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St Helens Community Safety Partnership

Domestic Homicide Review

'Sarah'

Died June 2022

Chair and Author: Dan Bettison

Date: 28 July 2023

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1 Introduction

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

1.2 Sarah was single and had two children. Sarah was 46 years old when she took her own life. At the time of Sarah's death, one of her children (Jamie[2]) was of secondary school age, and one (Max[3]) was an adult. Jamie lived with Sarah in a privately owned property in St Helens. For more than 25 years, Sarah was employed as a healthcare assistant at a local hospital: where she worked permanent night shifts.

1.3 In March 2022, Sarah formed a relationship with Jordan[4], who would often stay overnight at her house. On occasions, Sarah would stay overnight at Jordan's house, along with Jamie.

1.4 From 2002 until the timeframe of this review, Sarah reported domestic abuse incidents to the police and Children's Social Care. Early incidents involved the father of Sarah's eldest child. Sarah continued to report domestic abuse by several partners after this time, some of whom were subject to arrest.

1.5 In April 2020, Sarah first reported Max's disruptive behaviour to the police. Over the following 23 months, she reported three further incidents involving Max, which were recorded by police as domestic abuse.

1.6 In 2022, Sarah reported further domestic abuse involving two partners – the latter being Jordan, who was arrested.

Following this incident, Jamie was made subject to a Child Protection Plan – to safeguard them from the effects of potential domestic abuse between Sarah and Jordan.

1.7 Sarah reported further domestic abuse from Jordan, who in June 2022 was made subject to a Domestic Violence Prevention Order (DVPO). This was in place at the time Sarah took her own life whilst alone at home.

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

1.8 In addition to agency involvement, this review will also examine: the past to identify any relevant background or trail of abuse before Sarah'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.

1.9 The review considers agencies' contact and involvement with Sarah, Jordan, Max, and Jamie from 1 September 2019 until her death in June 2022.

This time period was chosen as it covers a period when Sarah did not report any domestic abuse. The panel felt it important to establish what her life looked like during this time and what changed when she began to report abuse from Max and her partners, including Jordan. This period also included several safeguarding concerns regarding Jamie, and therefore this timeframe ensures that relevant interactions with support agencies were captured.

1.10 The intention of the review is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.11 **Note:**
It is not the purpose of this DHR to enquire into how Sarah died: that is a matter that has already been investigated by the police and coroner.

2 Timescales

2.1 This review began on 1 December 2022 and was concluded on 28 June 2023.

More detailed information on timescales and decision-making is shown at paragraph 5.2.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family (including any advocacy support) during the review process.

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

4 Terms of Reference

4.1 'The purpose of a DHR is to:

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

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

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

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

Contribute to a better understanding of the nature of domestic violence and abuse; and Highlight good practice'.

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

4.2 Timeframe Under Review

The DHR covers the period from 1 September 2019 to 20 June 2022.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Sarah, aged 46 years

Sarah's child: Max, aged 19 years

Sarah's child: Jamie, secondary school age

Sarah's partner: Jordan, aged 47 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Sarah, and how did your agency assess the level of risk presented by the alleged perpetrators (Max and Jordan)? Which risk assessment model did you use?

2. What knowledge did your agency have that indicated Sarah could be at risk of suicide because of any domestic abuse?

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

4. What consideration did your agency give to any mental health issues or use of controlled drugs when identifying, assessing, and managing risks around domestic abuse?

5. In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?

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

7. How did your agency ascertain the wishes and feelings of Sarah, Max, and Jordan in relation to alleged offending, and were their views considered when providing services or support?

8. How effective was inter-agency information sharing and co-operation in response to Sarah, Max, Jamie, and Jordan, and was information shared with those agencies who needed it?

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

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

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

12. What impact did factors such as Covid-19 restrictions, staffing shortages, cuts or budget constraints have on services provided to Sarah?

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

14. What training did your agency provide to staff around domestic abuse, including between parent and child? Had staff who interacted with the family, completed the training and when?

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

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

5 Methodology

5.1 On 6 September 2022, St Helens Community Safety Partnership held a meeting to consider multi-agency information held in relation to Sarah, her children, and Jordan. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review [para 18 Statutory Home Office Guidance][5] and recommended one should be conducted. The Home Office was informed on 1 May 2023.

5.2 The first meeting of the DHR panel took place on 1 December 2022, via Microsoft Teams video conferencing. Some subsequent meetings took place in person and some using Microsoft Teams. The panel met five times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 26 May 2023, after which, amendments were made to the report that were agreed by the panel.

5.3 The Chair attempted to make contact with Sarah's sibling to offer them an opportunity to read the final report, provide feedback and make observations. They did not respond.

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

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

6.1 Family

6.1.1 The DHR Chair wrote to Sarah's mother, inviting her to contribute to the review. The letter included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[6] leaflet. Sarah's mother spoke with the Chair briefly, by telephone, but was upset and felt unable to discuss her daughter. She asked that the Chair speak with Sarah's sibling.

6.1.2 Sarah's sibling contacted the Chair. On behalf of them and their mother, they politely declined an opportunity to contribute to the review. The Chair did speak with Sarah's sibling on several further occasions and provided updates in relation to progress, along with further offers for the family to share background and give Sarah a voice throughout the review.

6.1.3 The panel discussed at length, the appropriateness of offering an opportunity for Max and Jamie to contribute to the review. Jamie is a child and lives with their grandmother (Sarah's mother), who is seeking parental rights via a Special Guardianship Order. Safeguarding concerns had previously been raised in respect of Jamie; consequently, following Sarah's death, Jamie, along with their grandmother, have been supported by Children's Social Care.

6.1.4 The panel considered observations made by Sarah's sibling. They felt that to invite Jamie to contribute to the review, would place unmanageable pressure on them, which could have a detrimental effect on their health and impede recovery from trauma following the death of their mother.

6.1.5 The panel also considered the views of Children's Social Care, Jamie's school, and the legal advisor to the panel. All suggested that to not offer Jamie an opportunity to contribute, would be unfair and would be contrary to the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

6.1.6 The panel therefore considered notifying Jamie that a review was taking place through existing social and educational support services. Jamie's grandmother did not provide consent for Jamie to be approached by the panel or contribute to the review.

[6] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

6.1.7 Max is an adult but has also experienced traumatic and violent events throughout their life. They have a close relationship with Jamie, and the panel was conscious that anything discussed with them, would likely be shared with Jamie. The panel still felt that it was important to offer Max an opportunity to contribute to the review, and through their Probation Service offender manager, made contact with them. Max did not wish to speak with the Chair or contribute to the review; however, observations made by them during meetings with their Probation Service offender manager, have been considered by the panel.

6.1.8 The panel felt that further attempts to persuade Sarah's family to be involved would be inappropriate and agreed to respect their privacy.

6.2 The Perpetrator

6.2.1 The Chair wrote to Jordan and asked if he was prepared to contribute to the review. He did not respond.

6.3 Employer

6.3.1 Sarah was employed as a healthcare assistant at a local hospital. Her role was in physical health care. The Chair met with Sarah's manager, who had known her for more than 10 years. Their contribution is referenced within the report.

6.4 Friends

6.4.1 One of Sarah's friends agreed to speak with the Chair. They also agreed to try and facilitate contact with other friends of Sarah; however, this was never achieved. Their contribution is referenced within the report.

6.4.2 The DHR Chair wrote an open letter to Sarah's work colleagues, which was distributed by her manager. Friends contacted the Chair anonymously by email and provided background information within a work context: these are referenced within the report.

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

7.1.1	**Agency**	**Contribution**
	Merseyside Police	IMR
	Children and Young People Services (Referred to as Children's Social Care throughout the report)	IMR
	Safe2Speak	IMR
	Cheshire and Mersey Integrated Care Board	2 IMRs (one for each GP Practice)
	Mersey Care	IMR
	St Helens and Knowsley NHS Trust	IMR
	North West Probation Service	Short report
	We Are With You (formally Addaction)	IMR

7.1.2 In addition to the IMRs, each agency provided a chronology of interaction with all subjects of the review, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of the subjects of the review, nor had any involvement in the provision of services to them.

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

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions

[7] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with the subjects of the review.

taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 The IMRs in this case focussed on the issues facing Sarah and her children. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency, and by the DHR Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.2 Information About Agencies Contributing to the Review

7.2.1 Merseyside Police

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

7.2.2 Children and Young People Services

St Helens Children and Young People, offers services to support vulnerable children and families within the borough. The services offered, range from early help and community services, to protecting and safeguarding children with dedicated social work teams. The services offered will often include assessment of need, with plans for intervention working alongside stakeholders and partnerships in the interest of working together to safeguard children in St Helens.

7.2.3 Safe2Speak

Safe2Speak is the specialist domestic abuse service in St Helens, commissioned by the local authority and based within Torus Housing. Safe2Speak supports all victims of domestic abuse and works with all levels of risk. IDVAs work with high-risk victims of domestic abuse, and the outreach workers support medium- and standard-risk victims of domestic abuse.

