St Helens Community Safety Partnership

Domestic Homicide Review

Executive Summary

Report into the death of Emma (pseudonym)

March 2019

Author and Domestic Homicide Review Chair - Stephen McGilvray 2020

Contents

Glossary

CCG Clinical Commissioning Group.

CGL Change Grow Live (provider of substance misuse services).

CPA Care Program Approach. Support for patients who have a long enduring mental health condition or those who have a range of complex needs which require the support from secondary mental health services to support and co-ordinate their care.

DHR Domestic Homicide Review.

IDVA Independent Domestic Violence Advocate. Is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies.

IMR Independent Management Review

MARAC Multi Agency Risk Assessment Conference. This a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

MASH Multi Agency Safeguarding Hub. Co-located agencies formed to provide the highest level of knowledge and analysis of all known intelligence and information across the safeguarding partnership to ensure all safeguarding activity and intervention is timely, proportionate, and necessary.

MeRIT Merseyside Police domestic violence risk assessment tool

Non-CPA Utilised when a patient does not require a full CPA approach however continues to require support and monitoring from services for their treatment and recovery.

Risk Assessment Grades.

- Gold Victim is at a high risk of serious physical assault or homicide.
- Silver Victim is at medium risk of serious violence.
- Bronze Victim is at standard risk of future violence.

S.I.Review Serious Incident Reviews. Completed by National Health Service. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse. Investigations carried out under this Framework are conducted for the purposes of learning how to prevent a recurrence.

VPRF1 Vulnerable Person Referral Form.

1. The Review Process.

1.1 This summary outlines the process undertaken by St Helens Community Safety Partnership Domestic Homicide Review Panel in reviewing the murder of Emma who was a resident in their area.

1.2 Following discussion with Emma's family the pseudonyms below were agreed by the Panel and are used throughout this report to protect the identity of the individual(s) involved and their family members.

Emma	Deceased	Aged 46 years
Dean	Perpetrator.	Aged 47 years

1.3 Emma and Dean were partners. Both are white British adults with English as their first language.

1.4 Criminal proceedings were completed when Dean pleaded guilty to the murder of Emma at Liverpool Crown Court in June 2019 and was sentenced to life imprisonment with a minimum term of 18 years

1.5 The process began with an initial meeting of the Community Safety Partnership in March 2019 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Emma and Dean prior to the point of the murder were contacted and asked to confirm whether they had involvement with them.

1.6 Twelve agencies were contacted and confirmed that they had contact with the victim and/or perpetrator and were asked to secure their files.

2. Contributors to the Review

2.1 The following agencies contributed to this Review through their presence at Panel meetings and by the completion of Independent Management Reviews (IMR).

- Merseyside Police
- North West Boroughs Healthcare (Mental Health Services)
- St Helens Clinical Commissioning Group
- Torus Housing
- Adult Safeguarding St Helens MBC.

2.2 All authors of the IMR's were independent and had played no part in the provision of services to either Emma or Dean or in the supervision of those providing services to them.

2.3 Making Space, the 3rd Sector providers of support to Emma, were present at the first meeting of the Panel and provided information regarding their processes and contact with Emma. Adult Safeguarding provided independent chronological information and IMR information on behalf of the 3rd Sector provider.

2.4 Following the initial meeting the Panel Members reviewed membership of the Panel but felt that there were no agencies absent from the group who could make a contribution to the work of the Panel.

3. The Review Panel Members

3.1 A DHR Panel was established by St Helens Community Safety Partnership and comprised of the following agency representatives:

- Stephen McGilvray. Independent Chair of DHR Panel and Author of the Overview Report.
- Beverley Hyland. Detective Chief Inspector, Merseyside Police.
- Neil Fairhurst. Manager Torus Group (Communities Housing).
- Jacquie Byrne. Manager Torus Group (St Helens IDVA Independent Domestic Violence Advocate Service provider).
- Jackie Hodgkinson. Northwest Boroughs Healthcare Mental Health Safeguarding Officer.
- Nina Ellament. Principal Solicitor Peoples Services St Helens MBC.

- Helen Newton. Safeguarding Officer, St Helens Clinical Commissioning Group.
- Dr. Michelle Loughlin. St Helens MBC, Assistant Director Public Health.
- Rachel Fance. Manager, Change Grow Live (Substance Misuse Service provider).
- Beverley Jonkers. St Helens MBC Community Safety Partnership.
- Simon Cousins. St Helens MBC Equalities Officer.

