SEFTON SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Denise'

Date of death – September 2020

OVERVIEW REPORT

FOR PUBLICATION

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1. INTRODUCTION

1.1 The panel offers its sincere condolences to Denise's family.

1.2 This report of a domestic homicide review examines how agencies responded to, and supported, Denise, a resident of Sefton, prior to her death in September 2020.

1.3 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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'.

1.4 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.'

1.5 Martin was Denise's partner. Denise lived alone as a sole tenant in social housing. Martin was a regular visitor at Denise's address and there were often arguments and disturbances that resulted in police intervention.

1.6 Denise had a long history of alcohol misuse and dependency and previously accessed several support services and inpatient detoxification.

1.7 In July 2020 the ambulance service attended an incident at Denise's address where she reported right sided chest pain. Denise was transported to hospital. The police were involved as Denise advised she had an altercation with a neighbour two weeks previously and the injuries were believed to have been linked to that event.

1.8 Towards the end of July 2020 there was an argument between Denise and Martin which resulted in Martin pushing Denise against a chair; Denise called the police and due to previous domestic abuse history, a referral was made to MARAC.

1.9 In early August 2020 the ambulance service attended at Denise's home due to reports of difficulty in breathing and she was transported to hospital. Denise advised the crew that she had been assaulted previously. Denise self-discharged from hospital.

1.10 Denise died in early September 2020. Merseyside police began a criminal investigation and Martin was arrested in connection with Denise's death and later released under investigation.

1.11 A Home Office post-mortem determined the cause of Denise's death as -

1a - Pneumonia and multi organ failure and;

1b - Alcoholic liver cirrhosis with blunt force chest injury.

The pathologist concluded that the injuries including rib fractures and collapsed lung were a significant factor in the victim catching pneumonia and subsequent death.

1.12 Martin died in December 2020, after being found collapsed at home. Martin had suffered multi organ failure because of acute chronic hepatic failure.

1.13 Merseyside police conducted a criminal investigation into the circumstances surrounding Denise's death and determined that the threshold for referring the matter to the Crown Prosecution Service (CPS) was not met and the investigation was finalised as no further action.

1.14 The inquest into Denise's death was heard on 21 July 2021 and the coroner's conclusion was a narrative verdict.

2. TIMESCALES

2.1 On 16 October 2020 Sefton Safer Communities Partnership determined the death of Denise met the criteria for a domestic homicide review [DHR].

2.2 The first meeting of the review panel took place on 15 December 2020. Thereafter the panel met five times. Due to the Covid-19 pandemic, panel meetings were held virtually, and contact was maintained with the panel via email and telephone calls.

2.3 The DHR covers the period 1 September 2018 to early September 2020.

2.4 The domestic homicide review was presented to Sefton Safer Communities Partnership 9 September 2021.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim and perpetrator, which were agreed with Denise's family.

3.3 This table shows the age and ethnicity of Denise and Martin. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Denise	Victim	47	White British female
Martin	Partner	44	White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference after its first meeting on 15 December 2020. These were shared with the family who were invited to comment on them.

4.2 The review covers the period 1 September 2018 (prior to the start of the relationship) until September 2020.

The purpose of a DHR is to:[1]

a] Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b] Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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

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

f] Highlight good practice.

N.B. –This DHR is not a review in accordance with the requirements of NHS Serious Incident Framework[2].

4.3 **Specific Terms**

1. How effectively were disclosures or indicators of domestic abuse addressed? What was the response?

2. What services did your agency offer to the victim and perpetrator and were they accessible, appropriate, and sympathetic to their needs.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

Were there any barriers in your agency that might have stopped engaging with help for the domestic abuse?

3. What knowledge did your agency have that indicated Martin might be a perpetrator of domestic abuse against Denise and what was the response? Did that knowledge identify and controlling or coercive behaviour by the perpetrator?

4. What risk assessments did your agency undertake for the subjects of the review; what was the outcome and if you provided services, were they fit for purpose?

5. When and in what way were practitioner's sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

6. How many MARACs[3] were convened on this case? Did the MARAC provide support/reassurance for agencies working with Denise in relation to the risk of domestic abuse? Did all partners actively participate, were there any barriers to the process?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Denise and Martin?

8. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Denise and Martin, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

9. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were these followed in this case? Has the review identified any gaps in these policies and procedures?

10. How did your agency gather the wishes and feelings of the subjects of the review in relation to the services that were provided or being offered?

11. What learning has emerged for your agency?

[3] MARAC- Multi agency risk assessment conference.

12. Are there any examples of outstanding or innovative practice arising from this case?

13. Does the learning in this review appear in other domestic homicide reviews commissioned by Safer Sefton Communities Partnership?

5. METHODOLOGY

5.1 Merseyside Police notified Safer Sefton Communities Partnership in September 2020 of the death of Denise and that the case potentially met the criteria for a domestic homicide review. A meeting held on 16 October 2020 determined the criteria had been met for a Domestic Homicide Review to be undertaken.

5.2 On 18 November 2020 Carol Ellwood-Clarke was appointed as the Independent Chair and Sara Wallwork appointed at the Independent Author supporting the Chair.

5.3 The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews[4] (IMR). Some agencies submitted short reports.

5.4 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. Prior to any interviews taking place agreement was obtained from the Senior Investigating Officer from the Police due to the ongoing criminal investigation.

5.5 The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.6 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Denise's family who were invited to make any additional contributions or corrections.

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

6. INVOLVMENT OF FAMILY, FRIENDS, AND WIDER COMMUNITY.

6.1 The Chair wrote to Denise's mother. The letter was delivered by the Police Family Liaison Officer (FLO). The letter contained the Home Office Domestic Homicide Review leaflet for families and a leaflet from Advocacy After Domestic Abuse[5] (AAFDA).

6.2 The DHR Chair liaised with the panel members to identify other family members or friends to help inform the DHR process. In early June 2021 the independent author spoke with Denise's mother and cousin via telephone. Details of the DHR process were discussed including the terms of reference and both were invited to make any suggestions as they felt necessary.

6.3 During the Covid-19 pandemic the Chair and author informed the family of the progress on the DHR via letter and through email and telephone calls. Denise's mother and cousin attended a panel meeting in July 2021.

6.4 There was no opportunity to involve Martin in the review as he died in December 2020.

[5] https://aafda.org.uk

7. CONTRIBUTORS TO THE REVIEW.

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Community Rehabilitation Company (CRC)	✓	✓	
HMP Liverpool			✓
Liverpool University Hospital NHS Foundation Trust (Aintree)	✓	✓	
Merseycare	✓	✓	
Merseyside Police	✓	✓	
North West Ambulance Service (NWAS)	✓	✓	
One Vision Housing			✓
NHS South Sefton Clinical Commissioning Group (CCG)-on behalf of GP services	✓	✓	
Sefton Children's Social Care			✓
Sefton Adult Social Care	✓	✓	
Sefton IDVA service	✓	✓	
Sefton MARAC	✓	✓	
Sefton Women & Children's Aid (SWACA)[6]	✓	✓	

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 As well as the IMRs, each agency provided a chronology of interaction with Denise and Martin including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no

[6] https://swaca.com/

previous knowledge of Denise and Martin nor had any involvement in the provision of services to them.

7.4 The IMRs in this case were of good quality and focussed on the issues facing Denise and Martin. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.5 Alcohol addiction and dependency services in Sefton are provided by Merseycare NHS Foundation Trust. The service is called Ambition Sefton[7] and was formerly called LifeLine.

7.6 Nil responses were received from –

- Southport and Ormskirk Hospitals Trust
- North West Boroughs Healthcare (0-19 service and Walk
- in centres)
- Lancashire and South Cumbria Care

[7] https://www.merseycare.nhs.uk/our-services/a-z-of-services/drug-and-alcohol-services/ambition-sefton/

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Kieley Blackborow	Service Manager	Sefton Metropolitan Borough Council: Children's Social Care
Julie Bucknall	Service Manager	Sefton Metropolitan Borough Council: Children's Social Care
Carol Ellwood-Clarke	Review Chair	Independent
Crispin Evans	Interim Safeguarding Lead for Local Division	Merseycare
Trevor Evans	Head of Offender Management Unit	HMP Liverpool
Neil Frackelton	Chief Executive	Sefton Women's & Children's Aid (SWACA)
Rosie Goodwin	Community Director	Merseyside Community Rehabilitation Company
Paul Grounds	Detective Chief Inspector	Merseyside Police
Susan Hewitt	Safeguarding Practitioner	North West Ambulance Service NHS Trust
Bev Hyland	Detective Chief Inspector	Merseyside Police
Jennifer Kavanagh	Liverpool & Sefton Women's Interchange Manager	Community Rehabilitation Company
Dr Bryony Kendall	Named GP Safeguarding Adults	NHS South Sefton Clinical Commissioning Group
Julie Luscombe	Advanced Practitioner	Sefton Metropolitan Borough Council Adult Social Care
Janette Maxwell	Locality Team Manager DA Strategic Lead IDVA/MARAC	Sefton Metropolitan Borough Council: Communities
Rachel McCarthy		HMP Liverpool
Laura Parr	Detective Inspector	Merseyside Police

Natalie Hendry-Torrance	Designated Adult Safeguarding Manager	NHS South Sefton Clinical Commissioning Group
Debbie Ward	Assistant Director	Liverpool University Hospital NHS Foundation Trust (Aintree)
Sara Wallwork	Review Author	Independent

8.2 The chair of Sefton Safer Communities Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to examine the events and prepare an unbiased report safely and impartially.

8.3 Matters were freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic panel meetings met virtually. Outside of the meetings the Chair's queries were answered promptly via email or telephone call and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

9.2 The Chair, Carol Ellwood-Clarke, and Author Sara Wallwork are both independent practitioners who between them have served over 60 years in British policing, with additional expertise in safeguarding and vulnerability. They were judged by the chair of Sefton Safer Communities Partnership to have the experience necessary to conduct an independent and thorough enquiry.

9.3 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking Domestic Homicide Reviews.

9.4 Neither practitioner has worked for any agency providing information to the review.

9.5 Carol Ellwood-Clarke has undertaken one previous domestic homicide review in Sefton in 2019. This DHR was submitted to the Home Office quality assurance panel and approval received in February 2021. The Report has yet to be published.

10. PARALLEL REVIEWS

10.1 The Chair notified Her Majesty's Senior Coroner on 15 December 2020 that a DHR was being undertaken. Her Majesty's Senior Coroner for the Sefton, Knowsley & St Helens Coroner's Office opened and adjourned an inquest into Denise's death. The inquest was concluded on 21 July 2021.

10.2 Merseyside Police undertook a criminal investigation into the circumstances surrounding Denise's death.

10.3 Denise's GP undertook an 'in-house significant event review'. The learning identified from this has been shared and incorporated in this DHR.

10.4 The review is not aware of any other investigations that have taken place since Denise's death.

10.5 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There is no suggestion that any agency involved in the review has initiated any disciplinary action.

11. EQUALITY AND DIVERSITY

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

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer can lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian, or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the

opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[8]

11.3 Denise and Martin were born in the United Kingdom and their ethnicity is White British. There is nothing in agency records that indicated that Denise or Martin lacked capacity in accordance with Mental Capacity Act 2005[9].

11.4 Neither Denise nor Martin had any known protective characteristics that would have fallen within Section 4 of the Equality Act 2010. Professionals applied the principle of Section 1 Care Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'

11.5 Both Denise and Martin had interventions from their GPs and alcohol services in relation to alcohol dependency and addiction. It is recorded that Denise's use of alcohol commenced in her teenage years. In 2009 Denise had contact with her GP in relation to alcohol dependency. In March 2012 Denise was referred to Merseycare Foundation Trust (MCFT) due to her alcohol use and was seen by at Windsor clinic[10]. Between December 2018 through to December 2019, Martin was issued with medical sick notes by his GP due to alcohol dependence syndrome.

11.6 The misuse of alcohol is statutorily excluded from the definition of disability under the Act.

11.7 Both Denise and Martin had interventions from their GP in relation to anxiety and low mood. Denise was prescribed antidepressants on a long-term basis and in May 2020 the dose was increased. Martin was prescribed beta blockers for anxiety.

[8] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[9] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

[10] Mersey care - inpatient unit offers medically assisted detoxification programmes for people who are unable to detoxify from alcohol within the community and need 24-hour care to enable them to do so.

11.8 In completing this review the DHR panel also took account of the definitions of 'mental health'[11] and 'mental ill health'[12] which were referred to within agency contacts.

11.9 Denise had co-existing issues which made her additionally vulnerable; Drugs and alcohol misuse and mental health.

11.10 Further analysis is covered in Term 7 of the report.

[11] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[12] https://everymind.org.au/mental-health/understanding-mental-health/what-is-mental-illness

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Sefton Safer Communities Partnership
- All agencies that contributed to the review
- Merseyside Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, OVERVIEW AND CHRONOLOGY

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, input from Denise's family and material gathered by the police during the criminal investigation. This section does not detail all contact between the subjects of the review. Appendix C contains a table of events for reference.

13.1 Denise

13.1.1 Denise was an only child and was described by her mother as a good daughter with a lovely personality. Denise was close to her mother and she would contact her daily. Denise also had a close relationship with her female cousin. Denise was a mother to two children who had not lived with her for several years. Denise's family were aware of her struggle with alcohol and had supported her when she went on detox programmes. Denise's family felt that her struggles with alcohol were linked to her father being an alcoholic and her mother stated that Denise started to drink heavily in her early thirties. Denise's family believed that she was lonely and stayed in the relationship with Martin due to not wanting to be on her own.

13.2 Martin

13.2.1 Martin has a son with a previous partner with whom he had regular contact. Martin was known to have alcohol dependency issues and engaged with alcohol support services. Martin was unemployed.

13.2.2 Martin has previous convictions which date back to 1990 for violence, theft and three offences of driving under the influence of alcohol, the most recent in April 2019, for which he received a suspended sentence and a disqualification from driving. Martin has no convictions for domestic abuse prior to his relationship with Denise.

13.2.3 Merseyside Police have numerous records of domestic incidents with Martin as the perpetrator against Denise. Denise was referred to MARAC twice as a high-risk victim of domestic abuse. Martin was arrested several times for assaulting Denise. In September 2019, Martin was convicted for an assault on Denise when he entered a guilty plea and he received eighteen weeks suspended sentence for one year. In December 2019 Martin was issued with a DVPO against Denise which he breached and received fourteen days

imprisonment. The other assaults resulted in no further action being taken against Martin.

13.3 Denise and Martin's relationship

13.3.1 Denise and Martin went to the same school and met up again as adults, via social media. Martin was described by Denise's family as having a negative influence on her. Martin would regularly bring alcohol to Denise's flat and stay with her, encouraging her to drink. There were regular arguments between Denise and Martin and the relationship was described by Denise's family as very 'on and off'. Denise's family stated that Martin did not like Denise speaking to other people. Denise's cousin told the Author that she had suggested the two of them went on holiday together, so that Denise could have a break from Martin and the drinking; this had been the cause of an argument that was reported to the Police. The family stated that looking back they now recognised that Martin's behaviour was controlling and resulted in Denise being isolated from her family.

13.4 Events prior to the start of the review

13.4.1. Denise had been a victim of domestic abuse in her previous relationships. During many of these incidents Denise was physically assaulted. Denise was recorded as a 'gold'[13] victim by the Police. Denise was referred to support services but declined to engage.

13.4.2 From 2010 Children's Social Care (CSC) were involved with Denise and her children due to Denise's alcohol use, mental health, and domestic abuse. This involvement resulted in the children being subject of a child protection plan.

13.4.3 In 2014 the court granted a Child Arrangement Order in favour of the children residing with their father. Concerns were still being reported regarding domestic abuse and Denise's alcohol misuse.

13.4.4 In August 2016 Denise was referred to the Brain Injury Rehabilitation Centre in relation to her alcohol consumption she was signposted to the Walton Centre for Neurology. Denise engaged on a community detox programme later that year.

