6.2 Dawn had received support from a local church and had regular contact with the Priest. Stephen McGilvray made contact with the Priest, who described Dawn as intelligent and funny. Whilst the Priest described his interaction with Dawn as being a sounding board for her, he also concluded that Dawn would always be "*sucked back into the influence of her abusive partner. She wanted to take responsibility for her actions but because of her addictions she couldn't*."

6.3 The Priest also described an ex-partner Francis with whom Dawn had a recent relationship lasting 12 months. "*He was the love of her life but both realised that because of her suicidal thoughts the couple could never stay together".*

6.4 When spoken to Francis described Dawn as a determined individual who *"was beyond help, she was determined to take her own life*." Francis tried to help Dawn by putting her in contact with support agencies in an effort to help her break the cycle of suicidal thoughts she was suffering. Francis said that she "*tried speaking to them a few times but it never lasted*."

6.5 A letter was written to Ewan including a copy of the Home Office leaflet on the purpose of a domestic homicide review, inviting him to take part in the Review and share his thoughts on the death of Dawn. Ewan did not respond to this offer.

6.6 Housing First continue to maintain contact with and support for Ewan. They were asked by the Panel if they were able to speak to Ewan about issues discussed within this review but declined stating that they felt that their relationship with him may be damaged if they did so.

6.7 Stephen McGilvray shared draft copies of this review with Dawn's parents and shared the final copy of this review with them prior to its submission to the Home Office for quality assurance.

7. Contributors to the Review

7.1 The following agencies contributed through their presence and input at Panel meetings and through their completion Individual Management Reviews.

- Adult Social Care Sefton Council.
- Change Grow Live
- HMPPS. (Probation)
- Housing Options, Sefton Council
- Housing First
- IDVA Service, Sefton Council

- Liverpool University Foundation Hospital Trust.
- Sefton MARAC. Sefton Council
- Mersey Care NHS Foundation Trust.
- Merseyside Police.
- One Vision Housing
- NHS Cheshire and Merseyside Integrated Care Board.
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- SWACA. Sefton Women and Children's Aid
- Liverpool MARAC
- Venus
- PSS Ruby Project

7.2 All authors of the IMRs were independent and had played no part in the provision of services to either Dawn or Ewan or in the supervision of those providing services to them.

8. The Review Panel Members

8.1 A DHR Panel was established by Safer Sefton Together and comprised of the following agency representatives:

Louise O'Rourke	Sefton MARAC, Sefton Council
Natalie Hendry-Torrance	NHS Cheshire and Merseyside ICB
Sue Platt	Sefton Women and Children's Aid
Cherry Collison,	NHS Cheshire and Merseyside ICB
Holly Chance	Merseyside Police.
Carla Whittaker	Mersey Care NHS Foundation Trust.

Sharon Seton	Mersey and West Lancashire Teaching Hospitals NHS Trust
Felicity Shepley	Adult Social Care Service Sefton Council
Michelle Dean/Johnathon Platt	HMPPS
Claire Mumford	Liverpool University Hospitals NHS Foundation Trust
Rita Chambers	The Ruby Project
Kelly Miller	Change Grow Live
Allan Glennon	Housing Options, Sefton Council
Suzanne Meylan	One Vision Housing
Ellie Moss	Housing First
Janette Maxwell	Sefton IDVA Service, Sefton Council

The Panel met a total of six times and none of the Panel Members had direct contact with or direct supervisory responsibility for those who did have contact with either Dawn or Ewan.

9. Chair of the Domestic Homicide Review Panel and Author of Report

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

9.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children.

9.3 Stephen has successfully completed the Home Office training course for Chairs of DHRs. He has Chaired and written Overview Reports for several Domestic Homicide Reviews as well as taking part in several Serious Case Reviews.

9.4 Prior to being appointed as Head of Community Safety Stephen had completed 30 years Police service with Merseyside Police. It was 18 years ago that Stephen retired from Merseyside Police.

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

10. Parallel Reviews

10.1 H.M. Coroner at Widnes was made aware that this DHR was taking place. H.M. Coroner later recorded the cause of Dawn's death to be an overdose of prescription drugs.

10.2 There were no other reviews in relation to this death which had taken place, or which were running parallel to this Review.

11. Equality and Diversity

11.1 All aspects of equality and diversity were considered throughout this review process including all of the Equalities Act protected characteristics. Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** Dawn was 46 at the time of her death and Ewan was 44. There are no known age considerations in this case.
- **disability** Dawn had a medical history of Type 1 diabetes, aneurism, multi organ failure, and chronic lung disease. Dawn had received a diagnosis of mental and behavioural disorders due to multiple drug use, and a

diagnosis of Emotionally Unstable Personality Disorder. Ewan had no known disabilities.

- **gender reassignment** Gender reassignment was not a consideration in this case.

- **marriage and civil partnership** Dawn and Ewan had been in a relationship for approximately 26 years during which there had been frequent periods of separation. The relationship had not progressed to marriage or a civil partnership.

- **pregnancy and maternity.** Dawn had one child from a previous relationship. No children were born during Dawns relationship with Ewan. Dawn was not pregnant at the time of her death

- **race** Dawn and Ewan were both white British
- **religion or belief** Religion or belief was not a consideration in this case/.
- **sex**
- **sexual orientation** Dawn was a female heterosexual, and Ewan is a male heterosexual and there are no indications from the Review that this is an area for further consideration.

Section 6 of the Act defines 'disability' as:

A person has a disability if;

[a] The person has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities

Dawn and Ewan were born in the United Kingdom and their ethnicity is White British. There is nothing in agency records that indicated that any of them lacked capacity in accordance with Mental Capacity Act 2005. Professionals applied the principle of Section 1 Care Act 2005:

'*A person must be assumed to have capacity unless it is established that they lack capacity'*

To ensure the review process considered issues around domestic abuse the panel included representatives specialising in domestic abuse.

11.2 As later paragraphs within this Review will show the Panel believe that Dawn was discriminated against because of her sex.

11.3 Office of National Statistics analysis of data supplied by England and Wales Police forces releveled "*that the victim was female in 73.5% of domestic abuse related crimes recorded by the Police in the year ending March 2023, compared with 26.5% of domestic abuse related crimes where the victim was male*"[1]. Dawn was subjected to unlawful conduct of a sexual nature and was subjected to high levels of intimate partner violence.

11.4 "*There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt or killed than male victims of domestic abuse. Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours.* [2]

11.5 Whilst in her relationship with Ewan Dawn disclosed that she was the victim of several incidents of physical violence. She was subject to controlling and coercive behaviour and was the victim of financial abuse. Details of this discrimination will be dealt with in the chronology and analysis sections of this Review.

11.6 During the work of the Panel no challenges had to be made by the Chair to any Panel member for a breach of equality standards.

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[1] https//www.ons.gov.uk/peoplepopulationandcommunitry/crimeandjustice/domesticabusevictimcharachteristicsenglandandwales/yearendingmarch2023.

[2] Domestic Abuse is a gendered crime. Women's Aid.co.uk 18th November 2015

12. Dissemination of Report

12.1 In accordance with paragraph 79 of the Statutory Guidance for the conduct of Domestic Homicide Reviews following receipt of Home Office approval for publication, the Overview Report, Executive Summary and Home Office letter will be provided to all parties referenced in paragraph 79 of the Guidance. These are listed within this report as Contributors to the Review and they include.

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

The report will also be provided to Dawn's parents and copies shared with the Office of Police and Crime Commissioner for Merseyside and the Office of the Domestic Abuse Commissioner.

13. Background Information

13.1 Dawn lived in the Sefton area of Merseyside, and died, following an overdose of prescription drugs together with traces of illegal substances, in a flat belonging to a friend in Widnes. Dawn was living in the Widnes area having been placed in a hotel in Widnes as a temporary place of safety following an incident of domestic abuse. No notes or messages were left by Dawn prior to her death.

13.2 At the time of her death Dawn and Ewan had been in a relationship for approximately 26 years.

13.3 Safer Sefton Together believe that Dawn's death met the criteria for conducting a DHR on the grounds of the recent incident of domestic abuse requiring Dawn who was unable to return to her home to be found a place of safety. Sefton agreed to complete the DHR rather than authorities in Widnes because of Dawn's long history of domestic abuse which had largely taken place in Sefton. H.M. Coroner in Widnes was made aware of this decision and the reasons behind it.

14. Chronology

Background history of Dawn and Ewan.

Background of Dawn.

14.1 Dawn was 46 years of age at the time of her death, she had one sibling, a younger brother and lived most of her adult life in the Sefton area of Merseyside.

14.2 Dawn had made a number of disclosures of domestic abuse in which Ewan was named as the perpetrator over a period spanning several years. Incidents of domestic abuse involving Dawn and reported to have been perpetrated by her long-time partner Ewan had been discussed at Sefton MARAC first in 2015 and in total 10 times before her death in 2021 and three times at Liverpool MARAC in 2015, 2018 and a third time in 2021 just one month before her death.

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

14.4 Contact was made with the Local Authority in which Dawn lived and had given birth, for information which could assist this review but the records relating to Dawn and her child were paper records and those records could be found.

14.5 Dawn moved to Sefton where her parents and sibling lived and there she met and began a long-term relationship with Ewan.

14.6 Dawn suffered a number of medical conditions and did require a number of in-patient hospitalisations and the daily use of medication due to recurrent pancreatitis. She also had a medical history of Type 1 diabetes, aneurism, multi organ failure, and chronic lung disease. Dawn had received a diagnosis of mental and behavioural disorders due to multiple drug use, and a diagnosis of Emotionally Unstable Personality Disorder. Dawn was an intravenous illegal drugs user.

14.7 Throughout the period of this Review due to the complexity of the challenges Dawn faced she found it difficult to engage fully with support services. Whilst clearly suffering physical and controlling abuse from Ewan the impact of contextualisation may have inhibited Dawn from supporting a Police prosecution and did tell services that she "was not a grass". However, on two occasions did support obtaining a Non-Molestation Order against Ewan with the support of NCDV but revoked the Order's shortly after they had been granted on both occasions. Dawn later disclosed that she would not engage

with services due to a fear that she would suffer retribution from Ewan had she done so.

14.8 Between 2015 and the time of her death Dawn self-harmed by taking a drugs overdose on several occasions. These included overdoses of prescription drugs. The first overdose took place in 2016 then again in 2017, 2020, and 2021.

14.9 In 2017 Dawn's heart stopped for six minutes after taking an overdose. When she recovered from this Dawn disclosed to the Venus Project that she was angry with her mother who had called an ambulance to treat her daughter and also the hospital at which she received treatment with who she was angry because their treatment enabled her to survive the attempt to take her own life.

14.10 In 2021, Dawn took an overdose of prescribed medication and illegal substances on eight occasions. Several of them were self-reported when speaking to professionals, and others required urgent medical care and treatment. Mental Health Act Assessments were completed however Dawn was considered not detainable; however, she did agree on three occasions to an informal admission to a mental health ward. All agencies had difficulties in forming therapeutic engagement with Dawn, and it is considered by the Panel that this was exacerbated prior to her death due to the national restrictions imposed to control the spread of Covid19. Face to face contact with Dawn in the last years of her life was primarily based upon crisis situations i.e. within the acute hospital environment or following arrests.

14.11 Dawn had been open to Community Mental Health Team for several years. She was not open to the service on the Care Programme Approach [CPA] framework and support from the Community Mental Health Team was via the mental health duty practitioner.

14.12 In 2018 whilst living in part of Liverpool Dawn received a caution on two separate occasions from the Police for prostitution offences.

14.13 Dawn reported being the victim of serious sexual assaults on three occasions once by an ex-partner a second by her current partner and a third by a neighbour. Dawn was referred to the Rape and Sexual Abuse Support Centre

(RASASC) on two occasions but declined Police involvement. This signifies significant adverse life experiences experienced by Dawn.

14.14 In addition to the physical assaults reported to have been committed by her partner Dawn was also subjected to controlling and coercive behaviour and financial abuse. Dawn disclosed that Ewan had threatened her with knives, prevented her from leaving her home and would also stalk Dawn whilst she was out of the house. On two occasions Dawn reported that Ewan had taken her medication from her and refused to give it back and on one occasion when Dawn told Ewan to leave her home, he took all of her shoes and her medication with him. Dawn disclosed that her benefit was paid into Ewan's bank account and he had control over her finances as well demanding money from her. Dawn had disclosed to one agency that she was being subjected to financial abuse by Ewan as long ago as 2017.

14.15 During the period of this Review Dawn suffered periods of homelessness. This always followed an incident of domestic abuse following which Dawn felt unsafe to return to her home being in fear of further abuse. On occasions this meant that Dawn slept rough on the street. Because of a history of substance misuse and complex needs agencies could not access Dawn a place at a domestic abuse refuge. A number of agencies worked together to help Dawn to find safe accommodation and Dawn was provided a home at supported living properties as well as a tenancy of properties in her own name. In the days before her death Dawn was identified as being in need of a safe discharge destination by safeguarding staff at Southport and Ormskirk Hospitals NHS Trust where she had been receiving treatment following a physical and sexual assault, and threats which she reported had been perpetrated by Ewan. Accommodation was found for her at a hotel outside of Merseyside which was a temporary measure only and before her death work was underway between Dawn and the Sefton Housing Options team to identify a more permanent address for her.

14.16 Research has found that levels of trauma, such as those experienced by Dawn, three serious sexual assaults, the removal of a child, a period in prostitution, and the physical and controlling abuse she now suffered "*can lead to self-*

medication to numb the pain in an attempt to dilute the reality of the occurrence, which in turn can lead to dependency and/or addiction." [3]

14.17 "*Trauma is often an "underlying" condition informing other problematic presentations, (e.g., drug/alcohol misuse/difficult behaviours)*".[4] Whilst the pathway into Dawn's addiction cannot be mapped with certainty the Panel believe that these traumas may have been the catalyst for the history of substance misuse and several incidents of self-harm during Dawn's life. A trauma informed approach was not taken at any point during Dawn's life and this is a lesson to be learned for all agencies involved in this review.

14.18 On the day of her death Dawn, visited a friend's flat in Widnes. She was visibly upset and told the friend she had recently had an argument with her ex-partner who she had just telephoned. Whilst at the friend's home he reported that Dawn self-administered a bag of Heroin. The friend later found Dawn who had collapsed and died in one of the rooms at the flat.

Background of Ewan

14.19 Ewan aged 44 years had been in a relationship with Dawn for 26 years at the time of her death. There were no children born out of the relationship.

14.20 During the period of this Review incidents of physical violence against Dawn were discussed at MARAC meetings and Ewan was named as the perpetrator in six of those MARAC cases. Police arrested Ewan three times for physical assaults on Dawn but neither arrest resulted in a prosecution due to insufficient evidence being available to charge Ewan with the offences.

14.21 During the review period Ewan appeared at Court and was convicted on six occasions. Of these six events, four were actively supervised by Merseyside CRC. The other two were disposals of a fine and a Suspended Sentence Order (Standalone). The offences in the main related to stealing and shop thefts,

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[3] Carole Bennett M.A. Psychology Today 2015
[4] Academy for Social Justice Commissioning 2019

possession of an offensive weapon, possession of class A drug and Threatening and Abusive behaviour. Dawn and Ewan were arrested together on two occasions for offences of shoplifting at premises within the Sefton area and for an offence of harassment with a homophobic element and criminal damage which followed a dispute with a neighbour.

14.22 Ewan was also reported by Dawn to have made threats towards her family, on one occasion threatening to burn out her father's car. None of those threats were carried out and Ewan was not charged with any offence as a result of the reported threats.

14.23 For a period of two years from 2015 Ewan did engage with drug treatment services in Sefton though is described as having only sporadic attendance towards the end of that period.

14.24 Within days of Dawn receiving hospital treatment at Southport and Ormskirk Hospitals NHS Trust for injuries sustained whilst being locked in a shed by Ewan, which resulted in Dawn being placed at a hotel in Widnes, Dawn was found dead in a flat belonging to a friend in Widnes. At the same time Ewan was admitted to hospital for treatment having taken an overdose of prescribed medication.

Chronology of events.

Chronology

14.25 In July 2015 Dawn reported her partner had assaulted her and stole Diazepam and £40 cash from her. She provided a statement to Police following this incident in which she declined to prosecute Ewan. Police Officer's completed a VPRF 1 which assessed the level of risk Dawn faced as Silver/medium risk. Consideration was given to issue a DVPN and Restraining Order against Ewan but neither were applied for. Ewan was however, issued with a Harassment Warning and Dawn was referred to Sefton Adult Social Care. Twelve days later Dawn called Police again about this incident, she alleged Ewan sexually assaulted her but later withdrew that allegation, and also that the missing

money was lost and not stolen by him, she stated that Ewan was not her partner just a friend.

14.26 In October 2015 the IDVA service and MARAC received a referral from Aintree University Hospitals NHS Foundation Trust who had completed a DASH risk assessment form for Dawn following a physical assault with Ewan named as the perpetrator. After being discharged from Aintree University Hospitals NHS Foundation Trust Dawn was accommodated in St Helens Refuge and it was reported that Dawn would be staying there as she was wanting to move out of Sefton.

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

14.28 In February 2016 Dawn contacted police about an incident which occurred the night before, she said that Ewan ejected her from the house without her medication and threw a hairbrush at her. She went to stay with her mother. Two days later Police interviewed Dawn she stated that no assault had taken place. A VPRF 1 was completed, which assessed Dawn as being at low risk of further violence and she was provided with domestic abuse support agencies information.

14.29 In July 2016 Ewan made a 999 call to report Dawn had taken an overdose, he stated she was armed with a knife and had inserted something into her vagina. She was removed to Aintree University Hospitals NHS Foundation Trust by Ambulance. Dawn was able to tell police before she deteriorated that she had not been assaulted and there had been no foul play. Nevertheless, a VPRF 1 form was completed and a referral made to Adult Social Care for Dawn. On receipt of the referral Adult Social Care informed the social care lead

practitioner in the Community Mental Health Team and then recorded no further action was required by Adult Social Care.

14.30 In July 2016 Dawn was an inpatient on a Mersey Care NHS Foundation Trust Mental Health Ward. During examination by a doctor Dawn reported feeling very distressed with a number of issues. She had thoughts to self-harm, thoughts that she cannot go on, guilty feelings towards her mum and about how her self-harm may affect her mum, and grief for a broken relationship and a child that was placed into care some years earlier.

14.31 At the start of January 2017 Dawn received treatment at Aintree University Hospitals NHS Foundation Trust following a physical assault she reported had been inflicted by Ewan. A DASH risk assessment form was completed by staff at the hospital who also made a referral to the IDVA service, the Ruby Project and to MARAC. Dawn had left the Aintree University Hospitals NHS Foundation Trust before agencies could speak to her and offer support and for the next two days agencies faced a dilemma of how to make safe contact Dawn. They were unable to contact Dawn as her telephone number was not in use and they were unable to send letter to Dawn as Ewan lived at the same address. A decision was made to not attempt making contact with Dawn until after the MARAC meeting scheduled for early February.

14.32 Nine days later Police received a 999 call from Dawn reporting that Ewan threw an object at her which hit her on the head. Police advised her to leave the house but she went into a separate room instead, Dawn said she was "*not a grass*" and would not speak to Police. Dawn was seen by Police officers but would not engage with them other than to request alternative accommodation. She went to stay with a friend and was seen again by officers later that day. Dawn denied any assault had taken place and there were no injuries apparent. A VPRF1 was completed by the officers who assessed Dawn's future risk of violence as low. Details of support agencies was again offered to Dawn.

14.33 Later that same day Dawn contacted Adult Social Care at Sefton MBC regarding this incident. She stated she did not want to press charges against Ewan and would like to speak to social services regarding the abuse. Adult

Social Care responded by informing the social care lead practitioner in the Community Mental Health Team of the call and Dawn's request. Dawn was then readmitted to Aintree University Hospitals NHS Foundation Trust. A DASH risk assessment was completed at the hospital with Dawn who asked to go into a refuge. Arrangements were put into place for Dawn to speak to the Ruby Project to discuss placement at a refuge.

14.34 On 20th January 2017 Adult Social Care at Sefton MBC attempted to contact Dawn in response to a referral regarding this incident. Dawn's phone number was not operational so a letter was sent to her home by Adult Social Care.

14.35 In the first week of February 2017 Dawn's case was discussed at the Sefton MARAC. The meeting was advised that the Ruby Project had arranged a refuge place for Dawn. The action from the meeting was for the Ruby Project to confirm which refuge Dawn was placed into and what her future plans were.

14.36 In late February 2017 Adult Social Care at Sefton MBC received a referral regarding Dawn from the Police who had attended Dawn's home address following a referral they had received from the National Centre for Domestic Violence helpline. Dawn had called the helpline wanting support to find alternative accommodation following an assault. Dawn did not want Police involved or to press charges against Ewan. As a result, Adult Social Care informed the social care lead practitioner who is employed by Sefton MBC but based within Sefton Community Mental Health Team. This is a missed opportunity for agencies coming together via a safeguarding strategy meeting or a MARAM meeting.

14.37 In April 2017 the Safeguarding Team at Adult Social Care made contact with SWACA regarding Dawn following receipt of a Section 2 notice from Aintree University Hospitals NHS Foundation Trust due to safeguarding concerns they had for Dawn regarding her partner Ewan. The result was that Adult Social Care following its contact with SWACA sent a letter to Dawn's home address detailing social care contact information for her use when needed. Adult Social Care also liaised with a number of support agencies including Dawn's G.P. who agreed to invite Dawn in for an appointment and ask if Dawn would like referral

to domestic violence services and the G.P. surgery would make that referral if Dawn agreed.

14.38 In late April 2017 Dawn contacted Police to report an incident which occurred two days earlier during which Ewan threw her on the bed before kicking and punching her. She told Police she was safe at another location he was unaware of. The Police call handler completed the VPRF 1 with details from the record of the call, no level of risk was assigned to this assessment, and the call handler scheduled an appointment for Dawn to be seen by officers. Records show that despite numerous attempts to make contact with her Dawn did not respond, a 'seven-day letter" sent by Police also went unanswered. Following the failure of these attempts to communicate with Dawn no further Police action was taken over this matter.