3.2 The DHR Panel met a total of five times and all Panel Members were independent and had played no part in the provision of services to either Emma or Dean or in the supervision of those providing services to them.

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

4.1 St Helens Community Safety Partnership commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in December 2019. Stephen McGilvray is also the author of this Overview Report.

4.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years but he has never been employed by St Helens MBC. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children. During the period this unit was under Stephen's management the team achieved CAADA Leading Lights accreditation for the quality of its systems and risk management processes.

4.3 Stephen has successfully completed the Home Office training course for Chairs of DHRs. He was responsible for the development of a reciprocal agreement with a neighbouring Authority in relation to the Chair and writing of reports following the work of DHR Panels and has Chaired and completed Overview Reports for

several Domestic Homicide Reviews as well as taking part in a number of Serious Case Reviews.

4.4 Prior to being commissioned to complete this Review Stephen had completed 30 years Police service with Merseyside Police. It was 16 years ago that Stephen retired from Merseyside Police and it is 41 years since he worked as a Police officer in St Helens.

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

5. Terms of Reference for the Review

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

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

5.2 The DHR Panel agreed the focus of this Review should be upon the following Key Lines of Enquiry.

A. The extent of Control Dean imposed upon Emma within their relationship.

B. How effective in terms of communication and identifying risk in domestic abuse cases were the pathways between agencies.
C. The role of mental health services in responding to domestic abuse within Emma and Dean's relationship.

6. Summary Chronology

6.1 Emma and Dean were in a relationship between 2018 and her murder in 2019. After spending the evening at Dean's home Emma was murdered in the bedroom of the house. She died of multiple stab wounds inflicted by Dean who had been consuming alcohol prior to Emma's murder and Dean was currently on Police bail following a recent assault and unlawful imprisonment of Emma.

6.2 Emma was a 46-year-old female with a diagnosis of Emotionally Unstable Personality Disorder who at the time of her murder was subject to a Care Program Approach (CPA) which describes the approach used in secondary care mental health services to assess, plan, deliver, review, and coordinate the range of treatments, care and support needs for people who have complex mental health issues.

6.3 Between 2010 -2014 Emma was detained for treatment under Section 3 of the Mental Health Act 1983 being released from hospital in 2014. The treatment she received whilst in hospital included counselling for alcohol abuse.

6.4 Once released from hospital in 2014 Emma remained subject to a Section 117 Mental Health Act 1973, After Care Order. The After-Care Order remained in place at the time of her murder.

6.5 In Emma's case the aftercare she received was in the form of, supported living accommodation and six hours support per week from a support worker. Emma received aftercare support from the same 3rd Sector support agency from the time of her discharge from hospital in 2014 until her murder in 2019. Emma had an

Aftercare Plan review meeting held in December 2018 which recorded that she remained under the Section 117 Care Order.

6.6 Emma's family noted a change in her behaviour whilst she was in a relationship with Dean. "*She changed from being family orientated, never forgetting birthdays and anniversaries, and being in regular contact with her sons and sisters to having little contact with her family*".

6.7 There is no recorded history of domestic violence incidents with other partners for either Emma or Dean.

6.8 Dean was diagnosed with Bipolar Affective Disorder over 20 years ago and following this diagnosis had three short stays in hospital in the two years immediately following this diagnosis. He has not been admitted to hospital since that time and his condition has been managed in the community with support from his G.P.

6.9 Dean has a history of alcohol dependency and had received hospital treatment for detoxification from alcohol. Following treatment Dean relapsed and was consuming significant amounts of alcohol during the time of his relationship with Emma and at the time of her murder.

6.10 Before the first meeting of the DHR Panel a meeting was held between Stephen McGilvray and the family of Emma. A copy of the Home Office DHR leaflet for Family and Friends was given to each of the family members at this first meeting. It was established that the family were supported by Victim Support Homicide Service however, the family did not wish them to attend the meeting. The family did provide a file in which they had detailed key events in Emma's life and a series of questions they had of agencies surrounding the care and support Emma had received prior to her murder. The questions focussed upon the duty of care and a lack of action afforded to Emma when incidents had been disclosed by Emma to care agencies, and when matters were raised with those services by the family themselves.

