# Domestic Homicide Review –

Home Office reference 20210209/0

## Overview Report

## Report into the death of Gill (pseudonym)

## February 2020

Author and Domestic Homicide Review Chair - Stephen McGilvray 2021

**Trigger warning – this report discusses issues regarding suicide**

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## Glossary.

AAFDA Advocacy After Fatal Domestic Abuse.

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

DHR Domestic Homicide Review.

IAPT Improving Access to Psychological Therapies.

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 Committee. 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 risk assessment check list.

PTSD Post Traumatic Stress Disorder.

RASAC Rape and Sexual Abuse Centre.

Risk Assessment Grades

- Gold Victim is at 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

Safe2Speak Independent Domestic Violence Advocate Service.

VPRF1 Vulnerable Person Referral Form.

## Foreword

Gill suffered several traumatic events throughout her life and whilst the Panel experienced difficulties in making contact with her family and friends' people who supported Gill comment about her ability to make others laugh. The Panel wish to record their sadness that her life should have ended this way and our sympathies go out to all who knew her.

## 1. Introduction.

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and the support given to Gill, a resident of St Helens prior to the point of her death in February 2020.

1.2 In addition to agency involvement the Review will also examine the past to identify any relevant background or trail of abuse before Gill's death, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions to make the future safer.

1.3 The circumstances which led to this Review being undertaken are as follows. In February 2020, Merseyside Police were called to Gill's home address. Friends who she shared the house with had met Gill, who was extremely upset, in St Helens town centre the previous evening. Due to the level of her distress friends took Gill home and she went straight to her bedroom. Later that day a friend found Gill in her bedroom and that she had taken her own life. Gill at the time of her death had been in a long-term abusive relationship with Francis.

1.4 The Review will consider agencies contact and involvement with Gill and Francis from 1st January 2017 until Gill's death in February 2020. The panel decided on this time frame because this would capture information about any history of abuse and violence within their relationship which Gill had previously advised Merseyside Police begun when Francis began drinking heavily three years prior to her death. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included within the agency's individual management review.

1.5 The key purpose for undertaking this DHR is to enable lessons to be learned from incidents where a person takes their own life as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible professionals need to understand fully what happened in this case and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

## 2. Timescales.

2.1 In 2020 Merseyside Police conducted a review of all cases where an individual had taken their own life and domestic abuse was present within that person's relationship. As a result, in September 2020 Merseyside Police notified St Helens Community Safety Partnership of the suicide which is the subject of this Review.

2.2 Members of the Community Safety Partnership agreed there was a requirement to complete a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016. The Home Office were notified of this decision.

2.3 As a result of the Community Safety Partnership decision the Chair of the DHR Panel was commissioned in October 2020 and the Review was completed in October 2021.

## 3. Confidentiality

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

3.2 The following pseudonyms were agreed by the Panel and are used throughout this report to protect the identity of the individual(s) and their families.

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| Gill | female partner in relationship. Deceased | Aged 41 years |
| Francis | male partner in relationship. | Aged 45 years |

The ethnicity of both Gill and Francis was white British.

## 4. Terms of Reference.

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

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.

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

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

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

1. How effective was the management of risk between MARAC (Multi Agency Risk Assessment Conference) and substance misuse support interventions?
2. Were appropriate criminal justice interventions applied to both Gill and Francis?
3. Was there a need for mental health services, and the adult safeguarding service to support Gill?
4. The Suicide Prevention Strategy Action Plan for St Helens includes the use of safety planning, with at risk individuals, by organisations. In accordance with the provisions of the Suicide Prevention Strategy was a safety plan ever completed with Gill.
5. Did the challenge of substance misuse and the lifestyles of both Gill and Francis inhibit risk assessment and MARAC actions?

6. Did the partnership take advantage of the period that Francis was in custody between October 2019 – February 2020 to deliver intensive interventions, meeting the needs of Gill, and breaking the cycle of substance misuse and abuse that she was suffering?

## 5. Methodology.

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

5.2 At the commencement of the Review the Chair attempted to contact and engage with the family and friends of Gill but without success.

5.3 Panel members were asked to provide chronological accounts of their agencies contact with Gill and Francis within the agreed timescale of 1$^{st}$ January 2017 and Gill's suicide in February 2020. Where there was no involvement or insignificant involvement, agencies advised accordingly.

5.4 Having reviewed the chronological accounts provided by Panel members the Review Panel agreed the key lines of enquiry the Review should focus upon.

5.5 Agencies completed Individual Management Reviews (IMR) and each IMR covered the following areas: A chronology of their interaction with Gill and Francis, what was done or agreed; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view. Whilst completing the IMR Panel Members interviewed colleagues who had direct contact with Gill or Francis.

## 6. Involvement of Family, and Friends.

6.1 The Panel were unable to engage with any of Gill's family in this Review. Using contact details provided by one of the Panel members, prior to the first Panel meeting phone calls were made and letters were written to the family advising them of the commencement of the DHR and establishing if they wished to contribute to the Review. The Home Office leaflet for family and friends accompanied the letters sent but to no avail. After considerable effort to engage with the family Gill's father did respond to the Chair of this Review. However, when he was speaking to the Chair of this Review Gill's father denied having a daughter and took no part in this Review.

6.2 Those agencies who had built up a relationship with Gill say that Gill was close to her mother but unfortunately her mother had died in recent years.

6.3 Efforts were made to engage with those who Gill shared a house with including by letter and enclosure of Home Office guidance leaflets but without success.

6.4 It was established that no advocate from Advocacy After Fatal Domestic Abuse (AAFDA) was or had been supporting the family. Additionally, guidance and advice was sought from AAFDA about other ways in which the Panel could encourage the family to feel able to take part in the Review but no additional means of generating that participation beyond the steps which had already been taken could be found.

## 7. Contributors to the Review.

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

- Change Grow Live (CGL).
- Merseyside Community Rehabilitation Company.
- Merseyside Police.

- North West Boroughs HealthCare Trust.
- Safe2Speak Domestic Abuse Service.
- St Helens MBC Adult Safeguarding.
- St Helens and Knowsley NHS Trust.
- St Helens Clinical Commissioning Group.

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

**8. The Review Panel Members.**

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

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| Alison Edwards. | Case Worker Change Grow Live. |
| Anne Monteith. | Named Nurse for Safeguarding Children. |
| Beverley Jonkers. | Co-ordinator St Helens Community Safety Partnership. |
| Beverley A. Hyland. | Chief Inspector Merseyside Police. |
| Francesca Smith. | Head of Adult Safeguarding St Helens MBC. |
| Charlotte Stenhouse. | Operations Manager, Safe2Speak Domestic Abuse Service. |
| Helen James. | Manager Community Rehabilitation Company. |
| Helen Newton. | Safeguarding Officer at St Helens CCG. |
| Jacqueline Hodgkinson. | Safeguarding Officer at Merseycare. |
| James Mawhinney. | Case Worker at Change Grow Live. |

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| Jennifer Grayson. | Head of Service, Safe2Speak Domestic Abuse Service. |
| Jeremy Harris. | Manager St Helens Community Safety Partnership. |
| Natalie Kennedy. | Public Health Suicide Prevention Coordinator. |
| Paul Grounds. | Chief Inspector Merseyside Police. |
| Rachel Fance. | Manager at Change Grow Live. |
| Shana Begum. | Domestic Abuse Prevention Officer St Helens MBC. |

8.2 All MARAC meetings on Merseyside are now chaired by the same person. That Chairperson was invited to be part of the Panel, but work commitments prevented them from taking up that offer.

8.3 The following agency was also contacted regarding their involvement with either of the key individuals within this Review but reported no contact with them.

- Private Sector Landlord & Tenant Liaison Officer, St Helens MBC.

8.4 The Panel met a total of five times and none of the Panel Members had direct contact with or direct supervisory responsibility for those who did have contact with either Gill or Francis.

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

9.1 St Helens Community Safety Partnership commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in October 2020. Stephen McGilvray is also the author of this Overview Report.

9.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years. 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 SafeLives/CAADA Leading Lights accreditation for the quality of its systems and risk management processes.

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

9.4 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 several Serious Case Reviews.

9.5 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.

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

## 10. Parallel Reviews.

10.1 There were no other reviews in relation to this suicide which had taken place, or which were running parallel to this Review. H.M. Coroner was made aware that this Review was taking place.