14.39 In May 2017 the Mental Health Liaison Team, who are staff employed by Mersey Care but employed within the acute trusts, received a referral for Dawn from the Aintree University Hospitals NHS Foundation Trust Critical Care Unit were she was receiving treatment following an overdose. The Mental Health Liaison Team were not informed that Dawn was medically fit for assessment and that discharge was planned, therefore a mental health assessment did not take place.

14.40 On 3rd July 2017 Dawn contacted Police to report her father had received threats from Ewan that he would burn his car out and smash Dawn's face in. Dawn reported that she had received several threatening messages from Ewan but was unable to provide details. She told Police she was terrified of Ewan and believed he knew her location. Dawn was later seen by Police and disclosed that Ewan was living in Scotland and neither she nor her father thought he would carry out his threats. A VPRF 1 was completed and assessed the risk of future violence as being low. The MASH informed Adult Social Care at Sefton MBC of these malicious text messages who shared the information with the social care lead practitioner in Sefton Community Mental Health Team South. Adult Social Care Sefton MBC followed up this referral and recorded that no further action was required from their service and that an appointment had been made for Dawn with Mental Health Services planned for 31st July

2017. No Police action was taken in regard to the threatening telephone messages.

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

14.42 In July 2017 Dawn received treatment as an informal in-patient on a Mental Health Ward. Dawn reported that she was experiencing distress and reported that she had thoughts to harm herself. Staff on the mental health ward were to continue to support Dawn in finding safe accommodation. It was documented at the time that Dawn's diagnosis was emotionally unstable personality disorder with behavioural disorders due to multiple drug use. There is no indication within records that Adult Social Care were involved in this care plan

14.43 After receiving treatment for one week as an inpatient on the mental health ward Dawn signed a Discharge against Medical Advice form, she was provided with seven days medication and agreed to work with the CMHT and drug team. The issue regarding accommodation had still not been resolved and Dawn reported that she is going to stay with her friend until a refuge place is found.

14.44 In August 2017 whilst receiving treatment at Aintree University Hospitals NHS Foundation Trust where she had been admitted due to a complaint of epigastric pain Dawn disclosed that Ewan had assaulted her when he approached Dawn in the street, assaulted her and stole her mobile phones. When interviewed by Police Officers Dawn would not say where or when the incident happened and she declined to prosecute Ewan. With no investigative opportunities open to them the assault was filed as undetected by the Police. There is no record of a VPRF1 risk assessment form being completed by the Police.

14.45 Whilst in hospital a referral was made to the Mental Health Liaison Team at University Hospital Aintree due to Dawn having thoughts of self-harm and stabbing others. It was recorded that Dawn was a victim of domestic violence and felt unsafe returning home. Dawn said that she feels '*madness*' when she thinks of her partner, she explained that madness is when she has visions of herself stabbing her partner, then she feels ok, then becomes tearful and then wants to harm herself. Dawn has a diagnosis of Emotionally Unstable Personality Disorder and suffers from substance misuse which may impact upon her ability to safeguard herself. A mental state examination was completed and no concerns were identified by clinicians conducting the examination.

14.46 A mental health assessment was completed by the Mental Health Liaison Team. It was recorded that Dawn is planning on engaging with the Ruby Project to '*get her life in order'*. A risk to others was reported due to experiencing thoughts of stabbing other people, this specifically was in relation to stabbing her partner who she alleges has been violent towards her in the past although she denied any plan or intent to act upon these. There was no indication that there was a need for an inpatient admission to a mental health ward at this time. It was discussed with Dawn that the Ruby Project would organise a refuge for her to stay in and that staff on the acute ward would liaise with them to organise this. Dawn was happy with this plan.

14.47 On 16th August 2017 a Section 2 Notice was sent by Aintree University Hospitals NHS Foundation Trust to Adult Social Care at Sefton MBC. Adult Social Care recorded that this was not progressed to a safeguarding review due to Dawn having mental capacity and no care or support needs and that she has been sign posted to agencies which support victims of domestic abuse.

14.48 In addition to the Section 2 Notice the Women's Turnaround Project contacted Adult Social Care at Sefton MBC for help in rehousing Dawn who reports being a victim of domestic violence and feels unsafe to return home. They were advised that no women's refuge will accept Dawn given her needs. Adult Social Care at Sefton MBC advised Dawn to attend Housing Options but that service was currently closed therefore she may need to stay in hospital if it was deemed

a risk for her to return home. Having been unable to safely rehouse Dawn the Women's Turnaround Project worker advised Dawn to contact the Emergency Duty Team part of the Adult Social Care team.

14.49 In terms of this incident there was no completion of a MeRIT assessment and a referral to MARAC or completion of a VPRF 1 by professionals speaking to Dawn. Aintree University Hospitals NHS Foundation Trust did complete a risk assessment of Dawn which assessed her as being at high-risk of future violence or homicide but this assessment was not referred to either the MARAC or IDVA service.

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

14.51 On receipt of the referral from the Ruby Project and following a failure to make contact with Dawn by telephone the IDVA Service sent a letter to Dawn's home and the case was deferred by that service until further contact was received from Dawn.

14.52 On 21st August 2017 a second Section 2 notice was sent from the Aintree University Hospitals NHS Foundation Trust to Adult Social Care at Sefton MBC requesting an accommodation placement for Dawn to enable her discharge to go ahead.

14.53 Five days after making the MARAC referral the Ruby Project reported that Dawn had moved to supported living accommodation, which was arranged through the Housing Options Team. However, within eight days information was received that Ewan had been staying over at the property the last two nights. This information was shared with the Ruby project and IDVA Service as he should not be seeing Dawn.

14.54 At the MARAC meeting following the referral by the Ruby Project the Ruby Project reported that Dawn has stated that she would not attend Court or make

a statement to Police in relation to Ewan. The Ruby Project described Dawn as being very chaotic and with complex health needs. Ewan was open to Ambition Sefton (drugs service) but only had sporadic engagement. He was also under supervision by Probation for a Suspended Sentence Order (SSO) imposed by Court following his conviction for Possession of an Offensive Weapon. At the meeting actions were set for the Ruby Project to encourage Dawn to engage with Ambition Sefton and liaise with CRC to establish if there is any contact between Dawn and Ewan. Venus were to feedback to Dawn's case worker that she was having issues accessing her benefits.

14.55 In October 2017 Dawn was being supported by staff at the Venus Project. Dawn disclosed to them that she has been taking opiate based drugs. She has been to 5 G.P. practices in 5 weeks and there are concerns about why she is doing this. Venus expressed concerns that they have had reports of a male being at the safe property which had been arranged for her and staying overnight even though Dawn has been told this is not allowed. The Venus worker supporting Dawn explained that they are trying to get cameras installed so that they can monitor who is coming in and out of the safe house as if it is Ewan he would be breaking his conditional bail.

14.56 One month later Venus again spoke to Dawn. She admitted to smoking heroin. She also said that Ewan has been coming to see her at the flat but not staying over. Dawn also said her benefit is being paid in to his bank account which is a worry as he has control over her finances. Staff expressed concerns to Dawn they had about taxis coming round in the middle of the night, a male staying overnight and raised voices coming from the flat. They also had concerns about Dawn's "*G.P. hopping*" and calling ambulances when not needed. There were concerns about the amount of medication she is taking.

14.57 The support worker at Venus arranged to see Dawn on Friday and will try and arrange a post office account for her and arrange for her to go to the substance misuse support service.

14.58 In December 2017 while officers were taking a report from Ewan on an unrelated matter, the disabled resident of the premises in which they were

staying alleged exploitation by Dawn and Ewan who were taking his money, and sleeping at his home without his permission, Dawn had also changed her benefit address to his home address. A VPRF1 was completed in relation to the tenant of the property. Target hardening was arranged with MFRS, a Treat as Urgent marker was placed on the neighbour's address for three months and a referral to Adult Social Care at Sefton MBC made in relation to his reduced mobility and the neighbours home circumstances. His housing provider was also contacted because the fire alarms in the flat were not working.

14.59 On 22nd December 2017 Venus contacted Dawn who told them "*she is no longer at the flat. She is on a tag and is now at her exe's (Ewan) place.*" Both Ewan and Dawn had been arrested one month earlier for shoplifting and later failed to appear at Court. They were arrested on Warrant and entered Guilty pleas. Dawn said that she no longer wants support from the Ruby Project and will not make any further contact with the service.

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

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

14.62 On 27th January 2018 following a dispute with a neighbour involving herself and Ewan, Dawn attended the Accident and Emergency Department of Aintree University Hospitals NHS Foundation Trust where having voiced suicidal thoughts to the Accident and Emergency Department Doctor she was again referred to the Mental Health Liaison Team. Following assessment by the Mental Health Liaison Team Dawn verbally agreed to an informal hospital admission. Dawn maintained throughout the assessment that she was unable to maintain her own safety and had plans to end her life by overdosing. Dawn disclosed a 20 year history of Domestic Violence from her partner Ewan and is open to MARAC. Dawn initially was offered a referral to "stepped up" care however declined this stating '*I won't be here, this time I will end my life, I've had enough, I can't do this anymore*'. The member of the Mental Health Liaison Team also noted that there is a previous history of heroin / crack cocaine use and that Dawn is still living with her partner Ewan whose benefits have been stopped and Dawn alleged that he uses her money for himself. A Section 2 Notice was sent by Aintree University Hospitals NHS Foundation Trust to Adult Social Care at Sefton MBC who commenced a Safeguarding enquiry. This did not result in a safeguarding strategy meeting.

14.63 There is no record of any action being taken as a result of the disclosures by Dawn. No domestic abuse risk assessment was completed nor referral made to MARAC or request for a safeguarding review be undertaken.

14.64 Dawn became a voluntary in-patient on a mental health treatment ward but the following day attended Southport Hospital Accident and Emergency Department with abdominal pain diagnosed to be chronic pancreatitis. Dawn attended with a carer from the mental health ward and was referred to surgery for a review, however, Dawn wished to return to the mental health ward. She was assessed to have mental capacity, and self-discharged against medical advice to return to the mental health centre.

14.65 After returning to the mental health ward Dawn was reviewed by a Junior Doctor and Consultant Psychiatrist. Dawn reported that she was feeling "*Shit*" and appeared worried about going home, due to the domestic violence situation she is currently in. Records made following this review show little consideration of

the safeguarding risks should Dawn return home. No MeRIT or DASH risk assessment were completed or housing support options discussed.

14.66 On 2nd February 2018 whilst still an in-patient at the mental health ward Dawn was reviewed by a Staff Nurse prior to her discharge. A plan for future care was developed prior to discharge which was for an outpatient appointment to be arranged. Seven days medication was supplied to Dawn, a notification was to be sent to Dawn's G.P.to review her prescription for Diazepam, and her psychotropic medication to be reviewed by Mersey Care CMHT. A 48 hour follow up was to be completed by the CMHT, Dawn was to be provided with details of women's refuges as she has confirmed she did not wish to return home with her partner. Dawn declined information for a refuge or sit up service and said she would be returning to her partner's address.

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

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

14.69 On 20th July 2018 Adult Social Care at Sefton MBC received a Section 2 Notice from the Liverpool University Hospital NHS Foundation Trust where Dawn was receiving treatment. The referral stated that Dawn was homeless. Dawn was discharged from hospital seven days after receipt of this referral and there is no indication of any action taken in respect of the Section 2 Notice or Dawn's homeless state.

14.70 On 1st August 2018 Police Officers suspected Dawn of being a sex worker and she was given an official warning.

14.71 On 22nd August 2018 Dawn reported a Burglary at her room during which her prescription drugs were stolen. This was the third time that reports had been made by Dawn over the theft of her prescription drugs.

14.72 Four days later on 26th August 2018 Dawn attended Liverpool University Foundation Hospital Trust Accident and Emergency Department with a foot injury diagnosed as a metatarsal fracture. Dawn said that she has not taken her insulin for five days due to domestic violence, so staff completed a domestic abuse risk assessment which identified the following risks low mood, isolation, recent separation, use of weapons to cause injury, harassment, previous threat to kill, had hurt someone else before, threat of self-harm by perpetrator, and previous Police involvement for perpetrator. Dawn refused permission for the hospital staff to report this matter to the Police and declined to give details of the perpetrator. She reported that she felt safe to go home and was not currently living with the perpetrator.

14.73 One month after her first warning from the Police for being a sex worker Dawn received a second warning. At the time of this warning Dawn reported that she had been struck on the head the previous night while she was walking along a road in Liverpool, causing her to lose consciousness. She was still showing dried blood on her face but declined an ambulance. Police Officers referred Dawn to Changing Lives a charity who provided support to sex workers who had been assaulted but Dawn did not engage with the service when they contacted her.

14.74 In December 2018 during a Probation Service case discussion, concerns were raised that Ewan was living at the same address as Dawn and the risk this posed in view of Dawn's vulnerability to abuse from him.

14.75 In November 2019 Police received an abandoned 999 call. A female was heard crying and a male saying he '*did not mean it'*. The call was traced to an unregistered mobile and when Police called back the telephone number Dawn answered saying she was fighting with her partner in a hotel which she was leaving as she put the phone down. Dawn was located near-by and confirmed to Police Officers that she had argued with her new partner. The new partner

was the brother of Ewan and he is also a Silver/Medium Risk Domestic Abuse perpetrator with his own partner. A VPRF1 was completed and graded the future risk of violence faced by Dawn to be low.

14.76 In November 2019 concerns were raised with the Probation Service who were concerned about Dawn as she has a male, Ewan, staying with her at the hotel. Agencies also advised that they are "*struggling to get Dawn to engage as Ewan is always with her and has been answering Dawn's phone*". These concerns regarding Ewan were raised with Adult Social Care at Liverpool MBC.

14.77 In November 2019 One Vision Housing were made aware that Ewan had been bailed by Court on the recommendation of the Probation Service to an address in Ainsdale which Dawn held the tenancy for. This was with Dawn's agreement. One Vision Housing raised their concerns with Housing First who confirmed that Dawn had given her permission for this to take place.

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

14.79 At the start of December 2019 Housing First emailed the Probation Service regarding Ewan who following arrest had given Dawn's address as the location from which electronic monitoring imposed as part of his sentence could take place from. Dawn and Ewan had moved into the flat provided following Housing First negotiations with housing associations with no electricity, gas or furniture. Housing First raised a safeguarding concern regarding Dawn and Ewan as there have been numerous complaints from neighbours about their arguing and causing disturbance.

14.80 On 29th January 2020 the Probation Service referred Dawn to a number of domestic abuse support networks, the Women's Turnaround Project, the Freedom program and the Mental Health Clinic for mental health support.

14.81 Two weeks later the Ambulance Service informed Police that they were in attendance at Dawn's home address. Dawn alleged she was punched in the stomach by her partner Ewan who had left the premises and she was now detained in Southport and Ormskirk Hospitals NHS Trust. Concerns were raised by the Police that she may return to Ewan and these were heightened when Police learned she had been discharged from hospital.

14.82 Dawn was visited by Police Officers and confirmed to them that the assault had taken place the previous day, she signed a statement to this effect but declined to prosecute Ewan. There is no record of a VPRF1 risk assessment having been completed by the officers but they did make a referral of Dawn to SWACA. There is no record that consideration was given to identify Dawn as a high-risk victim of abuse or to make a referral back to MARAC.

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

14.84 The Probation Service also arranged a professionals meeting on the same day, 12th February 2020, to discuss the risks Dawn faced. Involved in the meeting with Probation were the Women's Turnaround Project and Housing First. The meeting agreed that Dawn's risk to the public remains low, however the risk to herself has increased due to a further disclosure of domestic abuse. It was agreed that a referral to Ruby Project and MARAC should be completed.

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

14.86 After attending the hospital and speaking to Dawn the Police made a referral to SWACA regarding this assault. SWACA being unable to contact Dawn by telephone then sent a letter offering support to Dawn and including SWACA contact details. The letter was sent to the home address Dawn shared with Ewan the reported perpetrator of the latest assault.

14.87 No risk assessment from domestic abuse was made of Dawn and no referral made to MARAC by any agency involved in this incident.

14.88 The MARAC meeting held in late February 2020 was following the Probation Service referral of Dawn who they had assessed the levels of risk she faced as being high. Information was shared at the meeting by the Probation Service that Ewan was temporarily staying with Dawn as he was homeless and that Ewan was completing 1-2-1 domestic abuse work. The only actions agreed at the meeting were for the Police to add markers which are alerts that should Dawn and Ewan be arrested in the future the Criminal Justice Mental Health team (CJMH) should be contacted and substance misuse testing should be carried out on them. There were no actions reflective of the Control and Coercion discussed at the professionals meeting 10 days prior to this nor evidence of Police action around this offence.

14.89 Information shared with the Probation Service was that on 4th March 2020 a Housing Officer visited Dawn in her home and reported that Dawn was under the influence of a substance and that the Housing Officer ended the meeting due to Ewan being in the property and the potential safety risk this posed to the officer.

14.90 On 9th March 2020 Housing First contacted Dawn who stated that she was waiting for an ambulance to convey her to the hospital as she was in pain with her stomach. Housing First again contacted her later that evening and Dawn explained that she attempted suicide by injecting heroin and was found by Ewan in the bathroom of the flat. She said that she felt as if she was having a mental breakdown and that the pain she was in at the moment was the reason for her wanting to commit suicide. The Housing Officer visited Dawn's home address to offer support following this incident but she was out.

14.91 Following this incident the Probation Service made a decision to introduce weekly contact with Dawn due to her recent attempted overdose with Heroin and the fact that Ewan was still living at her flat.

14.92 In April 2020 the Ruby Project at a meeting with the Probation Service advised that they were looking to close their support to Dawn as there is no safe way that she can be communicated with

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

14.94 On 28th April 2020 Dawn had a planned meeting with the Probation Service. Dawn reported poor mental health "*at the moment*", she stated that she is struggling as she has no money as she does not have a bank account. Support was offered to help Dawn set up a bank account and arrangements made for a foodbank voucher to be sent to her. Dawn reports there to have been no other incidents of domestic abuse with Ewan and there had been no further use of drugs or alcohol, however her speech was noticeably slurred. Dawn stated that she will engage with the Ruby Project when she felt it safe to do so.

14.95 Later that same day Dawn contacted Merseyside Police saying she was being prevented from leaving the house during an argument which was taking place with Ewan. Police Patrols attended Dawn's home address. Dawn denied any assault had taken place and was not showing signs of injuries. Ewan was wanted by Police at this time and following a search of the premises he was

located in the loft and arrested. A VPRF1 was completed in respect of Dawn and the case was referred back to MARAC by the Ruby Project.

14.96 The following day 29th April, 2020, Dawn contacted her support worker at the Ruby Project who heard that there was again a dispute taking place with Ewan who was using profane language. Dawn confirmed that there had been further incidents but it was not safe to make any disclosures. Dawn requested emergency accommodation. The support worker advised Dawn that she would contact housing and get the support needed and asked Dawn to leave the tenancy and go to a safe place to diffuse the situation but she refused and said that "*she would be okay*". The support worker spoke with her manager and a decision was made to contact the Police using the emergency 999 service given the history of domestic abuse between Dawn and Ewan and because there was an arrest warrant outstanding for Ewan.

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

14.98 On the 14th May 2020 a MARAC meeting discussed a referral regarding Dawn which had been made by the Ruby Project and in which Ewan was shown as the perpetrator. At the time of the meeting, Dawn was continuing to engage with the Ruby Project. She was also engaging with Housing First. They reported that the locks had been changed at Dawn's property and that she was stating that she wanted to move, but within a couple of days Ewan was back

living with her. Police reported no current investigation as Dawn had denied any knowledge of a domestic abuse incident and denied that Ewan was in the property although he was later found in the loft. Ewan was currently being supervised by the Probation Service under a 12-month Community Order for stealing from shops.

14.99 Actions agreed at the conclusion of the meeting were for the Ruby Project to liaise with the IDVA Service to establish if any further support was needed for Dawn and for the Probation Service to consider commencing domestic abuse work with Ewan.

14.100 On the 1st of June 2020 a meeting was held within the Probation Service between a manager and Ewan's allocated officer. The meeting was held to discuss whether there was any further actions that could be taken to help safeguard Dawn. They discussed support for Ewan to move out of the property and get his own place, and enforcement action to be taken if he continues to remain at Dawn's address. It was agreed that emotional management work was to be completed with Ewan and Dawn in order to help them become less dependent on each other. Dawn will be instructed to attend the Women's Centre regularly which would provide her with a safe place to speak about what is going on in the relationship and for the service to obtain visible reassurance that she is unharmed.

14.101 At the start of July 2020 a One Vision Housing Meeting held a discussion

regarding all the quality-of-life issues impacting upon residents in the road on which Dawn lived. The disturbance to residents caused by the number of disputes and the anti-social behaviour Dawn and Ewan were causing in the area was discussed as part of this. It was agreed that an Acceptable Behaviour Contract (ABC) would be drawn up for Dawn as the tenant of the property to sign and Housing First would put systems in place to support Dawn in calling emergency services if she is threatened.

14.102 On the 6th July, 2020 Dawn was arrested for stealing from shops and was seen whilst in Police custody by the Criminal Justice Mental Health Team. She appeared well kept, her personal hygiene had been adhered to, and there were

no signs to indicate self-neglect. From discussion with Dawn the Team found no evidence of any current psychotic symptoms in the context of delusional beliefs and auditory hallucinations. Dawn described her current mood as up and down. She does have extremely low days in which she doesn't wash or get out of bed. She stated that she has recently been released from prison and has struggled to cope with the outside world upon her release. She states that she has been supported to access benefits and accommodation but has struggled with her mental health.

14.103 Dawn is currently prescribed mediation which does help a little, however she has not had a medication review for a while and feels that they do not help her as much as she needs. She has not visited her G.P. for a long time. She refused help from the inpatient mental health team whilst in prison as she stated that they were "*rubbish*". Dawn currently lives alone. She is close with her family and they are her protective factor.