6.11 NWBH undertook two S.I. Reviews, one for Emma and one for Dean, parallel to this DHR and there were several areas in which the key lines of enquiry for both reviews crossed over. Dean refused to allow the S.I. Review completed in respect of him to be shared with the Panel and those wishes have been respected. Emma's S.I. Review was shared and elements of it have been incorporated within this Review.

6.12 Emma was subject to a Section 117 Mental Health Act Aftercare Order from being discharged from hospital in 2014 until the time of her murder. Part of the aftercare package provided under this Order was that Emma would receive six hours per week carer support.

6.13 As part of the After Care Order requirements in July 2018 Emma was involved in the development of a relapse prevention plan, the latest version being added to her care records on 10 July 2018. Within this plan, the early warning signs of Emma's relapse were identified as drinking alcohol, poor engagement with services, and neglecting herself or her surroundings. Actions identified within the plan to help Emma prevent a relapse included speaking with and accepting additional support from staff involved in her care from both mental health and the 3rd Sector care agency services and seeking support from family members.

6.14 In November 2018 Emma had disclosed to her carer that she was being controlled by her partner Dean. He refused to allow her to speak to other men and made her remove all males out of her Facebook contacts as he believed she would sleep with them. Dean demanded sex all the time and refused to let her sleep in pyjamas he said "*its naked or not at all*." He was verbally abusive towards Emma and she was scared.

6.15 Carer records show that this disclosure by Emma was shared with the nominated Mental Health Practitioner who advised the carer to report this information to the Safeguarding Team in Adult Services. Emma's carer states that as advised she made contact with Adult Services Safeguarding Team but was told by them that no further action would be taken by Safeguarding because, based upon the information given Emma did not meet the safeguarding threshold. The carer states

that the Safeguarding officer she spoke to advised her "*to keep an eye on the situation and go back to them if felt the situation had worsened*."

6.16 This information regarding the control which Dean was imposing over Emma was not shared by either the 3rd Sector carer, Mental Health Services or Adult Services with any other agency and there is no information available to show that any further action was taken by any service in relation to this disclosure. There was no domestic abuse risk assessment completed or referral into MASH (Multi Agency Safeguarding Hub)

6.17 At the same time as Emma disclosed that elements of her life were being controlled by Dean, Emma had begun missing pre-arranged Doctors' appointments. This was not a trait Emma had previously displayed and it is not clear the reason why she stopped attending.

6.18 In December 2018 following a referral made by his G.P. to Mental Health Services Dean was contacted by the Mental Health Team as part of a telephone triage assessment of his mental health. During this assessment Dean disclosed he was suffering from bouts of raging anger. He was becoming irritable with his partner and mother and had a belief that his partner was the Devil and he had thoughts at times that he was Jesus. An urgent medical appointment was arranged for Dean by the Mental Health Service following this triage assessment.

6.19 One month after the Mental Health Services triage assessment of Dean in December 2018 Dean, at the time accompanied by Emma, was seen by a Hospital Psychiatrist. During this hospital appointment Emma disclosed that she was concerned Dean had been getting more irritable with family members of late. The Psychiatrist concluded that Dean was presenting with mental and behavioural disturbances due to chronic alcohol misuse, but Dean assured the Doctor that he did not require any support to give up consuming alcohol which the Doctor accepted.

6.20 On 12th February 2019 one of Emma's sisters rang a Mental Health Practitioner and former Care Coordinator for Emma expressing her concerns that

Emma's was "*currently consuming alcohol excessively*". The Mental Health Practitioner who had worked with Emma for a number of years agreed to respond to these concerns and the missed Doctors' appointments Emma had been making in recent months. The practitioner tried to contact Emma by telephone but was unsuccessful and this was followed by writing to Emma a letter which included details of a new Doctors appointment. The letter did not generate a response from Emma who missed the new appointment. No further attempts were made to contact Emma or changes made to the support she was receiving, and no further action was taken regarding Emma's sisters concerns.