## 11. Equality and Diversity.

11.1 All aspects of equality and diversity were considered throughout this review process including Equalities Act protected characteristics of age, gender

reassignment, being married or in a civil partnership, pregnancy or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex, and sexual orientation. To ensure the review process considered issues around domestic abuse the panel included representatives specialising in domestic abuse.

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

11.3 Analysis of reported cases of domestic abuse releveled "*the victim was female in 73% of domestic abuse-related crimes in the year ending March 2021*" (A). Gill was subjected to unlawful conduct of a sexual nature and was subjected to high levels of intimate partner violence.

11.4 "*There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt or killed than male victims of domestic abuse. Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours.* (B) Whilst in her relationship with Francis Gill was the victim of several incidents of physical violence. She was a repeat victim of such violence and was subject to controlling and coercive behaviour.

11.3 The Panel also recognise the intersectionality barriers Gill faced in her life specifically the interaction of barriers relating to sex, class, and physical and mental health and these will be dealt with in the analysis section of this report.

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

## 12. Dissemination.

12.1 In accordance with paragraph 79 of the Statutory Guidance for the conduct of Domestic Homicide Reviews following receipt of Home Office approval for publication the Overview Report, Executive Summary and Home Office letter will be

provided to all parties referenced in paragraph 79 of the Guidance who are listed within this report as Contributors to the Review.

## 13. Background Information.

13.1 Gill lived in St Helens Merseyside, and she took her own life, by hanging, in the bedroom of the house she shared with friends.

13.2 At the time of her death Gill and Francis had been in a relationship for approximately 12 years and at the time of her death Gill was homeless but had been offered a room at the home of friends where she lived, separately from Francis, for seven months prior to her death. The friend and owner of the property told Police that he initially gave shelter to both Francis and Gill, but he threw Francis out for being aggressive towards Gill.

13.3 St Helens Community Safety Partnership believe that Gill's death met the criteria for conducting a DHR on the grounds of the domestic abuse Gill had been the victim of during her relationship with Francis and the abuse she was subjected to by him on the evening of her death.

## 14. Chronology

### Background history of Gill and Francis.

14.1 Gill had made a disclosure of domestic abuse involving a previous partner to CGL the identity of this previous partner was however unknown to agencies and he therefore took no part in this review. Gill reported to Police that she only began suffering violent abuse at the hands of Francis when he began consuming alcohol heavily in 2017 but during the period 2017 until her death Gill suffered significant levels of physical abuse and coercive control from Francis.

14.2 It is the view of Change Grow Live (CGL) which supported Gill up to the time of her death and continue to support Francis today that "*co-dependency was evident in the relationship and the dependence on substances added an additional layer of*

*complexity to ending the relationship as this was a factor in Gill continuing the relationship and declining specialist support on a number of occasions.*"

14.3 Gill and Francis had a child together who was born in 2011. That child was subject of care proceedings and removed from their care in 2013 at age two years following the ingestion of Methadone that had been lawfully prescribed to Francis. Both Gill and Francis were later charged with an offence of child neglect following this incident. However, neither Gill nor Francis subsequently received any support following their child's removal to help manage the trauma of such an event.

14.4 Gill had also disclosed to substance misuse treatment services that she had for a time turned to prostitution in lieu of payment for drugs which had left her "*feeling vulnerable and upset about her past."*

14.5 At no time following these traumatic events, nor during the period reviewed, did Gill receive any emotional support or therapy to help her.

14.6 Both Gill and Francis were receiving weekly support from CGL the organisation commissioned by St Helens MBC to provide drug and alcohol treatment and support. Each had a Recovery Co-ordinator assigned to them. A Doctor is on site at CGL to deal with any medical issues and would prescribe methadone and other medication to be taken under supervision at the issuing chemist to both Gill and Francis.

14.7 Gill and Francis's substance misuse impacted upon their engagement with CGL and the work that was able to be completed with them. "*Often Gill and Francis would attend, not at their scheduled appointment times but just before the service closed, which impacted upon planned interventions preventing them from taking place".* A lot of the intervention work which was completed focussed on harm reduction, and physical health. On some occasions CGL staff had to manage their immediate need for treatment due to an overdose of illegal drugs they had taken prior to visiting the service.

14.8 The levels of substance misuse varied but on average amounted to each injecting four "bags" of Heroin, together with four "rocks" of Crack Cocaine, and drinking three cans of alcohol per day.

14.9 Research has found that levels of trauma, such as those experienced by Gill, two serious sexual assaults, the removal of a child, a period of prostitution, and the physical and controlling abuse she now suffered "*can lead to self-medication to numb the pain in an attempt to dilute the reality of the occurrence, which in turn can lead to dependency and/or addiction.*" (C)

14.10 "*Trauma is often an "underlying" condition informing other problematic presentations, (e.g., drug/alcohol misuse/difficult behaviours)*". (D) Whilst the pathway into Gill's addiction cannot be mapped with certainty the Panel believe that these traumas may have been the catalyst for the history of substance misuse and several incidents of self-harm during Gill's life.

14.11 During their relationship Gill and Francis, had periods of homelessness during which they lived in a tent, were "sofa surfing", and lived at a hostel for homeless people.

14.12 Their accommodation at the Hostel included periods when Francis was being physically abusive towards Gill.

14.13 Gill suffered physical and financial abuse at the hands of Francis whom she also described as very controlling. No complaint was made to Police following each assault with the result that none of these incidents of abuse ended in Criminal Justice proceedings apart from one incident in October 2019 during which Francis physically assaulted Gill and attempted to take money from her.

14.14 Following this assault Francis was charged with Assault Occasioning Actual Bodily Harm and remanded in custody to await trial. Francis remained in custody on remand until February 2020 when following a guilty plea to a charge of assaulting Gill he was sentenced to a nine-month prison sentence and a Restraining Order of five years preventing him from contacting Gill. Because of the time spent in custody on remand Francis was released from custody very soon after his Court appearance. Eight days before Gill's death.

14.15 The Chair of this Review did try to speak to Francis but was advised, by an agency supporting him, that he had been profoundly affected by the death of Gill.

He had attempted to take his own life himself and was not mentally strong enough to undertake such a discussion.

**Chronology of events.**

14.16 On 27th February 2017 Gill attended CGL for a one-to-one session and disclosed she has been speed-balling (injecting heroin and crack cocaine together) daily and was struggling to find veins in her arms. Gill disclosed that her partner was very controlling and verbally abusive to her and felt that she could not end the relationship as he does not take it seriously and continues to contact her. Gill also admitted that she was unsure if she wanted the relationship to end. Gill was offered support in relation to this and discussed obtaining a non-molestation order, but this was declined as Gill felt this was too extreme as she did not know what she wanted from the relationship. Gill stated that the violence has been ongoing for some time Gill disclosed that the violence had escalated "*because of them living in separate hostels and her partner did not have as much control over her*". No MeRIT forms were completed, and no information regarding the risks from domestic abuse that Gill faced was shared with any other agency.

14.17 In March 2017 a female member of the public called 999 to report a domestic incident between Gill and Francis outside the YMCA in St Helens. The caller initially stated Gill had been assaulted but later said it was verbal argument only and Gill confirmed to Police Officers attending the incident that she had not been assaulted. A Vulnerable Persons Referral Form (VPRF 1) which includes a MeRIT checklist is used by officers and agencies to assess the level of risk of future violence a victim faces was completed and assessed that Gill was at a standard/low risk of future violence.

14.18 Also in March 2017 an emergency call was made to the Police to report of an unconscious female outside the walk-in medical centre in St Helens. The report said Gill had been assaulted by Francis who grabbed her around the throat and punched her in the nose, with members of the public intervening to stop the assault. Gill was found asleep in the toilets of the medical centre and when awakened by Ambulance staff said that "*Francis refused to let me sleep*". Gill did not require hospital

treatment. She was under the influence of drugs and alcohol and declined to make a complaint of assault. With no visible injuries, traceable witnesses, or CCTV there was no opportunity for evidence led prosecution. A VPRF 1 completed after the incident graded Gill to be at Silver/medium risk of further violence.