7.2.4 Cheshire and Mersey Integrated Care Board

Cheshire and Mersey Integrated Care Board is the commissioning organisation for local health services and providers. For the DHR process, its role is to facilitate and enable the engagement of health services / primary care in the review.

7.2.5 Mersey Care NHS

Mersey Care NHS Foundation Trust provides mental health care services such as inpatient care, community mental health services, and urgent care services (including A&E Liaison services as well as Criminal Justice Liaison and Diversion services). They also provide community care services for physical health: they only provide limited community care services in St Helens, as the main provider is St Helens and Knowsley Trust for this. However, community care services include services such as Talking Therapies, which are provided in St Helens (this is just for adults). They also have 0-19 services for children, and specifically to St Helens, a Safeguarding Specialist Nurse sits within the MASH team.

7.2.6 St Helens and Knowsley (STHK) NHS Trust

STHK NHS Trust provides both acute and community-based services within St Helens and Knowsley, with services available to patients in all surrounding boroughs, including Warrington, Wigan, and Ormskirk. There are three main sites located in Whiston, St Helens, and Newton Hospitals, with additional community services at various localities, including St Helens Urgent Treatment Centre and Marshalls Cross GP Practice. Services are offered to adults and children of all ages, including maternity, acute paediatrics, accident and emergency, and care of the elderly. STHK hosts the Northwest Specialist Burns and Plastics Unit, accepting adult patients from Merseyside, Cheshire, North Wales, and the Isle of Man.

7.2.7 We Are With You (formerly Addaction)

Addaction was a commissioned service for people over 18, living in St Helens, who were worried about either their drug (including prescription drugs) or alcohol use, or someone else's that they knew. This service ran from April 2012 to January 2017 and although it's interaction preceded the timeframe under review, the panel felt it necessary to understand what support Sarah had previously received; especially considering that she did not access substance misuse services provided by a different provider commissioned during the timeframe.

7.2.8 School

Jamie's current and previous school were both approached. Information was requested from them in respect of information held: this covered the timeframe of the review. Both schools had difficulty in accessing information due to a previous cyber-attack: where data was lost. Jamie's current headteacher did attend one panel meeting and provided an educational viewpoint on their current wellbeing, safeguarding, and progress. The panel did not feel that their continued involvement

in the DHR was necessary, as relevant information was captured through Jamie's ongoing engagement with Children's Social Care.

8 The Review Panel Members

8.1	Dan Bettison	Chair and Author
	Bev Jonkers	Neighbourhood Support Officer, Community Safety, St Helens Borough Council
	Jane Arrowsmith	Team Manager, Community Safety, St Helens Borough Council
	Lindsay McAllister	Designated Nurse Safeguarding Adults, Cheshire and Mersey Integrated Care Board
	Anna Lock	Team Leader, Safe2Speak
	Jo Bibby	Head of Service EDT, MASH, Duty, Complex Safeguarding, Children and Young Peoples Service
	Anne Monteith	Assistant Director Nursing Safeguarding, STHK NHS Trust
	Sarah Shaw	Assistant Director of Safeguarding, Mersey Care NHS
	Leanne Hobin	Detective Chief Inspector, Merseyside Police
	Martine McClear	Quality Lead for St Helens, Change Grow Live CGL
	Sharon Hymes	Legal, Children & Young People and Adults & Integrated Health
	Francesca Smith	Head of Safeguarding,

	St Helens Local Authority
Donna Birch	Housing Options and Advice Manager, St Helens Borough Council

8.2 The DHR Chair was satisfied that the members were independent and did not have any operational or management involvement with the events considered by this review.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors. In this case, the Chair and Author were the same person.

9.2 Dan Bettison was chosen as the Independent Chair and Author of the review. Following a career in policing (not Merseyside), he is now an independent practitioner who consults within mental health services, education, and Children's Social Care. He is an Associate Trainer for the College of Policing and an Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services. He has completed accredited training for DHR Chairs, provided by AAFDA, and has chaired and written previous DHRs.

10 Parallel Reviews

10.1 An inquest was held on 15 February 2023.

The coroner concluded a drug-related death: the medical cause being Venlafaxine Toxicity.

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

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

11 Equality and Diversity

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

Age (for example an age group would include "over fifties" or twenty-one-year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range).

Disability (for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act).

Gender reassignment (for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act).

Marriage and civil partnership (for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic).

Pregnancy and maternity

Race (for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens).

Religion or belief (for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be).

Sex

Sexual orientation (for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation).

Section 6 of the Act defines 'disability' as:

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

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

11.2 Sarah had a long-standing association with alcohol. Records of historic domestic abuse incidents, from as far back as 2002, include references to alcohol use being a contributory factor. It is not always clear within historical records whether that was due to alcohol being used by the perpetrators or by Sarah.

11.3 Historic records held by Children's Social Care, include reports of Sarah's alcohol use allegedly impacting her ability to care for her children.

11.4 Sarah's family and friends felt that she suffered with alcohol use disorder, and they described several occasions where they offered to help Sarah access support services. Sarah declined their offers of support. In 2015, she did, however, self-refer for support in respect of alcohol use. She received advice over a period of six months before being discharged by the service provider.

11.5 In 2019, Sarah was arrested for driving a vehicle whilst over the prescribed limit. This followed a road traffic collision and resulted in her conviction (non-custodial).

11.6 Sarah worked for over 20 years as a healthcare assistant and although there were periods of absence due to ill health, none were attributed to alcohol use.

11.7 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010.

Alcohol addiction is not, therefore, covered by the Act.

11.8 Sarah suffered with depression and anxiety and was prescribed medication for this throughout her adult life.

11.9 All subjects of this review are white British. During the period of the review, all subjects were living in an area that is predominantly white British demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

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

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

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

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

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

11.11 The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has conducted a study to establish preliminary data about women who died by suicide while employed as nurses. The study revealed that over fifty percent of nurses who died, were not in contact with mental health services.

Their June 2020 report, stated:

'Some indicators of suicide risk in female nurses, such as depression and substance misuse, are common to most groups who are at risk. They show the importance of comprehensive, needs-based clinical care in improving prevention.'

11.12 Despite Sarah's medical conditions and use of alcohol, the panel did not feel that her ability to carry out day-to-day activities was affected to the extent that she was disabled within the meaning of the Equality Act.

12 Dissemination

12.1 Sarah's family
Home Office
St Helens Community Safety Partnership
Merseyside Police and Crime Commissioner
Domestic Abuse Commissioner
All agencies contributing to this review

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, discussions with Sarah's family, friends, and employer, and material gathered by the police during their investigation following Sarah's death.

The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1 Relevant History

13.1.1 Prior to the timeframe of the review, police recorded Sarah as being a victim of domestic abuse on 14 occasions: the earliest being in 2004. She was a victim of abuse and physical assault by several previous partners, some of whom were arrested and convicted of relevant offences. On two occasions between 2006 and 2008, Sarah was referred to Women's Aid[8] for support following domestic abuse.

13.1.2 On one occasion in 2010, Sarah and Max were both assaulted by Sarah's partner. Sarah's case was referred to MARAC, and she received specialist support from domestic abuse services and Children's Social Care. Sarah also obtained a restraining order against that partner, to prevent further contact.

[8] Women's Aid Federation of England, commonly called Women's Aid within England, is one of a group of charities across the United Kingdom. Its aim is to end domestic violence against women and children.

13.1.3 Between 2012 and 2019, Sarah reported one incident of domestic abuse to police. During that same period, Children's Social Care continued to engage with her regularly – following allegations of excessive alcohol consumption impacting her ability to care for her youngest child, Jamie. During this time, Sarah's eldest child, Max, spent several periods of time living with Sarah's mother.

13.1.4 Family and friends described that throughout Sarah's life, she experienced challenging and sometimes abusive relationships. They also described how, on occasions, Sarah's children had been present and witnessed both domestic abuse and excessive alcohol use by Sarah and her partners. This resulted in Sarah's family challenging her and taking both children away to care for them for short periods, until Sarah had recovered from the effects of alcohol.

13.1.5 Whilst Sarah was the victim of domestic abuse in most of the reported cases, there were also occasions when the family were informed by Sarah's partners that they themselves had been the victim of abuse or violence committed by Sarah.

13.1.6 Sarah was described as a smart individual, who gained qualifications leading to her career as a healthcare assistant. She chose to work permanent night shifts, as the pay enabled her to provide greater financial support for her children. Max and Jamie's fathers had no contact with the children, leaving Sarah as a single parent. Sarah was supported by her mother for childcare when needed.

13.1.7 Prior to the timeframe of the review, Sarah had three periods of absence from work due to anxiety and depression. She accepted offers of support from occupational health services, and she informed managers that she had received counselling.

13.1.8 Sarah and her children attended the same GP surgery for most of their lives, and since 2015, Sarah had been prescribed medication to treat anxiety and depression.