6.21 Two days after the missed rescheduled Doctors appointment Merseyside Police responded to an emergency call which they traced to Dean's home address. During the call a female was heard crying and the voice of a male was heard saying *"Shut your f…..g mouth then"* followed *by "Shut your f…..g mouth now you don't need to speak do you".* The Police call handler endorsed the log to the effect that the male was not shouting but his tone was aggressive. The male was then heard to say *"Shut up, you think I'm playing around, you're playing around with my life here, next time I will f..k you up".* The female, was heard in the background saying *"Dean I want to go home, let me go home, get off me, get off me."* The male's response was *"Are you going to shut up then"* to which she replied *"Please, oh please don't".*

6.22 Officers attending the incident arrested Dean for the assault of Emma, her unlawful imprisonment and making threats to kill her. A Vulnerable Persons form, VPRF 1, was completed by the Police Officers and the risk Emma faced was assessed as high or 'gold' and referrals were made to Adult Services.

6.23 Speaking to Police Officers immediately after Dean had been arrested Emma disclosed that Dean had behaved in a controlling manner towards her since their relationship began, "*he controlled her phone contact with others and dictated when she could or could not leave the house*". After the Police Officers had left, Emma disclosed to her carer additional information about the threats Dean had made towards her. The content of this conversation was sexually graphic and offensive. The carer believes that Emma had not disclosed this information when interviewed

by Police Officers because she would not discuss matters in the presence of people she did not know or trust.

6.24 Following the Police investigating officer's consultation with the Crown Prosecution Service and with Emma's carer, during which she expressed concern that the couple would resume their relationship, Dean was granted bail with conditions not to approach Emma by self, servant, or agent.

6.25 A referral was made following this incident to Adults Safeguarding who held a strategy discussion which took place two days after the assault by Dean for which he had been arrested. It is recorded during this strategy discussion that Emma's carer believed that Emma and Dean had, despite the conditions imposed on Dean by Police Officers when granting him bail, been seeing each other again. The meeting noted that following this assault Emma had been referred to MARAC as a high risk/gold case, and that the carer would share with Emma details of domestic abuse support services for victims in their local area. The strategy discussion recorded that the Safeguarding intervention was to ensure Emma had access to an Independent Domestic Violence Advocate (IDVA) and domestic abuse support. That being in place the referral was then closed by Adult Safeguarding.

6.26 Two days before the fatal attack the Police officer in charge of the assault case visited Emma in company with Emma's carer. Emma remained adamant that she would not provide evidence to support a prosecution of Dean, she also stressed her relationship with Dean was now over for good. Emma was advised about the option to apply for a non-molestation order, as was the procedure and the support available for seeking such an order should she choose to do so. There is no evidence that the option of obtaining a Non-Molestation Order had been pursued prior to her murder.

6.27 After the fatal attack Merseyside Police received a telephone call from Dean's sister. She told Police that Dean had earlier called her in a distressed state advising that something had happened to Emma who was in a bedroom at his house.

6.28 Following receipt of the phone call Police Officers attended Dean's home and found Emma dead in an upstairs bedroom. She had suffered multiple stab wounds. Dean was still at the scene, he was arrested and taken into Police custody. The Coroner recorded the cause of Emma's death as being multiple stab wounds. Dean was later charged with the murder of Emma.

6.29 Dean admitted to having consumed a significant amount of alcohol on the night of the fatal attack.

6.30 After being charged with the offence of murder and whilst on remand awaiting trial Dean was examined by a Doctor who concluded that Deans actions on the night he murdered Emma were not the result of his mental disability impairing his judgement or self-control.

7. Key Issues Arising from the Review

7.1 In November 2018 Emma had disclosed to her carer that during their relationship she was subjected to controlling behaviour from Dean. The carer shared this information with the Mental Health Team and on their advice with the Safeguarding Team within Adult Services who were contacted by telephone by the carer to report the disclosure. Whilst it is accepted that the call was made there is no record of the report made to Adult Services nor of any other action being taken to support Emma by the carer's organisation, Mental Health Services or Safeguarding teams within Adult Services following this disclosure of controlling and abusive behaviour. Neither is there any indication that this information regarding Dean's abusive controlling behaviour was shared outside of those three agencies.

7.2 Clinical advice received from North West Boroughs Healthcare Mental Health Trust's Safeguarding Adults Professional Lead has identified that these disclosures from Emma "*should have triggered a safeguarding adult referral as she was an adult at risk as defined by the Care Act 2014 and was at risk of abuse and neglect. This refusal by Adult Services to accept Emma at this time as a safeguarding referral should have been challenged*".

7.3 The Trusts Safeguarding Adults Professional Lead also believed that there was "*an over reliance on Emma's 3rd Sector carer in this situation*" and highlights a lack of action from the nominated contact/care coordinator within Mental Health Services over this matter.