14.19 Gill attended an appointment with CGL in April 2017, and disclosed she was smoking up to three bags of heroin and three rocks of crack cocaine daily and discussed wanting to reduce this use but did not feel she was in the right frame of mind to do it. Gill also told staff that she was evicted from the YMCA yesterday and was now sleeping in a tent, therefore housing options was discussed with Gill, and she stated she would call in next week. YMCA were contacted by this Review but could not locate any information to explain Gill's eviction.

14.20 In April 2017 Gill moved into a hostel in St Helens and through support a house was found which may have been available for Gill and Francis in Blackburn. This transfer into more stable accommodation never took place.

14.21 In July 2017, Police attended to a group of people arguing in the street. It was reported that Francis had been captured on CCTV assaulting Gill by pushing her into the middle of the road where he threw a can of beer over her after she fell and hit her head. Francis was arrested for assault and Gill for being drunk and disorderly. A statement was not obtained from her during her time in Police custody due to her intoxicated condition, and subsequent attempts to obtain a statement were unsuccessful. Despite there being CCTV footage of the incident, which was seized, and an admission from Francis during Police interview that he had assaulted Gill there was no consideration of an evidence led prosecution for assault. The matter was referred to a Police Decision Maker who deemed it suitable for no further action. A VPRF1 was completed for Gill and the incident originally graded Silver was upgraded to Gold/high risk of serious violence or homicide and MARAC and IDVA referrals were made.

14.22 Seven days after this assault Gill attended CGL and had her arm in a sling. When asked about this Gill stated she had a fall and had been to hospital and the x-ray revealed that her shoulder was badly bruised. Gill stated that she is speed balling four bags of heroin and four rocks of crack cocaine daily. Gill also disclosed that she

drank strong lager daily but the quantity changes. Harm reduction was discussed with Gill. Gill reported that she was living in a tent and was hungry, therefore, a food voucher was issued.

14.23 Later in July 2017 agencies were alerted to the fact that Gill had gone into hospital over the weekend due to an overdose and later had discharged herself against medical advice.

14.24 Following the assault by Francis at the start of July on 27th July 2017 Gill's case was discussed at MARAC. Notes from the meeting show that Adult Services had made relevant checks and no mental health or care and support needs were identified for Gill and that no further action was required of the Local Authority. The only action resulting from this MARAC meeting was for CGL to link in with IDVA when Gill attends her next appointment.

14.25 It is clear from events in the lead up to this MARAC meeting that several issues were intersecting and overlapping in Gill's life at this time and yet on this first occasion when a number of service providers and statutory agencies had met to reduce the level of risk faced by Gill this intersectionality was not considered or acted upon.

14.26 Gill attended CGL the day after MARAC had been held and staff held a discussion with her regarding the relationship with Francis and how this could be abusive, Gill agreed with this. Gill was asked to consider ending the relationship and the support available to her was highlighted, including legal orders, refuge accommodation but Gill refused this and stated, "*she wanted to go and score with him (buy drugs) as he had money and she needed to use drugs*". It was highlighted to Gill that she was putting herself in danger and she said, "*she was aware of this but needed to use drugs"*.

14.27 On 31st August 2017 the IDVA Service closed the referral contained in the action from MARAC "*due to no further contact from CGL or Gill."*

14.28 On 16th September 2017 Francis was flagged in their records as a safeguarding risk to others by CGL due to previous incidents of domestic abuse to his partner Gill.

14.29 A member of the public reported a male was hitting another person in the street, a further call from another member of the public stated the victim was a female and the offender on a bike had ridden off. Police Officers attended the scene and located Gill who said Francis had scratched her and pushed her to the floor causing bruising, she declined to prosecute Francis despite the officer explaining she would be supported to do so. Harassment was also discussed as an alternative, but Gill was adamant, saying she could not be bothered going to court. Her injuries were photographed, and she was taken to a friend's home. Gill declined offers of support for domestic abuse. A VPRF 1 was completed, the incident was graded Gold/high risk and referred back to MARAC, last heard in July 2017. Police searched the area for Francis without success. Police closed the matter with the result that No Further Action would be taken.

14.30 The next day CGL at an internal safeguarding meeting closed the risk posed by Francis on the basis that there had been "*no further incidents of domestic abuse between Francis and Gill. Francis engaging well therefore Safeguarding was closed*"

14.31 Following the on-street assault and referral to MARAC Gill's case was discussed at the MARAC meeting in November 2017. The discussion concluded with a single action for CGL to safeguard Gill, "*On-going support, Try and encourage Gill to re-engage. If you do get her to re-engage, see if you can refer / link in with IDVA"*.

14.32 In December 2017 Francis began an inpatient detoxification program for alcohol and opiate users but after two days was asked to leave the course after consuming alcohol on the ward.

14.33 In January 2018 Gill was dealt with by the Courts for an offence of possessing drugs with the intention of supplying them to another for which she had been arrested in April 2017. Gill served a term of imprisonment for 6 months during which time Francis was homeless and slept on the streets.

14.34 Less than one month after being released from prison a member of the public contacted police to report seeing Gill being dragged across the ground. Gill told police she had been assaulted by Francis but did not wish to make a complaint, he was assaulted by Gill who said they were both drunk and both sustained superficial

injuries. Gill did tell officers that Francis was very controlling and extremely jealous. She added that she would support police action if she were assaulted again. A VPRF1 was completed by officers attending this incident who assessed the level of risk faced by Gill to be Silver/medium risk.

14.35 In July 2018 Gill attended CGL and a Personalised Assessment was completed following her prison release. During the assessment Gill stated her physical health was poor and she was hoping to register with a local medical centre. Gill also discussed experiencing Post Traumatic Stress Disorder (PTSD) because of past domestic violence and had not been prescribed any medication. Gill was sign posted to register with a G.P. for support in this area. Gill disclosed she was in a relationship with Francis where domestic violence was present.

14.36 Following the personalised assessment Gill was examined and assessed by the Doctor at CGL. Gill explained she experienced anxiety and depression and explained she has previously self-harmed whilst in an abusive relationship.

14.37 Due to their presence as a member of MARAC staff at CGL would be aware that Gill was being abused physically and through the controlling behaviour of Francis. No risk assessment or safety plan, in respect of domestic abuse or suicide prevention, was developed following these disclosures by Gill until two weeks later when plans were made to arrange for Gill to complete a safety plan with staff at CGL.

14.38 The MARAC after discussing the assault of Gill by Francis agreed one action, that being for the IDVA to liaise with the hostel at which Gill was currently staying. Hostel staff were contacted by the IDVA and agreed to facilitate a meeting between the IDVA and Gill when it was safe to do so. Seven weeks after MARAC the case was closed by the IDVA service "*due to no contact (from the Hostel) and Gill remains in the relationship*".

14.39 In November 2018 Gill attended the Nurse Drop-In and asked the CGL Nurse to look at her left wrist. Gill stated that she cut her wrist on Wednesday following a row with her partner, Francis. Gill also cut her right wrist but from observations the right wrist appeared to have healed well. Following examination Gill was advised to

attend Accident and Emergency Department at a local hospital for treatment to the wound.

14.40 In December 2018 the Recovery Co-ordinator at CGL spoke to Gill when she attended CGL, she was in distress. Gill and a staff member from the Hostel reported that Gill's partner, Francis had slapped Gill in the reception area of the hostel and the staff member had removed Gill from the area. Gill stated that she had not slept and had been drinking until 06.30am. A safety plan for the following day was agreed between Gill and the staff member from the hostel. Fresh, superficial cuts were also visible on Gill's left arm, Gill stated that this was due to her telling Francis about a time where she '*did some prostitution for drugs'* when she was living on the streets and a male allowed her to stay with him to be a cleaner and dog walker in exchange for crack cocaine and oral sex. Gill stated that Francis was angry about this, and this left her feeling vulnerable and upset about her past. It appeared to staff at CGL that this had been the catalyst for the self-harm.

14.41 In late January 2019 Gill attended late for a session with her recovery coordinator at CGL. She had self-harmed by cutting her left arm with a piece of glass. Gill stated that she had an argument with her partner, Francis as he thought she had '*robbed someone'*. Gill did not want to sit and have a one-to-one session, she stated she had reduced her alcohol use and had not had a drink so far that morning.

14.42 In March 2019 Francis was evicted from the hostel where he was staying with immediate effect after an incident two days ago where he was seen smashing a bottle over another resident's head. Gill had been permitted to stay at the hostel but left with Francis and did not return that evening.