13.4.5 In 2017 Denise was referred to the Early Intervention Programme (EIP) for support around her alcohol misuse. Later that year Denise self-referred for detox. The following year, Denise was referred to Independent Initiatives[14]. Denise also was involved with Adult Social Care.

[13] Merseyside Police categorises risk to victims of 'domestic abuse' as 'gold', 'silver', or 'bronze'. Each category has a list of interventions commensurate to the risk with 'gold' being the highest risk level.

[14] https://www.seftondirectory.com/kb5/sefton/directory/service.page?id=rphuATaYZNU

13.4.6 In 2018 Denise was involved with Phoenix Futures[15] who assessed Denise as having low mood, depression, low self-esteem. Denise disclosed a sexual assault whilst under the influence of illicit drugs. Denise self-referred to the Rape and Sexual Abuse support RASA[16] in 2014. The reason for the referral is not documented. Denise did not attend for an initial nor engage with further appointments offered and the case was closed. In July Denise was admitted to the Hope Centre and spent ten days in detox. Upon discharge Denise, initially engaged with Ambition Sefton; by August Denise had relapsed.

13.5 Events within the timeframe of the review

September – December 2018

13.5.1 In September, Martin was arrested for driving with excess alcohol. Whilst in custody Martin was seen by the Criminal Justice Liaison team (CJLT) and stated that he had heightened anxiety levels; suicidal thoughts and his alcohol intake had increased due to anxieties. CJLT provided support and a crisis plan. Martin was referred to Ambition Sefton by his GP.

13.5.2 In October Denise missed appointments with her recovery worker and attempts to contact her and re-engage were unsuccessful.

13.5.3 At the end of October, Martin received a suspended sentence, an Alcohol Treatment Requirement (ATR) and fifteen days rehabilitation activity (RAR) CRC oversaw these requirements. Martin fully complied and attended all twelve sessions before discharge. Martin was referred to Access Sefton[17] for additional support.

13.5.4 On 25 October NWAS responded to a 999 call from Denise after she had taken an overdose of tablets. Denise was deemed to have capacity and refused to attend hospital and refused GP acute visiting service (AVS). Denise said she would contact her GP the next day.

13.5.5 At the start of November Martin disclosed to Ambition Sefton that he was drinking a high level of alcohol, which he stated was due to a separation from a previous partner. CRC continued to case manage Martin and an OASys[18] risk assessment was undertaken. Denise missed appointments with her recovery worker and was sent a 14-day letter. This was the first of two letters sent to Denise.

[15] https://www.phoenix-futures.org.uk/
[16] https://www.rasamerseyside.org/
[17] Access Sefton provides NHS talking therapies services to people experiencing a wide range of common mild-to-moderate mental health conditions, including depression, anxiety, and stress.
[18] https://www.gov.uk/guidance/risk-assessment-of-offenders

13.5.6 On 11 November Denise called the Police requesting Martin to be removed from her house. Denise and Martin had both been drinking. Martin left. A Vulnerable Persons Referral Form[19] (VPRF1) was completed and assessed as 'bronze'. Denise was signposted to support. This was the first reported domestic abuse incident between Denise and Martin.

13.5.7 On 15 November Denise was taken to hospital by ambulance due to feeling unwell. It was noted that Denise had bruising to her lower lip. Denise did not disclose domestic abuse. Denise was referred to Ambition Sefton by the hospital liaison service and she engaged with the service until February 2020.

13.5.8 On 9 December Denise called 999 and reported that Martin had assaulted her and her dog. Denise was intoxicated and stated she did not wish to see an Officer. Denise stated she had instigated the argument. The incident log was delayed. On 11 December Denise called the Police and stated she did not want to pursue the matter. A crime report was recorded. The incident was finalised as 'no further action.' A VPRF1 was completed and assessed as 'bronze'.

13.5.9 On 19 December, during an ATR session with Sefton Ambition, Martin mentioned that he had a girlfriend. Details of the girlfriend were not recorded. Later that day Denise called the Police and report an argument with Martin. Police attended Denise's house. Denise and Martin were intoxicated. Martin was removed from the house by Police. A VPRF 1 was completed and assessed as 'bronze'.

2019

13.5.10 On 20 February Denise called the Police after an argument with Martin. Denise and Martin appeared to be under the influence of alcohol. A VPRF1 was completed and assessed as 'silver' with referrals made to SWACA and alcohol services. SWACA made several attempts to contact Denise by telephone but were unsuccessful and a letter was sent to Denise. Denise did not respond to the contacts and the file was closed on 13 March.

13.5.11 On 4 April Denise made two calls to the Police. Denise reported she had been assaulted by Martin. Denise did not support a prosecution. No further action was taken. A VPRF1 was completed and assessed as 'bronze'. Attempts by SWACA were unsuccessful and the case was closed.

13.5.12 On 10 April Martin received a warning letter from Merseyside Community Rehabilitation Company (MCRC) after he failed to attend an ATR session.

[19] Officers must identify any risk factors present at the time, to inform the risk assessment process. They must complete a Vulnerable Persons Referral Form (VPRF 1) at the scene and categorise the level of risk there and then at the scene. This is to avoid unnecessary delay and provide instant intervention to those deemed at high risk.

Five days later breach action was initiated. This was withdrawn after Martin's GP provided a sick note explaining his absence. Martin's final session with ATR was on 24 April, thereafter his compliance with MCRC became more problematic. The domestic abuse incidents between Martin and Denise were not known to MCRC as information was not shared by the Police. This is covered later in Section 14.

13.5.13 On 28 April Denise reported a domestic abuse incident with Martin. Martin agreed to leave the address. Denise and Martin were under the influence of alcohol. A VPRF1 was completed and assessed as 'bronze'.

13.5.14 0n 4 June Police responded to a report of assault and disturbance at Denise's address. The Police also received a call-in relation to this assault from Denise's GP practice following a call Denise made to the surgery. Martin was arrested. A VPRF1 was completed and assessed as 'silver'. Denise's account to the Police was captured on body worn video and she stated she did not remember what had happened and did not support a prosecution. Denise was contacted by a Police specialist domestic abuse officer and maintained her view with regards to a prosecution. Denise did not have any injuries and there were no other witnesses. The matter was finalised as 'no further action'. Denise was seen in surgery three days later with physical evidence of assault. When asked about the injury Denise denied being assaulted.

13.5.15 On 6 July Denise was assaulted by Martin, resulting in bruising to her chest, eye, and face. Both Denise and Martin were under the influence of alcohol. Denise commented that she wasn't frightened of Martin and that this behaviour was the norm. Martin was arrested for the assault, charged with Section 39, and was remanded in custody. A VPRF1 was completed and assessed as 'gold'. The case was referred to MARAC and referrals were made to Independent Domestic Violence Advocate (IDVA), Adult Social Care and alcohol services. Martin was released on bail with conditions. On 9 August Denise contacted the Police to retract her statement, citing a deterioration in her physical health because of the case and being unable to face attending court. Denise's GP provided supportive evidence and the matter against Martin did not proceed. SWACA attempted to contact Denise was unsuccessful and the case was closed.

13.5.16 On 9 July Denise attended a Gastroenterology Clinic she was seen to have a bruised eye socket and right cheek when she attended the clinic, however these injuries were not explored during the appointment.

13.5.17 On 14 August Denise called 111 and reported experiencing anxiety for the previous four days which related to her going through a difficult time with her ex-partner. Denise was seen by an ambulance crew and she was

advised to see her GP if her anxiety continued. There were no safeguarding concerns at this incident.

13.5.18 On 20 August Denise reported to the Police that Martin was in breach of his bail conditions. A scheduled appointment was made to see Denise two days later. A VPRF1 was completed and assessed as 'bronze'. Seven days later Denise called the Police, as Martin was at her address. Martin was arrested for breach of bail on 28 August and released from court with the same bail conditions;

-Not to approach Denise or go within one hundred metres of her home.

A VRPF1 was completed and assessed as 'bronze'.

13.5.19 On 7 September there was a further domestic abuse incident. Martin was arrested for breach of bail and assault. A VPRF 1 was completed and assessed as 'bronze'. Martin appeared before the magistrates' court and received a fourteen-day custodial sentence on 9 September for assault by beating. On 17 September Martin pleaded guilty to the assault against Denise from 6 July. Martin was released from court having served time remanded in custody. MCRC completed a risk review and Martin's risk level was raised to medium risk of serious harm.

13.5.20 By mid-September the IDVA service had received seven referrals. There had been eleven incidents of domestic abuse within a twelve-month period. The IDVA service was unsuccessful in their attempts to contact Denise.

13.5.21 Towards the end of September Martin spoke with his GP via telephone to discuss plans for a baby with his current partner (believed to be Denise)

13.5.22 On 16 October Police received a third-party report of a naked female in the foyer of the flats where Denise lived. Denise was found and reported that Martin had manhandled her out of the premises after she had refused to have sex with him. A VPRF1 was completed and assessed as 'bronze'.

13.5.23 On 1 November NWAS contacted the Police after they received a call from Denise. Denise stated she had thrown a mug at Martin causing a minor cut to his neck. Denise and Martin were under the influence of alcohol. Martin was removed from Denise's address. A VPRF1 was completed and assessed as 'bronze'. A crime of common assault was recorded against Martin. No crime was recorded in relation to the injuries to Martin's neck after enquiries confirmed they were caused when Martin fell out of bed. Ten days later there was a further incident graded as 'bronze' which resulted in a referral to the IDVA service due to a history of 12 incidents in the previous year, and Denise being a previous 'gold' victim with two ex-partners.

13.5.24 Towards the end of November, Martin's case was allocated to the resettlement team. The case worker was made aware of Martin's domestic abuse status and the requirement for domestic abuse intervention, with a referral to 'HELP'[20] perpetrator programme. IDVA services made telephone contact with Denise in November and offered her the service but she declined support.

13.5.25 On 19 November Denise attended at the alcohol specialist nurse clinic and the intervention followed the FRAMES[21] framework. Concerns, safety at home and the triggers to Denise's drinking were discussed and a further appointment was made for eight weeks' time.

13.5.26 On 28 November Denise reported to the Police that she had been assaulted by Martin. Martin was arrested for the assault, interviewed, and denied assault. Denise was reluctant to support a prosecution and provided a retraction statement. The matter was put before the Police Decision maker, who determined no further action should be taken and Martin was not charged with the assault. Martin was issued with a Domestic Violence Protection Notice (DVPN)[22]. A VPRF1 was completed and assessed as 'gold'. A referral was made to MARAC. A Domestic Violence Protection Order (DVPO) was granted on 2 December. The details of the DVPO were shared with Denise's housing provider. The IDVA services contacted Denise. Denise did not want to engage with the service.

13.5.27 On 3 December during an appointment with MCRC, Martin minimised his offending behaviour, reporting himself to be the victim. Martin was reluctant to engage in the domestic abuse perpetrator programme and as this was not a mandated requirement from court or his licence and there was no statutory requirement for him to attend a programme.

13.5.28 On 10 December Denise reported that she had been assaulted by Martin. Police were unable to locate Denise until 12 December. Denise denied calling the Police. Later that day Police and NWAS responded to an incident at Denise's home where she had sustained a broken wrist. It was suspected Martin had been with Denise and was responsible for the assault. Police enquiries established CCTV footage of Martin in the lobby area of Denise's home, and he was arrested for breaching the DVPO. A

[20] HELP is a Healthy Relationships Programme taking a preventative approach to domestic abuse. This course is for men or women where there are domestic abuse concerns in a heterosexual relationship.

[21] https://www.nice.org.uk/Guidance/PH24/chapter/glossary#frames

[22] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

VPRF1 was completed and assessed as 'gold'. The case was referred to IDVA.

13.5.29 Three days later, Denise made a 999 call to Police, the call was abandoned. Martin was heard shouting in the background, 'You better not phone the Police.' Martin was arrested for the assault on 10 December and for breaches of the DVPO. Denise was reluctant to make a complaint of assault. Martin was charged with both breaches and received two weeks custodial sentence. A referral was made to MARAC and IDVA.

13.5 30 Martin arrived at HMP Liverpool on 16 December. Martin was identified as a public protection case and was subject to an enhanced risk assessment. There were no concerns raised in relation to Martin's presentation. Martin was informed that a DVPO was in place and that he was not allowed contact with Denise. An alert was in place identifying Denise as a victim of domestic abuse and measures were put in place to stop Martin contacting Denise via telephone or letter.

13.5.31 The MARAC was heard on 19 December and the following information/actions agreed –

- Martin was on a waiting list for a domestic abuse perpetrator programme.
- IDVA and Police to visit Denise.
- Police to add markers to relevant addresses for 'Test on Arrest'[23]

There was no confirmation that the joint visit took place to Denise. The action was later recorded as incomplete.

13.5.32 Martin was released from custody on 20 December and prior to release, Martin signed an acknowledgement form that a DVPO was in place and that he was not allowed to contact Denise. The DVPO expired on 30 December.

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13.5.33 In early January, One Vision Housing[24] (OVH) received reports of shouting at Denise's address. Denise had been shouting at a male (believed to be Martin) to leave her home and he left. Denise's neighbours reported that Martin had once slept in the communal area. OVH were aware of previous domestic abuse incidents from MARAC and were aware that the Police had attended the property to see Denise. The Neighbourhood Officer spoke to Denise about the shouting and asked if she needed anything or any support. Denise only asked for support around rent.

[23] https://www.gov.uk/government/collections/drug-testing-on-arrest-guidance-for-police-forces
[24] https://ovh.org.uk/

13.5.34 Martin continued to engage with MCRC during January. Martin agreed to a referral to a domestic abuse perpetrator programme and was placed on a waiting list. The intervention focused on alcohol misuse and thinking and behaviour work. Each time Martin was seen by the duty officer and his self-reporting on progress was accepted.

13.5.35 In February, Denise reported to the Police that Martin had threatened to snap her dog's neck, during an argument. The Police scheduled an appointment to see Denise on 12 February. The appointment was not kept and Denise was not seen. The Police submitted a VRPF1. Denise later reported a dispute with her neighbours and damage to her property. A crime report for criminal damage was recorded and filed no further action due to the period during which the offence occurred was over a few weeks and corroborative evidence could not be obtained. Denise was referred to IDVA but attempts to contact her were unsuccessful.

13.5.36 By February Denise's engagement with alcohol support services fluctuated. Denise was encouraged her to attend 'Life Rooms'[25] and was signposted to the addiction course. Martin was seen by his allocated MCRC case worker for the first time. A request for intelligence checks with the Police was documented but no return was recorded.

13.5.37 Towards the end of March Denise was following her reduction plan although she was experiencing a period of low mood due to being unable to see her family. Telephone contact was being undertaken. Martin gained employment with a three-month contract and continued to comply with MCRC.

13.5.38 Towards the end of June Denise had two telephone consultations with her recovery worker. Denise stated she felt low and "scared" but could not express what she feared. The recovery worker called Denise a few days later to check how she was and Denise could not recall the previous call due to her alcohol consumption.

13.5.39 Between July and August Denise attended hospital four times. On 7 July Denise called 999 and reported she had been assaulted four days earlier by a neighbour. Denise was transported to hospital and her injury was confirmed as a pneumothorax (collapsed lung). A Section[26] notice was sent to Adult Social Care and information was also received by the hospital social work and safeguarding teams. The referral highlighted Denise's vulnerabilities and risk of significant harm due to physical abuse, excessive

[25] https://www.liferooms.org/

[26] Care Act 2014, Section 2 requires an NHS body to notify social services of a patient's likely need for community care services after discharge

alcohol intake and being subject of MARAC. Denise was discharged without contact being made.