7.4 The Panel felt it important to note at this point that staff employed by the 3rd Sector provider of care to Emma had not received any training to help them recognise the signs and symptoms of domestic abuse within their clients. They had not received any training in completion of the MeRIT risk assessment forms and were unaware of the gateways into domestic abuse support services which exist in St Helens.

7.5 Between November 2018 and the fatal attack there were several occasions when the negative impact upon the relationship of excessive alcohol consumption was highlighted and disclosed to services. No referrals were made during this time of either Emma or Dean into alcohol support services.

7.6 In December 2018 a telephone triage assessment of Dean was completed by the Mental Health Team. During this assessment Dean disclosed he was suffering from bouts of raging anger. He was becoming irritable with partner and mother and had a belief that his partner was the Devil and he had thoughts at times that he was Jesus.

7.7 In mid-December Dean attended the Accident and Emergency Department of a local hospital after taking overdose of his prescribed medication. Staff record that Dean was intoxicated and was aggressive requiring hospital security to assist.

7.8 In January 2019 following the triage assessment by Mental Health Services a month earlier Dean, at the time accompanied by Emma, was seen by a Hospital Psychiatrist. During this hospital appointment Emma had disclosed that she was concerned Dean had been getting more irritable with family members of late. It was concluded that Dean was presenting with mental and behavioural disturbances due to chronic alcohol misuse, but Dean assured the Doctor that he did not require any

support in order to give up consuming alcohol. No referral to alcohol support services of any kind was made at this time.

7.9 On review of patients held records it has been agreed, by Mental Health Services that in hindsight Dean should have been assessed within 24 hours of his disclosing anger towards his partner and his mother during the telephone triage and not have waited until January for further assessment.

7.10 There are no records to show that any risk assessments were completed in respect of Dean's partner Emma, or Dean's mother, who were identified within his triage consultation as the Devil. There is no information available to show that Emma had been questioned about Dean's belief that she was the Devil or that her personal health was enquired into. Nor is there evidence to show that Emma's earlier disclosure to her carer later, shared with Mental Health Services and Adult Services, that she was being controlled by Dean was assessed alongside his triage disclosure. It is now acknowledged by Mental Health Services that a further detailed risk assessment should have taken place to establish the impact these thoughts were having on his relationship.

7.11 Home Office research revealed that "*Alcohol use was a feature in a majority of domestic abuse offences (62%) and almost half the sample (48%) were alcohol dependent. Alcohol may be a distinguishing factor in domestic violence offenders. Problems of alcohol use should therefore be addressed where identified as a criminogenic need and consideration given to its potential impact on interventions and other needs"*. (a) Research into the link between alcohol abuse and domestic abuse shows that it is "*closer to the truth to say that domestic abusers like to also abuse alcohol. Where the (domestic) abuser is also an alcoholic, it is usually necessary for them to get treatment for both conditions*." (b). The failure to act upon the information that both Emma and Dean gave to Mental Health professionals and provide treatment and support to Dean for his alcohol misuse during this period ignores these links and placed Emma at greater risk.

7.12 VPRF1 submitted by Merseyside Police was received by the IDVA Service two days after the assault of Emma by Dean at his home in February 2019. The case was placed on the pending list. Cases were prioritised for contact by the IDVA based on when they were due to be heard at MARAC and this case was scheduled to be heard by MARAC on 14th March 2019.

7.13 Attempts would always be made by the IDVA Service to contact victims in cases listed for MARAC to ensure that the voice of the victim is heard at the MARAC meeting. The length of time between the referral being received by the IDVA and the date of the MARAC and the lack of capacity within the IDVA Service at that time prevented an immediate contacting of Emma by the IDVA. Emma was murdered before the IDVA was able to contact her and before the case was considered at MARAC.

7.14 It is also worthy of noting that following Emma's disclosure that she was in a controlling relationship, November 2018, and following the serious assault which took place only days before her murder, February 2019, the Panel were unable to find records that show any extra mental health support or additional support of any kind was provided to Emma by any of the services legally obliged or commissioned to support her mental health.

8. Conclusions

8.1 Emma and Dean had a relatively short relationship towards the end of which the risks Emma faced from domestic abuse escalated very quickly and disastrously.