14.43 In April 2019 Gill, having served a prison sentence after breaching suspended sentence conditions imposed upon her, attended CGL and spoke to a member of staff. Gill disclosed previous domestic abuse from her ex-husband and explained that a member of her ex-partner's family had seriously sexually assaulted her, and that she had never received support around this and instead blocked it out of her memory. Gill stated that she was happy in her relationship with her partner, Francis

and stated they have been together for eight years. Gill stated that she was living with her partner.

14.44 In September 2019 Gill disclosed to her Recovery Co-ordinator that she stayed on the streets last night due to an argument with her partner, Francis. Gill said she was unaware where she would be staying tonight and would probably stay on her friend's sofa.

14.45 In the early hours of 15th September Police Officers dealt with two incidents both of which involved Gill and Francis who were on the street, intoxicated and had been fighting with each other. No arrests were made but VPRF1 forms were completed in respect of both Gill and Francis and the risk level assessed as medium/Silver.

14.46 One-week later Police Officers were again called to a fight between Gill and Francis on the street. Both were intoxicated and said that the fight had started over name calling. Witnesses said that Gill was the aggressor but neither Gill nor Francis wished to make a complaint of assault to the Officers. A VPRF1 was completed in respect of Francis who was assessed as being at a medium/Silver risk of further violence.

14.47 In early October 2019 Police received an emergency call reporting a male beating a female on the floor on a street in St Helens. Police Officers attending the scene spoke to Gill who told them that Francis "*had dragged her to the floor and went through her pockets to try and take forty pounds from her*". She had cuts and swelling to her face. Gill and a witness both provided statements about the assault and Francis was arrested and charged with assaulting Gill. He appeared in Court the next day, and he was remanded in custody. A VPRF 1 was completed which assessed the level of risk from future violence faced by Gill was medium/Silver and not requiring of consideration at MARAC. Francis was convicted of this assault at Liverpool Crown Court and received a prison sentence and a five-year Restraining Order imposed on 5th February 2020.

14.48 Over the next few weeks following the assault in October the IDVA attempted to contact Gill by telephone to speak to her and offer her support. After three attempts at making contact, all of them unsuccessful, the case was closed by the

IDVA Service. During this same period whilst Gill continued to use illegal drugs, she did become alcohol free and CGL staff noted how well she was now looking and taking care of herself.

14.49 In late February 2020 Francis was released from custody having served much of his prison sentence on remand.

14.50 At the end of February 2020 Gill took her own life. House mates of Gill reported to Police that they had found Gill earlier that evening in St Helens in an extremely distressed state following an encounter with Francis who it is alleged had thrown bottles at Gill and shouted that she had been seriously sexually assaulted by a close member of her family.

## 15.Overview

15.1 Gill and Francis had been in a long-term relationship and were both poly drug users receiving support from a public health commissioned drug treatment and support service CGL.

15.2 The relationship was a violent one with Francis who was also controlling being the primary aggressor. Though on occasion Gill filled that role and on most of these occasions both parties were intoxicated. The risk Gill faced of future serious violence or homicide was assessed high enough to be referred to MARAC on three occasions. Actions agreed at those MARAC meetings did not reflect the intersectionality of issues Gill was facing. The risk Francis faced from domestic violence was assessed as medium/Silver and he was not referred to MARAC.

15.3 Gill faced several traumas during her life. At two years of age a child born out of the relationship with Francis was the subject of care proceedings after ingesting methadone which had been lawfully prescribed to Francis. Gill disclosed that she had been subjected to a serious sexual assault by her ex-partners close relative and on the night, she took her own life it is reported that Francis had been shouting in the street that Gill had also been subject to a serious sexual assault by a close member of her own family. Gill did not receive any support or help to manage these traumas.

15.4 Gill also disclosed that she had self-harmed when subject to domestic abuse and during the relationship with Francis Gill did self-harm on several occasions, but no mental health support or suicide prevention plan was ever put in place for her.

**16.Analysis.**

16.1 Whilst receiving support from CGL Gill and Francis regularly presented to the service whilst intoxicated through the use of both illegal drugs and alcohol. The result was that sessions with their respective Recovery Co-ordinators would be spent dealing with immediate welfare concerns, rather than long term recovery planning and goal setting. Yet MARAC actions placed CGL in a pivotal role in the task of reducing the level of risk Gill faced from domestic abuse.

16.2 The Panel considered one of its key lines of enquiry was to examine if the challenge of substance misuse and the lifestyles of both Gill and Francis had inhibited agencies thinking and action to reduce the level of risk Gill faced from domestic abuse and the actions of MARAC. Reflecting upon this question the Panel agreed that this was the case and that ineffective safety/action planning by MARAC continued throughout the three years the Panel reviewed.

16.3 The Panel noted that the MeRIT risk assessment tool in use during the period under review did not question the victim of domestic abuse regarding their suicidality. It did however ask this question of the perpetrator. The SafeLives DASH risk assessment check list does ask a question of the victim are they "*feeling depressed or having suicidal thoughts*". This clear gap between domestic abuse and suicide in the practice of those tasked with increasing the safety from domestic abuse of victims was recognised and since the commencement of this Review has been closed by the inclusion in MeRIT of a question "*Has the victim recently had any suicidal thoughts or previously attempted suicide or self-harm*" now being asked of the victim.

16.4 In the period under review Merseyside Police attended nine incidents where physical violence between Gill and Francis was present. In five of those incidents Francis had grabbed Gill by her throat. The Domestic Abuse Commissioner states

that "*The violence of strangulation and suffocation is widespread. It is used to control mostly women and increases seven-fold the risk of those being controlled to go on to be killed." (E)*

16.5 Between 2017 and her death in 2020 Gill's case was heard at MARAC on three occasions. (27th July 2017, 16th November 2017 & 26th July 2018). On two of those occasions Gill had been risk assessed as Silver or at medium risk of further serious violence, but these assessments were upgraded to a Gold or high level of risk following the application of professional judgement by the Police Inspector based within MASH (Multi Agency Safeguarding Hub).

16.6 Merseyside Police were the only agency to complete a MeRIT risk assessment check list and refer Gill to MARAC following incidents which they attended. However, Gill felt unable to support Police in making a referral to other agencies or commencing a criminal prosecution of Francis. In the only case, which was successfully prosecuted, prior to the guilty plea being entered by Francis, Gill was summoned to attend Court and give evidence in the case.

16.7 CGL is a voluntary sector organisation specialising in substance misuse and criminal justice intervention projects in England and Wales. As part of their role to reduce levels of substance misuse in individuals they make use of risk assessment and safety planning processes with clients. The Panel believe that Gill and Francis had a level of trust in CGL as CGL was the only agency they would turn to in times of crisis or when they required help, with their physical health needs.

16.8 Between 2017 and Gill's death in 2020 CGL completed a safeguarding review of the risk Francis posed to others because of the domestic violence he was showing towards Gill. Separately two safety plans were completed with Gill by CGL. The safety plans highlighted risks Gill faced due to domestic violence and homelessness and one of those plans included the fact that Gill was suffering from PTSD due to domestic abuse. In addition to the physical abuse Gill suffered from Francis she also disclosed to CGL on two occasions that Francis was very controlling. CGL are members of St Helens MARAC and details of those safety plans were shared verbally with other MARAC members at the meetings.

16.9 There is no description available to the Panel to further define this controlling behaviour but action to reduce the impact and risk of controlling behaviour faced by Gill does not appear in any MARAC action plans.

16.10 A safeguarding concern for Gill regarding the domestic abuse she faced was referred to Adult Safeguarding Services in April 2017 following an incident dealt with by the Ambulance Service.

16.11 As a result of this referral there was no action taken by the Safeguarding Adult Unit and the referral was closed for the following reasons. It was believed that Gill did not have any identified social care or mental health needs defined by the Care Act 2014. The appropriate services, the Independent Domestic Violence Advocate (IDVA) service and CGL were working with Gill and her issues where predominately "*down to her substance misuse*". There was no reference or response given to the coercive control Gill was suffering identified in the disclosure to the Ambulance Service personnel that "*Francis had prevented her from sleeping*."

16.12 The Panel could find no evidence following this incident that anyone or any agency had shown professional curiosity and enquired into or recorded the reasons behind Gill's substance misuse.