13.1.9 Sarah enjoyed going to the gym and using sunbeds. After forming a relationship with Jordan around March 2022, this stopped, and Sarah spent much of her time at home with him. Jordan would attend a local shop as early as 8 am to buy alcohol for them both.

13.1.10 Max and Jordan did not get on well, and after Sarah began that relationship, her contact with Max was significantly reduced. Sarah and Max had always been close, and her friends were surprised that immediately before she took her own life, when Sarah sent a final goodbye text message to Jamie, she did not send a similar message to Max.

13.2 Events within Timeframe of Review

The following paragraphs summarise domestic abuse and safeguarding issues affecting Sarah within the timeframe of the review, which the panel felt were most relevant.

13.2.1 On 8 September 2019, the police attended a road traffic collision in which Sarah had collided with another vehicle whilst parking. She was arrested on suspicion of driving whilst under the influence of alcohol and was later convicted of driving whilst over the prescribed limit.

13.2.2 On 13 September 2019, Children's Social Care received an anonymous letter that made allegations that Sarah's misuse of alcohol affected her ability to care for Jamie.

13.2.3 Enquiries were undertaken by the MASH, which concluded that no further action was required. Jamie's school attendance was good, and Sarah's family did not agree that at that point, her alcohol use was unreasonable. Sarah disputed the allegation and although she admitted to excessive alcohol use in the past, she stated that this was no longer the case. Children's Social Care advised Sarah to refer to CGL for support with her use of alcohol, but she refused.

13.2.4 On 30 September 2019, Sarah reported that her partner had died. Friends and Sarah's employer believed that this was due to an alcohol-related illness and described her as being badly affected by the event. After his death, Sarah's GP increased her medication to treat anxiety and depression, and she was absent from work due to the deterioration of her mental health.

13.2.5 On 6 October 2019, Sarah was accused of assault by a different partner. The police recorded Sarah as the suspect but took no further action after her partner retracted his complaint. The police recorded that there was insufficient evidence to pursue an evidence-led prosecution.

13.2.6 On 27 October 2019, Sarah's now former partner reported that she had made threatening telephone calls to a terminally ill member of his family. The victim did not wish to pursue a complaint, and the police took no further action against Sarah.

The police did, however, complete a Vulnerable Person Referral Form (VPRF 1[9]) in relation to domestic abuse by Sarah against her former partner. They graded the risk as bronze[10].

13.2.7 On 25 April 2020, Sarah contacted the police at 3 am to report that her eldest child, Max (who at the time was 17 years old), was being disruptive at home. She suspected that Max was under the influence of drugs. Sarah was provided with advice over the telephone, after stating that she did not want the police to attend the address. A VPRF 1 form was completed; however, no referral was made to Children's Social Care because Sarah did not provide consent to the information being shared with other agencies. The police signposted Sarah to the Merseyside Police website page to find information about domestic abuse.

13.2.8 On 20 July 2020, Sarah was issued with a not fit for work note by her GP due to pain and inflammation in her foot. Blood tests were taken, which revealed that she was suffering with gout.

13.2.9 On 5 December 2020, Sarah contacted the police to report that Max (now 18 years old) was under the influence of cannabis and was arguing with her. When the police arrived at Sarah's home, she informed them that she wanted Max to leave the house, which he did. Max was in possession of cannabis, and the police issued him with a warning. A VPRF 1 was completed, and the risk was graded as bronze.

13.2.10 On 20 March 2021, Sarah attended the emergency department, at a local hospital, reporting back pain. She informed staff that she had not been subject to any direct trauma and was diagnosed with lumbar muscular pain. The hospital recorded that Sarah had a history of anxiety but received no regular medication. She was discharged with co-codamol, naproxen (analgesia medication), and diazepam to treat muscle spasms.

13.2.11 On 22 March 2021, Sarah had a telephone appointment with her GP, reporting further mechanical lower back pain. She was prescribed additional diazepam medication.

[9] Police officers responding to domestic violence incidents, use the Merseyside Risk Identification Tool – MeRIT – to establish the level of risk faced by the victim. This information, together with any additional comments by the officer, is used to populate the VPRF 1.

[10] Domestic abuse victims are risk assessed and categorised as Gold, Silver, or Bronze. Gold is the highest risk.

13.2.12 On 26 March 2021, Sarah had a telephone appointment with a different GP. Sarah asked for further pain relief medication, and after a review by the GP, she was prescribed co-codamol and naproxen.

On the same day, Sarah had another telephone consultation with the same GP, requesting pain relief for her adult child, Max, who had fractured his hand four days earlier. The GP also spoke to Max during the telephone call and prescribed him co-codamol.

13.2.13 On 23 January 2022, Sarah reported to the police that Max was being aggressive towards her, and she feared that she may be assaulted by him. When the police arrived, Max had already left, and Sarah did not wish to make a complaint. They recorded the incident as domestic abuse and graded the risk as bronze.

13.2.14 On 17 February 2022, Sarah reported to the police that her partner had been assaulted by Max and that he was in possession of a knife. Sarah did not provide a witness statement; however, Max was arrested in possession of drugs, an air weapon, and a meat cleaver. The police graded the risk to Sarah as bronze. No referral was made for Sarah to receive support from specialist domestic abuse services.

13.2.15 Max was charged and given bail conditions preventing him from contacting Sarah or entering the street where she lived. On conviction, Max received a supervision order.

13.2.16 Following this incident, the police made a referral to Children's Social Care in respect of Jamie, who had also been present.

13.2.17 On 22 February 2022, Children's Social Care conducted a Children and Families Assessment: this was following the incident where Max had assaulted Sarah's partner. The assessment focussed on allegations of sexual assault within Sarah's house at the same time as the incident took place. Jamie had been upstairs with friends, one of whom alleged that they had been sexually assaulted by another. The children concerned had been consuming alcohol in Jamie's bedroom whilst Sarah was downstairs with her partner.

13.2.18 On 25 March 2022, Sarah's mother contacted the police after Jamie had rung her to report that Sarah's partner (Jordan) was in their house and was being verbally abusive towards them and Sarah, accusing one of them of stealing a bracelet. The police attended and found Sarah and Jordan to be under the influence of alcohol.

Jordan was not arrested, but a crime was recorded for common assault relating to him pushing Sarah against a wall.

13.2.19 Sarah did not provide a complaint in respect of domestic abuse. The police recorded the risk as bronze and did not pursue an evidence-led prosecution. The police considered that the Domestic Violence Disclosure Scheme (DVDS)[11] was appropriate, due to Jordan's history of domestic abuse with previous partners. This was not issued to Sarah at the time, and the police later sought assistance from Children's Social Care to help make arrangements for issue.

13.2.20 On 6 May 2022, a strategy meeting took place regarding Jamie. Professionals agreed that a Child Protection Investigation should be carried out on the basis that Sarah had refused to meet with professionals to receive a DVDS, and they were also concerned that Sarah had allowed a relatively unknown male into her family home so soon into a relationship.

13.2.21 On 17 May 2022, Children's Social Care decided that their investigation justified progressing to an Initial Child Protection Conference.

13.2.22 On 17 May 2022, Sarah had a telephone appointment with her GP. She stated that work was making her unwell through stress and requested a not fit to work note, which was issued.

13.2.23 On 24 May 2022, Children's Social Care supported Sarah to access a DVDS in respect of Jordan. The social worker noted that Sarah was shocked and upset to learn of the extent of information held about Jordan.

13.2.24 On 26 May 2022, Jamie was made subject to a Child Protection Plan, to manage risks presented by domestic abuse from Jordan.

13.2.25 On 11 June 2022, Sarah contacted the police to report that Jordan had been abusive towards her by making threats and pouring water over her head whilst in bed. Jordan had left the house, and the police did not attend at the time.

[11] The Domestic Violence Disclosure Scheme (the "DVDS") – often referred to as "Clare's Law" after the tragic case of Clare Wood, who was murdered by her former partner in Greater Manchester in 2009 – was rolled out across all 43 police forces in England and Wales in March 2014. The DVDS was introduced to set out procedures that could be used by the police to disclose information about previous violent or abusive offending, including emotional abuse, controlling or coercive behaviour, or economic abuse by an individual, where this may help protect their partner or ex-partner, and any relevant children, from violent or abusive offending.

13.2.26 Officers did not attend Sarah's address immediately; however, following several reviews of the incident by control room supervisors, the police attended her address 42 hours later and found Jordan present. Jordan was arrested for threats to kill, threats to commit criminal damage, and common assault.

13.2.27 Sarah did not provide a statement to officers or make a complaint against Jordan. A VPRF 1 was completed, and the risks to Sarah were graded as gold. Referrals were made to MARAC and IDVA.

The police issued Jordan with a Domestic Violence Protection Notice (DVPN)[12], and a Domestic Violence Protection Order (DVPO) was granted at court on 13 June 2022.

13.2.28 On 14 June 2022, Safe2Speak (S2S) received and accepted a referral from the police; however, attempted telephone contact with Sarah was unsuccessful.

13.2.29 On 15 June 2022, Children's Social Care also contacted S2S to request support for Sarah. The IDVA requested assistance from Children's Social Care to contact Sarah, as she had not answered their telephone calls.