8.2 None of the agencies charged with supporting Emma or Dean's mental health recovery appeared to show any signs of professional curiosity about the risks from domestic abuse being faced by Emma.

8.3 There were several disclosures which should have raised alarm about the increasing risks from domestic abuse being faced by Emma. However, no domestic abuse risk assessment was completed until in the days before her murder Emma

suffered a serious assault at Deans home. This risk assessment was completed by Merseyside Police.

8.4 Risks were also increased due to different parts of systems being unable to talk to each other and important information therefore was hidden to professionals.

8.5 Following the serious assault by Dean in February this was also the first time that the domestic abuse suffered by Emma was enquired into further by any agency. Here Merseyside Police worked with the Crown Prosecution Services and engaged the help of Emma's carer in an effort to have Emma reconsider her decision and to cooperate with the criminal prosecution of Dean.

8.6 The S.I. Report concluded that based on the clinical and professional advice received, the actions taken by the mental health practitioner after receiving information from Emma's carer regarding Control and following the serious assault committed by Dean in February 2019 were not robust. The reviewer concluded that there was an over reliance by the mental health practitioner on the unqualified staff member from the 3rd Sector organisation to follow this through and provide an appropriate level of support to Emma.

8.7 Advice received from the Trust's named Safeguarding Adults Professional Lead confirmed that the mental health practitioner should have escalated actions through the Trust's internal Safeguarding Adults team. As such there was a missed opportunity for possible consideration by MARAC.

9. Lessons to be Learned

9.1 In October 2019, St Helens Council reviewed their existing Domestic Abuse Strategy by holding a Domestic Abuse Summit, bringing together partners across the borough to commence a discussion about how organisations can work together to tackle the issue of domestic abuse in St Helens communities. A key objective of the summit was how to "Stop the Silence" which the partnership believed surrounded domestic abuse within St Helens communities and to create responsive services to meet those needs.

9.2 In order to ensure that the Strategy was inclusive of the aims and objectives across the partnership, consultation took place with a number of fora and a multi-agency group, led by the Director of Public Health, then built upon the findings from the Summit and developed the priorities contained within the new Domestic Violence Strategy 2020 – 2022. Accountability for the delivery of the Strategy's Action Plan is now managed through a dedicated subgroup of the Community Safety Partnership and new governance structures have been developed to facilitate this work.

9.3 The Actions contained within the Strategy seek to challenge perceptions of abuse, highlighting issues such as coercive control, child to parent abuse and domestic abuse experienced by older people. The Strategy also recognises the need to safeguard children and vulnerable adults from the impact of domestic abuse and to work within communities to raise awareness of this issue, end the silence that still exists and to ensure that timely and effective support is available for victims and their families. The Strategy also highlights the need to address the perpetrators of abuse, considering both the provision of support for those who acknowledge their behaviour and to agreeing a way forward across the partnership to effectively hold to account serial perpetrators of abuse.

9.4 Following this Review several new practices and procedures have already been implemented.

9.5 A review of capacity within the IDVA service has resulted in the provision of four new posts within the IDVA Service funded by St Helens Council. These include additional IDVA's and Domestic Abuse Outreach workers.

9.6 Further changes have been implemented by Mental Health Services in St. Helens.

- The Mental Health Assessment team have a new process for screening a Patient who is telephone triaged. If there are any Safeguarding concerns, if the patient is pregnant, psychotic, or suicide ideation they will have a face to face assessment and will be seen within 24 hours up to a maximum 10 days.

- Mental Health Assessment Team will now follow up those patients who haven't responded or do not attend (DNA) their allocated appointment. There will be an emphasis on proactive engagement and staff will do home visits if contact has not been established.
- New patients to Mental Health Services will be discussed daily at a 3pm Multi-Disciplinary meeting. The sharing of information and assessment of risk will be part of this discussion.
- Nomination will be made of domestic abuse champions within both Mental Health Recovery and Mental Health Assessment Teams were previously none existed. This will take place once the full complement of staff is appointed. These champions will work closer with adult safeguarding team to support the teams.
- Closer working relationship has been established with Change Grow and Live (CGL) which includes joint home visits between Mental Health Services and CGL and the appointment of a drugs link worker within the Mental Health team. (CGL is the specialist drug and alcohol support provider within the Borough.)
- Development of a closer working relationship with IDVA service. The IDVA team manager is now attending both Mental Health Recovery and Mental Health Assessment Teams to share knowledge regarding domestic abuse services within St Helens.
- There has been a higher take up of NWBH internal domestic abuse training across both Recovery and Assessment Teams. This training which is delivered by the Adult Safeguarding team includes recognising coercion and control within an intimate relationship and how to complete the Merit risk assessment and make referrals to MARAC.
- A "safety huddle" meeting has been introduced for Mental Health assessment team and recovery teams which includes raising safeguarding concerns about clients.
- The Mental Health Assessment Team have freed up a daily appointment slot each day to enable one urgent appointment to be accommodated. Once