14.104 Dawn is currently open to Ambition substance misuse services but denies any current drug or alcohol use. She states that she has been clean since leaving prison but admitted that she used to be addicted. Notes recorded that. Risk to Self: Dawn has constant thought of suicide and experiences these thoughts every day. She has done so for many years. She denies any current plans or intent to end her life however states that she could not guarantee her safety upon leaving custody. She stated that she has made three serious suicide attempts in the past which have left her in a coma. Dawn reports that she self- harms often, usually by cutting herself. She does this as a coping mechanism. Dawn reported that she has been experiencing auditory hallucinations in the past two weeks and said she had not suffered these hallucinations before that time. Dawn said she didn't recognise the voice; she was not sure whether this was her own internal voice or whether this was an auditory hallucination. She reported that the voices say derogative statements about men, particularly when she is in the company of men (Dawn has previously been victim to sexual assault- although she did not mention this during the screening assessment). She stated that sometimes the voices can

be commanding in nature, asking her to harm herself. So far, she has not complied with the commands of the voices.

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

14.106 On 12th August 2020 Housing First contacted the Probation Service informing them that they had been made aware by the anti-social behaviour team that there was an incident between Ewan and Dawn between 12:30am and 5am this morning. They advised that there is video footage of Dawn repeatedly saying "*stop hitting me*". Housing First stated that the anti-social behaviour team were going to be putting in a safeguarding referral to the Police along with the video footage. Over the coming days the Police made a referral to the IDVA Service regarding this incident and the IDVA attempted to make contact with Dawn but without success.

14.107 On the 29th August 2020 Dawn made an emergency call to Police because

Ewan had taken her medication from her and refused to give it back, she ended the call before any more details could be obtained. When Police called her back, she stated she no longer needed Police as Ewan had returned the medication. An appointment was made for Dawn to see a Police Officer. However, when she was contacted to arrange this, she alleged Ewan had assaulted her the previous day, which was not mentioned in her original call. A Police patrol was then deployed and Dawn told them she was feeling suicidal earlier, hence Ewan taking the medication from her. Dawn was unsure whether to proceed with a formal complaint of assault and asked for an officer to see her later, but she declined to prosecute as she was due to go into hospital, she

said that her relationship with Ewan was over and she wanted to forget the incident. Dawn was referred back to MARAC following this incident by the Police on the grounds that she had been a previous high-risk victim of abuse and had been previously referred to MARAC and she was the victim of coercive and controlling behaviour.

14.108 Two days later the latest referral to MARAC was discussed at the CMHT Multi-Disciplinary Team (MDT) meeting. The following issues impacting upon Dawn were raised, ongoing issues with neighbours, problems with her current relationship. She was experiencing stress and anxiety, the victim of domestic violence, and has not been taking medication as directed. She has a history of self-harm. The outcome of the MDT meeting was for a routine Out Patient Appointment to be made for Dawn. Contact was also made with Dawn by the IDVA service the outcome from which was that Dawn did agree to speak to someone in the team.

14.109 The MARAC meeting following the incident at the end of August 2020 took place in mid-September 2020. At the time of the meeting, the Police investigation had been filed as no further action as Dawn had declined to provide a statement to assist in any prosecution case or charging decision. Both Dawn and Ewan were subject to bail and due to attend Sefton Magistrates on 30th September 2020 following a Public Order offence which was homophobic in nature. An IDVA had made contact with Dawn and she had agreed to engage with that service and her case was now pending allocation.

14.110 Dawn had been referred to Ambition Sefton on 3rd August 2020 but had not responded so the referral had been closed. Dawn was being supported by the Ruby Project and had been due to attend the Freedom Programme. As she was unable to attend the office due to the risk to her health from Covid, as she is in the high-risk category, she was currently receiving telephone contact only for safety planning. Dawn was also being supported by Housing First in relation to rehousing. Dawn had recently been referred to Mersey Care NHS Foundation Trust and had an outpatient appointment booked for December 20th. Actions set at the MARAC meeting were for One Vision Housing to offer

Target Hardening if Ewan was no longer living in the address and IDVA to liaise with Ruby to avoid duplication of work.

14.111 Over the course of the next two weeks a number of services, IDVA, Ruby Project and One Vision Housing attempted to make contact with Dawn but without success.

14.112 On 12th November 2020 Dawn attended the Accident and Emergency Department at Southport and Ormskirk Hospitals NHS Trust suffering with abdominal pain and reported that her legs had given way earlier in the day. She disclosed suffering domestic abuse from her partner and she did not feel safe to go home. In the past week her partner Ewan had booted her over the table and has recently punched and kicked her downstairs, she reported that he had previously hit her with a candle stick, and Dawn stated Ewan has illegal weapons but declined to elaborate further. Dawn declined placement at a refuge and stated she may stay at a friend's; she declined Police involvement. Dawn left the ward for a cigarette and then absconded prior to input from the safeguarding team and before safe contact methodology could be confirmed. A referral was made by the hospital to MARAC and a call made to Sefton IDVA'S who advised Dawn was working with the Ruby Project, and the hospital made contact with the Ruby project worker.

14.113 Three days later Dawn again attended the Accident and Emergency Department at Southport and Ormskirk Hospitals NHS Trust after being brought in by ambulance with a headache and abdominal pain. Dawn disclosed being assaulted by her partner Ewan two days ago. Staff asked Dawn why she left the ward two days ago against medical advice and she said she was getting calls and texts to come back home from Ewan.

14.114 When asked by Accident and Emergency Department staff if she feels safe at home her response was no. Extensive multiagency working to safeguard Dawn was then completed by the hospital prior to Dawn being discharged. The hospital Independent Sexual Violence Advocate (ISVA) attended the ward and

spoke with Dawn who stated she had spoken with her key worker at Probation and informed her she would like a refuge and an *'injunction, she is not bothered about her but bothered about her family as she has a mother and two nieces'* Dawn states *'he will kill me."* Due to threats to kill being made this was reported to Police by the hospital safeguarding team who had also sent a request to the National Centre for Domestic Violence (NCDV) for support in obtaining an injunction. There is no information indicating that a referral was made to Adult Social Care following this incident.

14.115 The Safeguarding team at Southport and Ormskirk Hospitals NHS Trust were also made aware of a professionals meeting being held that afternoon being hosted by the Probation Service. The Probation Service were unable to request a refuge for Dawn as they felt due to Dawn's substance misuse this would not be appropriate. The meeting tried to make contact with the Sefton IDVA via their duty line which is being monitored by SWACA, a message was left requesting return call from the IDVA service to discuss safety planning and a refuge place for Dawn. Housing First told the professionals meeting they had just received a call from Dawn requesting them to arrange a taxi to take her back to her property as she has received a text from Ewan stating he wants to retrieve his property from her flat. Dawn has informed housing that she wants to return as she is concerned the perpetrator will take valuable items Southport and Ormskirk Hospitals NHS Trust Safeguarding team advised Housing First that Dawn is currently working with Probation Service so Housing First advised hospital safeguarding that they will need to make contact with Probation to discuss this further.

14.116 Whilst Dawn remained an inpatient in Southport and Ormskirk Hospitals NHS Trust a call was made from the Doctor treating Dawn to the hospital Safeguarding team. He had spoken at length with Dawn regarding her desire to leave hospital. Dawn had reinforced to the Doctor that she wishes to return to secure her property and the Doctor has documented this within the medical notes. An e-mail outlining this incident was sent to the MARAC co-ordinator by

the hospital Safeguarding team to ensure that information is shared with relevant agencies.

14.117 The outcome of the Professionals meeting held that day between Probation,

Merseyside Police, the Ruby Project, Housing First and the Southport and Ormskirk Hospitals NHS Trust Safeguarding Team was that Merseyside Police will submit a DPA.

14.118 On 18th November 2020 Staff at Southport and Ormskirk Hospitals NHS Trust contacted Police again regarding Dawn, one week after her previous hospital admission. Dawn had told them Ewan threatened to visit the hospital the previous day and also said he would kill her. Dawn said she feared for her mother and other family members. She spoke about old injuries from a catalogue of incidents and asked to be placed in a Refuge and for an Injunction to be obtained against Ewan. She said that she was willing to engage with Police.

14.119 Following this contact from the hospital Merseyside Police took part in an

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

14.120 On 26th November 2020 the MARAC meeting was held. The meeting noted that. Dawn was a One Vision Housing tenant but due to ongoing anti-social behaviour issues and rent arrears, they were likely to look at possible eviction. Dawn was engaging with the Ruby Project and was being supported in relation to obtaining a Non-Molestation Order. It was noted by Housing First that this seems to be the most serious Dawn had ever been about ending the relationship. Actions at the meeting were for the IDVA to liaise with the Ruby Project to avoid any duplication of work, all agencies to note that Dawn was

temporarily staying with her parents and for Police to place a treat as urgent marker on the parents' address.

14.121 Adult Social Care at Sefton MBC received notification of this incident. They

noted that Dawn was currently staying with her parents who are aware of the situation with Ewan. They noted a referral to NCDV to progress a non-molestation order, and that Dawn was being supported by the Ruby Project. Dawn had agreed to a referral being made to SWACA to obtain support for her, a Police marker was on her property which would generate an emergency response to the address should an incident arise, and consideration was being given to the installation of a panic alarm. Adult Social Care made a number of telephone calls following this referral including to Merseyside Police who advised that Dawn was not engaging with Police, and that she had stated that her injuries were the result of a fall down stairs. Ewan had now been released on bail. A call to NCDV showed that they were awaiting a return call from Dawn to be able to proceed with non- molestation order. This case was closed by Adult Social Care Safeguarding team on 30th November 2020.

14.122 On 10th December 2020 the Ruby Project advised the IDVA service that Dawn is still open to their service and that confirmation had been received from NCDV that the non-molestation order had been served on Ewan.

14.123 On 17th December 2020 a Safeguarding referral was made to Adult Social

Care from Housing First. The referral contained information that Dawn had disclosed a sexual assault and rape by a neighbour. Police attended Dawn's home address following this following report. Housing First also advised partners about the return of Ewan to Dawn's property over the weekend. Dawn is still awaiting her appointment with secondary mental health services following their referral of Dawn for a routine appointment made in August 2020 and Housing First will monitor the situation over the weekend. Liaison also took place between Adult Social Care and a number of housing providers and the IDVA Service in an effort to find Dawn secure accommodation. However, no safeguarding strategy meeting was arranged following this incident.

14.124 On 21st December 2020 Dawn was admitted to Southport and Ormskirk Hospitals NHS Trust having been brought to hospital by ambulance. Dawn left a cubicle in the Accident and Emergency Department, and when found by nursing staff outside having a cigarette, she disclosed to staff that she had needed to go out as she was upset as Ewan was threatening her and her family. Dawn further added that she had a recent injunction against the Ewan because of his domestic violence and had attempted to drop the injunction a week ago but a Judge overruled this application and it remains in place. Dawn stated that she had got back together with Ewan. Dawn stated she did not feel safe to go home and that in the morning she will be able to call her support workers.

14.125 Adult Social Care at Sefton MBC in liaison with the Southport and Ormskirk

Hospitals NHS Trust Safeguarding Team noted that Ewan is alleged to have threatened to kill Dawn's parents so she is unable to stay there. A decision was made to admit Dawn into hospital as place of safety. A domestic abuse risk assessment was completed by the Hospital and the Hospital Safeguarding Team liaised with IDVA, a Housing Support Worker, and reported the incidents to the Police. Police attended the ward, and Dawn confirmed these were new threats made over the phone the previous weekend, and Dawn stated she now felt safe to go home and changed her mind regarding emergency accommodation.

14.126 On 7th January 2021 following Dawn's recent hospital admission Adult Social

Care at Sefton MBC held a meeting with Housing First because Dawn had advised them that she wants to remain where she is living. The meeting noted that Dawn has been offered support regarding domestic abuse and that she has an appointment in mid-January with South Sefton Neighbourhood Centre regarding her mental health.

14.127 On 13th January 2021 Adult Social Care at Sefton MBC telephoned Dawn to offer safeguarding support but Dawn declined further support at that time. Dawn stated that Ewan was present with her at time of call and all was fine.

14.128 On 14th January 2021 a MARAC meeting was held to discuss the referral

made in late December 2020. It was reported that the previous Non-Molestation Order had now been withdrawn. An IDVA had spoken to Dawn about a place at a refuge but she had declined this. SWACA had had an assessment booked with Dawn for 21st December 2020 but they had not been able to contact her to complete this. Dawn was open to Adult Safeguarding. Actions at the conclusion of the meeting were for Adult Social Care at Sefton MBC to feedback to Dawn's Social Worker that the relationship is continuing and to risk assess how to make safe contact with Dawn. One Vision Housing to look at action in relation to the anti-social behaviour concerns and Police to research a Domestic Violence Disclosure Scheme (DVDS) 'Right to Know' for Dawn.

14.129 On 20th January 2021 Adult Social Care closed the safeguarding referral

made regarding Dawn on the basis that Dawn declined further support.

14.130 One month later on 15th February 2021 Dawn attended the Accident and Emergency Department of Southport and Ormskirk Hospitals NHS Trust, having been brought in by Ambulance, and was reporting abdominal pain and a safeguarding concern. Dawn stated that she was in pain due to the fact that her partner Ewan has attacked her on Saturday 13th February and Sunday 14the February 2021. Dawn stated that an argument occurred and she was then kicked in the left leg, this bought her down to the floor where she was kicked repeatedly in the abdomen.

14.131 A Southport and Ormskirk Hospitals NHS Trust Safeguarding practitioner attended the Accident and Emergency Department to speak with Dawn; however she had called for a taxi stating she now felt safe to return home as the perpetrator had left the property, and she declined any further support. Dawn was offered admission to the Hospital as place of safety which she declined. Risk assessments were completed by Accident and Emergency Department staff and liaison completed by hospital safeguarding team with the Ruby Project who stated Dawn had been closed to their service.

14.132 The Safeguarding team at the Hospital also contacted Adult Social Care at

Sefton MBC to make them aware of Dawn's attendance and were advised that Adult Social Care had made contact with Dawn following her leaving the hospital but that Dawn had refused any support and that Housing Options had been in contact with Dawn and had paid for a taxi to take her home. Southport and Ormskirk Hospitals NHS Trust Safeguarding Team updated Police regarding Dawn's attendance and their concerns that the perpetrator had not left the property and that a MARAC and IDVA referral had been completed and submitted by them.

14.133 The following day 16th February 2021 Adult Social Care at Sefton MBC contacted Dawn who described to them a fear of being killed by Ewan, but she declined to move from her current accommodation because of a fear of repercussions. (There is no further information regarding this last statement defining what repercussions she feared and from who). Adult Social Care progressed information sharing with other agencies regarding this incident and during a phone call to Merseyside Police were advised that Dawn has agreed to them progressing a non-molestation order via NCDV. There is no record of a MeRIT or DASH risk assessment having been completed in respect of Dawn's disclosure.

14.134 On 25th February 2021 the MARAC meeting was held and a record of the meeting showed the following. Police had an ongoing investigation in relation to an offence of Common Assault made against Ewan but Dawn had denied any assault taking place and was avoiding contact from Police. Dawn had declined a DVDS disclosure stating that "*she wasn't interested*". An IDVA had spoken to Dawn and she had agreed to engage with this service. Sefton Adult Safeguarding had contact with Dawn and they made a referral to emergency housing on her behalf but she later declined this.

14.136 At the meeting actions were set for the IDVA to feedback to the MARAC Coordinator if a support letter for rehousing is needed once their initial assessment took place.

14.137 On 30th April, 2021 Dawn was taken to Southport and Ormskirk Hospitals

NHS Trust by ambulance which had been called by her partner Francis after he had found Dawn unconscious following her taking an overdose containing a mix of diazepam, amitriptyline and diamorphine, she was intubated and transferred to ITU. Liaison took place between the Hospital Safeguarding Team and Adult Social Care Safeguarding Team who shared information that Dawn was reported to be in a new relationship and to be eight weeks pregnant.

14.138 Liaison was also completed by the Southport and Ormskirk Hospitals NHS

Trust Safeguarding team with Dawn's housing officer who advised she had spoken with Dawn's mother and partner, and Francis stated that he and Dawn had argued prior to her taking the overdose and she had left a note. The Probation Service were also made aware. Intensive Therapy Unit staff were advised to complete safeguarding questions and a domestic abuse risk assessment with Dawn when she regained consciousness. Dawn was extubated on 2nd May 2021, following this she became agitated requesting drugs and cigarettes and stated she was going home.

14.139 Due to concerns for her safety she was detained under provisions of Section 5(2) of the Mental Health Act and referred to Mental Health Services for Assessment. Dawn said that this was an unintentional overdose stating that she had not been taking all her medications recently and she wanted to go to sleep but did not want to harm herself. She-reported to be in a new relationship and was very happy with no Domestic Abuse taking place within the relationship. Dawn reported that her ex-partner Ewan had moved out to the Liverpool area and she had blocked him from her social media and her phone and disclosed, no further episodes of domestic abuse with her ex-partner. Dawn advised the hospital safeguarding team she would call the Police if she has any domestic abuse concerns. Dawn reported her new partner Francis was living with her and she felt very safe. Dawn also said that she had a miscarriage a couple of weeks ago and consented for doctors on the ward to review and to complete a pregnancy test, which was carried out and the pregnancy test proved negative.

14.140 On the 4th May 2021 following assessment by two Psychiatrists Dawn was

deemed to be not detainable under sections of the Mental Health Act. The Section 5(2) Mental Health Act was rescinded and Dawn discharged to go home with Crisis Resolution and Home Treatment Team support; Dawn was agreeable to engage and keen for support at home and for a medication review.

14.141 On 14th May 2021 Dawn did not attend her Attend Anywhere appointment with a Consultant Psychiatrist from the Crisis Resolution and Home Treatment Team. The result being that Dawn was discharged from the Crisis Resolution and Home Treatment Team. The CMHT and Probation were informed.

14.142 On 24th May 2021 the Merseyside Fire and Rescue Service contacted Merseyside Police, advising that they were dealing with a fire at Dawn's home and they believed Dawn may have tried to kill herself. Neighbours who were alerted to the fire saw Dawn at a window with flames visible, but she ignored their calls to exit the flat. One neighbour smashed the window and pulled her out, whereupon she ran screaming down the road. Dawn was located on a road near-by and taken to Southport and Ormskirk Hospitals NHS Trust by Ambulance having taken an overdose of Diazepam and Pregabalin medication and suffering from smoke inhalation. The fire was confirmed as a deliberate ignition and Dawn was arrested for an offence of committing Arson with Intent to Endanger Life. At the time of her death in October 2021 the CPS had not yet reached a decision whether to allow the Police charging of Dawn with this offence.

14.143 Three days after Dawn's admission into hospital she was assessed by a Mental Health Practitioner from the Crisis Resolution and Home Treatment Team for informal admission to mental health ward. Dawn stated that she has been getting threatening text messages on her phone, she wouldn't disclose who they were from and exactly what they said as she was fearful of reprisals resulting from any disclosures. Dawn also alleged someone had cut the lock on her door so they could go into her flat whenever they want. Dawn believes people are out to hurt her and if she tells people why they will harm her family. Dawn disclosed that she took an overdose due to ongoing stress with the

intention of ending her life and that she still had intent to end her life. Diagnosis following the assessment noted a significant suicide attempt in the context of ongoing social stressors, possible substance misuse and issues with emotional dysregulation. Dawn shows no regret regarding the overdose and is still intent on ending her life.

14.144 There is no record of a safeguarding adult referral to Adult Social Care or a DASH risk assessment being completed nor any notification to Police regarding the threatening messages.

14.145 On 29th May 2021 two days after the first assessment the Crisis Resolution

and Home Treatment Team again assessed Dawn. The Team asked Dawn why she had not engaged with the Crisis Resolution and Home Treatment Team when referred to them at the start of May 2021. Dawn replied '*because I had the wrong people around me*'. When asked what would be different for involvement this time around and she stated *'those people have gone. I'm struggling I need help'.* As a result of this further assessment, it was considered that Dawn would remain an unpredictable risk to herself which is chronic in nature however it was not felt that Dawn required an admission to a mental health ward.

14.146 On 5th June a further meeting was held between Dawn, and a Mental Health Practitioner from the Crisis Resolution and Home Treatment Team. Dawn's parents were also present for this review. Dawn reported that her life was a '*mess*' and that she needed some support. She reported that her mood was low and there were concerns raised from her dad that she had been contacted by phone by people asking for money which had led to the recent overdose. Dawn was in a relationship with Ewan which was abusive and she has now blocked his telephone number. Dawn denied any recent use of illicit substances and denied previous frequent use of illicit substances reporting that she only used drugs occasionally. Dawn refused to engage with Ambition Sefton as she would likely come into contact with Ewan. A further home visit was arranged for the following day. Dawn declined a referral to Ambition Sefton. But agreed to engage with RASA.

14.147 Later that same day Dawn presented to the Accident and Emergency Department with suicidal ideation. On assessment by the Mental Health Practitioner from the Mental Health Liaison Team Dawn reported that she had attended Accident and Emergency because she did not feel safe to return to her flat due to threats of domestic abuse from Ewan to harm her and her family. Dawn reported the above was impacting on her mental health. She expressed hopelessness /worthlessness and that she could not get help for the domestic abuse because her "*ex is a big player and knows people who work for the DHS and can locate herself and family via social security'*. Dawn stated she was experiencing an intent to take her own life because of threats and was planning something big but would not divulge exactly what this was to the Mental Health Liaison Team. At 01.30 hours the next day Dawn left the hospital.

14.148 There is no record following this incident that the Police had been informed. A domestic abuse risk assessment was not completed, nor was safeguarding issues reported internally or a safeguarding referral made to Adult Social Care.

14.149 On 9th June 2021 Santander Bank made a safeguarding referral to Adult Social Care in Sefton expressing concerns of financial abuse. Dawn's account transactions did not fit her recent circumstance with regards to her being in hospital when transactions were made on her account. This information was transferred by Adult Social Care to the social worker employed by Sefton MBC within the Community Mental Health Team for follow up under Sefton's safeguarding processes.

14.150 On 21st June 2021 Dawn contacted the Homeless Section stating that she is fleeing a domestic abuse risk from ex-partner, Ewan, who has terrorised her and new partner so she wants to leave Southport area as soon as possible.

14.151 On 23rd June 2021 Probation was contacted by the Mental Health team who have been urgently trying to contact Dawn for assessment but cannot reach her. Probation confirmed their difficulties in making contact with Dawn.

14.152 On the 14th July 2021 the Mental Health Liaison Team received a referral for Dawn after an admission to the Aintree University Hospital NHS Foundation Trust following a mixed overdose which included an unknown amount of heroin. Dawn was now medically fit for discharge.