13.5.40 On 19 July Denise was admitted to hospital with symptoms linked to her recent trauma. Denise self-discharged against medical advice. Two days later Denise called the Police and reported an argument with Martin during which Martin had pushed her against a chair, banging her injury from 7 July. Denise did not complain of an assault. Martin left the premises. A VPRF 1 was completed and assessed as 'silver'. A referral was made to MARAC. IDVA services attempted to contact Denise but were unsuccessful.

13.5.41 On 24 July Denise made a complaint to the Police that Martin had sent text messages and made calls threatening to burn her mother's house down. Denise wanted to make a complaint about the previous incident on 21 July and crime reports were taken by the Police. Martin was arrested that day for assault and malicious communications. The investigation was active at the time of Denise's death. A VPRF1 was completed and assessed as 'silver'.

13.5.42 On 5 August Denise was admitted to hospital due to difficulty breathing.

13.5.43 The following day the MARAC was held. Agencies known to be actively involved with Denise at that time, were One Vision Housing and Ambition Sefton. Denise's GP was actively engaged with her at the time of the MARAC however this was not known to the MARAC coordinator. MCRC were still involved with Martin. The Police were allocated an action from the meeting to add a marker on Denise's record in relation to self-harm on both the Police National Computer[27] (PNC) and local Merseyside Police systems.

[27] https://www.acro.police.uk/PNC-services

14. ANALYSIS

Term 1

14.1 How effectively were disclosures or indicators of domestic abuse addressed? What was the response?

14.1.1 Merseyside Police responded to twenty domestic abuse incidents involving Denise and Martin. The incidents were as follows -

- two verbal arguments
- twelve physical assaults, either officers witnessing Denise had injuries or Denise reporting assaults
- two breaches of bail and DVPO
- three abandoned 999 calls
- one malicious communications and threats towards Denise's mother

14.1.2 Merseyside Police responded to each incident in accordance with their 'Domestic Abuse' (policy and procedure)[28] The policy focuses on taking positive action at domestic abuse incidents ensuring the safety of all parties present, considering criminal offences that may have been committed and taking steps to preserve evidence. At each incident consideration was given to the identification of any risk factors and a VPRF1 completed and the risk level categorised. Merseyside Police categorises risk to victims of domestic abuse as 'gold', 'silver', or 'bronze'. Each category has a list of interventions with 'gold' being the highest risk level with longer-term interventions. In Sefton there are specific pathways based and those relevant to Denise's case are outlined below:

'Bronze'

- Officers at the scene spoken to parties.
- Provide contact details on the VPRF1.
- Arrest
- Quality assurance of action at scene
- Letter to the victim offering support from MASH[29]
- Signpost to Venus charity organisation[30]

'Silver'

- Contact victim visit or telephone.
- Signpost to support services- Drug and alcohol teams

[28] https://www.merseyside.police.uk/SysSiteAssets/foi-media/merseyside/policies/domestic-abuse-policy-only-2019.pdf
[29] MASH- multi-agency safeguarding hub
[30] https://www.venuscharity.org/

- Signpost to programmes for victims; SWACA and perpetrators (e.g NSPCC voluntary programme)
- Social services
- Treat as Urgent markers (TAU)
- Equipment -target hardening, alarms mobile phones etc
- Improve home security via crime prevention.

'Gold'

- Visit by uniform 'Early Help Scheme' Police Community Support Officers (PCSO's)
- Threat assessment
- Referral to IDVA; Intimate Partner Abuse – Sefton IDVA team. Family Violence / Abuse – SWACA
- Work with IDVA to assist developing safety plans/exit planning
- Intelligence package
- MARAC
- MAPPA

14.1.3 The first reported incident of domestic abuse between Denise and Martin was on 11 November 2018. This was risk assessed as bronze.

14.1.4 The NWAS crew documented that Denise had bruising to her lower lip when responding to a call on 15 November. Denise was unable to confirm how the injury had occurred and stated that she had suffered a seizure two days before. There was no disclosure of domestic abuse from Denise and as the crew were responding to a reduced mobility issue, routine questions about domestic abuse were not asked. Questions about domestic abuse are based on professional curiosity and the presenting circumstances at each attendance. Denise stated she had fallen and that had resulted in the injury to her lip. NWAS IMR author stated that a safeguarding adult referral would have been made for Denise if they had been aware that she was a victim of domestic abuse. The Panel identified this as learning and have made a relevant recommendation [Recommendation 2].

14.1.5 On 9 December Denise reported she had been assaulted by Martin and that he had left the property. The Police scheduled an appointment with Denise to be seen two days later as she had left the flat and was going to her mother's address. Attempts to see Denise on this scheduled date were unsuccessful, Denise later informed the Police that she did not wish to pursue the assault. The panel considered that Denise's reluctance to support a prosecution and with alcohol misuse as a factor, meant it was difficult to establish robust evidence to satisfy the CPS prosecution thresholds.

14.1.6 There were incidents which the Police attended where Denise had reported there had been an argument with Martin. Denise denied she had been assaulted and evidence of other offences was not identified. Martin was often taken to an alternative address to prevent the situation escalating. Denise was made aware of support that was available for domestic abuse and alcohol services.

14.1.7 On 20 February 2019 Denise reported she had been assaulted by Martin. Denise did not provide a statement of complaint and did not support a prosecution. Police officers made three separate contacts with Denise to obtain a statement and obtain Martin's mobile telephone details. Denise stated that the relationship with Martin had ended. Denise declined a referral to the National Centre for Domestic Violence[31] (NCDV). Crimes were recorded for the two assaults and arrangements made for Martin to attend for a voluntary interview[32] . The Police IMR author acknowledged that Martin was not circulated as wanted, on the Police National Computer (PNC) in relation to this matter which is usual practice for an outstanding domestic abuse perpetrator. This meant that the Police attended three further domestic incidents between Denise and Martin whilst Martin was 'outstanding' for the assault on Denise. The Panel felt Denise may not have been left with a positive message that the abuse she suffered was unacceptable by this experience. The Police representative informed the Panel that Merseyside Police Policy states that 'arrest ready' named suspects should be considered for PNC circulation, in this case, the officer in charge of the investigations supervisor instructed them on 22 February to arrange a voluntary interview as Martin did not fit the criteria for PNC circulation. Three months passed before Officers arranged a voluntary interview with Martin, which occurred on 17 May. As Martin attended for a voluntary interview, no bail conditions could be imposed. A file of evidence was prepared for a decision on charging and included previous details of Police attendance at four domestic incidents since 20 February, one involving an assault on Denise on 4 June. A Police Decision Maker (PDM) reviewed the file of evidence and decided on 24 June that no further action should be taken against Martin.

14.1.8 In June 2019, Denise's GP surgery received a telephone call from her saying that Martin was assaulting her. This was recorded in Denise's notes and the information was forwarded to the Police. Denise was seen in surgery three days later with physical evidence of assault. Whilst the event

[31] https://www.ncdv.org.uk/

[32] Also known as voluntary attendance, a voluntary police interview takes place at a police station where the volunteer assists the police with their enquiries. They are not under arrest currently. An interview will be recorded and will take place under caution – meaning it may be used as evidence.

was discussed and denied by Denise, this was an opportunity for formal recording of the offer of support and signposting regarding domestic abuse. The Panel have identified this as learning and made a relevant recommendation. (Recommendation 4)

14.1.9 On some of the incidents attended by the Police, Denise either withdrew her original complaint or stated that she could not recall making the call due to the level of her intoxication at the time. On these occasions there was no supporting evidence to support a crime had been committed. The Panel felt that this review highlighted the difficulties in engaging with individuals who use alcohol. Sefton have looked at their services offered and have successfully secured Home Office funding to support the recruitment of 'complex case IDVAs'. The Panel felt that this was a positive development and a more creative way to focus on how to support people with complex needs including alcohol use.

14.1.10 On 6 July 2019 Martin was charged with an assault on Denise. Officers outlined to Denise, the support available via 'Enhanced Victim Entitlements'[33] under the Victim's Code[34], but she declined this and other support for domestic abuse. Martin was arrested, charged, and released on bail with conditions not to approach Denise. A trial date was set for 17 September. On 12 August Denise withdrew her support for the prosecution, stating that she felt unable to face attending court and that her health was suffering. Denise's G.P supported this view. The case proceeded to court without Denise's witness testimony and Martin pleaded guilty to common assault. Martin was sentenced to eighteen weeks imprisonment, suspended for twelve months.

14.1.11 There were other incidents reported to the Police were there was the potential for evidence that could support a prosecution. Once such incident was in October 2019 when Denise had been found semi-clothed by neighbour in a distressed state on the landing. Denise provided a statement that she had been assaulted by Martin, but later withdrew her support for the prosecution and refuted that any assault had taken place, stating that Martin had locked her out of the flat accidentally. The panel considered whether the Police routinely gathered other available evidence such as witnesses, body warn video and CCTV in responding to such incidents to support an evidence-based prosecution. The Police Panel representative confirmed that positive action was taken at every incident of

[33] Enhanced rights are services which are offered to victims who are more likely to require extra support and services through the criminal justice process due to the nature of the crime they are victim of or because of their vulnerability as a victim. There are three groups of victims who are entitled to receive enhanced entitlements: Victims of the most serious crime; Persistently targeted victims; and Vulnerable or intimidated victims.
[34] https://www.victimsupport.org.uk/help-and-support/your-rights/victims-code/

domestic abuse in Denise's case and evidence presented to either a Police decision maker or the Crown Prosecution Service to determine appropriate action. The Panel learnt that the CCTV at Denise's flat only covered the communal entrance hallway and not on the individual landings. Merseyside Police domestic abuse policy, outlines the guidance to officers for the use of body worn video and it is routinely used routinely when attending domestic abuse incidents. The case was filed by the Police as evidential thresholds were not met and no further action was taken.

14.1.12 On 28 November Denise called 999 stating she had been assaulted by Martin and had a black eye. Denise reported that Martin had placed his hand on her throat, applying pressure to her neck. Martin was arrested on suspicion of assault occasioning actual bodily harm (Section 47 assault)[35]. Martin denied the assault. A DVPO was granted by the Court. The 'gold' risk assessment recognised the increased risk to Denise as strangulation was a feature of the domestic abuse. The Police considered if Martin had committed an offence under Section 21 of the Offences Against the Person Act 1861[36] (attempt to choke, suffocate, or strangle any other person). The points to prove this offence evidentially, necessitate the pressure to the neck to have been applied before an indictable offence is committed. In this instance the sequence of events was reversed, with the pressure on Denise's throat applied after an indictable offence (assault) was committed. Non-fatal strangulation is a common feature of domestic abuse and a BBC podcast in October 2020[37] illustrated results of studies which show that if a victim is strangled by a partner, they are seven times more likely to be murdered later by that same partner. Merseyside police have undertaken research into domestic abuse crimes between January 2019 and December 2020 and evidence has shown non-fatal strangulation was a consistent feature, with a monthly fluctuation between 1.70% and 2.75%, an average 2.35% of all recorded domestic abuse crimes. In 2021 one out of three suspected domestic homicides the cause of death was determined as mechanical asphyxiation.

14.1.13 The panel learnt that the established process in Sefton when domestic abuse victims are considering withdrawing their support for a prosecution, is for the Police to refer cases to the IDVA service to provide support. The IDVA service try and contact the victim to discuss their reasons and encourage them to continue supporting the prosecution. Denise was referred to the IDVA service in October 2019 but there was no successful engagement with her. The IMR author for the IDVA service has reflected on how support offer works and there was a period where this process was

[35] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/47
[36] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/21
[37] https://www.bbc.co.uk/news/uk-50185648

less consistent than it had been, with the IDVA service receiving less referrals. This process has improved over the last six months and the IDVA service is regularly receiving referrals for withdrawal from prosecution support.

14.1.14 On 1 November 2019 Martin reported that he had been assaulted by Denise during an argument. A crime report was recorded and filed no further action as Martin declined to support a prosecution. A VPRF 1 was completed, and the incident was graded 'bronze'.

14.1.15 On 15 December 2019 the Police gathered supportive evidence and charged Martin with two breaches of the DVPO. The panel recognised that this was good practice to use all available to support a prosecution.

14.1.16 During some of the incidents reported to the Police Denise stated that Martin assaulted her dog and made threats to harm her dog. Statistics from research carried out into abuse to pets and domestic abuse shows that almost half (49%) of professionals working with pets, are aware of domestic abuse cases where the pet has been killed. In addition to the physical abuse that pets may suffer they are also often used as a means of controlling someone experiencing domestic abuse. 89% of professionals were aware of domestic abuse cases where pets had also been abused[38].

14.1.17 The MCRC IMR author highlighted that Martin's supervising officer concentrated interventions around alcohol misuse and improvements in employability. There was little professional curiosity demonstrated in relation to encouraging Martin to disclose information about any new relationship. It was only when Martin appeared before the court in early July 2019 that the first indications of a pattern of domestic abuse emerged. Martin breached a DVPO order which MCRC was unaware of. Martin was technically sentenced to two weeks imprisonment for assaulting Denise but left court following sentence due to time spent on remand. Martin advised his supervising officer that he had been acquitted of all charges which was incorrect and an indication that Martin could lie and manipulate the content of his order.

14.1.18 On 21 July Denise called 999 regarding a domestic incident with Martin during which she was pushed against furniture. The incident was graded 'silver' however, as Denise was a previous 'Gold' victim, this was upgraded to 'Gold' and a referral was made to MARAC. Denise did not support a prosecution until 24 July when she gave a statement of complaint to Merseyside Police.

14.1.19 Three days later, Martin was arrested on suspicion of an assault on Denise and sending malicious communications to her. Martin was still subject of a

[38] https://www.moretodogstrust.org.uk/freedom-project-parent/news-and-updates

12-month suspended sentence at this time. The panel heard from the Police that while these matters were under investigation Denise was re admitted to hospital on 5 August where she remained until her death in early September.

Term 2

14.2 What services did your agency offer to the victim and perpetrator and were they accessible, appropriate, and sympathetic to their needs. Were there any barriers in your agency that might have stopped engaging with help for the domestic abuse?

14.2.1 The Police provided Denise and Martin with details of support services for both domestic abuse and alcohol dependence. Denise was referred to MARAC on two occasions with Martin as the perpetrator. Denise and Martin were often under the influence of alcohol. Denise was offered support for domestic abuse after every incident. Denise did not always support the actions and prosecution. The Panel discussed as alcohol was a factor in Denise's case, whether the Mental Capacity Act 2005[39] could have been considered by professionals. Denise's decision making may have been impacted when she was under the influence of alcohol and it may have been appropriate to make a 'best interest decision' to safeguard her. Denise did often engage with alcohol services and then pull back from them. Denise had complex needs and the Panel felt that she would have benefitted from a 'key worker', one constant person, who could have assisted her with various support needs and links to other services. The Panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 6]

14.2.2 There were two occasions where Denise was spoken to and offered support from the IDVA team. This included the offer of a needs assessment to be completed to identify Denise's specific needs and key issues she wanted support with, and safety planning in relation to the current risks identified. On both occasions Denise declined to engage with the service and no further work was undertaken. Denise was provided with the team phone number should she change her mind.

14.2.3 IDVA support is not dependent on agency referrals and Denise could self-refer at any time for support. The referrals from the Police indicated that both Denise and Martin were alcohol dependent, and that Denise had mental health issues. The panel acknowledged that Denise's alcohol dependency is likely to have impacted on the IDVA team's ability to engage with her and potentially on Denise's own ability to accept the offer of support depending on her circumstances at that time, for example when Denise received a cold call from a service and workers she did not know.

[39] https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

Experience within the IDVA team highlights those victims of domestic abuse who have other complex needs outside of domestic abuse, particularly in relation to mental health and/or substance misuse (often termed the 'toxic trio'[40]) are the most challenging and difficult cases. These challenges include maintaining consistent engagement with victims if they do accept support initially and being able to offer practical safety support options which victims often find difficult to maintain due to their additional needs.