13.2.30 On a day later in June 2022, North West Ambulance Service attended Sarah's home address. Sarah's friend had entered to look for her after being unable to make contact. Sarah had passed away and was laid on the bathroom floor with empty medication packets nearby. The front door was closed but not locked.

13.2.31 Within the lounge of Sarah's house, the police discovered a number of notes that appeared to have been handwritten by Sarah. The notes did not state that Sarah intended to end her life but did suggest that she was frightened, that she felt that she was being 'kept in the dark', and that the perpetrator would be believed, rather than her. The writing included references to DVDS and DVPN.

13.2.32 The police attended and made enquiries, which established that Jordan had been at Sarah's address the previous day. He was arrested for a breach of the DVPO and also on suspicion of assault, due to injuries discovered on Sarah's face.

[12] A DVPN is an emergency non-molestation and eviction notice that can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by the police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

13.2.33 The police had insufficient evidence to charge Jordan with assault but did charge him with breaching the DVPN, for which he received a £200 fine at court.

13.2.34 A Home Office post-mortem was authorised, and the pathologist determined that Sarah's facial injuries had no causal bearing on her death. They concluded that the cause of death was Venlafaxine Toxicity.

14 Analysis

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Sarah, and how did your agency assess the level of risk presented by the alleged perpetrators (Max and Jordan)? Which risk assessment model did you use?

14.1.1 Merseyside Police recorded that Sarah first reported domestic abuse in August 2004, when she reported an incident that took place outside of their force area. From the date of that first report to 2019, Merseyside Police recorded a further 13 incidents of domestic abuse: where Sarah was the victim.

14.1.2 Merseyside Police reported that during a domestic incident in October 2010, both Sarah and Max were assaulted by Sarah's partner. Her partner was convicted and received a six-month suspended custodial sentence. Sarah was referred to MARAC and IDVA services and received advice leading to her obtaining a restraining order to prevent further contact from her former partner.

14.1.3 During the timeframe of this review, Merseyside Police reported two domestic abuse incidents where Sarah was recorded as the perpetrator and had been accused of assault and threatening telephone calls. No further action was taken by Merseyside Police in respect of either incident.

14.1.4 During the same period, Merseyside Police recorded four incidents where Sarah's child, Max, was the perpetrator of domestic abuse against her. Sarah had contacted the police to report Max's disruptive and abusive behaviour, which was addressed by the police in differing ways – from words of advice to Max's arrest on one occasion.

14.1.5 In March 2022, the police attended Sarah's address to the first incident of domestic abuse involving Jordan. The report came from Sarah's mother who had been contacted by Jamie to say that Jordan was screaming at them both, accusing them

of stealing a bracelet. Jordan was not arrested, and the matter was filed 'no further police action' because Sarah did not support a prosecution.

14.1.6 In June 2022, Sarah reported abuse and violence from Jordan. Although the police initially dealt with that incident by telephone, when they did arrive at Sarah's home, Jordan was arrested for threats to kill, threats to commit criminal damage, and common assault.

14.1.7 In all the incidents during the timeframe of the review, Merseyside Police used the MeRIT risk assessment tool, which is found within its VPRF 1 form. With the exception of the incident in June 2022, which was graded gold, the incidents were graded bronze on each occasion.

14.1.8 The MeRIT risk assessment tool consists of 40 risk factors laid out as questions on the VPRF 1.

The panel was informed that Merseyside Police officers are frequently reminded that the questions are intended to be a stimulus to explore risk and should not merely be read to victims, who may not always understand the terminology used.

Divided into three sections, the questions require a 'Yes' or 'No' response, with qualifying information if an explanation is deemed necessary. They are designed to illicit information about various facets of the relationship: breakdown, social, and violence. The answers help to provide an understanding of the incident in order to identify the appropriate intervention.

The incident is automatically scored between 1 and 72, resulting in a risk level of bronze, silver, or gold. Officers are trained to use their professional judgement during the assessment and to increase the risk level if they consider it necessary.

14.1.9 The panel considered the MeRIT assessments for all domestic abuse incidents reported by Sarah during the period of review. Max was recorded as the perpetrator in three of those incidents and Jordan in two of those incidents (no MeRIT was completed for the first incident with Max – 25 April 2020). Considering what was recorded by the attending officers in response to the questions asked within the MeRIT, the panel felt that the resulting gradings were correct.

14.1.10 The panel also considered whether the MeRIT risk factor questions were fit for purpose or encouraged effective assessment of risk to victims. Panel members sought operational feedback from their respective agencies on the suitability of MeRIT as a risk assessment tool. The following points are examples of feedback received:

- There can be an inconsistent approach to completing the MeRIT. For example, *'Is the victim a repeat victim'* is a vague question and will not always capture incidents involving different perpetrators

- There is no direct question relating to coercive and controlling behaviour or the impact of controlling behaviours on the victim

- There is no question regarding risk of suicide for the victim, and it does not ask about history or current risk around suicidal ideation or intent for the victim

- There is no question regarding type of occupation for the victim and perpetrator, reducing the likelihood of high-risk occupations being identified

- There is a lack of updated guidance for users.

14.1.11 The panel felt that when Sarah reported the first incident of abuse by Jordan in March 2022, the MeRIT tool failed to elicit key information that may have influenced the attending officer when considering the application of professional judgement in terms of overall grading.

14.1.12 Some of those key areas were the fact that Sarah had been a victim of domestic abuse by several perpetrators (including her son) over a period of around 18 years and that in the vast majority of those incidents, she had not supported a prosecution. The panel felt that this could have been an indicator that Sarah was facing barriers to accessing support services or supporting prosecutions.

14.1.13 It was also felt that the MeRIT did not effectively capture Sarah or Jordan's use of alcohol around the time of this incident: in the context of Sarah being at increased risk of abuse from Jordan.

14.1.14 The panel again considered the question set on the Merseyside Police VPRF 1 form, specifically the question that asks if the victim appears to have mental health issues or concerns (including self-harm / suicide attempts). The panel felt that the terminology may not be clear for victims, especially those who have not yet acknowledged the effect domestic abuse is having on their mental health.

14.1.15 When the police attended the first incident involving Jordan in March 2022, they sought to issue a DVDS to Sarah. The panel felt that this was a positive response; however, the MeRIT grading did not reflect the level of risk. Had that grading been higher, the panel felt that this may have changed the timeliness of the approach by Merseyside Police when Sarah reported the second incident in June 2022.

14.1.16 Despite there being significant delays in the police attending Sarah's address when she reported abuse from Jordan in June 2022, the attending officer requested the grading for this incident to be upgraded to gold: this instigated referrals to MARAC and an IDVA. The panel felt this was a good example of the police applying professional judgement to change the MeRIT grading, to reflect the level of risk more appropriately.

14.1.17 The panel felt that although MeRIT has been used within Merseyside for many years, it may no longer be the most appropriate risk assessment tool. Since MeRIT was developed, new legislation has been introduced and operational understanding of domestic abuse has evolved, particularly in respect of coercive and controlling behaviour.

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

14.1.18 The panel learned that in some areas of Merseyside, the police are trialling a new risk assessment tool launched by the College of Policing in September 2022. The Domestic Abuse Risk Assessment (DARA) replaces the previously used domestic abuse, stalking and honour based violence questionnaire (DASH) and has an increased focus on coercive and controlling behaviour. The trial is being conducted alongside MeRIT, and at the conclusion, the two risk assessment tools will be considered against each other.

The panel felt that this pilot should be monitored by St Helens Community Safety Partnership, and this leads to panel recommendation 1.

14.1.19 The panel agreed that the four incidents where Max was recorded as the perpetrator, were rightly recorded by Merseyside Police as domestic abuse, despite them failing to complete a MeRIT assessment for the first incident. Action was taken to address the immediate impact of Max's behaviour, and in February 2022, he was arrested for violent offences towards Sarah's partner and police officers.

The police IMR described Max's behaviour as "*their way of protecting*" Sarah. Children's Social Care and Sarah's friends and family reported that sometimes Max felt that Sarah's relationships impacted on her ability to properly care for Jamie. Arguments between them resulted in Sarah contacting the police and reporting Max's disruptive behaviour, which was recorded as domestic abuse.

14.1.20 The panel considered whether there was evidence that Max or Jordan had subjected Sarah to coercion and control, and in doing so, referred to the Crown Prosecution Service's policy guidance.

14.1.21 The Crown Prosecution Service's policy guidance on coercive control, states:[13]

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

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working

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

- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

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

14.1.22 The Serious Crime Act 2015 received royal assent on 3 March 2015. The Act created the offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine, or both. The offence, which does not have retrospective effect, came into force on 29 December 2015.