16.13 In July 2017 Gill was physically assaulted by Francis who was arrested by Police for an offence of assault occasioning actual bodily harm. Merseyside Police completed a MeRIT risk assessment, and this case was discussed at MARAC later that month. In between the assault taking place and the case being discussed at MARAC Gill was taken to the Accident and Emergency Department of a local hospital on four separate occasions for treatment to overdoses of illegal substances she had taken.

16.14 During the four attendances to the Accident and Emergency Department Gill was seen by the Alcohol Liaison Team based in the department who completed a risk assessment of her. It was concluded during the attendances that the overdoses were secondary to her addiction therefore, there was no requirement for additional mental health assessment.

16.15 Two weeks prior to the same MARAC meeting Gill disclosed to the CGL Designated Safeguarding Lead that she was living in a tent, was hungry, had no money to buy food and she was using four bags of Heroin and four rocks of Crack Cocaine per day. The meeting discussed her relationship with Francis and offered her support with this, however, Gill declined this offer of support and Gill stated, *"That she needed drugs more than ending the relationship*."

16.16 The Panel feel that the outcome of the MARAC meeting the intersectionality Gill faced was not recognised or dealt with. MARAC failed to identify the "*dynamics and converging patterns of disadvantage*" (F) Gill faced and the way in which various forms of inequality, domestic abuse, homelessness, trauma, and substance misuse were operating together and exacerbating each other. The only action agreed at the conclusion of this MARAC meeting was for the IDVA to link with CGL. Despite the incidents that had occurred in the weeks preceding the meeting, MARAC did not agree any actions to safeguard Gill's mental health, or social needs. Following this action there was liaison between CGL and the IDVA service. Arrangements were made for the IDVA to meet Gill at the offices of CGL but she didn't attend the scheduled appointment. There was no further contact from Gill and therefore the case was closed without any action to reduce to level of risk Gill faced from domestic abuse or other areas of disadvantage being taken. Home Office draft statutory guidance issued under Section 84 of the Domestic Abuse Act 2021 now states that "*It is important that commissioners, service providers and statutory agencies consider this intersectionality when developing their responses to both adult and child victims" (G*).

16.17 A second referral was made to the IDVA Service from Merseyside Police in October 2017 following a physical assault of Gill by Francis, and the case was allocated to a Domestic Abuse Outreach Worker. After several attempts to contact Gill the Outreach Worker was able to speak with her and Gill advised that she did not require support, therefore the case was closed, and no further action was taken.

16.18 During the period of this Review MARAC actions placed an overreliance upon the work of CGL and the IDVA Service to reduce the level of risk from domestic abuse faced by Gill. This reliance was reflective of a weakness in MARAC action planning given the resources available to the two services at that time. CGL make

clear that they were unable to complete any long-term planning with Gill or Francis as both individuals often presented whilst intoxicated which made it difficult to complete meaningful work with them outside of harm reduction and addressing their immediate physical health needs. Due to the high numbers of referrals into MARAC and the low numbers of IDVA's, only two for the whole borough, the IDVA service did not have the capacity to fully engage victims of abuse even those without with the complexity of needs that Gill displayed. In 2019 St Helens MBC provided funding to increase the IDVA Service provision by three extra posts and that funding currently remains in place. Two additional IDVA's were appointed and one Domestic Abuse Outreach Worker. Despite this doubling of IDVA capacity, the number of IDVA's is now four for the borough, this remains below the SafeLives recommended number of IDVA's in proportion to the referral rate of high-risk victims.

16.19 In September 2017 CGL completed a safeguarding review of Francis which concluded that he would be flagged as a risk to others because of the domestic violence shown towards Gill. The safeguarding review noted that "*the violence referred to, happened three months prior to this safeguarding review,* and recorded *that if there were no further incidents of violence within the next month the safeguarding review would be closed"*.

16.20 In October 2017 Francis again assaulted Gill. On the same day of the assault the CGL safeguarding review noted that there had been no further incidents of violence and that the risk Francis presented to others would now be closed. There are no records available which show that on becoming aware of the new act of violence Francis's safeguarding review was reopened and the level of risk he presented reassessed. Reflecting a weakness in the safeguarding system and a lack of focus upon issues of domestic abuse within CGL at that time.

16.21 The day after Gill was assaulted CGL completed a risk assessment with her. This assessment identified a number of issues that Gill was suffering. Substance misuse, domestic abuse, a lack of housing and physical health problems. It is not clear whether this risk assessment was undertaken as a direct result of being informed of the latest violence she had suffered, receipt of the MARAC referral, or whether the risk assessment was part of the schedule of support the service offered. However, having identified the "*dynamics and converging patterns of disadvantage*"

faced by Gill no action was taken by those completing the risk assessment to disrupt this pattern.

16.22 In November 2017 following the previous month's assault upon Gill her case was discussed at St Helens MARAC. Whilst details of the CGL risk assessment were shared at the MARAC meeting, the intersectionality of needs which had been identified in that assessment are not reflected in MARAC actions. MARAC meeting minutes show that the only action agreed at the conclusion of this meeting was for "*CGL to try to get Gill to re-engage with their service and if successful in that to try and link Gill with the IDVA service.*"

16.23 In July 2018, Gill was again physically assaulted by Francis and following a Police risk assessment was referred to MARAC. Less than two weeks after the assault and before the case had been discussed at MARAC Gill was again assessed at CGL as part of their safety planning process. This safety plan again highlighted the "*dynamics and converging patterns of disadvantage*" that Gill faced.

16.24 During this assessment Gill disclosed that she was suffering from PTSD caused by her homelessness and the domestic violence she was being subjected to. Gill disclosed that she had previously self-harmed when in abusive relationships and that physical abuse was present in her current relationship together with controlling behaviour with Gill describing Francis as being "*controlling and extremely jealous*". The Panel have no details of how this control and jealousy manifested itself nor are details available of if/how assessors responded to the disclosure of controlling behaviour in support of Gill.

16.25 Police Officers investigating the July assault were also informed by Gill that Francis was "*extremely jealous and controlling*" but insisted she did not want any Police action taken on this occasion, adding "*it had happened before, and she would take action if it did again*". The only action that was recorded at the MARAC meeting was for the IDVA to liaise with the Hostel were Gill was living to contact Gill. There is no record to show that Gill was referred into or that she was already receiving treatment for her PTSD from her G.P. or any other Health Service.

16.26 Had the outcome of the safety planning undertaken by CGL with Gill been shared at the July 2018 meeting, then MARAC appear to have taken no regard to

the CGL assessment that Gill was suffering PTSD because of her homelessness and the domestic abuse, both physical and controlling abusive behaviour, she was suffering. Nor that currently both Gill and Francis were living in the same Hostel. Thus, doing nothing to reduce the continuing risk Gill faced from Francis and placing the IDVA at risk when trying to contact and engage with Gill. Confirmation of what information was shared at this meeting has not been possible as it was identified by Panel members that the minutes from 26th July 2018 MARAC meeting at which Gill's case was discussed were incomplete and did not capture the full extent of the information which had been shared at the MARAC meeting.

16.27 There is no record of a Suicide Prevention Strategy safety plan having been completed following Gill's disclosure of self-harming, and the physical violence and controlling behaviour within her current relationship, which Gill disclosed increased the risk of her self-harming, either by staff at CGL or later as an action following this information being shared at MARAC.

16.28 In October 2019 Gill was again physically assaulted by Francis. This incident was witnessed and reported to the Police who arrested Francis and whilst a risk assessment was completed the risk faced by Gill was assessed as not being high enough to require presentation at a MARAC meeting.

16.29 Francis pleaded guilty to assaulting Gill in October 2019 and on 5th February 2020 was sentenced to nine months imprisonment, and a five-year Restraining Order was imposed prohibiting him from contacting or approaching Gill by any means. A Supervision Order was also imposed. No further action was taken against him for attempted robbery and the common assault of Gill. Francis was released from custody on 21st February 2020 having served most of his sentence on remand.

16.30 During the period October 2018 to 30th of January 2019 Gill disclosed self-harm injuries to her wrists and arms to staff at CGL on three separate occasions. The Panel have no explanation for why Gill self-harmed during this period nor have any indication that an agency was professionally curious enough to make these enquiries. Nor do records exist of Gill being referred to Mental Health Services or Adult Safeguarding Services or a Suicide Prevention Strategy safety plan following this period of self-harm.