screened the person will either be graded as emergency or downgraded to routine. If it is an emergency grading, they will be seen within 24 hours

9.7 Changes have also been made within the Safeguarding Adult's Team following this Review.

- On receipt of a referral to the Safeguarding Adults Team which discloses domestic abuse taking place. Even if it is identified that this person is not already in service or does not have any other identified care or support needs the Safeguarding Adults Team will make contact with the person making the referral, appropriate professionals, and the victim of abuse (if safe to do so).
- The Safeguarding Adults Team will ascertain what support the client requires, and whether all relevant professionals are aware of this abuse taking place. They will take action to minimise risk faced by the client and ensure that a MeRIT risk assessment form is completed.

10. Recommendations from the Review

10.1 Following completion of the IMR's some Panel members have made their own single agency recommendations. These together with the following recommendations which have been made by and agreed by this Panel.

10.2 In the area of mental health care and safeguarding, professional curiosity at the initial screening and throughout patient contact to be developed through further domestic abuse training and supervision.

10.3 Recognition of the need to complete domestic abuse risk assessments within G.P. practices.

10.4 Staff from 3rd Sector agencies engaged in front line service provision to people with mental health conditions are provided with multi-agency training on the signs and symptoms of domestic abuse and the pathways into the reporting of and support for these victims and the completion of risk assessments. This should be an ongoing program to capture new entrants into the services.

10.5 The Mental Health Service will continue working with staff from within mental health care providers, mental health services, and Adult Safeguarding to provide ongoing safeguarding supervision thereby ensuring that the need for domestic abuse risk assessment is recognised and provided.

10.6 The current practice of telephone triage for patients with complex needs to cease and those identified patients be offered face to face appointments.

10.7 Development of a system of referral to Adult Safeguarding which is open, transparent and auditable between mental health care providers, mental health services and the Adult Safeguarding team

10.8 Following the S.I. report into the care Emma had received from NHS Services several recommendations have been made to Mental Health Services and Adult Services Safeguarding Team and these are.

10.9 There will be a clear consistent process based on NWBH Policy and Procedure that can be appropriately benchmarked and which will provide clear direction to staff around the regarding of CPA and the involvement of service users and other agencies.

10.10 Care records will clearly document sharing of information alongside evidence of staff escalating concerns and acting on concerns where it is appropriate to do so.

10.11 Staff to complete an internal referral to NWBH Safeguarding Team with a communication form highlighting concerns.

10.12 Staff to update the risk assessment upon receipt of any information considered to be a risk.

10.13 In the area of mental health care and safeguarding professional curiosity at the initial screening and throughout patient contact to be developed through further domestic abuse training and supervision.

Appendix A

References

References.

A. Spotlight Report; Safe and Well: Mental health and domestic abuse. SafeLives.
B. The Link between Alcohol and Domestic Violence. U.K.-Rehab

AUTHOR OF THE OVERVIEW REPORT

Explain the independence of the chair (and author if separate roles) and give details of their career history and relevant experience (Section 4 paragraph 36). Confirm that the chair/author have had no connection with the Community Safety Partnership. If they have worked for any agency in the area previously state how long ago that employment ended.

TERMS OF REFERENCE FOR THE REVIEW

SUMMARY CHRONOLOGY

A summary of the key facts from the background and combined chronology of agency interaction with the victim and perpetrator and their family; what was done or agreed. The summary should provide sufficient facts to give context for the key issues arising from the review. Background information which also gives context to the victim's and perpetrator's story.

KEY ISSUES ARISING FROM THE REVIEW

(Add issues as required)

CONCLUSIONS

LESSONS TO BE LEARNED

RECOMMENDATIONS FROM THE REVIEW

(Add recommendations as required