14.153 Dawn disclosed to the Mental Health Liaison Team taking an impulsive overdose of medication with suicidal intent at her friend's house and denied being under the influence of illicit substances when making that decision. There was no degree of planning to her overdose, she didn't write a suicide note. She reported taking the overdose secondary to psychological trauma/feeling overwhelmed mainly in relation to her traumatic relationships with ex-partner Ewan with whom she had a history domestic violence. Dawn was regretful and she was pleased to have survived the overdose. She denied feeling low or depressed and denied any active thoughts, plans or intent of deliberate self-harm, suicide or harm to others. The Consultant Psychiatrist considered Dawn to be vulnerable to acts of deliberate self-harm as a component of maladaptive coping strategies and separate from any suicidality, she denied any suicidal plans, and that the risks were mitigated by engagement with services and seeking support. The Consultant noted that this may change especially when she is under the influence of alcohol or due to unstable accommodation and she was an unpredictable risk due to her impulsivity. There is no records available to the Panel which indicates that a domestic abuse risk assessment or safeguarding referral was completed nor that Dawn was referred to a trauma support service following this incident or her disclosures.

14.154 On 30th July 2021 Dawn contacted the Urgent Care Team at Mental Health Services. Dawn reported that she is safe and has not engaged in any self-harming behaviours. Dawn then passed the phone to her partner Ewan who reported that she has been panicking and getting paranoid whenever he leaves the room. Ewan reported that he is going to stay with Dawn and will be able to keep her safe. Ewan has taken Dawns medication to prevent her from taking

an overdose. Support and advice was provided to Ewan who was considered a protective factor despite an extensive history of domestic abuse.

14.155 On the 2nd August 2021 a Mental Health Community Nurse practitioner received a phone call from Housing First they reported that Dawn was currently living in the Norris Green area of Liverpool with Ewan. Dawn reported that she thinks she's broken her wrist from a fall; her finger is misshapen, and her wrist is bruised. The Community Nurse contacted Dawn via telephone, Dawn answered and Ewan could be heard in the background speaking and took the phone off Dawn. The conversation between the Community Nurse and Dawn was brief as the Community Nurse could not have an open conversation with her as Ewan kept interrupting. Dawn reported that she felt she needed a medication review as she has taken herself off all her psychiatric medications and she keeps '*losing the plot'* and '*feeling paranoid'*.

14.156 Dawn reported that she took an overdose of medication the previous week and slept for around 30hrs after. Dawn said that over the weekend, she collapsed in the bathroom and had potentially broken her arm; she said she is in excruciating pain and couldn't cope. Dawn said she also has burn marks on her, which she's not sure how they happened. It was reinforced to Dawn the need for her to attend A&E so that this can be checked over. No consideration was given for a safeguarding referral despite the concern over this disclosure and the extensive previous history of domestic abuse.

14.157 One week later on 9th August 2021 Dawn took an overdose of medication requiring admission to the Intensive Care Unit. Mental Health Services were informed and Dawn disclosed to them that she had taken an overdose of all her prescribed medication, as she felt it was not working and because she had her Oxycodone medication reduced from 40mls to 10mls. Dawn informed the Mental Health Care Practitioner that since the reduction she has reverted to using heroin as a replacement. Dawn now needed methadone to prevent symptoms of opiate withdrawal. Dawn described her mood as "*ok now*" and informed the Mental Health Practitioner that she was "*fine*" until her oxycodone was reduced and then the pain she was experiencing had got too much for her,

so she decided to try and take her own life by way of overdose. Dawn claimed she was found by her partner who then called an ambulance. Dawn cited her partner as a protective factor and stated that she wants help to "*get better*". Records show that Dawn was discharged from the Mental Health Liaison Team as there is no role for further support. An email was sent by the Mental Health Liaison Team to the CMHT to inform them of the assessment and seeking their follow up in the community.

14.158 On 11th August 2021 Dawn attended the Accident and Emergency Department at Aintree University Hospital NHS Foundation Trust requesting to see Mental Health services. When meeting with a member of Mental Health Services Dawn complained about her accommodation and that she is living with her partner who is physically abusing her. She said she had attended Accident and Emergency Department to see the safeguarding team regarding accommodation. Accident and Emergency Department staff referred Dawn to the Hospital Safeguarding and she was happy to wait. The Mental Health Practitioner telephoned a Housing Support Worker who advised that it is difficult to find Dawn accommodation due to her already having a flat in Southport. There are no records of this incident being referred to Safeguarding at the Mental Health Trust, or Adult Social Care and no record of a domestic abuse risk assessment being completed.

14.159 The next day at a Housing First meeting Dawns presentation at the Accident and Emergency Department was discussed. Sefton Adult Social Care Emergency Duty Team (EDT) had arranged emergency accommodation for Dawn last weekend at a local Hotel but she did not turn up. The Ruby Project noted that Dawn often requests emergency accommodation but does not access this. It was agreed that the Housing Options Team will continue to offer emergency accommodation and assess her. Dawn was not provided with alternative accommodation offer at that point as the property was suitable to return to if she wanted, Dawn was not sure of what she wanted to do around her tenancy at that point. Suitable advice was provided to Dawn around emergency accommodation if she did not want to return to the tenancy.

14.160 On 16th August 2021 support was provided by the CMHT to Dawn in the Complex Case Court. Notes following that support show that Dawn stated that she was fine generally but her persistent stressor is her partner. Dawn reported ongoing issues of violence with her current partner (over the past few weeks) which has led to multiple overdose attempts, including a very recent admission to the Intensive Care Unit and intubation. They were together for 26 years but split up for three months earlier in the year. Dawn stated that during this time she was with somebody else. Since getting back together he has been burning her with cigarettes and lighters, she showed the practitioner two significant burns to her forearm and hip which she stated were inflicted by Ewan. She states that she has reported these to the Police. They do not officially live together however they spend most of their time together. Dawn stated that she is taking the overdoses to get back at him and out of frustration at him being there. Once again, these disclosures of domestic abuse were not risk assessed nor were referrals made to safeguarding services.

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

14.162 On 23rd August 2021 Merseyside Police were contacted by a Safeguarding Officer at the Liverpool University Hospitals NHS Foundation Trust about Dawn, who presented the previous day alleging assault by her partner. She told staff neighbours came to help her, and that she suffered three seizures after the incident. Dawn referred to twenty-six years of abuse at the hands of the partner and felt suicidal. It proved difficult for Police to make contact with Dawn at the hospital as she kept wandering away from the hospital and her phone went unanswered. On 26th August 2021 with all attempts to contact Dawn proving negative consideration was given to recording Dawn as a Missing Person. Throughout this time Ewan was circulated as being wanted by Police and arrest attempts were ongoing following Dawn's allegations of assault.

14.163 On 24th August 2021 the Probation Service spoke with Dawn via telephone. Dawn informed them that she took another overdose at the weekend and the last two night's Ewan had assaulted her. She reported that she was in a friend's house but would not give her friends name or address and stated she had to be quiet because Ewan was asleep upstairs. The Probation Service officer advised it was not safe to continue their conversation and that she knew that she would be speaking with Ruby project later that day and appointments would be made via the Ruby Project.

14.164 That same day contact was made with Dawn by a Mental Health Community Nurse who explained to Dawn that the team were concerned about her mental health. There appeared to be people in the background. Dawn reported that she had, suffered seizures in the previous days and wanted to know how they had come about. Dawn reported that she had been assaulted the previous evening by her partner, punching her in the head three times Dawn stressed that she didn't want any Police involvement. Dawn said she was vulnerable from her partner and was going to go to the Accident and Emergency Department. There is no record of a domestic abuse risk assessment being completed following receipt of this information and no referral to safeguarding services or MARAC. A Doctor from Mental Health Services contacted Dawn

following the information she had given to the Community Nurse. Dawn confirmed that an assault had taken place but that she did not want to report the matter to the Police. She was again encouraged to attend Hospital to have the injuries assessed.

14.165 On 25th August 2021 the Ruby Project spoke with Dawn at the Liverpool University Hospitals NHS Foundation Trust. A record of that contact states that Dawn is not willing to assist the Police with a statement, she simply wants an injunction and safe accommodation. Dawn stated that she gets paid this evening and Ewan wants £300 from her, and it is more than likely that he will be seeking her out. Housing options (Sefton) are trying to contact Dawn regarding her to return to her own accommodation in Sefton as Ewan knows where she resides. Ruby referred to Dawn to the NCDV to obtain a non-molestation order and discussed safety planning with her.

14.166 Adult Social Care at Liverpool MBC received notification of this incident via the North West Ambulance Service and noted that a Safeguarding episode had been opened and that they felt this required a multi-agency meeting due to its complexity.

14.167 On 8th September 2021 the Ruby Project provided an update to the Probation Service following contact they had with Dawn. She advised them to refer Dawn to Housing Options prior to discharge. She has had a CT scan and this confirmed she had suffered bruising to the brain. Dawn stated she had no contact with Ewan and said that she was sofa surfing but would not provide any further details of this.

14.168 On 12th September 2021 Dawn had taken an overdose of unknown substances and was referred to Mental Health Liaison Team by the Clinical Decisions Unit at Liverpool University Hospitals NHS Foundation Trust due to the overdose and expressing suicidal thoughts. Dawn was not seen by the mental health team due to being discharged prior to assessment.

14.169 On 15th September 2021 Dawn was found sleeping rough in Liverpool and offered accommodation at a homeless shelter.

14.170 On 23rd September 2021 Merseyside Police were contacted by a British

Transport Police officer reporting a domestic incident at a local train station between Dawn and Ewan. He accused her of stealing one hundred and fifty pounds from him but later retracted his allegation saying he found his money. Dawn told the officer she had been kept in a shed by her partner who had punched her in the head eight times causing her to lose consciousness. She showed him a lock knife saying she would use it if necessary. Merseyside Police attended Southport and Ormskirk Hospitals NHS Trust later that day, following a call from a member of their staff about further disclosures Dawn had made, showing them a lighter burn on her hip, threats he made to her family if she tried to leave the shed, and naked videos he had made of her, she said she was homeless.

14.171 Dawn told a Doctor who examined her that Ewan had sexually assaulted her, she had woken up on the floor after consuming a drink he made for her, and Dawn also informed staff that Ewan had told her that he had carried out sexual acts on her whilst she was unconscious. A VPRF 1 was completed and graded high-risk/Gold and a referral to MARAC made. Dawn was admitted to Southport and Ormskirk Hospitals NHS Trust as a place of safety, and she was seen by the Hospital ISVA who obtained consent to refer Dawn to Police, MARAC, Sefton IDVA and RASA, consent was also obtained to liaise with a housing support worker. The Southport and Ormskirk Hospitals NHS Trust ISVA attempted to source a refuge place which was explored with IDVA Teams, Ruby Project and the Liberty Centre but they were unable to find a space due to Dawn's complex needs. Staff arranged temporary accommodation once Dawn was fit to be discharged at a Travel Lodge hotel in Widnes. Mental Health and other relevant services were updated regarding the discharge destination by the Hospital Safeguarding team prior to discharge.

14.172 On 27th September 2021 a safeguarding referral was received by Adult

Social Care at Sefton MBC who noted that Dawn was refusing to engage with Police or Mental Health services. Services are struggling to find a suitable housing placement due to Dawn's history and that she had recently relinquished a tenancy that she held. No further was action taken as Adult Care Service were informed that Dawn was declining support or investigation regarding domestic abuse. Dawn was discharged to temporary accommodation before contact on the Ward by Adult Social Care could be established. Attempts made by Adult Social Care to call Dawn on known numbers also failed.

14.173 On 27th September 2021 the Homeless Service alerted partners that Dawn has agreed to go to a woman's refuge out of the area. She accepts that she is not safe in Liverpool or Sefton due to threats from Ewan and his associates.

14.174 On 1st October 2021 the IDVA spoke at length to Dawn. She is awaiting the Police to take a statement. She wants to accept help and support, is due to be seen by the Mental Health team, and she is awaiting Housing Options to see what they can offer. Although she has issues with drugs and alcohol, she says that she can control this and help has been offered. She would like to work with IDVA and agreed to receiving support around the domestic abuse. Her main priority at present is housing. She will be staying in Southport and Ormskirk Hospitals NHS Trust until it's safe to leave.

14.175 When seen by the Mental Health Team later that day Dawn denied any suicidal ideation and is aware of an upcoming consultant appointment and psychology input. The Mental Health Practitioner documented a risk of death by misadventure due to Dawn's Emotionally Unstable Personality Disorder and lifestyle.

14.176 On 1st October 2021 Dawn was discharged from Southport and Ormskirk Hospitals NHS Trust and went to stay at the arranged safe place accommodation in Widnes. Three days after discharge the IDVA Service had experienced difficulties in making contact with Dawn but was told by her she has changed numbers as Ewan was trying to make contact and she doesn't

want to hear from him. Dawn said that she felt safe in her current location. However, the Homeless Section confirmed that a room is booked at a different Hotel for her and the hotel address is in Sefton. Dawn did not take up the accommodation at this new hotel prior to her death.

14.177 On 7th October 2021 a MARAC meeting discussed the referral of Dawn to MARAC following the latest incident. Police reported that Dawn had provided an initial statement in relation to Common Assault but had then made further allegations before later denying them. It is recorded that the "*Police will take no further action in this case as the victim refused to provide a further statement*". Dawn was open to Mental Health Services but had sporadic engagement, a further appointment was arranged for 20th of October, ten days after her death. Dawn was also open to Adult Social Care who were looking at holding a multi-agency meeting to discuss concerns. The Mental Health representative advised that Dawn's mental health was assessed two weeks ago and she did not require sectioning. Actions at the meeting were for Adult Social Care at Sefton MBC to consider if a multi-agency meeting was still necessary as Dawn is now out of area.

14.178 On 8th October 2021 the Homeless Service reported receiving a call from the manager of the safe place that Dawn was staying at in Widnes to say they can't keep her there any longer. The reason for this decision was because an ambulance was called there last night and she was taken to hospital with a seizure and this disturbed other guests.

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

15. Overview

15.1 Dawn and Ewan had been in a long-term relationship lasting 26 years. The relationship was marred by physical violence and controlling and coercive behaviour which included financial abuse. Ewan was named as the perpetrator of much of this domestic abuse.

15.2 Dawn received treatment at hospital on a number of occasions for injuries she reported as having received from Ewan and following self-administered overdoses of prescribed medication and illegal substances.

15.3 The level of domestic abuse on many occasions left Dawn afraid to return to her home address for fear of being subject to further abuse from Ewan and housing services in Sefton had frequent contact with her together with other agencies in assisting Dawn to find safe accommodation.

15.4 It was a challenge for agencies including the Police to progress support for Dawn which Dawn disclosed was because of her fear of repercussions from Ewan should she engage with services.

15.5 There are several examples of good communication between agencies supporting Dawn and good interagency work responding to a crisis situation. However, there is little evidence of agencies working together once the crisis situation had ended or to find a long-term resolution of the domestic abuse and episodes of self-harming that frequently reoccurred. Agencies have identified that communication during non-crisis periods of intervention with Dawn was poor and unstructured and no agency identified the escalating situation in the months before Dawn's death.

15.6 There is little evidence from MARAC meetings or meetings of professionals that any action was taken to change or control the behaviour of Ewan who Dawn identified as the perpetrator in much of her abuse.

15.7 No single agency or individual assumed the lead role in seeking a long-term solution to the challenges Dawn faced. This resulted in the escalation of both physical abuse, in terms of frequency and severity, and the self-administration

of an overdose by Dawn particularly in the latter months of Dawn's life going unnoticed.

16. Analysis

16.1 The analysis will focus upon the key lines of enquiry agreed by the Panel at the start of this Review.

16.2 Do the actions of agencies and of MARAC show a co-ordinated and planned approach to the interconnected issues impacting upon Dawn?

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

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

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

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

16.6 However, away from the crisis situations which occurred a number of Panel members observe that multi-agency engagement and good communication was ad hoc, rather than a continuation of collaborative and proactive working

between agencies which would have aided in reducing risk. An outcome of this failure was that not all agencies had full oversight of the interconnected issues that were impacting upon Dawn. Agencies feel they would have benefitted from more multi-disciplinary team meetings, MARAM's or professionals' meetings held more frequently as opposed to separate communication sent to all agencies. It would have been more productive to have agencies together in more regular meetings to have discussed safety management solutions together.

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

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

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

16.10 In 2016 whilst receiving treatment following an incident of self-harming Dawn expressed thoughts "*that she cannot go on*" and feelings of guilt about the child she gave birth to and who was taken into care and also how her episodes of self-harm may impact upon her mother.

16.11 On two occasions in 2021, a period when the number of times that Dawn's episodes of self-harming was at its highest, she disclosed taking the overdose secondary to psychological trauma and feeling overwhelmed mainly in relation to her traumatic relationships with ex-partner Ewan. She "*could not take it*

anymore and she felt that there was no other way out other than taking the overdose".

16.12 Agency's recognised that Dawn did have complex needs and it was difficult to support her as she kept returning to Ewan. It was difficult to engage with her at times as she changed telephone numbers constantly and The Ruby Project and others provided her with new mobiles on several occasions. The Panel also acknowledge a lack of resources being in place to support a trauma informed approach during the period of this review.

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

16.14 On six occasions during the period reviewed agencies stated that Dawn "*has complex needs*" but no joint agency action accompanied these observations. A MARAC meeting held two days before Dawn's death agreed an action for the "*Organisation of professionals meeting to be considered*". One of the agencies attending that meeting recorded in notes made following the MARAC "*Not clear who the responsibility to organise a professionals meeting would fall to*". Illustrative of a lack of leadership, coordination, and planning at the multi-agency MARAC meeting.

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

16.16 On one occasion Dawn was seen by a member of the Aintree University Hospitals NHS Foundation Trust Mental Health Liaison team and during that assessment Dawn refused to go home, after being told she could now be discharged, due to her fear of suffering further domestic abuse and physical violence. Dawn reported thoughts of self-harm and harming or stabbing others when threatened. Dawn said that she feels '*madness'* when she thinks of her partner, she explained that madness is when she has visions of herself stabbing her partner, then she feels ok, then becomes tearful and then wants to harm

herself. The assessment concluded that there was no indication of a need for an inpatient admission to a mental health ward at this time. At the conclusion of the assessment neither a MeRIT or DASH risk assessment nor a referral for a safeguarding review was completed.

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

16.18 The National Institute for Health and Care Excellence (NICE) produces guidance for the NHS and other organisations responsible for people's health and care. They say that "*people who have a severe mental illness and drug or alcohol problem should get help under the Care Programme Approach (CPA)*"[5]. Though Dawn was referred to the CMHT following assessment by mental health clinicians in hospital there is no record of Dawn ever being referred to an MDT for assessment of her need for a Care Programmed Approach to be followed.

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

16.20 In 2020 a referral in respect of Dawn was discussed at a MARAC meeting. During the course of the meeting, called following an assault of Dawn by Ewan and due to the high-risk of further physical violence being faced by Dawn, it was shared that Ewan was open to the Probation service and that he had stated that he was temporarily staying with Dawn as he was homeless. Also shared at the meeting was the fact that Dawn had stopped engaging with agencies previously supporting her, (the Ruby Project and the IDVA service.)

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

16.21 MARAC actions following this meeting appeared to condone Dawn a high-risk victim of abuse living with the perpetrator of that abuse. It also appeared that despite the vulnerable position Dawn was now in MARAC was willing to accept that support agencies should be out of contact with Dawn. The meeting did not include any action to resolve Ewan's homelessness or agree attempts be made to re-engage Dawn with the support services of IDVA or the Ruby Project.

16.22 Two months after this MARAC meeting a referral was made of Dawn to the next MARAC meeting following further physical abuse by Ewan.

16.23 Actions agreed at the conclusion of each MARAC meeting in the case of Dawn did not include interventions which considered the history of Dawn's abuse by Ewan and did not seek to provide a longer-term solution to prevent further abuse and increased safety for Dawn. A number of actions were not requiring of a multi-agency meeting to resolve they could have been achieved via telephone call or email between agencies. Actions included, "*Confirm what refuge Dawn was in, liaise with CRC to establish if there is any contact between Dawn and Ewan, put a trace and locate marker on PNC to trace Dawn, establish if any further support was needed for Dawn and IDVA service and Ruby project to liaise to avoid duplication of work."*

16.24 The Tackling Domestic Abuse Plan published by H.M. Government in 2022 states. *"We are clear that perpetrators are the ones who need to change their behaviour and stop offending. By relentlessly pursuing them we can make this happen. We can drive down the prevalence of domestic abuse and reduce the number of domestic homicides*"[6]

16.26 SafeLives also produce a summary of aspects required within an effective MARAC action plan. This included a statement that an "*action plan that does not address the perpetrators behaviour through management, disruption, diversion or proactive prosecution will mean they will continue to abuse*."[7] Apart from one MARAC at which an action was agreed to "*consider domestic abuse work with Ewan*" there were no other MARAC meetings or meetings of

[6] Tackling Domestic Abuse Plan - Command paper 639 (accessible) Updated 1 September 2022
[7] SafeLives Briefing for MARAC's Repeat Cases

professionals which concluded with actions which focus upon changing Ewan's behaviour. Therefore, the risk to Dawn remained unchallenged and ever present throughout the 26 years of their relationship.

16.27 This lack of perpetrator focus is reflective of the previous lack of a strategic multi-agency framework focusing on tackling perpetrators of domestic abuse, with this response being one example of the impact of this. The lack of focus is also symptomatic of a lack of resources applied and made available to address this issue beyond statutory provision delivered by Police and Probation services, which has increased the challenge. This position is now changing with a focus on tackling perpetrators now included within Sefton's Domestic and Sexual Abuse Strategy and the issue is now a standing agenda item on Sefton's Domestic Abuse Partnership Board with the aim of continuing to push the responsibility for perpetrator management across all agencies. In early 2024 Sefton is also taking part in a pilot focussed upon perpetrators of domestic abuse. This will take the form of a disruption panel/ MATAC (Multi-Agency Task and Coordination) approach which is being led by Merseyside Police within a multi-agency framework

16.28 Were powers which are available to agencies and which may have provided support and protection to Dawn used effectively?