14.1.23 The panel felt that, by definition, Max's behaviour may have amounted to coercion and control of Sarah; however, this may not have been obvious to agencies during their interaction with the family. The panel was mindful of the fact that Max had grown up in environments where domestic abuse took place frequently and sometimes felt the need to protect both Sarah and Jamie by taking control of situations. Although this may not have always happened in a reasonable manner and sometimes escalated to disruptive or abusive behaviour, the panel was mindful that Max was a child transitioning into adulthood and may have needed support to manage his feelings and behaviour.

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

14.1.24 The panel agreed that when considering the information provided by the police, Children's Social Care, and Sarah's friends, that she had been subjected to controlling and coercive behaviour by Jordan.

14.1.25 The panel considered whether Jamie may also have been subjected to controlling and coercive behaviour by either Max or Jordan; however, the panel did not see any evidence of this.

14.1.26 Following Max's arrest in February 2022, Children's Social Care conducted a Children and Family Assessment: this was based on the Assessment Framework and utilised the Signs of Safety model[14] in terms of assessing protective factors and risks. The panel felt that the Children and Family Assessment lacked sufficient analysis of the relationship between Sarah and Max, thereby limiting their ability to identify domestic abuse indicators.

This a learning point that leads to panel recommendation 2.

14.1.27 In March 2022, Children's Social Care received a referral from Merseyside Police in respect of Jamie – following the first incident of domestic abuse by Jordan. It was identified that Jamie appeared to quickly change their opinion of Jordan from one of being scared of him to liking him, and they commented that his presence made Sarah happy. The reporting social worker considered this view to be inappropriate.

14.1.28 The assessment process identified that the risk of domestic abuse presented by Jordan, was sufficiently serious to justify a Child Protection Plan to safeguard Jamie.

14.1.29 In May 2022, Sarah spoke with her GP, by telephone, and requested a not fit for work note, due to feeling stressed by work. GP records outline that although Sarah was asked about self-harm and suicide, there was no discussion around, and thereby no consideration given to, domestic abuse affecting Sarah.

14.1.30 The panel learned that domestic abuse screening questions were not used in circumstances such as this, and the panel felt that this may have been a missed opportunity to provide domestic abuse support to Sarah in a clinical rather than an enforcement or social setting.

14.1.31 The panel reflected on Sarah's GP appointment in May 2022 and felt that the absence of any formal risk assessment or domestic abuse screening questions, resulted in the GP not considering that Sarah was being subjected to domestic abuse. The panel felt that the GP could have been more professionally curious and was informed that since the start of this review, the ICB and Safe2Speak had begun work to improve professional curiosity in regard to the identification of domestic abuse during consultations and also to improve awareness and referrals to IDVA service.

This is included within single agency action plans.

[14] A framework for building positive relationships with families in a way that will achieve better outcomes for children. The framework provides guidance for practitioners across partner agencies to best understand how to work in partnership with children and families and help them to find solutions to the problems they experience.

14.1.32 Three days after Sarah's GP appointment in May 2022, a different GP at the same practice received a letter from Children's Social Care, requesting the practice contribute to the Child Protection Conference in respect of Jamie. The letter made clear that there were significant safeguarding concerns due to Sarah being in a relationship with Jordan: a perpetrator of domestic abuse. This request and subsequent reply were not attached to Sarah's medical record.

The panel felt that this was a missed opportunity for the GP to consider that Sarah was a victim of domestic abuse, assess risks to her, and share observations with other agencies.

14.1.33 The panel was informed that since the start of this review, Sarah's GP practice has introduced monthly safeguarding meetings – which in these circumstances, would have captured the potential link between Sarah's health deterioration and domestic abuse.

14.1.34 Recent research conducted by the University of Manchester, intrinsically links elements of coercive and controlling behaviour with heavy use of alcohol and drugs by both offenders and victims.[15]

The panel was of the opinion that in this case, there was evidence that alcohol use was a contributory factor; however, this had not been identified, as such, by agencies who were engaged with Sarah, Jordan, Max, and Jamie.

This is a learning point that leads to panel recommendation 3.

14.2 What knowledge did your agency have that indicated Sarah could be at risk of suicide because of any domestic abuse?

14.2.1 Sarah suffered with anxiety and depression and had been treated with medication for several years prior to the timeframe for this review. When she spoke with her GP in May 2022 to request a not fit for work note, she was offered alternatives to medication, which she declined. Sarah stated that she was content with the current level of support from her GP.

14.2.2 The GP recorded that they explored thoughts of suicide and deliberate self-harm and that none were reported by Sarah. The panel again felt that increased professional curiosity around the root cause of Sarah's reasons for needing time off work, may have presented an opportunity to consider domestic abuse and more fully explore the risk of suicide.

[15] https://www.mmu.ac.uk/media/mmuacuk/content/documents/rcass/Briefing-on-alcohol-and-domestic-abuse-in-context-of-Covid-19-1st-April-2020.pdf

14.2.3 The panel was made aware of research indicating a significant number of domestic abuse victims suffer from suicidal ideation. A study[16] in 2019, estimated that up to 80% of victims of domestic abuse, reported suicidal ideation. Another study[17] also found that '*the chances of being suicidal were 1.68 times greater for those with alcohol difficulties'* and *'3.5 times greater for those who were feeling depressed.'*

14.2.4 The panel also considered research[18] that suggested that women who experienced abuse from a partner, are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse.

14.2.5 Other research[19] has identified higher suicide risk occupations, including women working in the arts and media or nursing professions and both male and female carers. A report by the Cavell Nurses Trust[20] concluded that nurses are three times more likely to have experienced domestic abuse in the last year than the average person. The report states that 14% of nurses had experienced domestic abuse in the past year, compared with 4% of people nationally.

14.2.6 The panel felt that there was sufficient information held by agencies to suggest that Sarah was suffering with depression, that she may have consumed alcohol excessively, and that she was a victim of domestic abuse, thereby increasing the risk of suicide. No agency identified that increased risk.

14.2.7 The panel felt that a briefing note, disseminated by St Helens Community Safety Partnership, would appropriately highlight the issue. The panel also felt that this may raise awareness within the NHS and may encourage supervisors to be professionally curious when managing staff absences.

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

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

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

[17] Domestic abuse and suicide: Exploring the links with Refuge's client base and work force *[Ruth Aitken and Vanessa E. Munro]*

[18] https://www.agendaalliance.org/news/new-figures-reveal-link-between-suicidal-thoughts-and-domestic-abuse/

[19] Suicide by occupation, England: 2011 to 2015. Office for National Statistics

[20] A charity supporting UK nurses, midwives and healthcare assistants, both working and retired, when they're suffering a personal or financial crisis often due to illness, disability and domestic abuse.

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

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

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

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

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

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

(a) having money or other property stolen,

(b) being defrauded,

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

(d) having money or other property misused.

14.3.2 No agency contributing to the review, considered that Sarah was an adult at risk. The panel felt that this was an appropriate view.

14.4 What consideration did your agency give to any mental health issues or use of controlled drugs when identifying, assessing, and managing risks around domestic abuse?

14.4.1 In September 2019, Sarah was arrested for driving a vehicle whilst over the prescribed alcohol limit. In the same month, Children's Social Care received anonymous reporting around Sarah's use of alcohol, and during their investigations, she described her 'previous problems with alcohol'.

14.4.2 In October 2019, Merseyside Police recorded Sarah as the perpetrator in an allegation of assault against her partner and an allegation of threatening telephone calls to her former partner's parent.

14.4.3 Around the same time, Sarah reported to her GP that she had lost her partner and requested increased levels of medication for anxiety and depression, which was prescribed. The surgery was aware of Sarah's history of mental health and had prescribed medication for this since 2015.

14.4.4 GP records do not include any rationale for prescribing increased medication and do not document any considerations around exploring the potential that the request could be linked to issues around domestic abuse.

14.4.5 In March 2021, Sarah had a telephone appointment with her GP. Following attendance at the local hospital's emergency department two days earlier, Sarah reported further mechanical lower back pain. The GP prescribed additional diazepam medication.

14.4.6 Four days later, Sarah had a telephone appointment with a different GP. She requested further pain relief medication, and after a review by the GP, she was prescribed co-codamol and naproxen. On the same day, Sarah had another telephone consultation with the same GP. She requested pain relief for her adult child, Max, who had fractured his hand four days earlier. The GP prescribed further co-codamol.

The panel considered whether Sarah's requests for additional medication could have been an indicator of either addiction or increased use due to deteriorating mental health. The panel felt that the medication prescribed to Sarah was appropriate, considering her physical health condition at the time.

14.4.7 Children's Social Care records suggest that in 2015, Sarah may have attended 'confidence building' and 'dealing with stress' courses, held by the Chrysalis Centre[21]. The panel was unable to confirm Sarah's attendance due to patient records being appropriately weeded. The DHR Chair spoke with current staff at the Chrysalis Centre, but they did not recall Sarah attending any counselling or support sessions.

14.4.8 Addaction reported that around the same time in 2015, it provided services to Sarah after she self-referred for support with her alcohol use. Sarah was supported for a six-month period before being discharged after reporting reduced alcohol use.