14.2.4 SWACA were aware that both Denise and Martin were alcohol dependent and recognised the potential impact that could have on Denise's ability to engage with support. SWACA staff made several attempts to contact Denise via telephone call, leaving her messages and sent a letter with information about SWACA services and how to contact the organisation. Denise was sent information about the drop-in service. Denise did not respond. The Panel learnt that Primary care and SWACA are working on a series of learning events for primary care to raise awareness of domestic abuse and the Sefton support services pathways. The objective is that this will lead to greater collaboration between agencies with the outcome being greater support given to victims and encouragement to engage with domestic abuse support services. The Panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 3]

14.2.5 The GPs and staff within the surgery where Denise was registered, were aware that she was a victim of historic abuse and aware of the current domestic abuse with Martin. The surgery had a longstanding relationship with Denise. Whilst the relationship with the surgery was good the Panel felt that there were missed opportunities when Denise attended the surgery and was seen with bruising after a telephone call, she had made three days earlier saying that she was being assaulted. There was no evidence of the GP or staff asking Denise about domestic abuse on this occasion. Martin's GP had a telephone call with him requesting support with conception with a new partner (believed to be Denise) There was evidence of professional curiosity with the GP asking Martin about his new relationship and his previous child. The Panel felt this should have been explored further and the name of the new partner documented. The GP made a follow up telephone call to Martin two weeks later and at this time Martin was intoxicated. Martin was given an appointment for the following day, which is expected practice and he did not attend. The IMR Author for the CCG highlighted that there was an opportunity to proactively follow up with Martin and to offer further support, signposting and explore his drinking and behaviours.

40 https://safelives.org.uk/sites/default/files/resources/Risk,%20threat%20and%20toxic%20trio.pdf

14.2.6 NWAS provided Denise with pre hospital emergency care via Patient Emergency Services (PES) 999 or via an ambulance disposition outcome following a call to the 111 service. NWAS provided the NHS 111 service for urgent care and advice to the Denise. Denise had 19 contacts with the 111 service and 8 contacts with PES services. These contacts were in relation to health concerns and anxiety. On occasion, Denise refused to travel to hospital against advice and stated she found it difficult to attend hospital due to anxiety. In these circumstances alternative pathways were found and provided for the victim.

14.2.7 Denise was offered support from the Alcohol Specialist nurse within Aintree Hospital, and she was referred to Ambition Sefton for community support. Throughout Covid-19 pandemic support was continuously offered as the Alcohol Specialist Nurse maintained telephone contact with Denise. At times when Denise would cancel an appointment due to being intoxicated a new appointment was arranged.

14.2.8 Ambition Sefton provided support to Denise and at times her engagement was sporadic. During the Covid-19 pandemic restrictions meant that the face-to-face contact with Denise was replaced with telephone contact and although the contacts continued, it is unclear whether more could have been achieved with face-to-face contact. Denise's RIO[41] records demonstrate appropriate records of assessments related to alcohol addiction and evidence of suitable attempts to engage with Denise to moderate her use of alcohol. Since February 2020 Denise reported boredom being a major trigger factor to her use of alcohol.

14.2.9 The panel heard that Adult Social Care did not make direct contact with Denise whilst she was an inpatient at hospital in July 2020. The panel were informed that there had been a directive from senior management for social workers not to go onto the wards without agreement from a manager and an appropriate risk assessment. The social work team attempted to contact the ward but were unable to get a response. The Panel felt there was an opportunity for the social worker to contact the hospital safeguarding department and consider how to progress contacting Denise. Due to Covid-19 pandemic the acute trust was extremely busy, however the hospital wards were 'open' for professionals and social workers were able to visit wards. All potential ward visits were presented to the Hospital Social Work Team Manager to establish if a visit was necessary and decide if it should take place. The panel determined that the social worker should have contacted their team manager to discuss Denise's case and to visit the ward, to speak directly with Denise.

14.2.10 MCRC work low to medium risk of serious harm offenders, providing interventions on order of the sentence of the Court. Most violent offenders are domestic abuse related and MCRC is equipped to provide the necessary

[41] RIO is the electronic patient record system used by Mersey Care.

interventions. Martin was referred to the HELP programme, the domestic abuse perpetrator programme, as part of his licence and post sentence supervision. Other interventions and focus on domestic abuse should have been considered, however as highlighted by the MCRC IMR author there were factors which affected this being completed with Martin; these included a frequent change of Martin's supervising officer, an over reliance on Martin's account of progress, Martin's reluctance to undertake a group work programme and the Covid- 19 pandemic restrictions which resulted in the Ministry of Justice (MOJ) ceasing all groupwork activity.

Term 3

14.3 What knowledge did your agency have that indicated Martin might be a perpetrator of domestic abuse against Denise and what was the response? Did that knowledge identify and controlling or coercive behaviour by the perpetrator?

14.3.1 The Police attended the first domestic incident involving Denise and Martin on 11 November 2018. Martin was not known as a perpetrator of domestic abuse but did have seven previous convictions between 1991 and 2019, which included offences of violence. Martin was convicted of assaulting Denise on 6 July 2019 and sentenced to fourteen days imprisonment. Martin was subject to a licence period followed by 12 months post sentence supervision.

14.3.2 Denise and Martin each had their own homes and would regularly stay with each other and consume alcohol exceeding safe recommended levels. The panel heard that Martin often bought the alcohol to Denise's home and this resulted in regular arguments and sometimes violence. Denise regularly contacted the Police making allegations against Martin, which she withdrew when Officers arrived or stated, she could not remember what had happened. Officers attending the incidents attempted to establish whether injuries sustained by Denise resulted from an assault or whether there was another explanation, for example she had fallen over whilst intoxicated. The panel acknowledged this difficulty, whilst also recognising that Martin on several occasions, denied assaulting Denise when spoken to by the Police and stated that Denise had fallen. Twice Martin returned to the scene at the request of the Police, knowing he was likely to be arrested which the Panel felt indicated a perpetrator confident in the control he had over Denise that he did not fear the consequences of arrest and expecting Denise not to support a prosecution. The Panel felt that Martin's outward and sustained compliance was evident in his interactions with different authorities and indicative of his ability to control his behaviour and that of others. The panel have identified this as learning and made a relevant recommendation. [Recommendation 5]

14.3.3 Denise's statement to the Police on 6 July 2019 referred to controlling and coercive behaviour. Denise stated that Martin objected to her going on holiday with her cousin and damaged her phone charger so that they could not communicate. Denise said she had become conditioned to domestic abuse and was no longer scared of Martin as his behaviour had become the norm. The panel determined that Martin's behaviour demonstrated elements of controlling and coercive behaviour. For example, when Denise was left naked, except for a sheet and locked out of her flat by Martin after she declined sexual activity, this humiliating behaviour was an indicator of controlling and coercive behaviour. When Denise telephoned the Police twice, pretending to Martin that she was speaking with someone else, this was an indication that she was in fear of him.

14.3.4 Denise attended her GP surgery in September 2019, three months after she was assaulted and requested a letter not to attend court as a witness. Denise attended alone and this was an opportunity to explore the situation with her. There was lack of professional curiosity regarding potential controlling and coercive behaviour. The GPs IMR author has highlighted to the Panel that this is not mainstream practice and the CCG in conjunction with NHS England have arranged to provide feedback to the relevant GP and share learning from the review. There is guidance for GPs in relation to such requests[42]. The GPs IMR Author has identified learning and has made a relevant recommendation.

14.3.5 The panel heard no other information that agencies had identified controlling and coercive behaviour.

14.3.6 Aintree hospital received information from MARAC that Denise was at risk of domestic abuse and an 'alert' was placed on Denise's hospital records to indicate that she was at risk of domestic abuse. The 'alert' does not identify details of alleged perpetrators and therefore there was no information in relation to Martin. On 8 July in recognition of the 'alert' nursing staff specifically asked Denise about the circumstances of the assault and she confirmed that it was a push by a neighbour, not domestic abuse.

14.3.7 Following the assault on Denise in July 2019, Martin was under the supervision of MCRC. A referral to a domestic abuse perpetrator programme was planned and the MCRC IMR author highlighted that the circumstances of the assault should have prompted MCRC to further explore domestic abuse with Martin at the start of his initial licence assessment in January 2020. There was an over reliance on Martin's account of progress and Martin appeared to have influenced the agenda and diverted it away from domestic abuse. There was a breakdown in communication relating to Martin's breach of DVPO. A DVPO is a civil order and one which would not automatically be brought to the attention of MCRC. In Martin's case MCRC was unaware of the breach or that Martin

[42] https://www.cps.gov.uk/legal-guidance/medical-certificates

had appeared in court and had been sentenced to a period of custody. The Panel heard that the Police and the Probation Service are in the final stages of agreeing an Information Sharing Agreement which will result in all domestic abuse contacts with the Police being reported to Probation if the person is under supervision. Merseyside Police and the Probation service have identified this as learning and the Panel have made a relevant recommendation. [Recommendation 7]

Term 4

14.4 What risk assessments did your agency undertake for the subjects of the review; what was the outcome and if you provided services, were they fit for purpose?

14.4.1 Incidents of domestic abuse are graded by the Police for a response according to the 'Calls and Response policy'[43] and the information gleaned by the call handler, the incident is constantly reviewed until officers are at the scene and can take over that role. On occasion the call handler used their expertise to keep Denise engaged on the telephone as a means of reassurance whilst officers were en-route to her.

14.4.2 The Police use the MeRIT[44] and DASH[45] risk assessment models to assess domestic abuse incidents. There were opportunities for assessment and decision making at the incidents, starting with the 'at scene' assessment by the officers in attendance, informing their grading of the incident and thereafter decisions regarding the action to be taken to reduce the immediate risk, such as arrest or removal of the perpetrator.

14.4.3 Denise was a vulnerable person with complex needs and officers completed a VPRF1 at each incident, assessing the level of risk presented. At various times Denise was risk assessed as 'bronze', 'silver' and 'gold' and appropriate referrals were made to the IDVA service. The Panel heard that the upgrading of risk following incidents with Denise and Martin was related to previous domestic abuse history and status as previous Gold Victim. Denise was a repeat victim of domestic abuse with previous partners. Returning either Denise or Martin to their own homes to defuse the situation was positive action taken by the Police, but it often resulted in further reports of domestic abuse calls when the parties met up again within a short period of time.

[43] https://www.merseyside.police.uk/SysSiteAssets/foi-media/merseyside/policies/call-response-policy--procedure-

[44] MeRIT (Merseyside Risk Indicator Toolkit) This is an established risk assessment tool used by the whole of Merseyside Police when responding to domestic related incidents.

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

14.4.4 A further risk assessment for each incident involving Denise and Martin was undertaken by staff at the MASH[46] upon receipt of the VPRF1. The incidents were assessed against previous reported incidents considering escalation in behaviour, which represented an increased risk for Denise. On one occasion the MASH increased the 'at scene' grading from 'silver' to 'gold', for an incident where Denise and her mother received threats from Martin. Risk assessments continued throughout the Police investigations, for example when considering bail for Martin bail conditions were requested as additional control measures to support Denise and mitigate identified risks. The application for a DVPO considered the risks to Denise and the opportunities it provided to support her.

14.4.5 MERIT and DASH risk assessments are not well established within primary care, although there is knowledge of domestic abuse as an issue and where to signpost for support locally. Denise was not subject to a specific domestic abuse risk assessment. It was not known to primary care that other agencies had completed assessments, and there is no documentation in Denise's records during the period of this DHR from any other agency aside from health. Denise's GP practice safeguarding lead was aware of her case. The police were contacted as appropriate. The Panel considered whether a further call to the Police would have been appropriate on seeing Denise with an injury in early June 2019. The Panel heard that as Denise had been referred to the police for this incident previously, the surgery would not usually make another call to the Police for the same incident, days later. The IMR author from the CCG felt there was learning, primarily around sharing good practice and practical advice as to how to enable and empower victims of domestic abuse to make disclosures and contact the Police and social care themselves from within the surgery. The Panel felt that the GP could have made a follow up contact to the Police (This is covered in Term 1).

14.4.6 NWAS crews carried out assessments of Denise when they responded to incidents and had 24-hour access to a Clinical Support Hub for advice and support. NWAS did not carry out domestic abuse risk assessments. If Denise had disclosed domestic abuse NWAS crews would offer appropriate support and advice and offer to raise the issue with adult social care. Professional curiosity is encouraged within NWAS, in all contacts with a patient whether this is face to face or by telephone. On 15 November 2018 the attending crew documented bruising to Denise's lip and asked Denise how she sustained the injury. Denise did not disclose domestic abuse and stated she had previously fallen.

14.4.7 General nursing assessments were undertaken when Denise attended hospital and they were completed in line with Trust policy[47]. No specific risk assessments were completed relating to domestic abuse and had

[46] MASH- Multi-agency Safeguarding Hub
[47] https://www.aintreehospital.nhs.uk/

Denise disclosed any concerns, the Trust domestic abuse policy would have been followed and a DASH Risk assessment would have been completed.

14.4.8 Martin's initial start licence assessment by the MCRC was carried out on 15 January 2020 by a duty officer. Martin's file was endorsed that a further review would be required by the allocated officer on their return from sickness absence. This was never completed as the allocated officer resigned and Martin's case was transferred to a new officer.

14.4.9 In the transfer the review request was missed. The plan to refer Martin to the HELP domestic abuse programme was postponed due to COVID 19 restrictions and the method of contact changed from face to face to telephone contacts. Martin's allocated officer focused efforts, during the telephone contacts, on supporting improvements in employability and missed opportunities to engage with Martin around current relationships and domestic abuse triggers. The MCRC IMR author has identified this as a learning point as often interventions are focused on practical elements of resettlement into the community at the expense of prioritising ongoing offence focused work. Martin's risk level was raised to 'medium' risk of harm at the start of his licence which was correct. This should have triggered a review of risk in accordance with MCRC Exceptional Delivery Model (EDM) but this review did not take place. The EDM was the model of service delivery put in place by the Government on all CRCs during the COVID 19 Lockdown.

14.4.10 Martin disclosed feeling anxious and depressed to MCRC and indicated that he had undergone a mental health assessment at Clock View[48] in December 2018. During this DHR enquiries have confirmed that Martin did not have this assessment as he had indicated to his MCRC worker. The Panel felt this highlighted the absence of robust liaison with between MCRC the appropriate mental health team and Martin's GP and a reliance on accepting what Martin was saying. Safeguarding checks were made at start of Martin's order/licence and should have been maintained and repeated throughout. MCRC have identified learning in relation to ongoing liaison with agencies. There was no management oversight of risk in Martin's case and this has been addressed with MCRC management and appropriate action taken.

Term 5

14.5 When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had

[48] https://www.merseycare.nhs.uk/about-us/a-new-generation-of-mental-health-hospitals/clock-view/

concerns. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

14.5.1 The Police used the VPRF 1 assessment to identify indicators of domestic abuse and any escalation is risk. Denise and Martin's alcohol dependency were sensitively dealt with and officers recognised that alcohol was the trigger for many arguments. The panel considered whether alcohol consumption could have masked the abuse being perpetrated by Martin and an acceptance that alcohol was a factor which resulted in a robust probed into incidents.

14.5.2 At times it was identified that no offences had been committed, and the Police separated Denise and Martin to minimise the risk of an escalation to the incident. This resulted in further calls to the Police when Martin returned to Denise's address. The panel considered that an arrest to prevent a further breach of the peace would have been an appropriate course of action, especially as the incidents became more regular and that this would have provided other agencies with information in relation to ongoing domestic abuse.

14.5.3 On 6 July 2019 Police officers recognised Denise was a vulnerable witness and was eligible for Enhanced Victim entitlements in accordance with the Youth Justice and Criminal Evidence Act 1999[49] and the availability of special measures during criminal processes.

14.5.4 The review panel have been assured agencies regarding the level of training of employees that equips them with the knowledge and understanding around domestic abuse and working with victims and access to specialist safeguarding training within their respective Organisations.