16.29 Whilst Dawn made numerous visits to Hospital's in Liverpool and Sefton for treatment of injuries following domestic abuse or following an overdose of prescribed medication and at times illegal substances, on occasions Dawn would discharge herself or be discharged by the hospital prior to assessment of her mental health. Therefore, the opportunity for safeguarding interventions was lost.

16.30 However, on two occasions Doctors in the Accident and Emergency Departments treating Dawn applied provisions contained within Section 5(2) of the Mental Health Act 1983. This facilitated a temporary holding of Dawn on a mental health ward in order for a mental health assessment to be arranged and ensured her immediate safety whilst the assessment is arranged. This the

Panel believe is a positive example of powers available to agencies used to provide support and protection to Dawn.

16.31 A further example of an agency's ability to provide support and protection is Housing First's use of a personalisation budget to support Dawn at times of crisis which facilitated safety measures through provision of mobile phones for Dawn to avoid further safeguarding incidents occurring and a means to get Dawn to safety, or to provide her with the ability to maintain contact with support agencies.

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

16.33 Ewan was arrested by Police having perpetrated acts of domestic abuse against Dawn. Also, Dawn's ex-partner was arrested following a complaint of a sexual assault. Dawn refused to make a statement of complaint and in the absence of any further evidence no further action was taken regarding this sexual assault. In 2017 Ewan was arrested for assaulting Dawn. The Police supported a prosecution with the use of hearsay evidence and evidence led policing. Tenacity was demonstrated when dealing with this incident but unfortunately the charge was dismissed at court. In November 2020 Ewan was arrested on suspicion of making threats to kill Dawn and an assault and battery of her. An evidence led prosecution was considered but without the key evidence from Dawn, required by the Police Decision Maker, the investigation did not progress.

16.34 In September 2021 whilst receiving treatment at Southport and Ormskirk Hospitals NHS Trust following physical abuse from Ewan Dawn reported to hospital staff and Police Officers that she believed Ewan had sexually assaulted her. She stated that she had woken up on the floor after consuming a drink he

made for her. Dawn also informed staff that that she had been locked in a shed for four days and unable to take her insulin and had received burns to her body and Ewan told her that during those four days he carried out sexual acts out on her whilst she was unconscious and had made naked videos of her.

16.35 No evidence to support a Police prosecution for these alleged offences was secured. However, consideration may have been given here for the Police to make application to the Court for the grant of a Sexual Risk Order. This order made by the Court would have imposed restrictions on Ewan's behaviour that the Court deemed necessary for the purposes of protecting the public from the risk of sexual harm. Such an Order can be made in respect of any person who the Police consider poses a risk of sexual harm to the public, notwithstanding the fact that they have not been convicted of a sexual offence. The Panel have received no indication that this course of action was considered.

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

16.37 During the period of this review a total of eight Section 2 Care Act 2014 notices were issued by local hospitals to Adult Social Care in Sefton. This section of the Care Act requires Local Authorities to take steps, including providing and arranging for services, which are intended to prevent, reduce or delay needs for care and support for all local people including adults and carers. In the majority of cases the Section 2 Notice was issued regarding Dawn's housing needs prior to discharge from hospital and one Section 2 Notice issued two months before Dawn's death gave the reason for the Notice as "*Patient is a victim of domestic violence and does not have a residence which it is safe to move to on discharge*". Yet on two occasions Dawn was discharged from

hospital before Adult Social Care could speak to Dawn and an intervention could be made to reduce the risks she faced. Better coordination and joint working between Hospital's and Adult Social Care may have provided more effective care and support for Dawn on her discharge from hospital.

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

16.39 The chronology clearly identifies multiple concerns which should have been shared by Mental Health Clinicians with Adult Social Care via the raising of a safeguarding concern in accordance with the Care Act 2014, and Mersey Care Trust Policy but which were not. There is no information available to the Panel to indicate that the raising of a safeguarding concern to obtain her views was ever discussed with Dawn. If Trust staff had raised these concerns with Adult Social Care via a Safeguarding Adults referral there would have been consideration under Section 42 of the Care Act 2014 for a Safeguarding Strategy Meeting to be held, which would have contributed to a multi-agency response to the safeguarding concerns and any actions which needed to be taken to improve Dawn's safety and wellbeing.

16.40 Following a safeguarding referral if a Safeguarding Strategy Meeting under Section 42 of the Care Act 2014 was felt not appropriate then alternative forums do exist which may have safeguarded Dawn. Since 2020 the MARAM process has been operational within the Sefton Safeguarding Partnership. Given the risks Dawn faced consideration should have been given to holding a MARAM meeting for her. The MARAM process would have enabled joint decision making to manage any risk associated with the issues which affected Dawn.

16.41 In October 2021 at the MARAC meeting held following Dawns imprisonment in a shed for four days when she reported that she had been physically and sexually assaulted the Probation service disclosed that both Dawn and Ewan were open to Probation but both were in breach of Orders imposed by the Court

and were not cooperating. Action agreed at the conclusion of this meeting was "*Probation to feedback the MARAC information to EWAN's offender manager*". There was no action included to take positive action against the breach of the Orders and the failure to cooperate. Two days later Dawn died. This lack of action is reflected upon within the IMR completed by HMPPS. "It is noted that enforcement processes were undertaken at times; however, a concerning feature of this case throughout the review period is that there were also many times enforcement actions were either withdraw or not proceeded with. The chaotic nature of how Ewan interacted with his HMPPS Practitioner and his poor attendance at times was therefore not addressed with enforcement. If such action had taken place action in a timely manner Ewan's engagement with Probation may have improved and the risks, he posed may have been addressed more thoroughly".

16.42 A further failure to take action to manage, disrupt, divert or proactive prosecution of Ewan which was available to the agencies of Sefton supporting Dawn took place in 2017. Dawn disclosed to the University Hospital Aintree that Ewan was stalking her when she left the house. The Ruby Project supported Dawn during her stay in hospital and following her discharge and completed a referral to Sefton MARAC. During the MARAC meeting held following this referral no reference can be found to any positive action being taken to control Ewan's stalking behaviour. The protocol on the Appropriate Handling of Stalking Offences between the Crown Prosecution Service & ACPO states that *"At the beginning of any investigation the police will ensure that victims are referred to relevant specialist support services. Victims of stalking are entitled to an enhanced service under the Victim's Code."*[8] There is no information available to the Panel that this took place.

16.43 Given the complexity and significant issues and risks impacting upon Dawn if professionals had come together in the form of a safeguarding strategy meeting, and/or a MARAM group meeting legal representation could have attended those meetings and consideration be given for an Inherent Jurisdiction to be made by the High Court to protect Dawn due to a possible compromising

[8] Appropriate Handling of Stalking Offences between the Crown Prosecutions Service & ACPO

of her decision-making ability caused by the abuse she was being subjected to by her partner. Inherent Jurisdiction entitles the court to make a decision, where there is no existing law available, and where it is clear that the decision of a court is required. This could have been considered after other legislation and action had been considered and discussed at a safeguarding strategy meeting or MARAM meeting.

16.44 What is the strategy to overcome difficulties in making contact with victims of abuse for the purpose of safety planning and did it work effectively in this case?

16.45 Five of the MARAC meetings discussing incidents of abuse suffered by Dawn took place during Covid-19 national lockdown periods. Due to the nature of the Covid restrictions agencies ways of working and engaging with victims changed and it was no longer possible to complete actions such as home visits or face to face meetings. The only exception to this was Adult Social Care Sefton who continued to hold face to face meetings with clients. Contacts were made with people remotely to maximise safety (e.g. telephone assessments and reviews) however where a visit was required these still went ahead using appropriate PPE and following risk assessment. Housing First would conduct welfare checks at the property during early stages of Covid-19 until full approach to support was agreed. For some agencies general staffing/resources were also extremely stretched at this time due to impact Covid19 was having on areas of service delivery.

16.46 The majority of crisis events involving Dawn occurred at hospitals across Merseyside and centred on the risk to Dawn's safety by her returning to a home she shared with Ewan and the unwillingness of refuges to accept Dawn due to "*her complex needs*". One Vision Housing and the Housing Options Team in Sefton were active partners in the task to provide safe living accommodation and reduce the risk of further domestic abuse by Ewan "*and ensure safety going forward*". However, throughout the period of this review despite the support given by One Vision Housing and the Housing Options Team and the numerous

incidents of physical and emotional abuse Dawn suffered she and Ewan shared a home together for the majority of their long relationship and this was known to inhibit agency contact with Dawn due to the presence of Ewan in the room.

16.47 In August 2021 the Housing First Panel recorded "*she (Dawn) is being very elusive to all the agencies"* and the Mental Health team shared that they "*have been urgently trying to contact DAWN for assessment but cannot reach her."*

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

16.49 Dawn did have sporadic periods of engagement with the Ruby Project which agencies made use of when wishing to communicate with Dawn but this was met with limited success. Aside from that direct communication with Dawn was problematic. Numerous attempts to contact Dawn by telephone failed and, on the occasions, when Dawn did answer the phone the conversion with agencies was subject to interference and control by Ewan.

16.50 In August 2021 a Community Nurse contacted Dawn via telephone. Dawn answered but Ewan could be heard in the background speaking and he took the phone off Dawn and the call ended. On other occasions the caller heard Ewan in the background telling Dawn what to say.

16.51 Planned appointments and meetings with Dawn were missed and, in such instances, where contact with a survivor is difficult there was no strategy in place to overcome this and it can lead to a removal of a survivor from service as was the case involving the Mental Health Service Crisis Resolution and Home Treatment Team in 2021.

16.52 The outcome of this inability to contact Dawn was that despite the controlling behaviour that Ewan exhibited a number of agencies, including the Police, IDVA Service and Adult Social Care wrote letters to Dawn at her home address

thereby increasing the risk of Ewan gaining access to the letters and being aware that Dawn was engaging with services and as a result subjecting her to further abuse. On one occasion Dawn reported to Merseyside Police that she had been physically assaulted by Ewan. Police records relating to that incident show "*numerous attempts to make contact with her (Dawn) but she did not respond, a 'seven-day letter" also went unanswered. The crime was filed as Undetected as there was insufficient information to investigate*." The Panel have been unable to establish if the failure to respond to Police requests was due to the fact that Ewan obtained access to the "*seven-day letter*" and prevented Dawn from responding to the Police request thus preventing a Police investigation of his alleged crime of violence from taking place.

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

16.54 Is the strategy to support victims who are repeatedly assessed as being at high-risk of further abuse robust enough to protect them?

16.55 MARAC meetings which are independently chaired, are held in Sefton and a small team exists to administer the MARAC process, accepting referrals, arranging meetings, and updating a database with outcomes from the meeting.

16.56 SafeLives identified that "*a repeated pattern of abuse can be more injurious and harmful than a single incident of violence*" [9]. During the period of this Review MARAC cases involving Dawn as a survivor of domestic abuse and Ewan named as the perpetrator of abuse were held in Sefton a total of ten times and the frequency of MARAC discussions involving Dawn and Ewan increased during the last quarter of 2020 and during 2021 when a total of five MARAC

[9] SafeLives Briefing for MARAC's Repeat Cases

meetings discussed their case. It is clear from this that agency interventions had not been effective or successful in reducing the risks that Dawn faced.

16.57 The Panel could find no evidence that the intensity of re victimisation during 2020 – 2021 was recognised by any agency or MARAC and acted upon. There is no strategic overview of high-risk cases of domestic abuse where the survivor is re victimised. HMPPS note that the initial OASys entry regarding Ewan did not highlight any domestic abuse concerns despite the CRC practitioner having information from the required domestic abuse and safeguarding checks. Later OASys documents do highlight and assess the risk as increasing to medium Risk of Serious Harm due to domestic abuse concerns. There are currently no arrangements in place within Sefton to review the impact of actions previously agreed at MARAC. Nor to safeguard re victimised survivors of abuse or to hold MARAC meetings where the cases being discussed are confined to those of survivors who have been re victimised and are again assessed as being at high-risk of serious injury or homicide. A Panel member expressed a means of overcoming these weaknesses, feeling it would be more beneficial to have a single MARAC point of contact or one named person to collate and distribute information to all relevant agencies.

16.58 As with the first key line of enquiry there is an appearance of MARAC dealing with referrals in isolation to Dawn's previous history and again not addressing the underlying issues which are causing Dawn to be continually referred to MARAC.

16.59 A number of Panel members identified that 20% of cases now being discussed at MARAC involve a survivor who has previously been subjected to a high level of risk from domestic abuse and has been previously discussed at a MARAC meeting. HMPPS, SWACA and Housing Options also reported an increase in complex cases of domestic abuse.

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

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

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

16.63 The banks expressed concern over access to and use of Dawns account. Were those concerns investigated effectively?

16.64 The parents of Dawn and the local Priest who had regular contact with Dawn both highlight that Dawns benefits were being paid into Ewan's bank and the emotional and practical problems for Dawn that this situation caused including restricting her ability to exit the abusive relationship.

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

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

16.67 Two voluntary sector agencies, The Ruby Project and the Venus Project did attempt to provide a high level of contact and supported Dawn with housing and financial issues effecting her wellbeing. On two occasions they assisted her to open a bank account in her own name, assisted her with enquiries at the

Benefits Agency over payments which Dawn believed had been accessed by Ewan and removed from her account and found Dawn accommodation and furnishings for the home. Dawn decided to end her relationship with the Venus Project at the end of 2017 and stated that she was again sharing accommodation with Ewan.

16.68 After its formation in 2019 Housing First maintained at times daily contact with Dawn who was a resident in one of their properties. They too assisted Dawn to open a bank account and overcome difficulties in accessing and retaining her benefits.

16.69 In June 2021 a safeguarding referral from Santander Bank was received by the Adult Social Care Services in Sefton which highlighted unusual transactions on Dawn's account and transactions which occurred during periods when Dawn was a hospital inpatient. The Bank also raised concerns that Dawn was coming into the bank accompanied by a male 'carer'. Santander put safeguarding measures in place until their investigation into possible financial abuse had been completed. The outcome of this safeguarding referral was that closure of the referral was made due to the inability of the Social Worker to contact Dawn. Other agencies were experiencing similar contact issues at this time. Santander put safeguarding measures in place until their investigation into possible financial abuse had been completed.

16.70 Two months later in August 2021 Dawn disclosed to her offender manager in the Probation Service that she would be receiving her benefit payments that day and Ewan was demanding she give him £300.

16.71 The Domestic Abuse Act 2021 came into force on 1 October 2021 and defined economic abuse as "*any behaviour that has a substantial adverse effect" on the other party's ability to "acquire, use or maintain money or other property" or "obtain goods or services"* [10]

16.72 The Domestic Abuse Act which came into force only nine days before Dawn's death does not make economic abuse a crime in its own right but does now

[10] Domestic Abuse Act 2021, H.M. Government

include economic abuse within the statutory definition of domestic abuse. This change is intended to highlight this form of abuse, and make agencies more likely to consider this abuse as constituting an offence of controlling or coercive behaviour contrary to the Serious Crime Act 2015.

16.73 The Panel were unable to identify any MARAC meeting at which the financial abuse was discussed or at which an action was agreed to safeguard Dawn from this form of abuse. The criminal offence of using controlling or coercive behaviour became law in 2015 the start of the period under Review and statutory guidance issued by H.M. Government, Controlling or Coercive Behaviour in an Intimate or Family Relationship, identified that action taken to prosecute this new offence will "*provide better protection to victims experiencing repeated or continuous abuse"* [11] yet there are no actions agreed at MARAC meetings or taken by individual agencies which focussed upon resolving the controlling or coercive behaviour Dawn was suffering.

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

16.75 How effective was the management of risk and safeguarding by and between agencies.

16.76 The Panel believe that weaknesses were present in the management of risk and actions to safeguard Dawn. There is an acknowledgement by MARAC and the MARAC Steering Group that some actions that may have been requested could not be delivered in practice. This is partly linked to Covid restrictions in place during some of the time period of this Review, but also due to what type of offer agencies could provide and gaps in service provision. For example a lack of appropriate safe accommodation for victims of domestic abuse with complex needs, services only being able to offer services in a reactive way rather than proactive contact (examples of when a service user is referred to a

[11]. Statutory guidance framework: controlling or coercive behaviour in an intimate or family relationship. Home Office 2015

service and they don't respond, or they miss appointments and the case is closed) no behaviour change programme available for perpetrators without children outside of the Probation Service offer.

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

16.78 Good practice was identified within Housing Options and Housing First who in an effort to overcome client disengagement have established a legacy system which enables the client to be supported by the same support worker each time they engage with the service. Thus, avoiding the need to establish trust and enabling the latest event to be placed in the context of the client's previous engagement and needs.

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

16.80 In August 2017 Dawn received hospital treatment following a physical assault on her by Ewan. Dawn had received a diagnosis of Emotionally Unstable Personality Disorder aggravated by illegal substance misuse. She was deemed medically fit to be discharged from hospital but expressed to hospital staff feeling unsafe going home fearing further domestic abuse.

16.81 Dawn additionally had thoughts of self-harming and stabbing others. She said that she feels '*madness*' when she thinks of her partner, she explained that *"madness is when she has visions of herself stabbing her partner*".

16.82 Enquiries showed that no women's refuge would accept a placement for Dawn given her complex needs. The Women's Turn Around project made enquiries with Sefton Adult Social Care regarding a safe place for Dawn to go to when

discharged but were advised that Dawn's case is closed to Sefton Adult Safeguarding service and signposted Women's Turn Around project to domestic abuse support agencies.

16.83 Despite the response received from Adult Social Care the Women's Turn Around project worker then advised Dawn to contact Sefton Adult Care Service Emergency Duty Team regarding her fear of the consequences should she return home. With no agency able or willing to take on the responsibility of supporting Dawn on this occasion support agencies passed the responsibility for finding accommodation back to Dawn. Without a safeguarding solution to Dawn's accommodation needs being found Dawn was then discharged from hospital back to her home address.

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

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

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

16.87 On another occasion following Dawn's hospital admission a psychiatrist concluded that "*Dawn remains changeable in presentation because of her diagnosis, scarce informal support network and repeated drug and alcohol misuse. As a result, Dawn will remain an unpredictable risk to self which is chronic in nature. Risk of death by misadventure due to emotionally unstable personality disorder and lifestyle.*"

16.88 Dawn had a dual diagnosis of mental health needs and substance misuse. During the period reviewed Mersey Care were responsible for mental health services and the commissioning of substance misuse services within Sefton. However, during the period reviewed the commissioned substance misuse service records only one referral into those services that received from HMPPS in respect of Dawn. There is a poor response by professionals to Dawn's substance misuse despite the threat it presented and documented risk within the psychiatrist report. There is a dual diagnosis practitioner now working within the community teams in Sefton, these posts have been operational for the past 18 months and therefore would not have been in place during the period reviewed.

16.89 Ambition Sefton, the substance misuse service provider at this time in addition to recording the HMPPS referral also recorded three occasions when Dawn missed her appointment with the service. There is no record of what steps Ambition Sefton took to engage with Dawn following the missed appointments. Change Grow Live have now been commissioned as the substance misuse service in Sefton. They have a clear strategy in place for making contact with clients. All referrals are entered onto the case management system as soon as they are received, and first contact is attempted within 24 hours. The process for a referral or missed appointment would be to try multiple means of contact to try and engage the person in services. This can include telephone call, letter, email, home visit, family members and professionals depending on the consent given on the referral. It is unclear what information or consent was given to Mersey Care by Dawn. At Change Grow Live Sefton, case notes must be entered within 24 hours, or a manager must enter a note confirming the reason they were delayed. All closures are reviewed by a team leader to ensure that

all viable options have been explored to encourage engagement. A team leader attends all MARAC meetings and as such if there is a case discussed at MARAC where Change Grow Live are struggling to make contact, they would liaise with any agency who the service user is engaging with to encourage engagement of the individual.

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

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

16.92 In August 2021 Dawn reported that she had been assaulted the previous evening by Ewan, punching her in the head three times and that since then she had been suffering seizures. On 8th September 2021 Dawn attended Royal Liverpool University Hospitals NHS Foundation Trust for a head scan which confirmed bruising to the brain as a result of the injuries to her head. Despite the seriousness of this physical assault no DASH form was completed by the hospital receiving this disclosure or the diagnosis.

16.93 The DASH form is a nationally recognised checklist used to assess the level of risk of further violence that a survivor of domestic abuse faces and is one of the main tools used to inform an agencies referral of the incident to MARAC. Additionally, Merseyside Police developed their own domestic abuse risk

assessment checklist referred to as MeRIT. It is a local decision which assessment is used to asses risk across partnerships on Merseyside but both forms of assessment are at the core of a referral of a case into MARAC.

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

16.95 There are examples of effective practice to reduce levels of risk and to safeguard Dawn. Dawn received treatment at three hospitals on Merseyside and in each alerts were placed on Dawns hospital electronic notes to alert staff treating her that Dawn was deemed a high-risk victim of domestic violence and prompting staff to inform safeguarding of the admission to hospital with the aim of ensuring full support for Dawn from relevant services to ensure Dawn's safety.

16.96 Aintree University Hospital NHS Foundation Trust Medical Social Workers supported Dawn during multiple admissions, ensuring community teams and Dawn's key worker were made aware of Dawns attendance and how they can support Dawn collectively with a safe place on discharge. There is also evidence to show that the hospital's Mental Health Crisis Team had exceptional communication and rapport with Dawn ensuring Dawn was more receptive of the support being offered by services.

16.97 Dawn's G.P. Practice did take action to prevent harm. The practice identified that Dawn was making frequent contact with the Practice, NHS 111, and out of hour's services requesting additional medication by reporting that this had been lost or stolen, either from her flat or by her partner. Dawn's prescribed medication consisted of significantly high doses of sedative medications, used in combinations seldom seen. Police records show Dawn's reports of lost or stolen medication were usually made within 24 hours of the prescription being issued to her.

16.98. As a result of the requests for additional medication outside that prescribed by her G.P. the practice notified the out of hour's service, asking them not to prescribe any further medication and to direct Dawn back to the practice. Additionally, the G.P. Practice took further preventative action. Dawn was known to be living outside of the practice boundary, but it was felt to be safer because of Dawn's medical history of which the practice was aware, to continue managing her care at the same surgery.