14.4.9 Sarah's employer also recorded that following Sarah's 160-day absence due to poor mental health in 2015 and 2016, she stated that she had been engaging in external support groups and was receiving cognitive behavioural therapy.

14.4.10 In May 2022, when Sarah requested a not fit for work note from her GP, she declined alternative treatment to medication.

[21] A charity whose aim is to support and inspire women. Including counselling provision for victims of domestic abuse.

Throughout the timeframe of the review, there is no record of Sarah being offered or self-referring for any specialist mental health support. The panel considered whether a factor in Sarah not engaging with services, was her role as an employee of an NHS Trust. During the period under review, mental health services were offered by Mersey Care Foundation Trust, which is a different Trust to Sarah's employer. The panel felt that Sarah would have known this and therefore did not think it would have been a barrier to her accessing support services.

14.4.11 The panel was told that during the Child Protection Conference in May 2022, Sarah's medical records were discussed: in respect of her mental health. Although that information was considered as part of the plan to safeguard Jamie, it was not used to consider the wider risks to Sarah from abuse from Jordan.

14.4.12 The panel considered the MeRITs for both incidents involving Jordan.

In the March MeRIT, the officer recorded that Jordan had a marker on police systems for self-harm. In the June MeRIT, the officer did not acknowledge the marker. Whilst inconsistent, the panel did not feel that this would have changed the overall grading in either incident.

14.5 **In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?**

14.5.1 During the timeframe of the review, Merseyside Police completed a VPRF 1 for each domestic abuse incident and, where appropriate, made referrals to Children's Social Care.

14.5.2 Following the incident in February 2022, when Max was arrested for assaulting Sarah's partner, the police made a referral to Children's Social Care. The police were concerned that Jamie had been present and had witnessed violence. Following that referral, Children's Social Care assessed the risks to Jamie and decided that due to Max no longer living at Sarah's address, there was no increased risk of Jamie being exposed to domestic abuse.

14.5.3 The assessment by Children's Social Care focussed more on the allegation that at the time of the incident, Jamie and other children were drinking alcohol at Sarah's house and one of Jamie's friends alleged sexual assault by another. They provided advice to Sarah in respect of supervision of children within her home.

14.5.4 Following the first incident involving Jordan in March 2022, the police again made a referral to Children's Social Care. Although Jordan was not arrested, a crime was recorded for assault on Sarah, and the police decided that a DVDS was appropriate to protect Sarah and safeguard Jamie.

14.5.5 Children's Social Care was concerned that Sarah had allowed Jordan to stay overnight at her house after only knowing him for a few days. They were also concerned that Sarah and Jordan had both been drinking alcohol at the time of the assault, which could increase the risk of harm to Jamie.

14.5.6 A strategy meeting took place six weeks later. Children's Social Care, Healthcare, Merseyside Police, and Jamie's school were present. At that meeting, a decision was made to progress to a Child Protection Investigation on the basis that Sarah had refused to meet with professionals to receive a DVDS and continued her relationship with Jordan.

14.5.7 Jamie was made subject to a Child Protection Plan, which involved engaging both Sarah and Jordan to help them better understand domestic abuse and identify the associated risks for Jamie.

The panel agreed that the plan lacked clarity around which agencies were leading on the domestic abuse element; therefore, most actions were focussed on protecting Jamie from harm, rather than also addressing the underlying risk of Sarah being a victim of abuse from Jordan.

The panel agreed that the actions were not specific, measurable, achievable, realistic, or timely; therefore, the plan had little impact on addressing domestic abuse.

14.5.8 Following the incident in June 2022, when Jordan assaulted Sarah, the police again made a referral to Children's Social Care in respect of risks to Jamie. A social worker was already supporting Jamie and their family by virtue of the Child Protection Plan.

14.5.9 Children's Social Care made contact with an IDVA, requesting advice on how best to support Jamie. They provided information on the DART programme; however, there is no record of Sarah and Jamie engaging with the programme.[22]

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

[22] Domestic Abuse, Recovering Together – an NSPCC programme delivered locally to support children and mothers who have experienced domestic abuse.

14.6.1 Agencies that directly engaged with Sarah were her GP, local hospital, Merseyside Police, and Children's Social Care.

14.6.2 Sarah's GP surgery provided primary care services. There were no barriers to accessing general practice due to the Covid-19 pandemic, and Sarah had several appointments with her GP during periods of national lockdown, albeit all were by telephone. Sarah was prescribed medication to manage anxiety and depression, and appropriate reviews were conducted.

14.6.3 On two occasions during the timeframe of the review, Sarah was provided with a not fit for work note: in July 2020, for foot pain; and in May 2022, when Sarah requested time off work due to her mixed anxiety and depressive disorder.

14.6.4 On both occasions, the GP did not ask Sarah if domestic abuse was a contributory factor. Sarah reported domestic abuse to the police shortly before and after each request for a not fit for work note, and the panel felt that this was a missed opportunity to identify that domestic abuse was present and to offer support through a clinical route.

14.6.5 The panel learned that since February 2022, S2S have funded an IDVA dedicated to the primary care sector. That service provides GPs with direct access to specialist domestic abuse advice outside of the wider referral pathways. The IDVA is able to provide immediate safety planning and guidance and ongoing support for victims of domestic abuse. GPs are also able to provide the IDVA contact details to patients, in order that they can self-refer.

14.6.6 Safe2Speak reported that the primary care IDVA role has not been accessed widely, and the panel agreed that the service should be promoted more proactively and have therefore included this within its single agency action plan.

Due to the low uptake of the primary care IDVA, the ICB and S2S agreed to undertake an audit to gain a better understanding of why there has been a low uptake of referrals to the primary care IDVA and establish what additional provision is needed within primary care to improve engagement with the service.

14.6.7 The panel also agreed that the two GP appointments with Sarah when she requested time off work, lacked professional curiosity. Had domestic abuse been considered, there may have been opportunities to encourage Sarah to access specialist support.

14.6.8 Following the incident on 25 March 2022, Merseyside Police established that Jordan had been named as a domestic abuse perpetrator on more than 80 previous occasions. They decided that it was appropriate to issue a DVDS to Sarah.

The panel learned that once an officer has requested that a DVDS be considered for a victim, they submit details to the Merseyside Police DVDS Unit, who triage, assess, and facilitate disclosures where appropriate.

In this case, the requesting officer submitted the request on 26 March 2022, and on 30 March, the DVDS officer made contact with Sarah by telephone. Sarah informed the officer that she was in the presence of Jordan and was therefore asked to recontact the DVDS Unit when it was '*safe and convenient*'.

On 31 March, Sarah had not made contact with the DVDS Unit; therefore, no further attempts were made to contact Sarah. The rationale provided by Merseyside Police was:

'No return call had been received from [Sarah]. Given that contact had been made with her and she had been provided with DVDS Unit contact details and was clearly aware of the opportunity for disclosure, a decision was made to result the application as 'FAILED TO ENGAGE' pending contact from [Sarah].'

14.6.9 Furthermore, following the incident on 25 March, Merseyside Police made a referral to Children's Social Care in respect of Jamie. Six weeks later, on 6 May, a strategy meeting was held.

14.6.10 Following the strategy meeting on 6 May, the MASH requested Merseyside Police make further attempts to issue Sarah with the DVDS and suggested that they make use of existing appointments between Sarah and Children's Social Care to facilitate it.

14.6.11 On 12 and 19 May, Children's Social Care had face-to-face meetings planned with Sarah and intended to facilitate a call with Merseyside Police in order that they could issue the DVDS. Sarah did not attend either appointment.

Children's Social Care also spoke with Sarah on 17 May and attempted to discuss the DVDS disclosure with her, but Sarah was reluctant to access it.

Children's Social Care met with Sarah again on 24 May, and on that occasion, facilitated a telephone call with Merseyside Police, who issued the DVDS.

14.6.12 The panel learned that if Sarah had not answered the phone to the DVDS officer on 30 March, further options would have been considered to utilise partners to establish contact with her, but because she answered the call, this was not considered.

National guidance around the issue of DVDS is that the disclosure should be made within 35 days of a victim's agreement to engage. Merseyside Police did achieve this, but the panel felt that police attempts to explain the process to Sarah and secure an agreement to engage, could have been more creative and persistent, resulting in the DVDS being issued earlier.
The panel felt that the management of the DVDS disclosure was not effective. Merseyside Police knew that Sarah had been in company with Jordan when she received the call and therefore was unable to speak freely or safely.

14.6.13 The panel was reassured that work was already underway to provide the police with support in this area. During this review process, S2S and Merseyside Police have commissioned a trial whereby both will work together from the point where the police consider a DVDS as an appropriate course of action. This should enable pre-existing contact arrangements, skills, and resources of Safe2Speak staff, to be utilised from an early stage, thereby increasing the likelihood of successfully engaging victims of domestic abuse.

This remains a learning point that leads to panel recommendation 4.

14.6.14 Following the Child Protection Conference in May 2022, professionals agreed that Jamie would be subject to a Child Protection Plan. The plan was intended to safeguard Jamie, although actions were also intended to support Sarah and encourage her to understand that she was a victim of domestic abuse and appreciate the impact on both her and Jamie.