14.5.5 Throughout Denise's clinical records at hospital it was documented that staff showed sensitivity to Denise through all her admissions. On one occasion Denise wanted to leave the accident and emergency department and there was evidence that the Consultant went to speak to Denise to raise his concerns about her leaving. In July 2020 it was recorded that Denise wanted to self-discharge and there is an entry stating that the conversation with the clinician explained the risks to Denise. Denise listened and made her own decision based on the information she was given. Although against medical advice, the Trust had no reasons to doubt Denise's capacity to make these decisions.

14.5.6 There was evidence of a communication breakdown between Adult Social Care, the hospital social work team and hospital safeguarding team, in relation to the referral following Denise's admittance and her vulnerability in July 2020. Denise was discharged from hospital before her needs were considered and assessments were undertaken. The Panel heard that had

[49] https://www.cps.gov.uk/legal-guidance/special-measures

the hospital social work team been advised of the outcome of safeguarding alert, they may have offered an assessment.

Term 6

14.6 How many MARACs were convened on this case? Did the MARAC provide support/reassurance for agencies working with Denise in relation to the risk of domestic abuse? Did all partners actively participate, were there any barriers to the process?

14.6.1 Denise was referred and discussed at MARAC twice.

The MARAC held on 19 Dec 2019 occurred 16 working days after the referral was made on 19 November 2019. The only agency actively involved with Martin was MCRC, however, they were not present at the MARAC, providing written information to be shared at the meeting. The following actions were allocated to the;

- To carry out alcohol tests on Denise and Martin should either be arrested.
- To place a criminal justice mental health marker (CJMH) on Martin in relation to future arrests.
- To liaise with Denise via Early Help Scheme, jointly with the IDVA team.

There is no record that the joint action above was completed.

14.6.2 The second MARAC held on 6 August 2020 occurred 13 days after the referral. Denise was open to Ambition Sefton; however, they were not present and provided written feedback to the meeting. Ambition Sefton were not set specific actions in relation to supporting Denise with her alcohol misuse.

14.6.3 Key agencies were absent at each of the MARAC meetings, providing written updates to be shared, which meant they were not active participants in the discussion and opportunities for specific actions were missed. Specifically in December 2019 MCRC missed the opportunity for actions to be determined in relation to Martin and his behaviours and in August 2020. The Panel heard that the MCRC update provided to MARAC stated Martin was medium risk of harm and low risk of re-offending and that Martin had not disclosed any new relationships. Martin was generally complying well and no ongoing issues in relation to alcohol and drugs there were disclosed. The Panel considered whether given the escalating incidents of domestic abuse, this an accurate assessment of Martin and the risk to Denise.

14.6.4 MARAC information on Martin's MCRC case file should have generated a review of risk assessment. The Panel felt that further action should have been taken by the MCRC worker following the MARAC meeting. The MCRC

IMR author has identified learning in relation to this and a revised case allocation and management oversight of cases is now in place.

14.6.5 The DHR panel have been informed that overall, representation and attendance by agencies at MARAC is good. Where an agency representative is unable to attend a meeting and the case is known to them, they usually provide written feedback, as illustrated above, which is positive and helpful for other professionals. The panel felt physical attendance at MARAC was crucial to the effectiveness of the process. One of the key values of MARAC is for professionals to actively engage and contribute to case discussions based on all the information shared. This was missed during this case with the two key agencies involved with Denise and Martin not in attendance. The Panel learnt that agency membership and meeting attendance is regularly reviewed by the MARAC steering group as part of the performance management framework. This DHR highlights the importance of all member agencies committing to regular attendance at the meetings. The Panel have identified this as learning and made a relevant recommendation. [Recommendation 1]

14.6.6 The Safelives recommendation is that cases should be discussed within 30 working days of the incident occurring. Both cases for Denise were within this timeframe. The IDVA and SWACA were present at both meetings and were able to share details of their attempts to engage with Denise as well as obtain information from other partner agencies.

14.6.7 As Denise's case went to MARAC in December 2019 and thereafter there were other domestic abuse incidents which should have triggered further referrals to MARAC. The repeat criteria for MARAC are set out in the MARAC Operating Protocol[50] as follows:

'A repeat MARAC case is one which has previously been referred to MARAC and a further incident has then taken place within twelve months of the original discussion. Any agency may identify a further incident regardless of whether it has been reported to the police. A further incident could include any one of the following types of behaviour:

- Significant violence or threats of violence to the victim (including significant threats against property) e.g., Assault with visible injuries, Threats to Kill, threats of Arson etc.
- A pattern of stalking or harassment
- Rape or sexual assault/abuse
- Breach of Restraining or Non-Molestation Orders

There are also specific instances where a further referral may be made to MARAC where no repeat incident has occurred. For example, cases where a perpetrator is about to be released from prison and this causes significant

[50] Sefton Multi-Agency Risk Assessment Conference (MARAC) Operating Protocol Version 3 - April 2021

concern, or where significant further risks have been identified but no specific threats have been made and the case is discussed to make sure that every agency is aware of the concerns to enable them to put in place any appropriate safety measures.

The Panel heard that there were three Police referrals made to the IDVA service in between the two which also went to MARAC. The referrals received on 12 and 17 December 2019 were not referred to MARAC as the case was already due to be discussed at the meeting on 19 December 2019 and those incidents were incorporated into the Police feedback. There was a referral received on 13 February 2020 following a 'Silver' incident and although Denise had initially reported receiving threats over the telephone, she later told Police that she could not remember calling them and no offences were disclosed, therefore it didn't meet the repeat criteria.

14.6.8 There was no record on the MCFT system that while Denise was 'open' to the service that she was subject of MARAC. Adult Social Care did not have information on their system in relation to MARAC. The Panel discussed this point and determined that all agencies involved in MARAC should have updated their internal systems accordingly via flags or alerts at the point of MARAC cases being scheduled. This is outlined in the MARAC Operating Protocol as follows:

'All MARAC cases should be 'flagged and tagged' by agencies so that any further incidents of domestic abuse disclosed can be referred into the MARAC process if necessary. All agencies are expected to systematically 'flag and tag' files involving MARAC families who are known to them. This is to include the removal of flags after a 12-month period from the date of the last discussion at MARAC. It is important to ensure that whenever a victim discloses domestic abuse to an agency that checks are completed to ascertain whether the victim is already known as a MARAC case'.
The Panel identified that 'Flagging' on agencies internal systems in relation to referral to MARAC both for victims and perpetrators was inconsistent. The Panel have identified this as learning and made a relevant recommendation. [Recommendation 2]

14.6.9 MARAC alerts were entered onto the hospital system in relation to Denise and information was requested from the hospital safeguarding team in relation to the MARAC towards the end of July 2020. The details of Denise's two admissions in July were shared. The safeguarding team did not recognise the significance of the injuries sustained by Denise and the subsequent MARAC referral by the police which occurred the day after Denise was discharged.

14.6.10 Denise's GP was actively engaged with her at the time of the August 2020 MARAC. The Panel learnt that work is taking place regarding involving general practice within the MARAC process locally and the CCG is working with the Named GPs for Safeguarding to develop an information sharing process between Primary Care and MARAC as this information is not

currently routinely shared. And work is taking place regarding involving general practice within the MARAC process locally.

14.6.11 The Panel felt that agencies may have experienced a sense of 'helplessness' within their own services that both Denise and Martin were repeat known individuals both with a history of significant alcohol issues and therefore a feeling that all options and pathways had been explored. The Panel identified that Merseyside has the Multi-Agency Risk Assessment and Management (MARAM) Process which may have offered another pathway of support from MARAC. The Panel have identified this as learning and made a relevant recommendation. [Recommendation 1]

14.6.12 The Panel felt that agencies could have considered the Domestic Violence Disclosure Scheme (DVDS)[51] known as Clare's Law, at any point during their contact with Denise including at the MARAC.

Term 7

14.7 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Denise and Martin?

14.7.1 Section 11 of this report sets out the issues of equality and diversity and considers whether either Denise or Martin should be treated as having a disability. Consequently, that information is not repeated here. Denise and Martin had contact with agencies in relation to their alcohol dependency and in relation to their mental health. This is covered further in Term 4.

14.7.2 The DHR panel learnt that there were no known issues in relation to racial, cultural, linguistic, faith or diversity when completing assessments and providing services to Denise and Martin.

14.7.3 Research acknowledges that women are more likely to experience domestic abuse then men.[5253] Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2017)[54] . Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and

[51] Clare's Law, or the Domestic Violence Disclosure Scheme (DVDS), is designed to provide victims with information that may protect themselves for an abusive situation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

[52]

[53] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/

[54] Office of National Statistics

controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

14.7.4 'Mental illness and domestic homicide: A population-based descriptive study 2013' [55] [56] focused on all convicted adult domestic homicide perpetrators in England and Wales between 1997 and 2008. The study identified that 20% of intimate partner homicide perpetrators and 34% of adult family homicide perpetrators in England and Wales had symptoms of mental illness at the time of offense, higher than had been reported amongst perpetrators of other types of homicide. When comparing the sociodemographic characteristics of adult family homicide perpetrators with and without symptoms of mental illness at the time of offence, the study identified no differences in respect to sex, age, racial-ethnic minority status, marital status, or living arrangement. Perpetrators with symptoms of mental illness were, however, less likely to be employed.

Term 8

14.8 Were there any issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Denise and Martin, or on your agencies ability to work effectively with other agencies?

14.8.1 On two occasions, 6 July 2019 and 7 September 2019, Merseyside Police did not meet the emergency response target for arrival at an incident within ten minutes. The panel were informed the Police were dealing with a high volume of ongoing high-risk calls at the time of the calls and therefore attendance was slightly delayed. The call handler on both occasions spoke with Denise reassuring her and monitored the call for any escalation in risk.

14.8.2 The Police referred Denise to the IDVA service via the expected pathway, with VPRF1 forms electronically received and uploaded onto the case file system. Thereafter 'duty' calls were made as the initial contact. There was a significant delay in the first referral being dealt with and although received in September 2019 it was not entered onto the case management system until November 2019.

14.8.3 There were occasions when the IDVA service would not contact Denise. Whilst it is possible that a letter was sent to Denise regarding contact and the IDVA service there was no record that this took place. On one occasion it was recorded not to send a letter to Denise as there were

[55] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201200484

[56] Dr. Oram and Prof. Howard are affiliated with the Department of Health Service and Population Research at the Institute of Psychiatry, King's College London, PO31 David Goldberg Centre, De Crespigny Park, London SE5 8AF, United Kingdom (e-mail: sian.oram@kcl.ac.uk). Dr. Flynn, Prof. Shaw, and Prof. Appleby are with the Centre for Mental Health and Risk, University of Manchester, Manchester, United Kingdom

concerns Martin was staying at the address. For every referral received, telephone contact was attempted with Denise on at least one occasion. Calls were made by different workers, offering different approaches to encourage Denise to engage with the support available. Two successful contacts were made with Denise, but she declined to engage with the service.

14.8.4 The panel have been informed that processes have already been reviewed and updated with a more consistent approach being established. Quality assurance for this process has been introduced by the IDVA management team with the establishment of an audit system. The capacity of the IDVA team was severely reduced at this time, which meant that there was a waiting list of cases for allocation to an IDVA worker. This required a difficult balancing act of repeatedly attempting to offer support to someone whilst also not keeping other new referrals waiting for too long and thereby reducing the chance of those individuals engaging with the service.

14.8.5 The IDVA service experienced significant capacity issues within the team due to sickness (2 out of the 4 IDVAs were absent) and a large-scale service restructure implemented the year before, which changed some processes, and caused some operational issues. The Panel heard that a new temporary system for triaging referrals and making first contact with victims was introduced with an extra member of staff to help support the caseload capacity of the available two IDVAs. This meant additional considerations around risks and subject knowledge needed to be considered (as the person was not IDVA trained). The referral that was initially missed within the system was graded 'bronze' rather than the usual 'gold'. It was acknowledged at the time that the management arrangements in place were not working, and since March 2020 this has changed to having consistent lead operational managers for the IDVA service and IDVA workers. The IDVA team is back up to strength of 4. The triaging process has also been reviewed and updated, with support being provided more consistently by well-established local specialist domestic abuse agency, SWACA, which the IDVA service works closely with. Initial contact timeliness is back to the levels previously expected and delivered and there is confidence that this issue of missing lower-level incident referrals has been resolved.

14.8.6 The panel heard that decreasing resources across the Sefton partnership was a factor impacting on the MARAC. Resources available to agencies has seen a change in the types of actions being offered with them becoming more 'standardised' and less innovative or 'out of the ordinary'. This has included a decrease in actions such as joint visits between agencies which have previously been used to try and engage victims with support services. The impact of this is particularly felt in complex cases where either the victim or perpetrator, or in some cases both, have additional issues, and

the standard agency and MARAC support offer cannot adequately address the root causes of the issues being discussed. Denise's needs were complex. and the panel reflected on what additional support could have been provided. Support agencies experience was that Denise would engage in the short term and there was positive progress and then Denise would pull away and disengage. The MARAC steering group has agreed to review the challenges with complex cases and learning has been identified by the partnership in relation to this.

14.8.7 There were difficulties for hospital social workers to speak to ward staff and this appeared to be an ongoing challenge, which increased due to pressures within the hospital due to the Covid-19 pandemic. The panel heard that the Covid-19 restrictions negatively impacted on the social worker's ability to visit the ward and assess Denise. Prior to the pandemic the hospital social work team may have considered a visit to the ward to offer an assessment to establish if Denise had care and support needs. The panel were informed that the Covid-19 pandemic did not prevent professionals from going onto wards to see patients. There appeared to be a breakdown between departments and this impacted on the outcome for Denise as she was discharged before being seen and assessments taking place. The Panel heard that improvements have made during this DHR and a revised safeguarding pathway developed. (Covered further in Term 9)

14.8.8 MCRC experienced significant staffing issues, with the long-term sickness absence of Martin's allocated case worker and professional competency concerns which directly affected the quality of how Martin's case was managed once the domestic abuse was known at the end of 2019. Wider sickness absence across the team resulted in Martin's case being supervised by up to 5 different officers and at the start of his licence Martin was seen for a significant period by a duty officer and his home visit was missed. Continuity of supervision was limited and oversight and risk management were disjointed and superficial. This resulted in Martin's behaviours and underlying needs being unmet.

14.8.9 During the Covid-19 pandemic Martin's supervision continued via telephone. There was no professional curiosity demonstrated in relation to Martin's relationships and a focus on resettlement at the expense of prioritising offence focused work. This arrangement made it more difficult to ask probing questions and have challenging conversations with Martin.

14.8.10 MCRC reported that regular intelligence enquiries were made with the Police throughout Martin's order but there was no record that these had been returned. MCRC were not aware of all the incidents of domestic abuse between Denise and Martin. This has been highlighted as an area of learning by MCRC and Merseyside Police.

14.8.11 The Covid-19 pandemic impacted on several NHS resources and operational responses were developed to support the delivery of safe services. At times the NWAS Resource Escalation Action Plan (REAP) level had been operating at level 4 (extreme pressure). The change in REAP level was due to increased pressure that was being experienced across NWAS services and this increased pressure was system wide and being experienced nationally. The levels are designed to maintain an effective and safe operational and clinical response for patients. NWAS has used a variety of resources during the pandemic such as private ambulance providers and continues to monitor resources as the current pandemic continues. There was no evidence that the NWAS service provided to Denise were negatively impacted.

14.8.12 There were no GP capacity or resource issues due to the Covid-19 pandemic. Telephone and email access were the first point of contact. Denise received the time she needed with the GPs and was seen in person twice during the early period of the pandemic on 9 April and 12 May 2020.

Term 9

14.9 Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were these followed in this case? Has the review identified any gaps in these policies and procedures?