16.99 Due to the high dose of prescribed medication the Practice also restricted the issue of medication to weekly and subsequently changed this further to daily prescribing for a period of time due to the identified risks of Dawn administering an overdose.

16.100 Referrals of Dawn were made by the G.P. Practice to Mental Health and Pain services to assist with the pancreatic pain Dawn was suffering however, the Practice were unable to refer to a service to support her with addiction related to prescribed medication as this service was not available within the Sefton area. However, Change Grow Live now provide a service to support clients with addiction of prescribed medication. They have a partnership lead and clinical lead who are working to increase the knowledge of this service within G.P. practices so that these patients can access support quickly.

17 Conclusion

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

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

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

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

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

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

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

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

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

18. Lessons Learnt

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

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

18.3 Alongside this work, there are also multi-agency discussions across Merseyside in which Sefton plays a part about developing more focused

perpetrator management within high repeat/high harm cases. In Sefton a pilot piece of work is currently being developed and planned to commence in early 2024 which will focus on high repeat/high-risk of harm perpetrators of domestic abuse. This will take the form of a disruption panel/ MATAC (Multi-Agency Task and Coordination) approach which is being led by Merseyside Police within a multi-agency framework. The aim of this will be to provide a coordinated approach to discussing serial /high-risk of harm perpetrators and with a view to agreeing a practical action plan to take forward to address their actions. It will also provide real time learning to understand in more detail opportunities for action that could be developed further as well as gaps in services/support to inform future commissioning need linked to Sefton's Domestic and Sexual Abuse Strategy. This work will be linked to other local multi-agency working developments, such as the new Complex Lives MDT referenced below in 18.4, to ensure learning is jointly utilised and to avoid duplication of effort.

18.4 Sefton have recently introduced a Complex Lives MDT meeting. This was developed following a recognition that agencies / services respond to immediate crisis, but often are not able to pull together the relevant agencies and services within the required timescales to provide long-term, joined up care for the client. Complex lives are defined as people who are experiencing the following needs: One or more physical health condition plus, one or more mental health condition. Plus- one of the following. Homelessness, substance use/dependence, history or current offending, high intensity user of Accident and Emergency Hospital departments or has a history of being a looked after child. Dawn would have met the criteria for support from a Complex Lives MDT.

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

people with complex needs whose needs prevent them from accessing appropriate accommodation, support and care services.

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

18.7 The G.P. practice is implementing regular searches on their register of patients for all patients who are coded with Domestic Abuse, these patients will be added to their important person register and would be reviewed at regular clinical meetings.

18.8 In relation to more general awareness and responsiveness to domestic abuse within GP practices, additional resources have been awarded to Cheshire and Merseyside ICB (Sefton Place) through the national Standing Together Whole Health Project to implement a pilot IRISi programme for 12 months starting in winter 2023. This will support continued education and practical frontline support to GP practices within Sefton and will be implemented by Sefton Women's and Children's Aid (SWACA), a local specialist domestic abuse service, in conjunction with IRISi and with support from the ICB (Sefton Place) and Sefton Council.

18.9 The structure of the Probation Service Women's Team specifically the female practitioners, links to local female specific service provision underpinned by the Female Offender Strategy and National Women's strategy, has facilitated a

model of good practice which enabled the Probation Practitioner to provide specialist management/support underpinned by a relational approach to supervision by that service.

18.10 Since the period reviewed, several changes have occurred within Mersey Care NHS Foundation Trust this includes alignment of services which has resulted in the alignment of processes and pathways to enhance the patient journey and to ensure a more consistent approach to care delivery. Furthermore, the safeguarding offer within the division has increased, with proactive support such as a formal supervision offer, safeguarding training brochure, safeguarding links within teams and the Safeguarding Duty Hub which ensures that the workforce are responding appropriately to safeguarding concerns by developing knowledge and confidence within operational teams. Additionally, the Trust has a Mental Capacity Act Team, who provide advice and support to the workforce including training on Mental Capacity. Since implementation of the team, the Mental Capacity Team have provided support to operational clinical services and completed quality and assurance audits of Mental Capacity practice within the workforce.

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

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

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

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

18.14 An initial audit of complex MARAC cases occurring within Sefton was completed in October 2021 for the period of 2020-21, this was followed up by a further audit of more recent cases in February 2023. From these audits Sefton MARAC has identified a need to review complex cases such as that presented by Dawn and examine if the main MARAC meeting is the right forum for them to be discussed and work is already underway on this. It is also linked into the strategic work of Sefton's Domestic Abuse Partnership Board and Merseyside's Strategic Domestic Violence and Abuse Group. As a wider Sefton partnership, it is recognised that it may be necessary to look for more innovative actions outside of the traditional MARAC forum in order to try and engage with these more complex cases. The Panel recognise this as an important area of work and recommend it continues until a resolution to this issue is agreed.

18.15 Immediate action has been identified by HMPPS in order to get learning underway. It appears that throughout their assessment the PSO has accepted the perpetrator's answers at face value. There is very little evidence of an investigative approach or professional curiosity. There are a number of points at which the PSO would have benefited from verifying information provided by the person on probation, which would have enabled a much more accurate assessment within all sections.

18.16 Linked to the lack of professional curiosity would be for the use of robust and immediate enforcement of breaches of Community and Suspended Sentence Orders. There is evidence that this was not done in this case. This is already being addressed by the unified Probation Service. With checks being made on cases to ensure that enforcement steps are taken as soon as any unacceptable absence is known, rather than wait for the person on probation to supply any appropriate evidence.

18.17 The new unified Probation Service has made further changes. All members of staff have completed mandatory domestic abuse and safeguarding training. There is now a procedure of Management Oversight of all cases which has been fully implemented. Therefore, checks should be made around the practice of the individual practitioners involved in this case to ensure they are adhering to the new policies and procedures with regard to domestic abuse, safeguarding, OASys, case recording and the use of professional curiosity.

18.18 Liverpool University Hospitals NHS Foundation Trust identified a need to work alongside statutory and 3rd sector colleagues regarding high-risk MARAC cases to ensure monitoring of the survivor's compliance and engagement with other services once discharged from hospital

19. Recommendations

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

DHR Panel

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

Housing Options

1 Appoint a new Domestic Abuse Housing Options Advisor.

2 Develop a new Complex Women's Service.

Liverpool University Hospitals NHS Foundation Trust

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

Adult Social Care Sefton MBC

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

General Practice

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

Housing First

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

Sefton IDVA Team

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

Liverpool MARAC

1. Address inconsistencies in attendance at Liverpool MARAC

1 Strengthen the ability to share information between partners within the Liverpool MARAC, ensure detailed updates are shared on actions set and establish the impact of actions completed

Mersey Care NHS Foundation Trust

1. Mersey Care NHS Foundation Trust workforce to have increased confidence in routine enquiry, professional curiosity, identification and responding to domestic abuse.

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

One Vision Housing

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

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

1. To continue to ensure staff use professional curiosity and complete routine enquiry for patients attending with indicators of domestic, and sexual abuse and in the event of a disclosure undertake the required risk assessment and referral to the Safeguarding Team.
2. To seek available funding for Health IDVA's and if successful the recruitment and ongoing funding for HIDVAs.
3. To review the process for adding domestic abuse alerts to the patient's electronic patient record even when criteria for MARAC not met.

4. Review the development of a BI report for patients with a DA alert attending the AED, to identify missed opportunity and any subsequent actions that could be undertaken.

HMPPS

1. Improve the assessment of cases where domestic abuse is a feature.
2. Improve the management of cases where domestic abuse is a feature, both in respect of male and female perpetrators including when the victim is male.
3. Reinforce the necessity for Probation Practitioners to use Professional Curiosity in domestic abuse and child safeguarding cases.
4. The OASys Risk Management Plan should contain relevant actions to reduce and manage the risks from Domestic abuse
5. Delius Case recording to contain appropriate comments that conform to the CHRIS model to enable appropriate risk management of cases

SWACA

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

Action Plans **Annex A**

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
DHR Panel							
Develop and embed a coordinated pathway within Sefton for tackling serial /high risk of harm perpetrators of domestic abuse above what is provided via MARAC.	Local	Review the current options in Sefton for arranging multi-agency/multi-disciplinary meetings for domestic abuse cases with the view to better understanding existing pathways, the support mechanisms for professionals, the scope and governance of these arrangements and development opportunities Using the outcomes of the review, including the new Disruption Panel/MATAC approach to agree an enhanced pathway for discussing serial/high harm perpetrators within a multi-agency setting. This should provide an enhanced and more informed understanding of risk, particularly to the victim and their family and enable	Sefton MARAC Steering Group reporting to Sefton Domestic Abuse Partnership Board	Review completed by MARAC Steering Group Report to DAPB to outline review outcomes and proposed options	January 2024 March 2023	There is a better response to tackling serial /high risk of harm perpetrators of domestic abuse Agencies have a better understanding of - of the risks and needs which informs the overall partnership response Victims of domestic abuse and their family are better safeguarded from harm. Perpetrators are better held to account for their actions, and where appropriate are offered ongoing support to change future behavior.	Update Feb 2025 Pilot Sefton Multi Agency Domestic Abuse Perpetrator Group established in Feb 2024. Meetings being held monthly to discuss top repeat/serious harm perpetrators Approach discussed and agreed with MARAC Steering group and DAPB. Review underway to assess progress and impact to date, with outcomes to be fed back to MARAC Steering Group & DAPB to inform further work around perpetrators Sefton is also part of work being led by the Merseyside Strategic Domestic Violence & Abuse Group (SDVAG) to look at the effectiveness of MARACs and outcomes they achieve. Workshop held July 2024, work and discussions

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		a range of proactive actions to be agreed and followed up.					ongoing. Sefton's MARAC Steering Group has agreed to a review of Sefton MARAC, this is underway. The learning from this DHR will be fed into this and the wider Merseyside work.
Housing Options							
Appoint a new DA Housing Options Advisor	Local	Recruit new post	Therese Sanders, Housing Options	Complete interviews Employee in post	Ongoing	Improved multi-agency working which provides better outcomes for victims of domestic abuse seeking homelessness support Improved case management from Housing Officers	Complete. Update June 2024 Post in place, working closely with DA victim support services.
Develop a new Domestic Abuse Complex Lives Women's Service	Local	Develop and commission a new complex Lives service	Service Manager Community Safety & Engagement, Communities , Sefton Council	Contact specification drafted in conjunction with DA Manager Housing Options Manager and Strategic Housing Relevant approvals in	Dec 2024	Improved in borough accommodation for victims	Complete. New service 'Athena House' commissioned for 3 years and launched in August 2024 run by Excel Housing and Venus. This provides 12 bed spaces in total for female victims of domestic abuse with other complex needs. 24 hour support is provided along with therapeutic

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				place to go out to tender Contract out to tender Contract awarded Service delivery and performance monitoring in place			interventions. Since opening, the service has been full. Early feedback from contract monitoring is evidencing the need for the service and the benefit of providing dedicated counselling and therapeutic support.
Liverpool University Hospitals NHS Foundation Trust							
LUHFT to have better understanding of agencies available in community to support high risk cases who have complex lives	Local	Directory of services available for NHS regarding 3rd sector agencies available to signpost DA victims to	To be confirmed	To be confirmed		Clarity regarding agencies available to support patients on discharge /members of the public presenting at AED (signposting) Each patient presenting at risk /victim of DA will be signposted to 3rd sector support on discharge	
Adult Social Care							
Deep dive audit into safeguarding episodes where there are multiple referrals for	Local	Design of BI dashboard that can interrogate repeat referrals.	PSW Safeguarding Lead	Key Steps listed in actions	The first Report to be produced by	To identify how a change in approach in managing the core concern can enhance the impact of the intervention and reduce	Action completed March 2024. Audit tool built into LAS and BI dashboard that provides details of repeat Safeguarding referrals and

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
an individual over a specified period. *Post HO approval, this recommendation has changed to:* Audit tool to be designed where there are multiple referrals for an individual over a specified period.		Design an audit tool that includes consideration of actions taken on repeat referrals	Audit Colleagues		Sept.23 based on audit activity undertaken during July/ August 23	the presence of the continued risk. Activity to be embedded into all future audit work.	Enquiries over a 12 month time period.
Identify if LAS capability could flag individuals more effectively with repeated referrals and how this could be incorporated into risk assessment and practice.	Local	Initially LAS capability to be interrogated. Consideration of how available information could be incorporated into risk assessment and practice. Conversations with Council system Lead and Software producer to discuss requirements. Discussions with regional colleagues to explore what mechanisms in place in their respective authorities to achieve them	IT Lead PSW Safeguarding Lead	Key steps identified in actions	Enquiries with relevant officers to commence immediately- June 23 - with additional actions taken, with regional colleagues, in the event of a	To ascertain if processes to identify repeat concerns can be effectively flagged in LAS system. To identify how this information can be incorporated into practice. All adjustments made to accommodate achievement of the aim. Promotion of the capabilities of the LAS system to be pushed out to all practitioners	Action Completed June 2023. Identified that LAS does have the capability to flag repeated safeguarding referrals. This action has now been superseded by the build in February 2025 of a BI dashboard that provides details of repeat Safeguarding referrals and Enquiries over a 12 month time period.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
					solution internally being found		
Training department to develop a more advanced/bespoke training package in relation to the functionality of LAS system outside of current basic training content.	Local	Development of training course Workforce Development officer to be engaged with regional colleagues if appropriate to identify relevant training materials	Training Lead/ IT Lead	Key steps Identified in actions	Workforce Developm ent and IT Lead to be alerted to the proposed developm ent immediat ely – June 23- and engaged in discussio n around module content	Staff will know how to utilise the LAS system to interrogate information more effectively and produce reports which assist in their understanding of a case over time. LAS use to be optimised by all practitioners	Action completed June 23 All Adult Social Care staff are required to complete a Liquid Logic training as part of their induction to Adult Social Care prior to full access to the recording system. Shadowing/learning opportunities are also offered within the safeguarding team for all practitioners.
Implementation of new safeguarding documentation.	Local	Work to develop the system currently in progress	Safeguarding lead/ IT lead	Key steps completed	New safeguard ing document ation implemen ted during Spring/	Framework for progression of safeguarding cases will support decision- making.	Action completed new documentation launched in summer 2023. This has now been superseded by new Safeguarding document following staff feedback and is currently in test. It will be launched May 2025.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
					Summer 23		
Review of outcomes from the safeguarding audits and benchmarking to ensure consistent standards. *Following HO approval this recommendation is now included in recommendation around updating safeguarding practice guidelines*	Local	Safeguarding Standard Operating procedure updated and this used to support audit programme	PSW	Key Steps in actions	Septembe r onwards 2023	Guidance will be used to support ongoing audit program within Adult Social Care Teams and individuals will be supported to improve practice, good practice will be recognised and shared.	Complete Safeguarding Standard Operating procedure in December 2024.
Adult Social Care to review current training offer for Liquid Logic to ensure that all staff receive training on use of and interrogation of the Safeguarding episode	Local	Review and update current training offer for all Adult Social Care staff. 7-minute briefing to be designed and shared with all staff	Service Manager for Safeguarding and IT lead Principal Social Worker and Advanced Practitioner for Safeguarding	Review complete 7 minute briefing	March 2024	Staff will know how to utilise the LAS system to interrogate information more effectively to assist in their understanding of a case over time to support decision making. Will form part of new staff to Adult Social Care induction	All Adult Social Care staff are required to complete Liquid Logic training as part of their induction to Adult Social Care, shadowing/learning within the safeguarding team. Advanced Practitioner for Safeguarding and Safeguarding Team manager provide regular learning to all team or staff who request.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Adult Social Care to review and update as required current Safeguarding practice guidance for frontline practitioners	Local	Review and update current safeguarding practice guidance. Launch new practice guidance at the Adult Social Care practice forum and teams talk.	Principal Social Worker and Advanced Practitioner for Safeguarding Operational Staff	Current Practice guidance review completed	March 2024	Adult Social Care teams and individuals will have access to current safeguarding practice guidance. Guidance will be used to support ongoing audit program within Adult Social Care	Action completed and superseded by new Safeguarding Standard Operating procedure in December 2024. Sefton Adult Social Care - Adult Safeguar
Adult Social Care to design new safeguarding episode documentation within Liquid Logic including a risk management document.	Local	New documentation in place.	Safeguarding lead/ IT lead	New safeguarding documents in place	Nov 2023	New documentation in place to provide streamlined process of recording in Liquid Logic and risk assessment in placement to evidence how identified risks are being mitigated.	Completed November 2023 Sample Sefton Generic Risk Assessm
Adult Social Care workforce to have increased confidence in supporting individuals who self-neglect.	Local	7 -minute briefing on self-neglect and the use of the self-neglect tool kit to be devised and disseminated to services.	Principal Social Worker and Advanced Practitioner for Safeguarding	7 minute briefing produced	March 2024	For the Adult Social Care workforce to have greater knowledge and awareness of what is self-neglect and methods/approaches to encourage engagement/reduce risks.	Action completed Self neglect policy reviewed and updated January 2025. Briefing to designed and shared with all staff in March 2025.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		Use of the Self-neglect tool kit to be discussed at all team meetings	SSAPB QPA production Operational Staff.				
Sefton Council Adult Social Care staff to have increased confidence in routine enquiry, professional curiosity, identification and responding to domestic abuse.	Local	Adult Social Care workforce to be offered domestic abuse awareness training. Adult Social Care Workforce to be offered professional curiosity training.	Principal Social Worker and Advanced Practitioner for Safeguarding SSAPB QPA production Operational Staff.		March 2024	For the Adult Social Care workforce to have greater knowledge and awareness to be able to identify and work with individuals who have been subject to domestic abuse	Action Completed March 2024. Seven minute briefing designed by ASC and SSAPB on professional curiosity which has been shared at the ASC Practice forum for staff 7_minute_briefing_-_professional_curiosity.pdf A further 7 minute briefing shared with all staff around professional curiosity and Domestic Abuse 7_minute_brief_professional_curiosity_domestic_abuse_and_suicide_-_seftonplace.pptx All Adult Social Care staff have access to Domestic Abuse awareness training through the Council Corporate training offer.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Adult Social Care staff to ensure multi-agency communication is maintained.	Local	Review and share 7-minute MARAM briefing to all frontline practitioners prior to case study discussion at Adult Social Care Practice forum, Use of the MARAM to be discussed at all team meetings	Principal Social Worker and Advanced Practitioner for Safeguarding SSAPB QPA production Operational Staff.	7 minute briefing in place and currently being reviewed for relaunch	Jan 2024	For ASC workforce to utilise the MARAM process when there are concerns regarding management of risk across multiply agencies.	Action completed January 2024: MARAM briefing reviewed and till fit for purpose. Briefing shared at ASC Practice forum and during Safeguarding Adults week ' lunch and Learn' sessions 7_minute_briefing_-_maram.pdf
Adult Social Care to implement regular safeguarding audits to be completed to ensure consistent standard of practice across Adult Social Care	Local	Audit tool developed and in use. Safeguarding thematic audit added to Adult Social Care audit tool.	PSW	Audit tool in place and thematic audit completed, Thematic review report current in draft	Dec 2023	Teams and individuals will be supported to improve practice, good practice will be recognised and shared within the Quality, Safeguarding and Practice Assurance Group.	
Adult Social care to design and deliver trauma informed	Local	Training content to be determined in negotiation with the Workforce Development Team	Workforce Development Team		March 2024	Training in trauma informed practice for staff is in the early stages of discussion. A module is	

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
practice training for all frontline practitioners			SSAPB QPA production			to be developed and delivered during 23/24.	
General Practice/Cheshire and Merseyside ICB							
MARAC information sharing process to be developed between general practice and MARAC	At ICB level (Cheshire and Merseyside)	ICB lead to be identified	ICB Safeguarding Oversight Board, Primary Care Networks, Named GP Network	Included as an agenda item at the next ICB Safeguarding Oversight Board	31.05.2023	Robust information sharing takes place between primary care and MARAC, Primary Care are aware of victims of Domestic Abuse	Update: MARAC information process is being developed at ICB level. At place, the IRIS project (which started in Jan 2024) will support information sharing.
Confirmation of commissioned pathways around patients dependent on prescription medication	Local Sefton Place	Meeting to be arranged between stakeholders	Assistant Chief Nurse	Confirmation of commissioned pathways	July 2023	Clarification of clinical pathways to be shared with index surgery and wider Primary Care to access appropriate services	Complete July 2023 Information about clinical pathways has been shared with all Primary Care practices in Sefton. Action completed
All general practice staff in index surgery to complete mandatory DA training	Local Sefton Place	Practice staff to be reminded to complete mandatory DA training as part of team meetings/individual management supervision Process in place to monitor compliance	Practice Manager/Training Lead for SSP Health	All staff to complete mandatory DA training	October 2023	Staff will have the knowledge and skills to identify DA and be able to support and refer any patient experiencing DA to appropriate services	Complete October 2023 All staff at the practice have undertaken domestic abuse training. Action completed

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Index surgery to identify and discuss patients who are experiencing DA at practice safeguarding meetings	Local Sefton Place	Process for identification of patients to be established Practice safeguarding meetings to include standing agenda item of DA	Practice Manager	Identification process in place Regular meetings, agenda and minutes	October 2023	Domestic Abuse victims are discussed at practice safeguarding meetings	Complete October 2023 System now in place and Domestic Abuse is a standing item on the agenda at the practice safeguarding meeting. Action completed.
Housing First							
Arrangement of more frequent MDTs with all agencies.	Both, MARAC are separate and should implement plan for meetings to be conducted as part of action outside of MARAC. This would encourage for regular weekly/monthly MDTs to try and manage safety concerns	Training for staff around MARAC and domestic violence. This was made through Individual Personal Plans within the service and was provided to managers first and is scheduled to be provided to staff this year. Additional action when reporting safeguarding concern internally or externally to set up MDT and follow ups until safeguarding concerns are managed. Should be standardised for all staff to follow this process when report is submitted.	Ellie Moss – Locality Manager	Frequency of MDTs has increased for safeguarding active concerns. Support with complex cases on a case by case basis also completed Regular safeguarding internal reviews with operational manager to reflect and ensure follow ups are recorded.	Housing First Sefton Team members all received MARAC briefing training in 2023. All Housing First staff now trained in Level 2, Level 3 or Level 4 Safeguarding	Staff are up to date with training and understand importance of safeguarding reporting and follow ups. Greater multi-agency approach to support for individuals. Training to be sourced by Housing First and rolled out to full staff teams as soon as possible. Internal updates to be made by August 2023. All staff team to receive following training -	Outcome achieved in the following areas. MDTs – part of safeguarding reporting and follow ups. Also to support with complex cases. Case by case basis for frequency. Internal reviews with safeguarding lead – full reviews monthly with operational lead. Daily reviews for open safeguarding concerns. Training completed 18 and 19 January 2024