16.31 In November 2018 Gill disclosed that she had self-harmed by cutting her wrists following a row with Francis. She was seen by the CGL Nurse and CGL Doctor, her left wrist looked infected and the CGL Doctor also believed she could have cellulitis. Therefore, Gill was sign posted to Whiston Hospital Accident & Emergency (A&E) Department and was given a letter by the CGL Doctor. Following this incident Gill was allocated to the CGL complex case worker who held interventions in the hostel Gill was living at, this was in the hope that Gill's engagement with CGL would improve so more meaningful work could be completed, rather than focussing on harm reduction and crisis management

16.32 In December 2018 Gill disclosed to CGL that she had made cuts to her left arm after she had told Francis about past acts of prostitution she had engaged in and he was angry about this which she stated "*left her feeling vulnerable*".

16.33 CGL acknowledge that during this period Gill should have been referred by their staff to Mental Health Services due to the number and frequency of occasions that Gill had self-harmed. There is no acknowledgement that by concluding that no mental health referral was required they did then support Gill in other ways to overcome the emotional distress/cry for help she was exhibiting through the self-harm.

16.34 The only occasions when Mental Health Services received referrals into service for Gill and Francis was when the Criminal Justice and Liaison Team were asked on separate occasions to assess Gill and Francis whilst in Police custody. Assessments concluded that neither appeared to be experiencing mental ill health and both declined the offer of further support. The role of the mental health liaison assessor is to ensure that the person in custody is safe to be detained and has the capacity to advocate their views. Although this is an initial assessment the assessors are all experienced Mental Health workers who can assess individuals in a crisis and can formulate a professional view based on the individual presentation. Both Gill and Francis were assessed as being fit to be detained in Police custody and had the capacity to advocate their views.

16.35 Gill's mental capacity was never called into question during her contact with Police, she was always deemed capable of making decisions. During the period of

this Review Gill was seen whilst in custody by several health professionals on behalf of Merseyside Police but was never deemed to need mental health support services.

16.36 The Centre for Suicide Prevention recommends that "*because self-harm can become suicide, it is highly recommended that every patient who self-harms be assessed for suicide risk*" (H). However, the Panel could find no evidence that Gill received support at any point for her self-harming or that she was ever assessed for suicide risk during the period reviewed.

16.37 The St Helens Suicide Prevention Strategy places the responsibility for completion of a safety plan upon the individual agency identifying the risk of suicide within the individual. No single agency ever completed a suicide prevention plan for Gill and there was no Suicide Prevention safety plan completion included as an action at any MARAC meeting.

16.38 Within the St Helens Suicide Prevention Strategy there is no standard risk assessment form or structure for a safety plan available to agencies faced with this task and no central collation or reporting of safety plans. The responsibility for action rests solely with the agency identifying a suicide risk and there is no quality assurance system in place for the plans. Despite St Helens annual suicide audits highlighting domestic abuse as a suicide risk factor domestic abuse nor the risks that domestic abuse presents does not appear anywhere within the current St Helens Suicide Prevention Strategy. Though the St Helens Suicide Partnership OK2ASK website refers to the Cheshire and Merseyside No More Suicide Prevention Strategy of which St Helens is a partner. Safety plans and domestic violence are identified and referred to within the Cheshire and Merseyside strategy and website.

16.39 Researchers agree that people self-harm for several reasons, including:

- *To feel better. Self-harm can release pent-up feelings such as anger and anxiety, or people who feel numb use self-harm as a way to feel "something"*

- *To communicate their emotional pain. Those who self-harm for this reason will obviously display their wounds as a way of reaching out for help.*

- *To feel a sense of control. People who self-harm may feel powerless and lack self-esteem. Self-harm may be used as a way to regain control. This is particularly common for those who have suffered abuse. There is often a pronounced feeling of powerlessness, self-loathing, and an absence of self-esteem.* (I)

16.40 This summary of self-harm risk factors is particularly relevant to Gill's history.

16.41 In addition to the removal into care of her child in 2013 and the physical and controlling abuse Gill was being subjected to by Francis the trauma Gill endured during her life was brought into focus by two further incidents. Firstly, in May 2019 Gill disclosed to her recovery coordinator at CGL that she had previously been raped by an ex-partners close family member. Secondly, on the night of her death friends of Gill told Merseyside Police that Gill had told them that the reason she was extremely upset when they found her in St Helens Town Centre was that Francis, only eight days following his release from custody, had been throwing bottles at her and had been shouting that she had been raped by a close member of her own family. At no point did Gill receive any support to help overcome these traumas.

16.42 Enquiries by the Panel show that neither of these serious sexual assaults had been reported to the Police. Gill having made the disclosure was not referred to RASAC and enquiries show that Gill had chosen not to self-refer herself to RASAC.

16.43 Despite the existence of a Restraining Order being part of Francis sentence for the October assault of Gill no prosecution of Francis has taken place for breaching that Order on the night of her death. Police did submit a file of evidence to the Crown Prosecution Service following this incident however, because the only evidence available was a hearsay account of what had taken place, provided by one of Gill's friends, it was deemed "*insufficient evidence to progress*" a successful prosecution.

16.44 There are several occasions during the period subject of this Review when agency records attribute Gill's self-harm behaviours to substance misuse and therefore there being no requirement for a mental health referral or assessment. The lack of professional curiosity sufficient to establish the catalyst for Gill's substance misuse resulted in the trauma she was suffering being ignored and her emotional and mental health being left unsupported. Agencies appear to have confined themselves to examining Gill's behaviour and its consequences yet giving no consideration to what might have been the antecedents to that behaviour/substance misuse.

16.45 *Experiences of domestic abuse are known to have long term adverse impacts on psychological well-being, particularly when these harms are both traumatic and chronic in nature. Depression, post-traumatic stress, anxiety, and their behavioural consequences, such as social isolation, substance misuse and self-harm (in its broadest sense), are common outcomes of such abuse. These negative consequences are recognised risks for suicide, and its precursor suicidality (suicidal thoughts, plans and attempts) amongst victims of domestic abuse, as well as the general population.* (J)

16.46 No referral to MARAC was made following the incident in October 2019. A risk assessment completed by Merseyside Police following the October 2019 assault assessed the level of risk faced by Gill as Silver or being at medium risk of further violence. Gill was a previous high-risk victim with the same perpetrator and strangulation was again a feature in this incident. However, upon review of the MeRIT forms completed by Police, it appears not to have been completed with the victim in person it does not fully reflect the details of the incident. Panel members believe that the elements of this incident combined with the history of high-risk incidents of physical and coercive behaviour perpetrated upon Gill by Francis should have resulted in a referral to MARAC.

16.47 During the period of this Review the Police attended several incidents of physical abuse inflicted upon Gill by Francis and following their risk assessment those matters were discussed at MARAC. The Panel discussed the absence of a Domestic Violence Protection Notice/Orders (DVPN/O) and their appropriateness to this case. The objective of such an Order is to provide a period of separation which would enable

agencies to secure a co-ordinated approach across agencies for the protection of victims and the management of perpetrators. On reflection Police observe that application for a DVPO would have been appropriate in this case however, no such notices or orders were ever considered or applied for by Merseyside Police.

16.48 Francis was remanded in custody following his assault upon Gill in October 2019 where he remained until his Court appearance in February 2020. During this time CGL recorded that "*Gill is starting to improve; her drug use is reduced, and she is looking after her appearance and personal hygiene*." Whilst no MARAC referral had taken place following the October assault on Gill no agency took the opportunity to utilise this time when Francis was in custody on remand to coordinate an intensive intervention to meet the needs of Gill and break the cycle of abuse she was suffering. All Panel members reflect that this was a missed opportunity.

16.49 In January 2020 prior to Francis's release from custody Gill stated that she did not want to be in a relationship with Francis and instead wanted to focus on herself. Gill said that she was waiting to hear back from her Probation worker regarding accommodation provided by Adullam Housing, a provider of accommodation ranging from hostels, self-contained flats, bedsits through to houses for vulnerable people.

16.50 The Panel recognise throughout this Review and the many periods of homelessness that Gill endured that accommodation available to people suffering the intersectionality challenges that Gill faced is in very short supply and more needs to be done involving housing providers and support agencies working together to increase the availability of safe and secure homes for them. In addition to benefitting the individual this may also alleviate challenges faced by those providers, for example hostels who are often the roof over the head of people with immediate housing needs combined with substance misuse, abusive relationships, and mental health needs.