14.9.1 The DHR panel have been informed that agencies involved in the review had in place policies and procedures for domestic abuse and safeguarding. These policies detail the expectations of staff, enabling victims to talk about their experiences, assessing the risk to victims and children, safety planning and providing support and information and signposting to specialist domestic abuse services. All agencies recognised that the incidents amounted to domestic abuse and therefore policies and procedures were followed.

14.9.2 In August 2020 Adult Social Care implemented a revised safeguarding approach within the hospital. This is a working partnership with other agencies to apply a consistent and joined up approach to safeguarding alerts with the aim to achieve better outcomes and improve management of risk for those who are vulnerable. The IMR author for ASC recognised retrospectively that Denise's case highlighted an area of concern in relation to the monitoring of all safeguarding referrals and this has subsequently led to the improvement being implemented. The Panel heard confirmation that practice had changed in August 2020.

Term 10

14.10 How did your agency gather the wishes and feelings of the subjects of the review in relation to the services that were provided or being offered?

14.10.1 The Police considered Denise's thoughts and feelings at each incident and recorded them on the VPRF 1. Wherever safe to do so, officers complied with Denise's wishes considering risk and in compliance with the Force's Domestic Abuse policy. The 'zero-tolerance' to domestic abuse was explained to Denise on several occasions. The Police were flexible considering Denise's situation with ongoing criminal proceedings. On 24 July 2020 when Denise decided to make a complaint of malicious communications against Martin, a statement supporting prosecution was obtained. On 12 August 2019 Denise informed Police that she could not attend court due to her health and officers obtained a further witness statement from her. This was supported with evidence from her G.P. The Panel acknowledged the flexibility in relation to witness statements obtained from Denise. The Panel felt that Denise could have benefited from multi-agency support in her decision making around providing a withdrawal statement. The Panel have identified this as learning and made a relevant recommendation. [Recommendation 3]

14.10.2 Denise was a lifelong patient at her GP surgery and she was well known to clinical and reception staff. Denise was signposted and referred for counselling, alcohol services, SWACA and psychiatry. This is evidence of the surgery listening to Denise's wishes and having systems in place to provide high quality and personalised care. Denise was able to speak to her GP, and was given time and space to do this. The services provided to Denise were holistic and not solely focussed on her usage of alcohol, although this was a key concern.

14.10.3 Denise's contacts with the NWAS patient emergency service considered consent for any treatment and agreed plan of care. On the occasions when Denise declined transport to hospital for ongoing treatment and assessment, her wishes were considered with alternative care pathways being discussed and agreed. Denise's use of the 111-service related to her seeking advice relating to ongoing matters and responses met Denise's needs.

14.10.4 The recovery worker from Ambition Sefton sought Denise's consent to contact Denise's mother. This demonstrated consideration of the wider aspects of Denise's welfare, family networks and current situation.

14.10.5 The IDVA team spoke with Denise on two occasions, the role of the team and details of the support available were explained to Denise to allow her to make an informed decision as to whether she wanted to engage with the service. Denise declined support.

14.10.6 On one occasion at Aintree hospital, Denise wanted to self-discharge against medical advice. The consultant discussed the risks associated with

the decision with Denise and she was supported to make her own autonomous decision about discharge.

14.10.7 MCRC encouraged Martin to complete a self-assessment questionnaire. This was Martin's opportunity to identify issues believed to be problematic and associated with their offending behaviour. Martin did not complete the self-assessment questionnaire.

Term 11

14.11 What learning has emerged for your agency?

14.11.1 Agency learning is identified with Section 16.1 of this report.

Term 12

14.12 Are there any examples of outstanding or innovative practice arising from this case?

14.12.1 No examples of outstanding or innovative practice were identified from this review.

14.12.2 The panel recognised that working from home and using telephone contacts to maintain support for Denise and Martin was a positive effort in the circumstances of the Covid-19 pandemic. However, the review identified that this was not without its challenges and impacted on engagement with Denise and Martin.

Term 13

14.13 Does the learning in this review appear in other domestic homicide reviews commissioned by Safer Sefton Communities Partnership?

14.13.1 Sefton DHR2 (from 2014) highlighted the need for MARAC to "look at all the evidence from the victim, perpetrator and agencies and develop more imaginative and collaborate solutions." This action was completed as part of a MARAC review which resulted in policies and procedures being updated and new processes being developed such as the MARAC steering group and MARAC performance management framework to ensure continual review and development. Whilst there is a similar point in this review, the focus now is that the challenges faced by reducing resources within the public and third sectors whilst managing services with increasing workloads, has directly impacted on the ability of agencies to keep developing new ways of working. For MARAC complex cases it is clear

wider consideration needs to be given on how best to support these individuals and families, including the resource and systems and process implications related to this.

15. CONCLUSIONS

15.1 Denise died weeks after an altercation with a neighbour and a separate domestic incident, where Martin had pushed Denise against a chair. Martin was arrested in connection with Denise's death and released under investigation. Martin died before the criminal investigation concluded.

15.2 Denise had a long history of alcohol misuse and dependency and was known to alcohol services. Denise had accessed several support services and inpatient detoxification. After each domestic abuse incident Denise was offered specialist domestic abuse support by IDVA and SWACA services. When contact was made with Denise, she declined the services. Denise was also offered specialist support for her alcohol dependency. The review identified the importance of combined support for victims of domestic abuse who have additional complexities and needs and developing methods to engage more effectively with those victims.

15.3 Throughout their relationship, Denise experienced domestic abuse perpetrated by Martin which manifested in physical assaults, assault on Denise's dog and verbal threats. Denise's case was referred to MARAC on two occasions as her situation was assessed as high risk. Denise was recorded as the perpetrator of domestic abuse towards Martin on one occasion. Alcohol featured in every incident of domestic abuse that was reported.

15.4 During the summer of 2020, Denise experienced several incidents of domestic abuse perpetrated by Martin which manifested in physical assault and threats to burn Denise's mothers house down. Denise told the Police that she felt a sense of misguided acceptance of her situation and normalised the domestic abuse. Denise's situation was captured within the VPRF1 forms and the risk assessments completed by professionals.

15.5 The review identified the importance of communication between different agencies, especially in relation to ongoing further incidents which could impact on risk assessments and potential ongoing actions to support Denise. Agencies unsuccessful attempts to engage with Denise was seen by professionals as being related to Denise not requiring support and the wider context of controlling and coercive domestic abuse was not recognised collectively by professionals. At no stage did professionals reconvene after the MARAC meetings to reassess Denise's situation.

15.6 The learning for the review has been captured into relevant recommendations which will be progressed through Sefton Safer Communities Partnership. The DHR Chair and Author have maintained regular contact with Denise's mother and cousin, who have contributed to the review process throughout, and provided valuable and relevant

information to assist the DHR panel. The DHR panel are grateful for the family's contribution and acknowledged their views during their attendance at a panel meeting in July 2021. It was evident that the family were unaware of the extent of the domestic abuse being perpetrated by Martin towards Denise and shared with the Panel that had they known, they felt they may have been able to provide more support for Denise. Denise's family asked relevant questions of the Panel, listened to the learning identified and were appreciative of the review.

15.7 Since this review has been completed, Sefton Safer Communities Partnership has developed their Domestic Abuse Strategy to include raising awareness of coercive and controlling behaviour. Therefore, this negates the requirement of a further recommendation.

16. LEARNING IDENTIFIED

16.1 Agencies Learning (taken directly from their IMRs)

Adult social care

- To ensure social workers have case discussion with Hospital Team Manager when wards visits are required
- Review of the safeguarding process and revised process in place since August 2020. Joint process to be drafted between ASC and LHFT. For existing process in place, a Standard Operating Procedure is required with a review in 6 months
- MARAC cases, outcomes to be shared and entered onto systems.

Children's Social Care

- Consider reasons for excessive alcohol use and emotional wellbeing, offering further support rather than withdrawing services when reported domestic abuse incidents ceased or relationships ended.

General Practice

- Increased awareness of domestic abuse in primary care. Training for GP's and revision of policy
- Increased recording of domestic abuse in primary care

IDVA

- Service changes and staff sickness resulted in delays when dealing with new referrals.
- Victims of domestic abuse with complex needs makes it more difficult for IDVA engagement /support.
- Wider systems review of complex cases to be considered. Innovative solutions.

Liverpool University NHS Foundation Trust (Aintree)

- Use of routine enquires in relation to domestic abuse and staff to be competent and confident to action responses.
- Professional curiosity is often lacking. Need to probe further into the potential causes of domestic abuse

- Revisit the purpose of MARAC both in attendance and follow up of actions. Current training and its effectiveness.
- A review of the current Domestic Abuse Policy.

MARAC

- Importance of attendance at MARAC meetings and active participation.
- Understanding partner agencies limitations /decreasing resources.
- Review managing complex cases at MARAC and consider more innovative ways of working.

Merseycare

- Reinforcement professional curiosity and understanding domestic abuse.
- Ambition Sefton staff, refresher training on professional curiosity and domestic abuse.

Merseyside Community Rehabilitation Company

- The importance of timely and accurate information sharing- by the Court
- Line management oversight of domestic abuse cases and allocation to experienced staff.
- Training events in the assessment and management of risk of harm.
- Professional curiosity, new staff development of this skill via training/ action learning.
- Improvement of intelligence sharing with the Police, particularly for breaches of civil orders e.g., DVPOs.
- Sustained focus on the criminogenic needs associated with domestic abuse.
- Safeguarding checks should be repeated during the life of the order/licence. It is not sufficient to accept that a case is closed with Children's Services without ongoing liaison, particularly following a significant event. This has been a feature of previous HMIP inspection reports and forms part of an HMIP action plan which will be reported on in due course.

Merseyside Police

- Raising awareness of strangulation in domestic abuse cases.

- Improvement of intelligence sharing with NPS in relation to domestic abuse incidents with individuals subject of ongoing probation supervision.

16.2 DHR Panel Learning

Learning 1 [Panel recommendation 1 & 2]
Narrative
The MARAC process identified Denise as a high-risk victim of domestic abuse. In Denise's case, agencies attempted contact with her but were unsuccessful in securing engagement and providing support. Whilst the MARAC meeting invited the appropriate agencies to the meetings, attendance was not consistent and written reports were submitted as an alternative to attending. This did not allow for those agencies to actively contribute to the discussions and decision making. Agencies were not consistent in the 'flagging' of their internal systems to identify Denise as a high-risk MARAC case. In Denise's case additional support via alternative pathways such as the MARAM could have been considered. A full review of the MARAC will explore the areas identified from this DHR.
Lesson
MARAC relies on the sharing of all available information, active contribution to discussions and decision making. Commitment to the MARAC process provides a robust framework for meetings, ensuring structure and accountability is maintained in the process and also ensures effective information sharing and communication.

Learning 2 [Panel recommendation 3]
Narrative
People who are experiencing domestic abuse and seeking help during times of crisis, need to know what options are available and be encouraged to accept support. Denise was additionally vulnerable due to her alcohol dependency and this impacted on her engagement with agencies. Face to face contact is vital with professionals with the specialist skills for complex cases. In Denise's case specifically when considering withdrawing from the criminal justice process, she should have been supported and understand options available.
Lesson
A specialist role such as a key worker or 'complex IDVA' would provide the necessary support to victims. By having a multi-agency approach to the process of withdrawal of support for a criminal prosecution, others as well as specialist police officers can ensure that elements of coercion or

duress can be properly assessed and maximum support provided to victims.

Learning 3 [Panel recommendation 4 & 7]
Narrative
Professionals need to ensure that when engaging with individuals, they consider the wider context and proactively seek out information to identify domestic abuse and have clear information sharing pathways to enable effective multi-agency working and avoid working in silos. Closer agency integration on a day-to-day basis would support this.
Lesson
Embedded and effective information sharing pathways, will support professionals in gaining a better insight to an individual's situation. This will help identify who can provide the best support to victims of domestic abuse. Ongoing multi agency information sharing and closer integration will prevent working in isolation and ensure information is current.

Learning 4 [Panel recommendation 5]
Narrative
Perpetrators of domestic abuse can develop skills to manipulate professionals. When dealing with perpetrators all agencies need to ensure that their staff look beyond compliance and consider controlling and coercive behaviours.
Lesson
All agencies to remind staff of controlling and coercive behaviour towards professionals and refresh awareness training as appropriate.

Learning 5 [Panel recommendation 6]
Narrative
Professionals need to consider the impact of alcohol dependency, in relation to the Mental Capacity Act 2005, when responding to individuals in domestic abuse situations and determine whether their decision making is impacted by alcohol. In a high-risk case, a best interest decision made on behalf of the victim may be appropriate.
Lesson
By considering the impact of alcohol and decision making, in the context of high-risk domestic abuse cases, professionals can properly assess and support victims.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Sefton Safer Communities Partnership review the MARAC protocol in terms of agency attendance, involvement, flags and pathways to other multi-agency meetings such as the MARAM.
2	That all agencies review their internal processes for documenting and flagging victims/perpetrators who have been referred and discussed at MARAC, including how these flags are reviewed and removed, taking cognisance of the Human Rights.
3	That Sefton Safer Communities Partnership and the Domestic Abuse Partnership Board review the support 'offer' to complex cases victims of domestic abuse and maximise the opportunities with the 'complex IDVA' /key support worker roles.
4	That all agencies provide Sefton Safer Communities Partnership with assurance and evidence that information sharing pathways have been embedded and that sharing of updates continue throughout interventions to prevent working in isolation.
5	That Sefton Safer Communities Partnership provides a learning document which captures the learning on this case and highlights the tactics and traits of perpetrators of domestic abuse, in relation to coercion and control, including their engagement with professionals.
6	That all agencies consider how to ensure their staff take cognisance of the Mental Capacity Act 2005 and the proactive opportunities available to support domestic abuse victims with additional alcohol dependency, considering a best interest decision if appropriate.
7	That Merseyside Police and the National Probation Service provide Sefton Safer Communities Partnership with assurances that the newly developed Information Sharing Agreement is effectively embedded

17.2 Individual Agency Recommendations
See Appendix D

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

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

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[57]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control, or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade, or dehumanise the victim;

[57] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g., threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list.

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review.

Events Table	
Date	**Event – Pre-Terms of Reference**
2009	Denise supported by her GP for her alcohol misuse/dependency.
17.07.14	The court granted a Child Arrangement Order in favour of Residence to the children's father.
2012 - 2015	The GP record had 3 x referrals with reference Domestic abuse.
Oct 2016	Denise undertook a community detox programme.
11.08.16	Denise signposted to the Walton Centre for Neurology in relation to alcohol consumption.
2017	Children's Social Care involved with Denise around access to her children. Denise was supported around alcohol misuse by MCFT
2018	Denise referred to Independent Initiatives after stating she wanted to be alcohol free. Denise intermittently engaged with alcohol support services.
February 2018	Denise referred for in-patient detox.
March - July 2018	Denise supported by Adult Social Care substance misuse team and was placed into a patient Detox/Rehab program.
May 2018	Denise planned to start the pre-detox sessions and rehabilitation assessment
14.05.18	Denise was taken to hospital via NWAS after reporting anxiety and wanting to go into rehabilitation for alcohol dependency.
June 2018	Denise engaged with Phoenix Future's inpatient service assessment and Ambition Sefton. It was noted that Denise only had one kidney and was prescribed Fluoxetine from her GP.
July 2018	Denise was admitted into the Hope Centre and underwent 10 days in detox. Denise intermittently attended the follow up group sessions.
August 2018	Denise relapsed and continued partial engagement with Ambition Sefton.
	Events within Terms of Reference
07.09.18	Denise attended appointment with recovery worker and reported her drinking had reduced and stabilised.
10.09.18	Denise arrested.
11.10.18	MCFT had their first contact with Martin after he received an alcohol treatment requirement.
21.10.18	Denise called NWAS 111. Refused to attend hospital.
25.10.18	Denise took an overdose and rang 999. Denise refused to attend hospital.
30.10.18	Martin convicted for driving with excess alcohol.