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
	for the individuals.	Internal update to safeguarding forms and policy.		Staff booked onto upcoming domestic violence courses and MARAC briefings. Domestic Violence training to be sourced by Housing First for staff to attend.	Children and Adults at risk of Harm. Specified Domestic Violence Training to be delivered to all staff in 2024.	'Working with survivors and perpetrators training' Dates of training – 18th + 19th January 2024.	
Accredited Safeguarding Training for all Housing First staff.	All agencies working with MARAC cases should consider accredited safeguarding training for extensive knowledge and how to respond to	This was made through Individual Personal Plans within the service and was provided to managers first and is scheduled to be provided to staff this year.	Housing First managers.	Recognition of needing to have further knowledge around safeguarding and enable staff to become accredited and have full knowledge of how to action, follow up and support to manage safeguarding	Manager's completed – March 2023. Practitioners completed in August 2023.	Greater knowledge for staff and developed confidence in understanding safeguarding areas as a whole and the importance of a multi-agency approach.	All Housing First Practitioners to have completed Accredited L3 Safeguarding Training. Staff team completed safeguarding training in March and August 2023

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
	incidents or concerns utilising the correct approaches .			concerns with service users.			
Sefton IDVA							
Explore options for continuation funding of the Complex Lives IDVA to ensure this additional support remains in place beyond the current temporary funding arrangements (currently March 2025)	Local	Update reports to continue to be taken to the DA Partnership Board to show impact and challenges. Funding options paper prepared and shared within Council governance structures and with DA Partnership Board	Service Manager Community Safety & Engagement, Communities , Sefton Council	Update reports provided to DA Board /relevant Council governance structures A commitment to future funding beyond March 2025 is secured Post remains within IDVA team	Ongoing basis March 2024 By April 2025	Victims of domestic abuse with complex needs receive the crisis IDVA support they need and are entitled to	Update Feb 2025: Complex Lives work is linked to the development of the new Multi Agency Perp Group. Continued discussions at MARAC Steering Group and across Merseyside forums. Funding options being looked at by Community Safety and Engagement Team to mainstream the post, grant funding from the MOJ via the PCC is in place for another year until March 2026
IDVA team continues to support the development and implementation of the Domestic Abuse Complex Needs Supported	Local	Service specification is finalised Service goes out to tender through open procurement process	Service Manager Community Safety and Engagement, Communities , Sefton Council	Contact specification drafted in conjunction with DA Manager Housing Options Manager and	Decem 2024 Ongoing from delivery point	Female victims of domestic abuse with complex needs have access to emergency accommodation that is appropriate to their needs	Complete Linked to Housing Options action. Service has been commissioned for 3 years and is operational (from Aug24) Community Safety & Engagement team

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
accommodation service.		Service is commissioned and starts delivery		Strategic Housing Specification is approved through Council governance and procurement arrangements Specification goes out to tender Service delivery in and monitoring in place Feedback from ongoing contract monitoring is fed into the DA Board performance arrangements			responsible for ongoing contract monitoring which takes place quarterly.
Liverpool MARAC							
Address inconsistencies in attendance at Liverpool MARAC	Local	Liverpool Citysafe Board to the CEOs of agencies to reiterate the requirements of and importance of their engagement with the Liverpool MARAC process	Safer and Stronger Communities Team, Liverpool City Council	Action approved by the Citysafe Board and letters sent.	October 2023	Improved and consistent attendance across all MARAC meetings to ensure a strengthened and good quality multi-agency response to risk.	This action was approved by the Citysafe Board and letters sent. Escalation completed with individual agencies.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				Review further to identify individual agencies where engagement is inadequate and escalate concern. Escalation completed with individual agencies. Trial of a face-to-face MARAC to identify whether this improves attendance Review of MARAC membership Approve further engagement from additional partners including higher			Engagement approved from additional partners including higher and further education. Ongoing work to establish how GPs can be included within the MARAC process. Presentation to the GP Learning Event in July 2023 to raise awareness of the need for multi-agency working to address the risk of domestic abuse and consideration of actions to address barriers. Liverpool has introduced a new MARAC process model which started on 30th September 2024. On implementation it was agreed to review the case numbers for the new Daily Domestic Abuse Safeguarding Meeting (DDASM) and consider whether the MARAC meeting frequency or duration can be reduced following 3 months of delivery. Following this, the next step would be to complete a wider review of the new MARAC

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				and further education. Ongoing work to establish how GPs can be included within the MARAC process.			process model following 6 months of delivery in April 2025. This review has now been completed and has a wider scope and considers the effectiveness of the new model and whether it should continue. This document sets out the key findings from the evaluation of the new model. Prior to the launch of the new model, the Liverpool MARAC Steering Group found a number of challenges faced by Liverpool MARAC which impacted the effectiveness, and sadly these issues were identified through Domestic Homicide Reviews. To summarise, the key challenges were: • Attendance and engagement issues - There was inconsistent attendance by MARAC representatives - Significantly less attendance on day 2 of MARAC

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							- Some representatives only attending the MARAC for their cases and therefore not inputting into the risk management process for other cases - When partners do not attend MARAC but send updates through prior to the MARAC to be shared, these are often simply a copy and paste of case notes rather than relevant information being pulled out and shared. A lot of the information is not relevant, e.g. blood pressure readings for Health, and the use of a lot of acronyms presented which are not clear to the MARAC who are not trained in that area. • High case numbers - Case numbers were significantly high, with some cases not meeting the MARAC criteria. This impacted not only the length of the MARAC meeting, but also

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							capacity to process each MARAC referral, complete research on each case and also to ensure enough time within MARAC to discuss those cases with the highest levels of risk. • Action Planning - Lack of creative action planning and conversation between all representatives in the MARAC meetings - Lack of feedback on completed actions - Lack of ability to measure impact or risk reduction following completion of actions • Capacity - Capacity issues for police to attend Chair all MARAC meetings. The introduction of the new MARAC process model, including the introduction of the Daily Domestic Abuse Safeguarding Meeting (DDASM) which sought to address such issues. The introduction of the DDASM sought to review all MARAC

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							process referrals to identify whether the criteria for MARAC was met, whether the case should be heard at MARAC or managed via an already established statutory safeguarding process with IDVA input; and to identify actions to address immediate safety. The overall aim of new MARAC process model is to ensure the effectiveness of the MARAC in Liverpool. Ensuring the right cases are discussed at MARAC and there is efficient capacity to discuss each case safely and build a collaborative action plan to address risk. The expected outcomes are: 1) **Professional Judgement cases**: by hearing all cases at the Daily Domestic Abuse Safeguarding Meeting, this would address any concern or risk of inconsistency in decision making between police and non-police referrals as all professional

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							judgement referrals would be considered in the same way during the meeting. 2) **Better engagement with and the voice of survivors**: Through the First Response IDVA making contact within 24 hours and already established statutory safeguarding interventions managing the risks individual to each victim in more systemic and informed way. 3) **Quicker responses to risk**: responses to victims of domestic abuse are quicker. 4) **Early intervention and de-escalation**: through increased understanding of risk along with engagement of the survivor. 5) **Reduced re-referral rates**: due to a more effective management of risk and the needs of survivors along with better partnership engagement.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							6) Reduced risk: due to dynamic reviewing of actions and tracking outcomes. **7) Increased engagement from partners**: by ensuring the right cases are being heard at MARAC, increased information sharing, and effective risk of management will make for stronger partnership working. **8) More creative action planning:** SafeLives recommend 10 to 15 actions per case. For cases that go through to the full MARAC, there will be two opportunities to raise actions, first through the DDASM for the immediate actions and secondly through the full MARAC. Actions should be SMART, with increased capacity, by hearing only the relevant high-risk cases, this will allow for better quality SMART action planning.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							As the new model has progressed, a strengthened approach has been implemented as of this week to address the additional capacity challenges that the new model brings. So far this week the strengthened approach is going well and addressing such issues. The below are the outcomes we have found since the launch: The DDASM allows for identification of the below, allowing an immediate response to address immediate safety during crisis point: • Contact details for the victim when contact cannot initially be established. • Bail conditions for the perpetrator, allowing this to be embedded into the safety planning. • Details of the Officer In Charge, allowing for

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							quicker joint up working and response to risk. • Understanding of any statutory involvement, allowed quicker information sharing and joint working approach to risk. Also allowing domestic abuse expertise to be embedded into statutory response earlier and therefore more effective multi-agency working. Identification of VPRFs/referrals that have not been received by statutory agencies and ability to rectify this. Faster identification of issues and the need for a Strategy Meeting if VPRFs haven't been sent through. (Note: where VPRFs have not been sent, this is not usually an oversite of the police, it is usually because no care and support needs were initially evident but following discussion in the DDASM further information was

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							shared. Or, where police had not been aware of linked children until further discussion in the DDASM). Faster contact with victims during point of crisis. IDVAs attempt contact within 24 hours of referral (previously 48 hours) and in some cases contact is within 3 hours of the referral being received. Cases can be heard within 24 hours (to a maximum of 72 hours over a weekend period apart from Bank Holidays) of the incident allowing a faster response to crisis and immediate risk. **462** actions have been agreed in the DDASM from October to December 2024 to address immediate safety before the case gets to MARAC. Actions can be put in immediately for safety such as target hardening, TAU

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							markers, DVDS considerations, making professionals aware of risk, e.g. risk of suicide. These actions no longer have to wait to be approved at MARAC allowing quicker reduction of risk. Reduction in duplication of actions between MARAC and statutory safeguarding responses and any potential conflict of actions with a number of different agencies completing different plans. Increased collaborative working at the earliest possible stage. Quicker information sharing. Allowing us to see individual and cumulative risk factors of multiple and complex needs. Less cases going to MARAC allowing more focus on the cases which really need it.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							More capacity to hear riskiest cases. Consistency in decision making on professional judgement referrals and considering wider agency information on risk. More actions to address: 1) Immediate risk 2) Long term risk 3) Increase of safeguarding to our most vulnerable victims and their families. There are many cases where the IDVA service have not received accurate or contactable information for the victim. Where this has happened, the reps at the DDASM have been able to share alternative contact details, allowing contact to be established earlier. Liverpool MARAC has also gone back to face to face MARAC meetings for one day a fortnight. This has

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							bought about strengthened discussion and creative action planning.
Strengthen the ability to share information between partners within the Liverpool MARAC, ensure detailed updates are shared on actions set and establish the impact of actions complete	Local	Commission a new MARAC IT system which is a single system which could manage the end-to-end MARAC process, including initial referral, assignment, information gathering, processing, update, outcomes and reporting.	Liverpool MARAC Steering Group	Funding has been approved and a system identified. The system is now in the process of being built.	October 2023	Improved information sharing Management of actions and increased accountability of actions set Improved data, e.g., the impact of actions completed	At February 2025 The new MARAC IT system has been commissioned and is getting closer to launch. Team training on the system is planned for March. Discussions are taking place with the Police as to how their system will link to the new MARAC system.
Mersey Care NHS Foundation Trust							
Mersey Care NHS Foundation Trust workforce to have increased confidence in routine enquiry, professional curiosity, identification and responding to domestic abuse.	Local	1. Trust staff to contact the Safeguarding Duty Hub for case consultation when there is a concern that a patient is being abused. 2. Trust workforce to access safeguarding supervision facilitated by the Safeguarding Adults Team.	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse	1. The safeguarding duty hub became operational 31/10/23. 2. Safeguarding Standard operating procedure	1. Ongoing. 2.complet e	For the Trust workforce to identify/recognise domestic abuse effectively. For the Trust workforce to respond appropriately to any disclosures of domestic abuse.	The following actions have been successfully completed however will continue to be reinforced. The Safeguarding Duty Hub is actively promoted through dedicated intranet spaces, team posters, and reiterated in safeguarding training sessions. We maintain

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		3. Trust workforce to be offered domestic abuse awareness training. 4. Trust workforce to be offered professional curiosity training. 5. Implementation of domestic abuse practice guidance for the workforce.	Safeguarding Adults Training Pool Safeguarding Adults specialist practitioners. Operational Staff.	operational as of 01/04/23. 3. Rolling programme of modular domestic abuse training since 01/04/2022. Further dates for 23/24 arranged. 4. Rolling programme of modular professional curiosity training since 01/04/2022. Further dates for 23/24 arranged. 5. Domestic abuse practice guidance in the process of being completed.	01/04/2023 3.completed 01/04/2022 4. completed 01/04/2022	The above will be evidenced by the completion of an audit within the 2023/2024.	detailed records of all team interactions with the hub to analyse trends and provide targeted support to less engaged teams. The Safeguarding Standard Operating Procedure, established in 2023, sees high attendance from operational teams, with supervision provided in various formats including ad hoc sessions for individuals or teams, and thematic reviews. Domestic Abuse Module Training is offered multiple times annually, with all trust workforce members encouraged to participate. Since 2024, the trust also provides toolkit sessions on identifying and responding to domestic abuse, including how to ask relevant questions and complete DASH/MERIT assessments. Quarterly audits are conducted for both the

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							safeguarding duty hub and domestic abuse practices. The trust's practice guidance on domestic abuse is approved is integrated into the overarching Domestic Abuse policy, both of which are accessible on the trust's intranet under a dedicated domestic abuse section.
Mersey Care NHS Foundation Trust workforce to adhere to Trust policy when there is a concern that an adult under there care is being or is at risk of being abused.	Local	1. Trust staff to receive supervision on the Care Act 2014 and the application of this into practice. 2. Safeguarding Adult Policy to be disseminated to all team managers to share with teams. 3. Trust staff to contact the Safeguarding Duty Hub for case consultation when there is a concern that a patient is being abused. 4. Trust staff to report internally any safeguarding adult concerns on RiO	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse Safeguarding Adults Training Pool Safeguarding Adults	1.Safeguarding Standard operating procedure operational as of 01/04/23 2.01/06/2023 3.ongoing 4.01/04/2023 5. Rolling programme of modular training of Making Safeguarding Personal for 23/24 arranged.	1.Complet ed 2.to be complete d by 01/04/202 3 3.ongong 4.01/04/2 023 5. ongoing 6. 01/06/023	For the Trust workforce to respond appropriately as per policy when there is a concern that an adult under there is at risk or is being abused ensuring that making safeguarding personal is embedded within practice. The above will be evidenced by the completion of an audit within the 2023/2024	The following actions have been successfully implemented and will continue to receive ongoing reinforcement: The updated Safeguarding Policy has been distributed across all staff and is readily accessible on the Trust's safeguarding intranet space. Comprehensive thematic supervision was provided to the entire Trust workforce on the eligibility criteria specified under the Care Act 2014, complemented by regular audits to ensure compliance

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		5. Trust staff to attend Making Safeguarding Personal modular training. 6. Making Safeguarding Personal 7 minute briefing to be disseminated.	specialist practitioners. Operational Staff.				with the Safeguarding Initial Records [Adults]. In the years 2024-2025, three sessions of the Specialist Safeguarding Adults Module training were held to deepen practitioners' understanding of the Care Act. This mandatory training is tracked and reported quarterly to the ICB, aligning with both KPIs and annual commissioning standards. The 7-minute Making Safeguarding Personal briefing has been circulated among all teams, with resources dedicated to this available on the intranet. Though the standalone Making Safeguarding Personal module training has concluded, its essential principles have been integrated into all module training. Importantly, the Making Safeguarding Personal element is now a mandatory component of the Internal Safeguarding Adult

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							Initial Record and is subject to regular reviews. Annual audits are carried out to evaluate how effectively Making Safeguarding Personal practices are being integrated.
Mersey Care NHS Foundation Trust workforce to ensure multi-agency communication is maintained.	Local	1. MARAM training to be delivered to Trust staff working in Mersey Care NHS Foundation Trust	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse Safeguarding Adults specialist practitioners. Operational Staff.	MARAM launched by the Safeguarding Adults Partnership Board in 2022. To be launched locally via lunch and learn sessions by 01/12/2023.	01/12/2023	For the Trust workforce to utilise the MARAM process when there are concerns regarding patients presenting with unwise decision making associated with risk.	The following actions have been successfully completed however will continue to be reinforced. MARAM training has been offered to all Trust staff and the plan is to offer further sessions on a regular basis. A dedicated MARAM section has been established within the Trust's safeguarding intranet space. Inclusion of MARAM in the Safeguarding Adults Policy. Provision of MARAM guidance and support to practitioners as needed, with the safeguarding team assisting clinical teams in facilitating MARAM.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							An ongoing review of the Safeguarding Initial Record is underway to explore methods for better capturing MARAM data.
Mersey Care NHS Foundation Trust workforce to ensure that carers of patients open to the Trust are provided with appropriate carer support.	Local	1. Workforce to be directed to the Trust's Carer's Strategy. 2. Workforce to ensure that local carer's support center details are easily available to any carer's.	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse Operational Staff.	The Trust has a Trust Strategy for Carers. Team Managers to be contacted by Safeguarding Adults Named Nurse to feedback requirement to think about any informal carer's and support they may require.	01/07/2023	For the Trust workforce to utilise the MARAM process when there are concerns regarding patients presenting with unwise decision making associated with risk.	This action has been successfully completed. Key learnings related to carers identified in the review have been communicated to the Trust's carer and engagement team. The in-place Carers policy details the support services available for carers and outlines the expected level of support that should be provided to them. A 7-minute briefing focused on 'Carers' is currently being finalized and awaits approval. Additionally, the development of the Think Family Strategy is actively progressing within the Trust

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Mersey Care NHS Foundation Trust workforce to have increased confidence in responding to patients who self-neglect.	Local	1.Trust staff to contact the Safeguarding Duty Hub for case consultation when there is a concern that a patient is self-neglecting 2. Trust workforce to access safeguarding supervision facilitated by the Safeguarding Adults Team. 3. Trust workforce to attend modular self-neglect training. 4. 7 minute briefing on self-neglect to be devised and disseminated to services.	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse Safeguarding Adults Training Pool Safeguarding Adults specialist practitioners. Operational Staff.	1. The safeguarding duty hub became operational 31/10/23. 2. Safeguarding Standard operating procedure operational as of 01/04/23. 3. Rolling programme of modular self-neglect training since 01/04/2022. Further dates for 23/24 arranged. 4. to be completed by 01/07/2023	1.Completed 2.Completed 3.Ongoing 4.01/07/2023	For the Trust workforce to have greater knowledge and awareness of what is self-neglect and methods/approaches to encourage engagement/reduce risks. The above will be evidenced by the completion of an audit within the 2023/2024	The Safeguarding Duty Hub is prominently supported through dedicated spaces on the intranet, posters in team areas, and regular mentions during safeguarding training. We keep comprehensive records of all team interactions with the hub to identify trends and offer targeted support to teams that are less engaged. We have conducted thematic supervision sessions, which were well-attended, focusing on self-neglect. Training modules on self-neglect have been consistently delivered in 2022, 2023, and 2024, with additional sessions planned for 2025 and 2026. The MARAM process has been implemented across various teams within the Trust. There is a dedicated section on the Intranet about Self-Neglect.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
							Periodic audit activity on self-neglect completed to meet KPI requirements regarding the trust's response of self-neglect. A 7-minute briefing on self-neglect is currently being developed.
For Trust staff to access relevant safeguarding information easily.	Local	The Trust intranet has been updated to include a dedicated safeguarding space with relevant local resources which are easily accessible to the workforce.	Mersey Care NHS Foundation Trust – Safeguarding Team with support from the Trust Communications Team.	Safeguarding space is now live on the Trust intranet, including safeguarding resources.	1.Completed.	For Trust staff to have a platform to access easily accessible safeguarding information.	This task has been completed, and a dedicated safeguarding section has been established on the trust's intranet, featuring various resources. Additionally, trust staff can contact the safeguarding duty hub from Monday to Friday for specialist safeguarding support.
Ensure that the workforce are aware of Carer Support services available within the locality and who to signpost family members who may be carer's too.	Local	Details of local carer support services to be obtained and disseminated to workforce.	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse	Carer support services to be disseminated to workforce. Trust Carers Strategy, to be reviewed 2026.	01/07/2023	Greater consideration of family members who are carer's.	This action has been successfully completed. Key learnings related to carers identified in the review have been communicated to the Trust's carer and engagement team. The in-place Carers policy details the support services available for carers and outlines the expected level of

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
			Safeguarding Adults specialist practitioners. Operational Staff.				support that should be provided to them. A 7-minute briefing focused on 'Carers' is currently being finalized and awaits approval. Additionally, the development of the Think Family Strategy is actively progressing within the Trust
For reflective supervision sessions to be provided to Trust staff upon publication of this report.	Local	Safeguarding Adults Named Nurse to facilitate reflective practice sessions upon publication of this DHR.	Mersey Care NHS Foundation Trust Safeguarding Adults Named Nurse Safeguarding Adults specialist practitioners. Operational Staff.	A key milestone will be upon publication of this report.	01/01/2024	For Trust staff to have an overview of Dawn, and able to reflect on the lessons learned to improve practice.	The details of the practitioner event will be communicated to the clinical teams who had been working with this patient. Additionally, once this report is published, the safeguarding practitioner who supports these teams will conduct reflective supervision sessions with them.
One Vision Housing							

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Strengthen OVH's risk assessment when supporting high-risk customers / families.	Local	Work with OVH's CST to review our risk assessment tools	Suzanne Meylan, Kyle Lane and Steve Aston, CST	Reviewed document. Process enacted and embedded in teams practice (as needed).	March 2024	Ensure that OVH has a robust RA for supporting victims. Ensure that processes are always applied	Complete – processes and documents reviewed – September 2024
Put into place oversight from the Safeguarding Team	Local	Agree a frequency to review DA cases which have an open ReAct case.	Suzanne Meylan and Steve Aston (CST)	Agree the frequency and scope of the review process. Complete reviews as required and formalise an action plan to include further actions as needed	January 2024 Review the process – January 2024	Ensure that all cases have management oversight	Meetings in place and completed monthly – Jan 2024