16.51 During the period reviewed both Gill and Francis spent time in prison. Both upon release also received supervision from the Probation Service and Community Rehabilitation Company.

16.52 Whilst on remand Francis successfully completed training courses. He completed the SMART course and attended educational classes achieving Level 1 in

both Maths and English. However, neither Gill nor Francis attended any training or support aimed at reducing the likelihood of reoffending as a perpetrator of domestic abuse or becoming a repeat victim of domestic abuse either whilst in custody or following release but remaining under supervision. Current practice is that the interventions available to Francis whilst on remand for the October 2019 assault of Gill would have been basic non-offence specific until after conviction thus excluding domestic abuse interventions being explored in his case. The Panel feel that such practice within the criminal justice system reflects a missed opportunity for preventative work to be undertaken.

**17. Conclusion**

17.1 Research with domestically abused women developed understanding about suicidality using a '*cry of pain*' hypothesis. Their hypothesis is that "*suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible*". (K)

17.2 Gill's response to the safeguarding officer in 2017 "*that she needed drugs more than ending the relationship."* may be reflective of her feeling of defeat and that neither rescue nor escape were possible. It also adds focus to the issues of intersectionality's *converging patterns of disadvantage* and incidents of self-harm Gill endured and the lack of agency action or assessment over these matters.

17.3 The Panel had no evidence about the impact that Francis release from prison so soon after the conclusion of the criminal trial had upon Gill's mental health and subsequent decision to take her own life. From the responses to her substance misuse support workers, explaining her desire to have no further contact with Francis, the Panel can only speculate that this may have caused her some distress. Due to the length of sentence Francis received Gill would not have been informed of Francis release from custody however, the five years restraining order imposed as part of his sentence for assaulting Gill which may have afforded Gill some reassurance and protection remained in place at the time that Gill encountered Francis on the night of her death.

17.4 The trauma that Gill had endured was never investigated or supported and agencies would have found providing support to overcome the impact of trauma and abuse that Gill had suffered challenging, due to a lack of resources. There were inadequate levels of action planning at MARAC, combined with a lack of resources within agencies MARAC tasked with supporting Gill. Gill's complex lifestyle, the pattern of disadvantage, and agencies labelling Gill's mental health needs as a substance misuse problem only, are symptomatic of the challenges a victim of domestic abuse who had complex needs faced at that time.

17.5 The Panel can only speculate on this but the result of being subjected to such emotional and physical abuse from Francis within eight days of his release from custody may have led Gill to conclude that there was only one means of escape left open to her when she took her own life.

17.6 The Panel could not find evidence to show that the risk that Gill may take her own life had ever been considered and although "*the role of traumatic experiences, such as domestic abuse and other forms of violence against women and girls is recognised as a precursor to suicide within national and international suicide strategies*" *(L)* specific mention is not made of domestic violence or other forms of violence against women and girls within the St Helens Suicide Prevention Strategy. At the time of Gill's death unlike within the DASH risk assessment, no question was included regarding a victim's suicidality within the MeRIT risk assessment used by all agencies in St Helens. This omission has now been corrected, and the MeRIT risk assessment form amended to include questions to the victim "*Has the victim recently had any suicidal thoughts or previously attempted suicide or self-harm*."

**18.Lessons Learnt.**

18.1 Recently completed DHRs have resulted in a number of changes being made to the policy and practice of organisations supporting domestic abuse survivors in St Helens and some of these are detailed in the following paragraphs. The Panel believe that many of these changes had they been in place at the time would have made a significant impact upon the level of support available to Gill and increased the effectiveness of agencies interventions. The recognition of this leads the Panel

to believe that they justifiably represent lessons learnt about future interventions and should be included within this Review.

18.2 MARAC minutes now being recorded, and actions agreed at previous meetings which have been completed are shared by agencies during the meeting. A review of outstanding risks takes place, and a follow-on action plan is recorded including which agency is accountable for the action's completion.

18.3 A MARAC action tracker has been introduced to record the progress of assigned MARAC actions to ensure there is evidence of outcomes being achieved via the MARAC process or identify areas that require improvement, by monitoring and identification where MARAC agencies need to address a failure to complete actions previously agreed at MARAC.

18.4 CGL have secured funding and support for a new post for the next 12 months to employ a Recovery Coordinator specialising in domestic abuse. The new post will provide the capacity to assertively engage and manage the complexities and risk of victims that have significant substance misuse issues. The aim being to improve victim access and engagement in safety planning, risk management, and linking them with specialist support such as IDVA by using an intensive engagement approach not previously possible.

18.5 There is a cross flow of training and interagency cooperation emerging now more than ever. The IDVA Service and CGL have developed a close working relationship and in addition to completing joint visits to service users they regularly share information outside of the MARAC to work collaboratively and reduce risk, providing a more holistic approach. CGL staff have attended both training offers facilitated by the IDVA service 'Domestic Abuse: Impact on the Child' and 'Merit and MARAC training'. CGL will be delivering bespoke training to the IDVA service to ensure that both services have good insight and awareness to each other's practice and to enhance collaborative working. CGL have shared their internal suicide prevention pack with the IDVA service which will assist with advice, guidance and safety planning for victims who access the IDVA service and report thoughts of self-harm and/or suicidal ideation. CGL have been offering bespoke training to the IDVA

service where mental health and substance use issues are explored. All staff across the Refuge and IDVA/Outreach service have completed suicide awareness training.

18.6 Domestic abuse training has taken place across both Recovery and Assessment Teams within Mental Health Services. 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.

18.7 Safe2Speak provide MeRIT risk assessment/MARAC Awareness/and Local domestic abuse referral pathways training, and Domestic Abuse – Impact on the Child Training to local partner agencies and professionals. Safe2Speak are now providing bespoke training support to several Primary Care services, including tailored MeRIT and MARAC Training to the Think Wellbeing Improving Access to Psychological Therapies, (IAPT) practitioners, and working with the Clinical Commissioning Group (CCG) to provide bespoke MeRIT and MARAC training to local GP's. This training has also been extended to trainee GP's.

18.8 Closer working relationships have been established between Mental Health Services and CGL staff which includes joint home visits between Mental Health Services and CGL and the appointment of a drugs link worker within the Mental Health team.

18.9 Torus Foundation, the charitable arm of the main housing provider Torus, have commissioned Solutions4Health to deliver a Health and Wellbeing programme to those accessing Safe2Speak domestic abuse services, including refuge residents. Solutions4Health have recruited a Domestic Abuse Wellbeing Worker and Domestic Abuse Group Facilitator, to support delivery of the programme and to facilitate individual and group sessions with victims.

18.10 When Gill was being physically assaulted by Francis many of the assaults included pressure being applied around her throat. This method of assault is a recognised indicator that a victim is seven times more likely to be killed by a partner who has assaulted them in this way previously and a new offence is contained within the Domestic Abuse Act 2021.

18.11  A recent Merseyside Police Domestic Homicide Review in another Authority area includes a recommendation that the Force consider raising awareness among officers and staff of the significance of strangulation as a form of domestic abuse, with the aim of ensuring there are no missed opportunities to detect this offence. The Panel support this recommendation as a means of ensuring that risk assessments are completed face to face with the victim and the full range of risk factors are explored.

18.12  There is emerging support for and movement towards adopting a trauma informed approach within services in St Helens which the Panel support.

18.13  CGL adopted a trauma informed approach in 2019 and has changed a number of processes because of this.  CGL reviewed their client base and recognised a cohort of people, who had a complex range of needs.  The process to routinely identify these clients is now in place and because of adopting this new approach CGL have strengthened their offer to people in their service who are victims of domestic abuse and have more robust suicide prevention planning in place.  Senior managers have changed their working patterns to ensure one was always on duty to ensure a meaningful intervention is completed for those clients presenting late or close to the end of business hours, a pattern of presentation which both Gill and Francis displayed.

18.14  A neighbouring Authority on Merseyside have begun a trial employing Complex Needs IDVA's.  Feedback on the outcome of this trial will be shared but early assessment of their effectiveness is very good.  Whilst awaiting the outcome of the trial in the neighbouring Authority Panel members believe that securing funding and the appointment of Complex Needs IDVA's will deliver a significant enhancement to the level of support that services can currently deliver and would have been invaluable in this case.