14.6.15 Children's Social Care allocated a family support worker to work with Sarah and Jordan around understanding domestic abuse and the impact on Jamie. This work had not been started at the time of Sarah's death.

14.6.16 The plan did not outline which individuals or agencies would lead on domestic abuse actions and did not include specialist domestic abuse support from S2S; therefore, there was no IDVA involvement at that stage.

The panel felt that the plan lacked clarity and focus in respect of supporting Sarah. The lack of IDVA involvement resulted in missed opportunities for engagement with Sarah to directly address the domestic abuse they were facing, and as such,

domestic abuse was considered secondary to the safeguarding considerations around Jamie.

This is included as a single agency action plan.

14.6.17 Sarah was employed in a position of trust. Her work as a healthcare assistant included treating patients who were children. The panel agreed that in these circumstances, Children's Social Care should have made an agency referral to the Local Authority Designated Officer (LADO), outlining that her daughter had been made subject of a Child Protection Plan. This would have resulted in Sarah's employer risk assessing her employment and would have provided an opportunity for them to provide support for her.

14.6.18 Following the incident in June 2022, the police graded the incident as gold and made a referral to MARAC and S2S for IDVA support. Within 24 hours, attempts were made by S2S to contact Sarah by telephone.

Sarah did not answer the calls or respond to voicemail messages and, as such, never accessed that support.

The panel felt that more creative options could have been considered to facilitate contact between Sarah and an IDVA. At that time, S2S were not conducting face-to-face meetings with victims and were reliant on telephone calls only. They have since returned to making physical attempts to engage with victims, as opposed to telephone only.

14.6.19 When Sarah reported domestic violence in June 2022, she did so by telephone and informed the police call handler that Jordan had left her house. Sarah stated that she wished to make a complaint against Jordan and wished to provide a statement to the police. The police incident log documents that Sarah was worried that Jordan would return and that he would attack her or her property.

14.6.20 The police incident log has warning markers attached as follows:

1. Child at risk. Child Protection Plan – treat all calls as urgent,
2. Clare's Law disclosure provided to Sarah in respect of Jordan,
3. Positive action must be taken if offences are disclosed,
4. Consider DVPO if offences are disclosed but not reported.

14.6.21 The markers are attached to the same page as where initial entries are recorded by the call handler. The markers are clear: it is highly unlikely that they could be missed by anyone opening, adding to, or reviewing the log.

14.6.22 In respect of Jordan, the incident records the following:

1. He has a marker for violence,
2. He is subject to a non-molestation order in respect of another victim of domestic abuse [from before they formed a relationship with Sarah].

14.6.23 The police call handler recorded that there were no patrols available to attend Sarah's address.

14.6.24 154 minutes after Sarah called the police, resources were deployed but immediately diverted elsewhere to another incident. The police did not attend Sarah's address until 42 hours after her initial call. During that time, the log was reviewed 10 times by different supervisors: each documented that no resources were available. One text message and several telephone calls were made to Sarah's phone, requesting she re-contact.

14.6.25 The panel felt that the response provided by Merseyside Police on 11 and 12 June 2022 was not timely or fit for purpose. A 42-hour delay in attending the scene was unacceptable and fell far below what should be expected.

The panel felt that the delay in attending, resulted in Merseyside Police missing an opportunity to secure evidence of serious offences committed by Jordan. They also missed an opportunity to obtain a witness statement from Sarah, who was keen to provide one at the time of reporting. By the time the police attended, Sarah had changed her mind and did not support a prosecution.

The panel also considered the handwritten notes found in Sarah's house when she died. The panel agreed that the level of service Sarah received from Merseyside Police may have resulted in her losing confidence in their ability to protect her from Jordan.

14.6.26 The panel also felt that there may be a lack of understanding by staff around DVDS, DVPO, and child protection matters – as control room staff supervisors did not acknowledge that those markers could increase the risk of harm to Sarah or Jamie.

14.6.27 When police officers attended Sarah's address, Jordan had returned. He was arrested for threats to kill, threats to commit criminal damage, and common

assault. The attending officer completed a MeRIT risk assessment, and although the resulting score was low, they acknowledged the increased risk to Sarah and requested that they be upgraded to a gold victim, based on their professional judgement. The case was referred to MARAC; however, Sarah passed away prior to it being heard.

14.6.28 The police did not pursue an evidence-led prosecution. Their rationale was that when they attended, Sarah had no visible injuries, made no complaint, and the suspect denied the offence. There were no witnesses to support Sarah's version of events, no sign of a disturbance, and alcohol was prevalent in both Sarah and Jordan. The incident was therefore filed on evidential difficulties.

The panel felt that had the police attended promptly, there may have been a greater chance of securing evidence that may have supported a prosecution.

14.6.29 The police did, however, recognise that Sarah was at risk of further abuse from Jordan; therefore, they took proactive steps to protect them by issuing Jordan with a DVPN. A DVPO was granted at court on 13 June 2022 and remained in place at the time of Sarah's death.

14.6.30 On a date later in June 2022, Sarah took her own life. No agency had identified that Sarah was at risk of suicide.

14.7 **How did your agency ascertain the wishes and feelings of Sarah, Max, and Jordan in relation to alleged offending, and were their views considered when providing services or support?**

14.7.1 During the timeframe of the review, on each occasion that Sarah reported domestic abuse to the police, she did not provide a witness statement or support a prosecution.

14.7.2 Although Max was interviewed following their arrest in February 2022, they made no comment. Merseyside Police have not recorded any discussion with Max following any of the other three recorded domestic abuse incidents.

The panel felt that this was a missed opportunity to understand the relationship between Max and Sarah. Furthermore, increased professional curiosity may have helped all agencies to better understand Sarah's vulnerabilities.

14.7.3 The Children and Family Assessment conducted following the incident on 22 February 2022, suggested that Max had behaved as they did because they were

angry that Sarah had spent time with her partner on Jamie's birthday. That assessment lacks any analysis of the relationship between Sarah and Max.

The panel felt that a more professionally curious approach by Children's Social Care may have elicited valuable information and background about the family dynamic, which may have influenced future decisions made by agencies when considering how best to support Sarah, Jordan, and Jamie.

14.7.4 Children's Social Care report extensive discussions between them and both Sarah and Jordan, as part of their child protection investigation and assessments. On several occasions, they offered to support Sarah in accessing the DVDS, which she initially refused. When Sarah did agree to access the information, despite being shocked, she did not accept that Jordan's history of domestic abuse posed any risk to Jamie. This view led Children's Social Care to implement a Child Protection Plan to protect Jamie.

14.7.5 Both Sarah and Jordan agreed that they would participate in work with social care professionals to address domestic abuse in their relationship. Sarah did engage with the allocated social worker, who reported that safety planning was discussed.

14.7.6 When he was arrested in June 2022, Mersey Care engaged with Jordan whilst in police custody. Jordan declined an assessment and therefore did not provide an opportunity to explore Jordan's views around domestic abuse. When Jordan was interviewed by the police, he made no comment to all questions asked. His lack of engagement with the police and healthcare professionals, made it very difficult to understand his motive or his specific needs.

14.8 How effective was inter-agency information sharing and co-operation in response to Sarah, Max, Jamie, and Jordan, and was information shared with those agencies who needed it?

14.8.1 Following the incident on 11 June 2022, Merseyside Police submitted a referral to S2S within 24 hours of the attending officer's submission of the VPRF 1.

14.8.2 Children's Social Care assisted S2S when they were attempting to safely make contact with Sarah. There was evidence of timely information sharing and good co-operation between the two agencies to support Sarah.

14.8.3 Children's Social Care also assisted Merseyside Police in their attempts to deliver the DVDS. On several occasions, they asked Sarah to meet with police and were present when she accessed the information.

14.8.4 Sarah, Max, and Jamie attended the same GP practice for most of their lives. However, it was not until May 2022, when the GP was asked for a report to support the Child Protection Conference, that they were aware of any safeguarding concerns regarding the family.

14.8.5 The panel felt that following the incident in March 2022, Merseyside Police made good use of the DVDS provision. They quickly identified that Jordan had extensive domestic abuse history with previous partners and shared that information with Children's Social Care: this allowed them to effectively assess risks to Jamie.

As outlined previously, the panel felt that more persistent efforts could have been made to issue the DVDS to Sarah sooner.

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

14.9.1 In April 2020, Sarah reported to the police that Max was being disruptive at home. She suspected that Max was using drugs. The police dealt with the report by telephone. They provided Sarah with advice and signposted them to the Merseyside Police website for further information. Max was not spoken to by the police, and no referrals for support were made because Sarah did not provide consent (Max was 17 years old at the time).

14.9.2 In December 2020, Sarah reported to the police that Max was under the influence of cannabis and was argumentative. The police attended, and Max left to stay elsewhere. The police discovered that Max was in possession of cannabis and issued them with a warning.