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
Provide a second Professional Curiosity (PC) course	Local	Develop a new PC course using learning from the DHR to underpin the training	Suzanne Meylan and Joanne Kenyon	Develop the training. Deliver training to an agreed cohort	April 2024 August 2024	Allow frontline teams to develop a further understanding of complexities which are present in DA and the importance of PC	In development, revised completion date of June 2025
Probation Service							
Improve the assessment of cases where domestic abuse is a feature.	Regional	Staff Training: 1. Complete/revisit mandatory child safeguarding and domestic abuse training. 2. Complete/revisit mandatory adult safeguarding training. 3. Complete/revisit Risk Assessment Practice (RAP) training and to embed the learning into practice. OASys:	Probation Service – Practitioners. Senior Probation Officer assurance activity.	Staff training: Upon completion/revie w of training events 1-3, SPOs to record attendance in each practitioner supervision notes. Each practitioner to engage in an individual reflective discussion with their SPO about the main learning points they have taken	Yearly refresher training for 1 and 2. 3 Required mandator y training if role specific.	Quality of risks assessment and reviews in line with AQA standards – evidence risk reviews at times of significant change	Update March 25 Practitioners (PPs) are completing mandatory yearly training as required. Reflective practice sessions are completed with PPs as part of SEEDS (staff supervision) process. OASys training is mandatory and on-going. PPs are expected to review OASys at significant change, this may be impacted by workload/capacity however PPs will immediately record significant changes on delius systems and share information with

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		1.SPO to ensure OASys training is completed by all staff members 2. Practitioners will familiarise themselves with the OASys Assessment Quality Assurance (AQA) guidance (EQuiP Keyword: AQA) in order to embed this into all OASys assessments and consistently produce assessments to the required quality benchmark. Practitioners will ensure OASys is reviewed at points of significant change. These include reoffending; emerging risk information; cumulative minor events; identification of new victim groups/changes in risk; termination of requirements; change of officer.		from each event and how this could have been applied in the case of EW. OASys: Practitioners are to provide assurance to their SPO in supervision that they are using the AQA guidance consistently, and this to be recorded in their notes. As part of the Countersigning framework, SPOs to provide ongoing developmental feedback to practitioners about	Mandator y inclusion in training package. Informatio n sent out to practition ers. On-going		partners/services involved in a timely manner. Additionally case management practice including review of OASys is implemented through the regional case audit tool (RCAT)

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		All OASys should be completed in a timely manner and in line with targeted timescales. SPOs to quality assure and retain practitioners as 'unapproved' roles in OASys and use the countersigning framework guidance and to provide developmental feedback until quality standards are consistent.		assessment quality and timeliness. Before practitioners are given approved countersigning status on OASys, they are each to produce 3 OASys to be quality assured by their SPO using the AQA tool which meet the required quality benchmark on the first attempt. Each practitioner should complete at least 2 of these assessments on cases linked to domestic abuse, and 1 should be a review prompted by	On-going Completed and on-going for new staff		

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				significant change.			
Improve the management of cases where domestic abuse is a feature, both in respect of male and female perpetrators including when the victim is male.	Regional	Allocation: 1.SPO should demonstrate accurate allocation practice using appropriate processes and basing decision making on relevant risk information Professional Curiosity: 1. Practitioner to complete P&Q Professional Curiosity workshops and demonstrate the application of learning through an investigative approach to their casework. Recording and Partnership information sharing: 1. Practitioners should attend the Effective Case Recording workshop run by P&Q. They should use this input to ensure their Delius entries clearly show the content of each supervision		Professional Curiosity: 1.Following attendance at the Professional Curiosity Workshop, each practitioner should provide Delius records to their SPO that evidence application of an investigative approach taken towards key risk issues and decision making in the following: One case with child safeguarding considerations. One case with domestic abuse considerations.	On-going Complete d via continuou s professio nal developm ent day. On-going	Evidence of responsive supervision and risk management to protect victims of Domestic Abuse	Update March 25 On-going, embedded in practice On-going regular training sessions available On-going

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		session, that addresses are accurate and that documents including induction packs and warning letters are completed and uploaded in every case. 2.All operational staff should utilise the registers checklist to Ensure that Delius registrations are accurate, reviewed as necessary and that notes reflect relevant information and rationale for inclusion/review. 3. Practitioners should routinely request up to date information from partner agencies, (including but not limited to FCIU and child/adult Social Care). Information should be appropriately recorded following guidelines around sensitive contacts and used to inform risk assessments.		One case with adult safeguarding considerations 2. Where PP5 does not make sufficient progress with any element of this activity, SPO3 should consult HPDU1 to determine whether any formal processes should be implemented. Recording and Partnership information sharing: 1. After practitioners have watched the recording,	On-going On-going		Part of practice. Registrations are reviewed 3 monthly or 6 monthly depending on the nature of the alert. Embedded in practice. Additionally the Probation Service in Merseyside and Merseyside Police have developed an automated domestic abuse process which provides automatic DA and safeguarding information to PPs for the duration of the POP's statutory supervision.

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		Information should inform decision making and risk assessment in the cases. 4. Practitioners should ensure that all relevant risk information is shared with EMS providers to ensure their safety when attending an address to fit an EM Curfew. Safeguarding activity: 1. Practitioners to ensure that Adult Social Care referrals and liaison are undertaken when people on Probation are caring for adult relatives with additional needs or where individuals are vulnerable or at risk. Any available support should be discussed and implemented, risks addressed in the RMP and SP and clear activity recorded in Delius.		QDO to undertake a dip sample of case recording practitioners, checking for detail and accuracy as well as a clear account of case progress. 3 cases for each practitioner should be selected, and feedback provided to the relevant SPO who will determine any onward activity required if any development areas are identified. Middle Managers across the PDU should ensure that the	On-going. Essential early work at beginning of requireme nt. On-going		On-going practice requirement

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		2. Practitioners to ensure that in every case they seek information about any child the PoP may have contact with, record their details accurately and undertake safeguarding enquiries with Children's Social Care. Where risk to children is identified, this should be robustly assessed, with specific activity identified in the RMP and SP and appropriate referral and liaison completed with Social Care. Information should be shared with Children' Social Care to mutually inform each agency's assessment of risk to children. Frequency of reporting: 1. Practitioners should review their caseload and ensure that all people on Probation are being seen in line with National Standards (via link below)		Registers Checklist is delivered in team meetings so that staff are familiar with this resource. When undertaking MO with staff, Delius registrations should be checked as part of that process to ensure they are up to date. 2. Practitioners to provide examples from Delius records to evidence that they are routinely requesting pertinent information from partnership agencies. These records should be from 3 different cases and show initial	On-going. Probation Service have created dedicated safeguard ing admin staff to expedite access to informatio n On-going.		On-going practice requirement. The Probation Service have dedicated safeguarding administrators embedded in MASH/Police with access to CSC systems which allow for an automatic safeguarding enquiry on ever newly sentenced case. Further to this, PPs utilise the safeguarding admin for any additional checks required - on-going embedded in practice. On-going, embedded in practice via national standards of contact and supervision requirements.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		and that the detail of the contact is sufficient to meet the identified risks and needs in each case. 2. SPOs to review and revisit the home visits policy framework and demonstrate adherence to it. All to demonstrate an understanding of the value added by home visits when assessing and monitoring risk and need Transfer of cases: 1. Practitioners to familiarise herself with the current transfer policy and ensure that all necessary risk information and case detail is shared with the receiving area. The next transfer she undertakes should be overseen by an SPO to ensure that all required activity has taken place.		requests and any follow up requests as required. It should be clear from Delius and OASys how this information has informed risk assessment and management. Information should be recorded in line with Handling Sensitive Information guidance (EQuiP keyword: sensitive. Document – 7-minute briefing sensitive information). 3.EMS notification form completed by Practitioners should be gate-	Complete d and monitored . Complete d. Dedicated transfer SPOC embedde d in teams to improve		New home visit policy implemented February 2025 streamlining the process to encourage (safe) home visit practice. National case transfer Policy in place to monitor and progress the safe transfer of POPs to other areas. Locally we have implemented SPOCs to oversee and address any barriers to full transfer

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		Head of PDU to ensure that systems are in place to monitor that when a case transfers internally between staff within the same team (other than unplanned sickness where the staff member is unavailable), a handover discussion should be recorded in Delius. This discussion should clearly state current risks, acute issues, next steps, and any actions required, and receiving staff should ensure updated FCIU and safeguarding requests are made to determine whether there are any indications of domestic abuse that require onward monitoring.		kept by SPOs to ensure the detail is comprehensive and accurate. Case to be noted in supervision notes. Safeguarding activity: 1.Practitioners to bring to supervision one case which demonstrates effective adult safeguarding practice, including identification and assessment of concerns, referral to the adult safeguarding team, responsive action to reduce	safe case transfers.		

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				risks and effective multi-agency information sharing. 2.Practitioners to each to bring to supervision one case which demonstrates effective child safeguarding practice, including identification and assessment of concerns, referral to the adult safeguarding team, responsive action to reduce risks and effective multi-agency information sharing.			

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				Frequency of reporting: 1.SPOs to use Management Information data relating to contact frequency to ensure contact is in line with National Standards (or where applicable the Prioritising Probation Framework). 2. Practitioners should provide evidence from their caseload of adherence with the Home Visit Policy, and the case details should be recorded in their supervision notes.			

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				Transfer of cases: 1.Practitioner to evidence in supervision application of case transfer policy framework (PF) SPOs to ensure where a case that requires transfer to another team that they undertake a management oversight to ensure that practitioners are adhering to the PF and progressing the transfer in a timely manner providing all accurate information required. Once			

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
				the transfer is complete, this is to be recorded in supervision notes			
Reinforce the necessity for Probation Practitioners to use Professional Curiosity in domestic abuse and child safeguarding cases	This will be undertaken both at a local and regional level.	Ensure that the Probation Practitioners CPP1, CPP2 and CPP4 have completed all mandatory Domestic Abuse and Safeguarding training and attended a Professional Curiosity workshop. Briefing to Probation Practitioners on learning from this DHR. Briefing to CMT and DA Leads Meeting. Share with other PDU Partnership Leads in Merseyside.	Head of PDU who will delegate to Senior Probation Officers	Audit learning via Regional Case Audit Tool (RCAT), the Performance & Quality Unit and QA activity and feedback, direct from Senior Probation Officers via countersigning.	March 2024	Informed risk assessments; preventative activity, reduced reoffending and public protection.	Update March 25 On-going, embedded in practice.
Reinforce the necessity for Probation Practitioners to use Professional Curiosity in domestic abuse and child safeguarding cases	This will be undertaken both at a local and regional level.	Ensure that the Probation Practitioners CPP1, CPP2 and CPP4 have completed all mandatory Domestic Abuse and Safeguarding training and attended a Professional Curiosity workshop.	Head of PDU who will delegate to Senior Probation Officers	Audit learning via Regional Case Audit Tool (RCAT), the Performance & Quality Unit and QA activity and feedback, direct	March 2024	Informed risk assessments; preventative activity, reduced reoffending and public protection.	Update March 25 On-going, embedded in practice and assisted through the automated DA and safeguarding processes in place.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		Briefing to Probation Practitioners on learning from this DHR. Briefing to CMT and DA Leads Meeting. Share with other PDU Partnership Leads in Merseyside.		from Senior Probation Officers via countersigning.			
The OASys Risk Management Plan should contain relevant actions to reduce and manage the risks from Domestic abuse	This will be undertaken both at a local and regional level.	CPP1 to have completed all mandatory Domestic Abuse and Safeguarding training. OAsys to be Quality Assured (AQA) Briefing to CMT and DA Leads Meeting. Share with other PDU Partnership Leads in Merseyside.	Head of PDU who will delegate to Senior Probation Officers	Audit learning via Regional Case Audit Tool (RCAT), the Performance & Quality Unit and QA activity and feedback, direct from Senior Probation Officers via countersigning	March 2024	Informed risk assessments; preventative activity, reduced reoffending and public protection. Targeted embedded learning	Update March 25 On-going, embedded in practice. Monitored through SPO countersigning processes and reviewed via RCAT.
Delius Case recording to contain appropriate comments that conform to the CHRIS model to enable appropriate risk management of cases	This will be undertaken both at a local and regional level.	CPP1, CPP2, CPP3 and CPP4 Probation Practitioners ensure the use of CRISS model for contacts in Delius Briefing to Probation Practitioners on learning from this DHR.	Head of PDU who will delegate to Senior Probation Officers	Audit learning via Regional Case Audit Tool (RCAT), the Performance & Quality Unit and QA activity and feedback, direct from Senior Probation	March 2024	Informed risk assessments; preventative activity, reduced reoffending and public protection. Targeted embedded learning	Update March 25 On-going, embedded in practice and quality assured via RCAT reviews.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		Briefing to CMT and DA Leads Meeting. Share with other PDU Partnership Leads in Merseyside.		Officers – Management Oversight			
Mersey and West Lancashire Teaching Hospitals NHS Trust (Southport and Ormskirk Sites)							
To continue to ensure staff use professional curiosity and complete routine enquiry for patients attending with indicators of domestic, and sexual abuse and in the event of a disclosure undertake the required risk assessment and referral to the Safeguarding Team.	Local	Continue to regularly review the routine enquiry documentation used in all clinical areas, making this mandatory were possible. Ensure process and policies are available and understood by staff. Develop and offer bespoke training in relation to Domestic Abuse. Ensure compliance to safeguarding training. Share external Domestic Abuse training opportunities with clinical staff.	Safeguarding Adults Named Nurse Safeguarding Adults specialist practitioners. Operational Staff.	Updated policy aligned to the Domestic Abuse Act Development and delivery of bespoke Domestic Abuse training Availability of resources available on the Trust intranet	On-going as the workforce is fluid and changing with new staff joining the AED team	For Trust staff to identify and respond to disclosures of Domestic Abuse. For staff to use professional curiosity when patients attend with indicators of Domestic Abuse, as per NICE guidance. Protection of victims through the completion of Domestic Abuse risk assessments, safety planning and onwards referrals.	Ongoing, safeguarding ambassadors training programme and Level 3 training have strong focus on Domestic Abuse, Bespoke training programme for A&E staff includes Domestic abuse. (Ongoing) Domestic Abuse policy in place and updated with legislative changes from Domestic Abuse Act 2021. (last updated 2/10/23) Prompts have been added to Domestic Abuse Risk Assessments completed by trust staff to support quality of information captured (Completed August 23) Audit of Quality of Domestic Abuse Risk Assessments is part of annual audit plan (last completed 2024/25 Q4-

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
		Undertake regular audit regarding routine enquiry. Development of the Trust intranet page to include Domestic Abuse information.					providing significant assurance)
To seek available funding for Health IDVA's and if successful the recruitment and ongoing funding for HIDVAs.	Local	Identify funding opportunities. Complete relevant applications for funding. Recruit as funding allocated. Develop new ways of working in the Safeguarding Team to include the role of the HIDVA. Complete required HIDVA data returns as required. Collaborate with potential Commissioners as required to secure long-term funding.	Assistant Director Safeguarding	Recruitment to the HIDVA post. Data submissions to commissioners. Data collection regarding Domestic Abuse disclosures, actions, and referrals. Bespoke training developed and being delivered.	March 2025 to review longer-term funding	The Trust recruits to a HIDVA to work alongside the Safeguarding team. The HIDVA responds to disclosures of Domestic Abuse, engaging and collaboratively working with external agencies. The HIDVA works with frontline staff to improve routine enquiry and professional curiosity delivering bespoke training and developing resources. Demonstration of the value of the HIDVA role in an Acute Trust setting to secure long-term funding.	Grant Funding in Lancashire to continue at 50% for financial year 2025/26, funding from Sefton to support the completion of the IDVA course for two members of the Safeguarding Team. (Partially achieved). Plan to skill up safeguarding practitioners through completing IDVA course to strengthen knowledge within the team due to recruitment/retention challenges with funding short-term IDVA posts.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
To review the process for adding domestic abuse alerts to the patient's electronic patient record even when criteria for MARAC not met.	Local	To review the criteria for adding an alert in the absence of a MARAC referral. Develop processes and ways of working that are responsive to the alert.	Safeguarding Adults Named Nurse	Alerts as per the recommendation added to patient's electronic record	Dec 2023	To improve professional curiosity and routine enquiry should a potential victim attend the Trust in the absence of a MARAC referral. Potential victims are identified early and prior to referral to MARAC to ensure early risk assessment, safety planning and onward referral.	Completed Team process in place for adding Domestic Abuse alerts when domestic abuse is confirmed but not at threshold for MARAC referral. DA alerts remain in place for 12 months on electronic patient records.
Review the development of a BI report for patients with a Domestic Abuse alert attending the AED, to identify missed opportunity and any subsequent actions that could be undertaken.	Local	To collaborate with BI to develop the required report. To review process and new ways of working because of the report being available.	Safeguarding Adults Named Nurse	Report developed and being accessed by the HIDVAs.	Dec 2023	To share missed opportunity with staff to improve professional curiosity and routine enquiry. Completion of risk assessments, referrals and risk assessments should the person still be a patient in the Trust.	Completed BI report in place and reviewed biweekly by safeguarding team to identify missed opportunities (in place from January 25)
SWACA							
To ensure joined up working between all services is effective	Local	Staff training and partnership working	Head of Operations	Staff training day on regular basis, ensuring	Next in house training	Easier path to engagement for victims.	Complete The in-house training day was completed in June 24.

Recommendation	Scope Local or Regional?	Action to Take	Lead Officer/ Agency	Key milestones	Target Date	Expected outcome(s)	Date of completion and outcome achieved
and all avenues of contact/engagement are discussed.				all staff are aware of partner agencies and their processes.	day is 15th June 2024		There are team meetings monthly, this is on the agenda and any new services are discussed. Multi agency meetings are attended by all staff and any possible alternative inroads with services users are identified and discussed.

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

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29th January 2025

Dear Jeanette,

Thank you for submitting the Domestic Homicide Review (DHR) report (Dawn) for Sefton Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 18th December 2024. I apologise for the delay in responding to you.

The QA Panel noted that this was a good report which was compassionately written. They felt that the foreword was appropriately sensitive, with condolences offered to Dawn's family. They noted that the family was involved throughout the development of the report, with their input on the key lines of enquiry and recommendations clear. The family was also able to agree the pseudonym used for Dawn.

The engagement of her family, friends and priest contributed to a valuable pen portrait of the victim. While there was no specific tribute to the victim, there was a good sense of who Dawn was and the adversities she experienced throughout her life.

The QA Panel further noted that the review was thorough, well-researched and nuanced. It looked with compassion at Dawn's vulnerability and the complexity of her needs. They commented that the Action Plan was SMART and the lessons and recommendations, while lengthy, felt appropriate for such a complex review.

The QA Panel felt that overall, this review has identified very relevant and important learning and made some useful recommendations. It feels as though the review had very active engagement from its panel members.

Finally, the QA panel said that the glossary of terms at the beginning of the report was a helpful addition given the number of agencies engaged.

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:

- There were many missed opportunities by agencies to identify safeguarding risks of Dawn returning to live with the perpetrator.

- In section 14.38, the report does not note the result or follow up of the seven-day letter to the domestic abuse victim. Did officers attend in person or did phone calls go unanswered? This had no resulting recommendations for the Police, and it would be worth considering whether to review practice on this basis. For CCB victims, letters may not be the most appropriate form of contact.

- The QA Panel would like to have seen more exploration around police and other agencies identifying the patterns of behaviours and police considering an evidence-based prosecution. For example, at 14.44.

- Although the tone of the review is generally compassionate and demonstrates a good understanding of the dynamics of domestic abuse, there are a few phrases that could be perceived as victim-blaming and should be expressed differently. For example:
    - ‘Throughout the period of this Review it was shown that *Dawn disengaged from a number of support services. Often against medical advice, she self-discharged from hospitals* a total of 15 times and on one occasion was found by staff using illegal drugs on a hospital ward. Whilst clearly suffering physical and controlling abuse from Ewan Dawn *would not support* a Police prosecution stating that she “was not a grass”.’
    - ‘At age 19 years Dawn had given birth to a child who because Dawn was not capable of caring for the child, due to the domestic abuse she was suffering and her substance misuse, the child was taken into Local Authority care and later adopted’ – could be rephrased as ‘Dawn had substance use issues which increased her vulnerability’ and ‘despite her protective efforts, the child/baby remained a risk from his (the perpetrator’s) behaviour’

- Although Dawn was referred (and heard) at MARAC multiple times (13 times between 2015 and 2021), there is little evidence of joined up work or no single agency assuming the lead role in seeking a long-term solution to the challenges faced by the victim.

- There were some missed opportunities within health services to explore domestic abuse on some of Dawn’s presentation to hospital/emergency department, and no onward referrals to adult social care.

- There is no information about which partners were involved in this decision to conduct the review and if it was only statutory partners. There is no date shown of when the decision was made.

- The delay between the victim's death and the commissioning of the review is not explained in the report.

- Section 1.3 needs to explain that Ewan is a pseudonym.

- Section 5.3 states that Panel members were asked to provide chronologies within the agreed time period, but there is no date shown when this was and no information regarding agencies being asked to secure their files. There are no dates given for panel meetings.

- Section 5.5 should be part of the lines of enquiry within the terms of reference.

- The equality and diversity section is superficial and would benefit from further development. The protected characteristics listed and explained could be referenced, but are not linked to this particular case and would be better referenced in an appendix. The report does not identify the specific characteristics pertaining to victim and perpetrator apart from sex. Sex as a protected characteristic is explained only later, in the context of male violence against women and girls.

- It is not clear from Section 7 section which agencies submitted IMRs and this blurs in with the Panel members. The report needs to be clear on the IMRs submitted for this review.

- The Panel members are listed in section 8, but the roles or job titles of the members are not detailed as per guidance.

- The Dissemination Plan at section 12 should fully list who will receive this particular review rather than just refer to the list given in the Statutory Guidance.

- While relevant and detailed, the Action Plan would be better as a separate document or Annex for ease of updating. It will need updating prior to publication.

- Generally, there are many errors of spelling and punctuation throughout, and this requires a proofread ahead of publication.

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,

Home Office DHR Quality Assurance Panel