02.11.18	Martin disclosed a high level of daily alcohol intake to Sefton Ambition.
07.11.18	Denise was sent a 14-day contact letter by MCFT,
07.11.18	Martin was seen by MCRC and an OASys risk assessment completed.
11.11.18	Police responded to domestic incident between Denise and Martin. Martin left house after advice.
15.11.18	Denise contacted NWAS 111 and taken to hospital. Crew noted bruising to Denise's lip.
20.11.18	Martin was referred to Sefton at Work by MCRC.
28.11.18	Denise was sent a 14-day letter by MCFT after failed to attend appointment.
Dec 2018 to Dec 2019	Martin issued with medical sick notes from his GP due to alcohol dependence syndrome
9.12.18	Denise reported she had been assaulted by Martin. Denise did not support a prosecution.
19.12.18	Martin mentioned to Sefton Ambition that he had a girlfriend. Details not given.
19.12.18	Police attended domestic incident between Denise and Martin. Martin taken to his home address.
January – April 2019	Martin complied with his ATR sessions. Accompanied by female in January sessions, (believed to be Denise)
20.2.19	Denise reported she had been assaulted by Martin. Martin removed from her house. Referral to SWACA.
04.04.19	Denise contacted Police twice. Reported she had been assaulted by Martin. Denise did not support a prosecution. Incident filed. SWACA attempted contact with Denise.
07.04.19	Denise saw her GP for a routine appointment. Denise had a bruised lip and when asked about it denied being assaulted
10.04.19	Martin received a warning letter from MCRC after he failed to attend ATR session and 5 days later breach action began. Breach action withdrawn after Martin's GP provided a sick note.
24.04.19	Martin attended his final ATR session.
25.04.19	Children's Social Care received information about the domestic abuse incident between Denise and Martin. No further action was taken.
28.04.19	Police attended domestic incident between Denise and Martin. Both were under the influence of alcohol.
04.06.19	Denise reported that she had been assaulted by Martin. Martin was arrested. Denise did not support a prosecution. Matter filed as NFA.
12.06.19	Martin failed to attend his MCRC appointment. First fail to comply.
06.07.19	Denise reported that she had been assaulted by Martin. Martin was arrested, charged, and kept in custody. MARAC, IDVA and ASC referrals made. Denise later withdrew her support for prosecution.
09.07.19	Denise attended at the Gastroenterology Clinic.
10.07.19	SWACA made various attempts to contact Denise. File closed on 2 September after no response.
30.07.19	Denise did not attend appointment with Alcohol specialist Nurse. Telephone consultation took place.

14.08.19	Denise called NWAS 111 service. Stated she was suffering anxiety and going through a difficult time with her partner.
20.08.19	Denise contacted Police regarding Martin breaching his bail. No evidence of offences was identified.
27.08.19	Martin arrested and charged for breach of bail.
27.08.19	Denise was unable to attend her appointment with the alcohol specialist clinic and a telephone consultation took place.
07.09.19	Denise made a 999 call to Police. Martin arrested for breach of bail.
09.09.19	Martin arrived at HMP Liverpool after receiving 14-day sentence for assaulting Denise.
10.09.19	Denise taken to hospital with a swollen abdomen due to increased alcohol intake. Denise self-discharged before being assessed. Denise requested letter from GP to support not being a witness at court
17.09.19	Martin pleaded guilty to assaulting Denise. Martin was released from HMP Liverpool as time served. MCRC increased Martin's risk of harm to medium.
19.09.19	Contacts with Denise by the IDVA team were unsuccessful.
24.09.19	Martin made a telephone call to his GP to discuss plans for baby with new partner (Believed to be Andea)
16.10.19	Police responded to incident between Denise and Martin.
01.11.19	Police and NWAS responded to domestic abuse incident between Denise and Martin.
09.11.19	Denise attended hospital with a distended abdomen, upper body pain and shortness of breath. Denise offered a review by an alcohol nurse.
12.11.19 & 19.11.19	Martin failed to attend appointments and breach action taken.
19.11.19	The Alcohol specialist Nurse Clinic reviewed Denise's situation, discussing triggers to and the consequences of continuing to drink.
28.11.19	Denise reported that she had been assaulted by Martin. Martin was arrested. Denise withdrew her statement and did not support a prosecution. Martin issued with DVPO. Referral to MARAC and IDVA. Denise did not engage with IDVA.
03.12.19	Martin seen by MCRC. Referral to DA perpetrator programme was discussed but not mandated by the court or in licence requirements.
10.12.19	Denise reported she had been assaulted by Martin. Referral made to MARAC and IDVA. Martin arrested for breach of DVPO.
12.12.19	NWAS responded to a call from Denise regarding a hand injury. Reported to have been from a fall over her dog. Denise refused to go to hospital. Further call five days later due to pain.
12.12.19	IDVA service received referral from Police. No record of contact with Denise.
15.12.19	Police responded to an abandoned 999 call from Denise. Martin was arrested for breach of his DVPO and assault on 10 December. Referral to MARAC and IDVA. Martin charged with both breaches.
16.12.19	Martin arrived at HMP Liverpool after receiving 14-day custodial sentence. MCRC alerted that Martin was in custody for breach of DVPO. Martin registered as a domestic abuse perpetrator.
17.12.19	IDVA service made unsuccessful telephone contacts with Denise.

19.12.19	MARAC meeting.
20.12.19	Martin was released from custody and inducted at gate by MCRC.
27.12.19	Martin attended MCRC office with cuts to face and said he fell off bike. A home visit was agreed but no evidence this was carried out.
30.12.19	DVPO expired.
08.01.20	One Vision Housing received reports of shouting at Denise's address. No issues raised by Denise.
15.01.20 & 24.01.20	Martin was seen by MCRC and an OASYs risk assessment was completed, and sentence plan reviewed. Martin agreed to a referral to DA HELP perpetrator programme on a voluntary basis.
03.02.20	Police received report from Denise reporting that Martin threatened to 'snap' her dog's neck, during an argument. An appointment was made for Denise, but she did not attend. Referral was made to IDVA services.
February 2020	Denise's engagement with her recovery worker and alcohol specialist nurse fluctuated.
17.02.20	Martin seen by allocated MCRC worker. Sentence plan was not being carried out.
03.03.20	Martin moved to monthly reporting with MCRC. Martin complied with his appointments. The focus was on employment and resettlement and less on domestic abuse.
05.03.20	Denise reported increased alcohol use to her recovery worker.
30.03.20	Denise reduced her alcohol intake, no withdrawal symptoms.
02.04.20 & 06.04.20	MCRC conducted Martin's interview via the telephone. Remained at medium risk. No domestic abuse focus.
07.04.20	Denise reported to her recovery worker that she was managing well in Covid-19 circumstances. However, Denise said she sometimes felt low because she could not see family.
16.04.20 - 28.07.20	MCRC maintained weekly telephone interviews with Martin.
18.06.20	Denise went to the hospital due to vomiting profusely. Symptoms attributed to alcohol withdrawal.
25.06.20	Denise had a telephone appointment with her recovery worker.
30.06.20	Denise had a telephone appointment with her recovery worker and could not recall the previous weeks call.
02.07.20	Denise taken to hospital via NWAS after reporting that she had woken up on the floor and could not move her legs. It was suspected she had sustained a fall whilst intoxicated.
06.07.20	Denise had a telephone appointment with her recovery worker.
07.07.20	Denise taken to hospital with rib injury and breathing difficulties. Reported she had been assaulted by neighbour 4 days earlier. Police attended incident.
07.07.20	Adult social care received a Section 2 notification in relation to Denise. Denise was discharged before being seen by social worker.
16.07.20	Denise had a telephone appointment with her recovery worker.
19.07.20	Denise admitted to hospital with chest pain and breathing difficulties. Self-discharged against medical advice on 20 July
21.07.20	Police attended domestic incident between Denise and Martin during which Denise was assaulted. MARAC and IDVA referral made.

24.07.20	Denise contacted Police regarding malicious communications from Martin. Denise stated she wanted to complain of the assault on 21 July.
05.08.20	Denise taken to hospital with difficulty in breathing.
06.08.20	MARAC meeting.

Appendix D

Recommendation Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That Sefton Safer Communities Partnership review the MARAC protocol in terms of agency attendance, involvement, flags and pathways to other multi-agency meetings such as the MARAM.	local	MARAC Steering group to review MARAC operating protocol MARAC Steering Group regularly review performance information	MARAC steering group	Review of protocol is completed and approved by Steering Group Performance information is shared and discussed on a quarterly basis	April 2022 Ongoing basis	Complete July 2022 Update sent out to MARAC partners July 2022 Complete - ongoing activity MARAC performance information, including agency attendance and involvement is discussed at every MARAC Steering Group meeting; any issues are escalated via

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Review of pathways and links between MARAC and MARAM for DA cases with other complex needs, outcomes to be used to refresh procedures to be shared across agencies		Review of multi-agency pathways completed	April 2022	group chair and /or MARAC Chair to the relevant agency Complete January 2024. Complex Lives is a standing item of the MARAC Steering Group as part of the review of performance information. This work continues to be fed back in the Merseyside wide DHR learning group looking at key themes, one of which is complex needs and context with MARAC. Since the completion of this report, Mersey

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							Care have established a Complex Lives Multi-Disciplinary Team (MDT) covering south Sefton, with a North MDT in development to start Feb/March 2024. In addition to this, a new multi-agency DA Perpetrator Group is being established starting Feb 2024 focusing on high repeat/high harm cases, using Police and MARAC data. This will be governed by MARAC and overseen by the

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							MARAC Steering Group. These new forums provide additional multi agency pathways for complex cases, therefore original action no longer needed.
2	That all agencies review their internal processes for documenting and flagging victims/perpetrators who have been referred and discussed at MARAC, including how these flags are reviewed and removed, taking cognisance of the Human Rights.	Local	Updated MARAC protocol – which includes updates on flagging files – is shared with all MARAC members agencies Outcomes of Nov 2020 Questionnaire on flagging and tagging sent to MARAC agencies to be reviewed and followed up	MARAC Steering Group	Updated protocol completed and circulated Review of information collected from agencies completed.	April 2022 April 2024	Completed July 2022 At Jan 2024. Long term issues with capacity within this team has meant this work has been delayed It is part of the MARAC

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Outcomes shared with MARAC Steering Group		Steering Group's work programme
3	That Sefton Safer Communities Partnership and the Domestic Abuse Partnership Board review the support 'offer' to complex cases victims of domestic abuse and maximise the opportunities with the 'complex IDVA' /key support worker roles.	Local	Share outcomes and learning from the Complex Needs audit with the DA Board and other relevant multi-agency partnerships and the DA Needs Assessment	Sefton DA Partnership Board	Complex Needs audit outcomes shared with MARAC Steering Group DA Partnership Board Learning from the Complex Needs IDVA is shared with Merseyside Strategic Domestic Violence and Abuse group to feed into regional DA work Complex needs learning is included in the Domestic Abuse Needs	January 2022	Complete Audit of MARAC complex cases 20-21 completed Oct 21, outcomes shared with MARAC steering group Nov 2021, further audit completed Feb 23, shared with MARAC steering group. Now a standing item within performance reporting. New funding secured for Sefton IDVA team for a

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Assessment to inform the DA Strategy refresh		new Complex Needs IDVA role, post in place January 2022 This role will continue to support the learning and development of DA complex needs work. Progress report presented at DA Board May 2022 Provision and gaps around complex needs captured with the DA Needs Assessment completed Aug 2022. Complex needs are a priority area in Sefton's DA Strategy 2023-28

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
4	That all agencies provide Sefton Safer Communities Partnership with assurance and evidence that information sharing pathways have been embedded and that sharing of updates continue throughout interventions to prevent working in isolation.	Local	DA Board to request key agencies in Sefton provide information on their information sharing protocols and pathways regarding domestic abuse and safeguarding and how these are built into practice and information is made available to staff Review of the information collected	Revised to be DA Partnership Board	Agencies submit information requested	April 2024	This has been incorporated within the wider DA Partnership Board work and is being progressed as part of the DA Strategy action plan sub group activities.
5	That Sefton Safer Communities Partnership provides a learning document	Local	Overarching learning and recommendations shared with Sefton Safer	Council DA lead/ DA Partnership Board	Presentation at Community Safety Partnership	August 2021	Completed August 2021

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	which captures the learning on this case and highlights the tactics and traits of perpetrators of domestic abuse, in relation to coercion and control, including their engagement with professionals.		Communities Partnership DHR case study and 7-minute briefing produced		Information resources produced/updated and shared across multi-agency partnerships	April 2024	At January 2024. This has been incorporated within the wider DA Partnership Board work and a review of all Sefton DHR learning to ensure repeat learning & key themes are being identified and addressed and appropriate resources are available across the partnership
6	That all agencies consider how to ensure their staff take cognisance of	Local	Sub group established by the DA Board in conjunction with the Adults	Domestic Abuse Partnership Board	Sub group established and meeting	April 2022	At April 2023. This has been incorporated within the wider DA Partnership Board

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	the Mental Capacity Act 2005 and the proactive opportunities available to support domestic abuse victims with additional alcohol dependency, considering a best interest decision if appropriate.		Safeguarding Board to consider how to take this forward		Terms of reference agreed for what will be reviewed a		work and will be progressed as part of the refreshed DA Strategy 2023-28 and action plan. Revised timescale of July 2023
7	That Merseyside Police & the Probation Service provide Sefton Safer Communities Partnership with assurances that the newly developed Information Sharing	Local	Evidence of implementation provided by Probation and Merseyside Police Update report provided to the DA Partnership Board on the implementation	Probation/ Merseyside Police	Progress updates provided Report(s) presented to DA Partnership Board	January 2022	Updates in Probation/police action plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	Agreement is effectively embedded		of the ISA and progress to date				

Adult Social Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Joint process to be agreed between Adult Social Care and Aintree Hospital regarding Safeguarding Alerts	Standard Operating Procedure to be developed. Review in 6 months	Julie Luscombe ASC in conjunction with LUFHT	Feedback from Manager Sefton Safeguarding Team, Manager Aintree Safeguarding Team, Team Manager Hospital Social work team Copy of the Process	December 2021 Processes around safeguarding alerts are consistently applied in relation to concerns about domestic abuse. Improved multi-agency approach Improved outcomes for victims of domestic abuse by ensuring their safeguarding is considered and acted	Complete Update January 2024 A Standard Operating Procedure has been in place since September 2021. It is regularly reviewed to ensure that it remains fit for purpose. Closer working relationships between ASC Safeguarding and Hospital teams and LUFT safeguarding staff is well

Adult Social Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
					upon in a consistent way	established to ensure coordinated support to individuals at risk of abuse.

General Practice						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Increased awareness of domestic abuse in primary care	Development and updates of policies on domestic abuse affecting primary care staff. Delivery of training to GPs and staff in collaboration with SWACA	Named GP for Safeguarding adults	Policies written and updated by the index surgeries Training materials created: PowerPoint presentation, minutes of planning meetings	31 August 2021 Embedding of domestic abuse recognized as a reason for staff absence. Appropriate safeguarding and signposting Increased referrals from primary care	Action completed September 2021 Victim's practice is reviewing and updating the existing policy. Perpetrator's practice is liaising with their parent company to ensure a policy is developed. Planning meetings have taken place with SWACA and a learning event in September 2021

General Practice						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
2	Increased recording of domestic abuse in primary care	Review of maternal post-natal check template on GP computer system	Named GP for safeguarding adults	Audit of template usage within index surgeries	31 October 2021	Audit completed October 2021 A national clinical coding group has been established by the Named GP Safeguarding in Sefton. There will be a national recommendation for one single code for Domestic Abuse in primary care records. This work is ongoing and will have national significance.