18.15  Merseyside Police is in the process of updating the force Strategic Mental Health Plan and developing a Suicide Prevention Plan.  As part of this work a Domestic Abuse Suicide Working Group has been established.  This working group includes representatives from Voice of the Victim, Health Services, Mental Health Services, Police, Community Safety Partnership (CSP) leads, a Coroner and

Advocacy After Fatal Domestic Abuse (AAFDA) and their focus is to prevent suicide in domestic abuse. In this work the group will be guided by the learning from suicide related DHRs.

## 19.Recommendations

19.1 Immediate action has been taken following this Review.

1. The MeRIT risk assessment tool has been amended to include questions regarding suicidality and self-harm being asked of the victim.
2. Funding has been secured to appoint a Complex Needs IDVA in St Helens via CGL.
3. Following a refresher training course for all Adult Safeguarding staff the Merit/ MARAC training has now been made mandatory for all new staff joining Safeguarding Services and this commitment has been included within the revised Domestic Abuse Strategy for St Helens.

19.2 However, several further recommendations have been made impacting upon national, regional, and local services.

1. The existing practice of prohibiting domestic abuse interventions from being offered to victims and perpetrators of domestic abuse whilst on remand in H. M. Prison be changed and such interventions be encouraged.
2. Preventative interventions aimed at reducing levels of domestic abuse are shown to have been considered in every case where a victim or perpetrator of domestic abuse is in prison or being supervised within the community.
3. Provide all domestic abuse victims with advanced notice of the perpetrators release from prison after sentences of less than twelve months.
4. A program of proactive intervention be developed, implemented and coordinated by MARAC aimed at providing increased safety for victims

and their families when a perpetrator is placed on remand or sentenced to a term of imprisonment for domestic abuse related offending and prior to their release.

5. Incorporate the issue of domestic abuse as a suicide risk factor, in any future regional or local Suicide Prevention Strategy Action Plan, with the aim of reducing the number of domestic abuse victims who take their own lives.
6. The profile of the suicide prevention strategy be raised in St Helens along with clear direction to individuals and agencies regarding the strategies expectations for safety planning and risk management and what tools are required to be used by all services within the partnership.
7. Funding be secured to appoint more Complex Needs IDVA's in St Helens
8. Embed a trauma informed approach into all training and that training to be co-ordinated and delivered across all relevant partnerships and agencies in St Helens.
9. Training be delivered to accommodation/hostel providers so that they understand their responsibility to safeguard individuals in their accommodation who are experiencing domestic abuse.
10. Accommodation provision be reviewed and relevant changes to current practice made to ensure that victims and perpetrators are able to be accommodated separately at the earliest opportunity.
11. The impact of temporary/short term funded posts be evaluated and sustainable funding be secured as part of a co-ordinated approach to domestic abuse and suicide prevention across St Helens.
12. Ensure that the contents of the Domestic Abuse Act 2021 are the subject of a joint agency training program across all agencies in St Helens.
13. MeRIT and domestic abuse referral pathways training be included as a mandatory training requirement for all front-line staff by all agencies.

## Action Plan

## Action Plan

| Recommendation | Scope | Action to Take | Lead Agency | Key milestone | Target date | Outcome |
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| The existing practice of prohibiting domestic abuse interventions from being offered to victims and perpetrators of domestic abuse whilst on remand in H. M. Prison be changed and such interventions be encouraged. | National | Change of policy regarding interventions whist on remand | Ministry of Justice | Introduction of domestic abuse prevention programs in HMP remand centres. | 6 months from publication of this report. | Maximising opportunity to effect positive changes for survivors and perpetrators of domestic abuse. |
| Preventative interventions aimed at reducing levels | Regional | Change of policy | HMPPS | System to flag up victims or perpetrators | | Maximising opportunity to |

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| of domestic abuse are shown to have been considered in every case where a victim or perpetrator of domestic abuse is in prison or being supervised within the community. | | | | of domestic abuse within prion or under community supervision. | | effect positive changes for survivors and perpetrators of domestic abuse. |
| Provide all domestic abuse victims with advanced notice of the perpetrators release from prison after sentences of less than twelve months. | Regional | Change of policy. | HMPPS Probation Service and CRC. | Increased contact with victims of domestic abuse. | 6 months from publication of this report. | Proactive safety planning for survivors and their families ahead of Prison release. |
| A program of proactive intervention be | Local | Monitoring of criminal justice systems. | Domestic Abuse Partnership | Active monitoring and intervention of cases | 3 months from | Opportunity presented to break the cycle |

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| developed and coordinated by MARAC aimed at providing increased safety for victims and their families when a perpetrator is placed on remand or sentenced to a term of imprisonment for domestic abuse related offending and prior to their release. | | Active outreach and engagement work lead by MARAC with victims and their families. | and Chair of MARAC | after initial MARAC meeting. | publication of this report. | of abuse faced by some survivors. |
| Incorporate the issue of domestic abuse as a suicide risk factor, in regional and local Suicide Prevention Strategy Action Plans. | Regional and Local | Inclusion of domestic abuse within suicide prevention strategies | Merseyside Police and Public Heath lead on the Suicide Prevention Strategy. | Recognising that inclusion is required. | 3 months from publication of this report. | Raised awareness amongst practitioners of the increased risk of suicide from domestic |

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| | | | | | | abuse leading to reduction in numbers of survivors of abuse who commit suicide. |
| The profile of the suicide prevention strategy be raised in St Helens along with clear direction to individuals and agencies regarding the strategies expectations for safety planning and risk management and what tools are required to be used by all services within the partnership. | Local | Revision of existing strategy and education across St Helens agencies of new strategies existence. | Public Health | Revision of existing Suicide Prevention Strategy | 3 Months from publication of this strategy. | Reducing the level of risk of suicidality amongst survivors of domestic abuse. |

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| Funding be secured to appoint more Complex Needs IDVA's in St Helens. | Local | Identification of budget | Domestic Abuse Partnership | Agreement of need for the posts. | 12 months from publication of this report. | Better outcomes for survivors with complex needs. |
| Embed a trauma informed approach into all training and that training to be co-ordinated and delivered across all relevant partnerships and agencies in St Helens. | Local | Training and inclusion plan being developed and implemented. | Domestic Abuse Partnership | Present position audit. | 3 months from publication of this report. | Identification of the cause of need amongst survivors and more accurate response to those needs. |
| Training be delivered with accommodation/hostel providers so that they understand their responsibility to safeguard individuals who they are accommodating | Local | Engagement with all accommodation/Hostel providers. | Domestic Abuse Partnership | Change of policy amongst accommodation/Hostel providers. | 6 months from the publication of this report | Safer accommodation delivered by removing proximity of perpetrator to victim. |

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| and are experiencing domestic abuse. | | | | | | |
| Additional accommodation be secured to ensure that victims and perpetrators who are homeless and suffering complex needs are able to be accommodated. | Local | Mapping local provision.<br><br>Filling gaps in provision. | Domestic Abuse Partnership | Mapping local provision.<br><br>Securing extra provision.<br><br>Engagement of all housing providers. | 6 months from publication of this report. | Safer housing provision for the survivors of abuse. |
| The impact of temporary/short term funded posts be evaluated and sustainable funding be secured as part of a co-ordinated approach to domestic abuse and | Local | Analysis of current short term funded posts, numbers and service being provided. | Domestic Abuse Partnership and Peoples Board. | Identification of posts affected by short term funding.<br><br>Assessment of need and funding to meet those needs | Within 1 year of the publication of this report. | Sustainable provision of services and certainty around support for survivors and perpetrators of domestic abuse |

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| suicide prevention across St Helens. | | | | | | |
| Ensure that the contents of the Domestic Abuse Act 2021 be the subject of a joint agency training program across all agencies in St Helens. | Local | Creation of training plan. | Domestic Abuse Partnership | Publication of Act. | Within 3 months of this report being published. | More effective response to abuse through increased knowledge of powers available. |
| MeRIT and domestic abuse referral pathways training be considered by all agencies as a mandatory training requirement for all front-line staff. | Local | Amendment of current training policy and plans. | Domestic Abuse Partnership | Inclusion of referral pathways into training plans. | Within 3 months of publication of this report. | Clarity for all front line staff and increased likelihood of action being taken following survivors disclosure. |

# Appendix B

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