IDVA						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Review IDVA team policies and procedures to ensure that they are up to date and reflect current working practices	Review current IDVA policies and procedures	IDVA Manager	Revised policy and procedure	31 August 2021 Clear understanding for IDVA staff and linked partner agencies of procedures for managing IDVA referrals, less	Completed 31 August 2021 Specific IDVA admin support and management in place

IDVA						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
					opportunity to miss things out	
2	Audit of IDVA complex cases to better understand the challenges with engaging and supporting these individuals and feed the outcomes into wider strategic discussions on complex domestic abuse cases	Dip sample of cases with the additional needs of substance misuse and/or significant mental health issues	IDVA Manager	Completed audit	30 September 2021 Better understanding of the challenges facing victims of domestic abuse with complex needs in engaging with support services to help influence future commissioning of needs led services	Completed October 2021 Additional funding secured for a new Complex Needs IDVA role, in post January 2022

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	To embed routine enquiry to ensure every 1st contact counts.	To review and update safeguarding adult level 2 and level 3 training to ensure routine enquiry for domestic abuse is incorporated	Ann Marie Cresham, Safeguarding Matron	New training packages which will include relevant information to support staff to undertake routine enquiry	End of September 2021 Increased awareness that every 1st contact will count and routine enquiry will occur.	Complete September 2021 Training package was reviewed to include specific DV training, 7 min briefing – Routine Enquiry produced and shared

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		Development of 7 min briefing to provide relevant and supportive information to all staff who are currently complaint with training to ensure they receive information		Minutes of Safeguarding and Vulnerable People Group to show 7 min briefing has been disseminated through divisions. Minutes from ward / department safety & governance meetings to show discussion relating to 7 min briefing.		
2	To improve knowledge of professional curiosity across all staff groups.	To review and update safeguarding level 2 and 3 training to ensure professional curiosity is explained in sufficient detail	Ann Marie Cresham, Safeguarding Matron	New training package which will include relevant information to support staff to understand the importance of professional curiosity	End of September 2021 Increased awareness of professional curiosity in relation to individuals who may be at risk of domestic abuse and other safeguarding risks	Completed September 2021 7 minute briefing – Professional Curiosity produced and shared

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		with examples to improve staff confidence with application in practice Development of 7 min briefing to provide relevant and supportive information to all staff who are currently complaint with training to ensure they receive information		Minutes of Safeguarding and Vulnerable People Group to show 7 min briefing has been disseminated through divisions. Minutes from ward / department safety & governance meetings to show discussion relating to 7 min briefing		
3	To review LUFHTs participation and process associated with all Local MARAC meetings (Sefton / Liverpool / Knowsley)	To review current working practice in relation to attendance at local MARAC meetings.	Deborah Ward, Associate Director Nursing – Safeguarding	Identification of Trust wide process to ensure appropriate attendance at MARAC meetings.	End of September 2021 Robust Trust process is implemented relating to regular attendance at MARAC	Completed December 2023 MARAC meetings are attended when LUFHT have been the referrer. An alert is routinely placed on the

Liverpool University NHS Foundation Trust (Aintree Hospital)						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		To review internal process for reviewing feedback from MARAC and how this is acted upon within Trust.		Identification of Trust wide process to ensure MARAC feedback is actioned and when appropriate added to patient hospital record. To ensure patient flag/alert relating to MARAC attendance is evidenced on patient hospital record	Actions are identified and acted on appropriately	patients record when identified through the MARAC research, which is ongoing.

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Reiterate through the wider-partnership the responsibilities of the core agencies to commit to attending	Email sent out to MARAC partners from MARAC Coordinator.	MARAC Coordinator and MARAC Steering Group Chair	Emails sent to partner agencies	April 2021 Agency commitment to attending MARAC	Completed 30 April 2021 Agency attendance at meetings good

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	all MARAC meetings and actively participate within case discussions as well as offering actions were appropriate	Periodic reminders given by Chair at MARAC meeting about the importance of consistent agency attendance and involvement MARAC operating protocol is re circulated to agencies as part of yearly review – includes a section on agency attendance and engagement		Record of agency attendance at meetings Information shared with MARAC partners about the DHR findings	meetings is clearly understood Consistent attendance by agencies at MARAC meetings Increase in range of actions offered by agencies	overall. Importance of agency attendance & participation is regularly highlighted at MARAC meetings by the MARAC Chair, it is also reviewed by MARAC Steering Group on an ongoing basis as part of data discussions. Any issues with attendance are escalated to the relevant agency. Actions offered by agencies is being looked at within the MARAC performance management framework.
2	Review with partner agencies how decreases in resources have impacted on their	Questionnaire devised to be sent out to all MARAC partner agencies	MARAC Coordinator	Questionnaire and email sent to partners Questionnaire outcomes	September 2021 Clear understanding of the range of resources	Revised timescale of April 2024 Ongoing –Review of current agency resources is part of

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	services and establish what actions they are now able to offer through MARAC	1:1 discussion with organisations after questionnaire completed		1:1 discussion outcome	available to MARAC across the partnership Identification in barriers/gaps to feed into wider review of MARAC complex cases	MARAC steering group work programme
3	To review how complex cases are dealt with through MARAC, ensuring the local Sefton context is linked into wider Merseyside wide discussions about the same issues and also into Sefton's strategic work on domestic abuse.	MARAC complex case audit conducted with partners, overseen by MARAC Steering group Review how complex cases identified within MARAC are dealt through the MARAC process, with consideration given to agency resources, service provision available,	Locality Team Manager/Service Manager	Completion of MARAC complex cases audit Outcome of review with MARAC partner agencies to understand impact of reduced resources and actions currently available to MARAC Minutes from Merseyside meetings	31 March 2022 Better understanding of the challenges facing victims and perpetrators of domestic abuse with complex needs in engaging with support services There is a focused and needs led multi-agency response to high-risk complex domestic abuse cases. Support services better able to respond to victims and perpetrators of domestic abuse	Initial audit of complex cases heard at MARAC in 2020-21 completed October 2021, outcomes fed into MARAC Steering group and DA Partnership & Merseyside's DA strategic group. Further audit completed Feb 23 and discussed at MARAC Steering Group Feb 23. Ongoing work also linked to Sefton's DA Board and Merseyside DHR learning group

MARAC						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
		commissioned contracts and cross over with other areas of managing complex needs Involvement in Merseyside MARAC discussions about complex cases		Overall review report completed to outline findings and recommendations for managing complex domestic abuse cases.		which feeds into Merseyside Strategic Domestic Violence & Abuse Group. Complex Needs IDVA continuing to collect frontline evidence on themes and key challenges around victims with complex needs. New Multi-Agency DA Perp Group being established Feb 24 to look at highest risk/harm perpetrators, closely linked to complex lives work Review with MARAC partners agencies re: resources still to take place.

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Re-enforced learning around Professional curiosity and domestic abuse.	Refresher training session for Ambition Sefton on Professional Curiosity	Crispin Evans, Interim Safeguarding Lead for Local Division	Copy of slides used	01 July 21 Increased awareness of domestic abuse and confidence of staff	Ambition Sefton services transferred to Change Grow Live in April 2022 as the provider for substance misuse support in Sefton. Mersey Care run modular training which supports the bigger, mandatory, Safeguarding packages which are required to be Intercollegiate framework compliant. The modular sessions include Professional Curiosity and Domestic Abuse. These are run by the safeguarding team and are open Trust wide to enable a greater mix of professionals/disciplines to learn collectively

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						The Trust launched a single point of access within the organisation for safeguarding advice in Oct 22 which is called the Safeguarding Duty Hub. Data from the hub can now evidence the ongoing professional curiosity from staff. Data sets can be broken down into divisions and teams for onward reporting and oversight. A presentation of this data has bee shared with the Safeguarding Adult Board in Sefton. The duty data highlighted that domestic abuse across Children's and Adults services is the primary concern

Mersey Care						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						shared by staff with the safeguarding leads. As a result of this we have established "safeguarding links" in each operational team and have run a targeted conference for the links on Dom Abuse. Future plans include a relaunch of Routine Enquiry in the "How Safe Do You Feel" campaign.

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	Allocation of cases should include an element of management oversight to assure correct decision making and re	New policy on allocation recently implemented. Review required as part of HMIP action plan	Senior leads MCRC	Review of HMIP action plan.	July 2021 Cases are allocated to suitably trained and experienced staff	Completed July 2021

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
	allocation if necessary					
2	Risk of harm training is quality assured to confirm professional competence	Quality development officers to have completed this project	Senior leads MCRC	Learning and development data	July 2021 Staff are assessed as competent in managing DA cases assessed as medium risk of harm	Completed July 2021
3	Training in professional curiosity is delivered as part of L&D schedule and ongoing as part of reflective practice discussion	Review of L&D schedule to confirm inclusion of professional curiosity as a key skill.	Senior Leads MCRC	Risk of harm training materials DA training materials Learning & Development schedule	July 2021 Staff have been given opportunities to consider the art of professional curiosity and supported into practice	Completed July 2021 Confirmed section on professional curiosity included in L&D training materials
4	Intelligence sharing between police and probation is improved	Review between Police and Probation	Senior Police and Probation leads Liverpool/Sefton	Progress report to Board	December 2021 Intelligence is shared to improve decision making around DA risk of harm and protection of the public	Complete December 2023 Regional agreement that current ISA, approved nationally by the Chief Probation Officer and National Police Chiefs Council, is used. Document provided as evidence.

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						Whilst there have been system and resource developments and improvements over the last 12 months. There is no further progress on moving to a reportable incident process..
5	Offence focused work on licence is improved.	Referral to lead senior resettlement manager for inclusion in resettlement practice development group for action.	Senior lead Sefton	Progress report to Board	Resettlement officers retain a focus on criminogenic need associated with offence.	Completed July 2021
6	Child/adult safeguarding checks are a feature of case management at times of significant change	Via HMIP action plan	Senior leads MCRC	Outcome of HMIP action plan and future HMIP inspection	Safeguarding practice improved	Completed August 2021 Safeguarding checks are mandated for all new cases, whether the offence is related

Merseyside Community Rehabilitation Company NB: Action Plan updates provided by Probation Service following national restructure of CRC and Probation services in 2021						
No	**Recommendation**	**Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						to safeguarding or DA issues, with the clear instruction that any new information, change in behaviours, or other information warrants a review of the case; this is also set out in the Policy Framework. This has been supported by a briefing from the Partnership Manager to all court and sentence management staff. Continued membership of MARAC and MACE. Awaiting next HMIP inspection

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
1	That the force considers raising awareness among officers and staff of the significance of strangulation as a form of domestic abuse and the current legislation i.e. S21 Offences Against the Person Act 1861, with the aim of ensuring there are no missed opportunities to detect this offence.	Delivery of training on this form of Domestic Abuse and the current legislation relating to strangulation. Review of working practices to ensure evidence gathering records the sequence of events correctly, and that photographic and medical evidence of strangulation are obtained whenever possible.	Detective Chief Inspector Protecting Vulnerable People	There is a specific question re strangulation on VPRF1 Awareness raising and communications relating to the new offence of non-fatal strangulation completed	May 2021 Awareness of the new offence of non-fatal strangulation (Domestic Abuse Bill 2021)	Completed January 2023 On 29th April 2021 the Domestic Abuse Bill received Royal Assent and became law. The Domestic Abuse Act will provide further protections to the millions of people who experience domestic abuse and strengthen measures to bring perpetrators to justice, as well as transform the support we give to victims ensuring they have the protection they deserve. The Act introduces a new offence non-fatal strangulation. Learning re the offence of strangulation: Section 21 Offences against the Person Act 1861: •A person commits the offence if, by any means,

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						they attempt to choke, suffocate, or strangle another with intent to commit an indictable offence. was incorporated into the DA Intensification CPD event. Officers were also made aware of the impending new legislation regarding the new non-fatal strangulation offence scheduled for spring 2022. On the 7th June 2022 section 70 of the Domestic Abuse Act 2021 commenced. The Serious Crime Act 2015 has been amended to introduce two new sections — section 75A and 75B— which create a new specific criminal offence of non-fatal strangulation and suffocation. The new

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						offence applies in England and Wales, where a person intentionally strangles or suffocates another person, including cases where this offence occurs in a domestic abuse context. It covers a range of behaviours, including strangulation, suffocation and other methods used by a person that affect a victim's ability to breathe (such as constriction of airways). The offence also applies where strangulation or suffocation has been committed abroad by a UK national (or a person who is habitually resident in England and Wales) as if the offence had occurred in England and Wales.

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						Communications have been cascaded force wide re this new offence and training provided at recent CPD events. Processes have also been implemented that ensure that NFS criminal investigations are always referred in to and investigated by a Detective within a PVPU department. With regards to identifying risk - With such cases, the MeRIT reflects the severity of the incident reported and this is an academically robust process of identifying risk used for many years across agencies within Merseyside. There is a specific question that asks "Did the perpetrator strangle/attempt to

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						strangle or place hands around the victim's throat" which will be ticked where cases involve strangulation. This tick will be considered when calculating the final risk assessment grade. There is no specific question around suffocation however, there is always the ability to upgrade cases on professional judgement either by police officers or by the risk assessors within the MASH. Training has been disseminated across strand so all officers have received it. The new offence Section 75a is embedded as part of the training criteria so not only do existing

Merseyside Police						
No	**Recommendation**	**Key Actions**	**Lead Officer**	**Key Milestones**	**Target Date & Expected Outcome**	**Completion Date and Outcome**
						officers receive this it is also given to new recruits as part of their initial training.
2	Improvement of intelligence sharing with Police and NPS in relation to domestic abuse incidents with individuals subject of ongoing probation supervision.	Review underway and an automated system is being developed to share information. An Information Sharing Agreement will be produced	Detective Chief Inspector Protecting Vulnerable People	Progress review ISA produced	December 2021 Automated ISA approved implemented Intelligence is shared with NPS to improve decision making around DA risk of harm and protection of the public	Complete December 2023 Merseyside Police are still in consultation with probation who are developing the ISA but have yet to finalise the reportable incidents implementation. We have been assured as soon as this is complete the ISA will be in a position to be reviewed, agreed and signed off. In the mean time they are using the national ISA as per other force and probation areas.

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

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Janette Maxwell
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Community Safety and Engagement
Sefton Council
Bootle Town Hall
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L20 7AE

23 November 2023

Dear Janette,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Denise') for Sefton Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 11th October 2023. I apologise for the delay in responding to you.

The QA Panel noted there was good family engagement with Denise's mother and cousin through the DHR process, including the family's attendance to a panel meeting. The pen portrait of the victim was positive in establishing a thorough understanding of Denise.

The QA Panel also commended the use of specialist domestic abuse representation on the panel. There is a good critique of the ways in which the agencies involved failed to see the big picture, or to understand what Denise was experiencing. The Panel commented this comes through clearly in the report. There is positive reference to the need for more multi-agency working. The report also benefits from a helpful use of research. The report is diligent, forensic, and unafraid to reveal the key issues whilst not being defensive.

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:

- The front of the report states that the death was in the Autumn of 2020. The DHR Statutory Guidance states that the month of death be the level of detail the report should disclose, but the body of the Overview Report further details (paragraph 1.10). This should be changed to 'Denise died in September 2020'.

- Martin was noted to have historic offences for violence, but there was no mention of the Domestic Violence Disclosure Scheme (Clare's Law).

- The report mentions that after engaging with the review, Denise's family now recognises Martin's controlling and coercive behaviour. Adding some context around what helped the family understand better would benefit the report and could inform a recommendation about improving awareness.

- The outcome of the inquest should be included in the published report.

- The Equality and Diversity section is underdeveloped. Protected characteristics were not identified, age and sex were not considered, and there was no analysis regarding links around domestic abuse, mental health, and substance misuse.

- The acronyms for MCRC and CJMH are not expanded upon.

- The report is let down by a significant number of typographical and punctuation errors and needs a thorough proofread.

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