14.9.3 In January 2022, Sarah reported to the police that Max was being aggressive, and she feared that she may be assaulted. Max had already left the house, and Sarah did not wish to make any complaints. Therefore, the police did not speak with Max.

14.9.4 In February 2022, Sarah reported to the police that Max had assaulted her partner. The police attended and arrested Max, as they were in possession of a knife, cannabis, an air weapon, and a meat cleaver. Whilst on bail, Max was subjected to bail conditions to prevent them contacting Sarah. They were convicted of public order offences and received a supervision order.

14.9.5 Although this incident led to action being instigated by Children's Social Care to safeguard Jamie, the panel felt that more could have been done to understand the

relationship between Max and Sarah. As Max had gone to live with Sarah's mother, the focus shifted to just activity within Sarah's house that affected Jamie.

14.9.6 When the police were called to Sarah's address in March 2022 to reports of domestic abuse from Jordan, they did not arrest him because Sarah did not wish to provide a statement. The police did not pursue an evidence-led prosecution but made use of the DVDS intervention and prepared a disclosure for Sarah. There were delays in issuing that disclosure, which the panel felt may have affected the impact of it, by allowing Sarah and Jordan's relationship to become more established.

14.9.7 The incident in March 2022 was treated seriously by the police, who shared information with other agencies: this instigated child protection actions to safeguard Jamie. However, at that stage, no referral was made to S2S for IDVA involvement, due to the incident being graded as bronze and therefore no referral pathway being available. The panel felt that this was a missed opportunity to engage with Sarah outside of the policing and social care environments, but it appreciated the reasons why this did not happen.

14.9.8 When Sarah contacted the police in June 2022, Jordan was arrested for common assault, threats to kill, and threats to commit criminal damage. Although Sarah did not provide a complaint, the police made good use of legislation to issue a DVPN, and a DVPO was issued by the court.

14.9.9 The child protection processes were led by Children's Social Care who did attempt to work with both Sarah and Jordan around domestic abuse. However, neither accepted that Sarah was a victim of domestic abuse nor that their actions or relationship affected Jamie.

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

14.10.1 On each occasion that Sarah reported incidents involving Max, the MeRIT assessment resulted in a bronze grading. The same was the case for the first incident involving Jordan in March 2022. In line with MARAC protocols, no onward referrals were made for specialist domestic abuse support (although safeguarding referrals were made to Children's Social Care in respect of Jamie).

14.10.2 The incident in June 2022 was graded as gold and was appropriately referred by the police to MARAC and IDVA. The case was due to be heard at MARAC on 1 July 2022: this was within MARAC timescales. Even though there was a MARAC

scheduled before that date, it was unrealistic to prepare Sarah's case in time for that meeting.

14.10.3 National guidance for the issue of a DVDS is 35 days from a victim agreeing to receive the disclosure. Even though Merseyside Police made the disclosure to Sarah within that timescale, it took 61 days from making a decision to issue a DVDS, to actually doing so.

This is a learning point that leads to panel recommendation 4.

14.10.4 The panel felt that the absence of a domestic abuse question set for GPs, when considering requests from patients for either additional medication or not fit for work notes, is a vulnerability. The panel received assurance that at Sarah's GP surgery, this had already been addressed; however, the panel felt that expanding questioning to include screening for domestic abuse should be extended across all primary care surgeries.

14.10.5 The panel was informed that although the GP surgery had received a request for information to support the child protection investigation in respect of Jamie, that request was not linked to Sarah's patient file. This resulted in those safeguarding concerns not being considered by the GP alongside Sarah's heightened anxiety and depression or her request for a not fit for work note.

The GP highlighted this as a gap and vulnerability: this has been addressed locally with the introduction of monthly safeguarding meetings where any similar requests or referrals are considered.

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

14.11.1 Sarah's family were aware that Sarah was in an abusive relationship with Jordan. The first report to the police in March 2022 was from Sarah's mother, who had been contacted by Jamie when Jordan was shouting at them and Sarah.

14.11.2 Sarah did not provide consent for any information to be shared with her mother; therefore, discussions between them and Children's Social Care was limited to support for Jamie.

14.11.3 Sarah's friend informed the DHR Chair that Max did not like Jordan and suspected that he did not treat Sarah well. Max and Jordan have not contributed to this review; therefore, this could not be explored further.

14.11.4 The DHR Chair spoke with Sarah's manager, who explained that neither they nor Sarah's colleagues ever suspected that she was in an abusive relationship at any point in her life. There were never any obvious physical indicators that she was a victim of domestic abuse, and she kept her family life private, other than confiding in colleagues that she had, on occasions, faced challenging behaviour from Max. Sarah's colleagues did not recognise that behaviour as domestic abuse, but rather typical behaviour of a teenager transitioning into adulthood.

14.11.5 Despite the fact that Sarah had several periods of absence due to poor mental health, none were ever linked to domestic abuse.

14.11.6 Although Sarah's friends knew that she was in a relationship with Jordan and some met him several times, Sarah did not discuss the relationship with them. Friends did, however, notice that once that relationship had formed, Sarah was less socially active. Her visits to the gym stopped, as did requests for childcare to allow her to meet friends socially. One of Sarah's friends observed that Sarah and Jordan spent most of the time in each other's company, usually consuming alcohol. Sarah's friend described that Jordan would regularly be seen visiting a local shop as early as 8 am and purchasing alcohol, some of which was a drink known to be Sarah's usual choice.

14.12 **What impact did factors such as Covid-19 restrictions, staffing shortages, cuts or budget constraints have on services provided to Sarah?**

14.12.1 Covid-19 restrictions did not adversely impact service provision from Children's Social Care. Meetings with Sarah and Jamie were all conducted in person.

14.12.2 Sarah was able to access primary care services by means of telephone and video consultation.

14.12.3 When Sarah's case was referred to S2S in June 2022, they were not conducting unannounced visits to clients. Even though this was a legacy policy introduced during Covid-19 restrictions, the practice continued after restrictions were lifted. Sarah did not respond to telephone calls from S2S, and the panel agreed that a home visit may have been a more appropriate method of establishing contact and assessing support needs.

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

14.13.1 The panel did not identify any examples of outstanding or innovative practice.

14.14 **What training did your agency provide to staff around domestic abuse, including between parent and child? Had staff who interacted with the family, completed the training and when?**

Taken directly from IMRs.

14.14.1 **Primary Care**

Practitioners received level 3 Safeguarding training for both adults and children as per the intercollegiate document recommendation (guide for health professionals on required levels of safeguarding knowledge and training). The training encourages staff to consider that the perpetrator may not always be the victim's partner but could also be a family member.
All staff who engaged with the family were in date with their training. Training includes domestic abuse and scenario work to bring about professional curiosity and having difficult conversations.

14.14.2 **Safe2Speak**

Safe2Speak has expert knowledge in domestic abuse. The IDVAs are all trained and have the IDVA accreditation. Safe2Speak delivers the MeRIT/MARAC training and domestic abuse impact on the child to support partner agencies in their knowledge around domestic abuse.

14.14.3 **Children and Young People Services**

Training is delivered across a range of partners and Children's Social Care by Safe2Speak, who deliver MeRIT and MARAC training and domestic abuse: Impact on the child training (includes performance by Access 27 'Right Here').

Quarterly reporting from Safe2Speak on impact and attendance to this training, has highlighted that the attendance of Children's Services staff is lower than other agencies. This is an area of improvement for Children's Services, considering the regular turnover of staff.

The duty social worker and duty team manager had both accessed domestic abuse training in 2022.

14.14.4 **Mersey Care**

Mersey Care provides domestic abuse training as part of their mandatory safeguarding adults training. They also provide a modular, bite-sized domestic abuse training.

14.14.5 St Helens and Knowsley NHS Trust

All staff complete domestic abuse training within all levels of safeguarding training. Additional ad-hoc training is provided to emergency department staff.

14.14.6 Merseyside Police

Student officers have a vulnerability week – during which domestic abuse features.

Domestic abuse features within the CID course.

Domestic abuse coercion and control courses were developed and delivered as a mandatory two-day course. This was condensed to half a day online, following the Covid-19 pandemic. This was delivered force wide. This training was continuous for a period of approximately two years, until May 2021.

A one-day mandatory vulnerability course has now succeeded the above course and has 4 key themes: Trauma Informed Practice, Violence Against Women and Girls, Domestic Abuse, and NVP. All staff are required to attend.

For four consecutive years, the force has focused on domestic abuse and held bi-monthly domestic abuse intensification periods. This has been delivered each year during November and December to coincide with United Nations 16 days of action and the pre-Christmas period, and it has now been adopted as an annual project. During this period, the force delivers CPD events, with the aim of improving the quality of domestic abuse investigations, with a particular focus on ELP. CPS and the PDM manager support the delivery and contribute to the content, which includes learning from a DHR, Res Gestae and Hearsay, preparing a prosecution case, and CPS requirements. Recent events have also included the Domestic Abuse Act 2021, learning from the joint CPS and police stalking or harassment meeting held under the NPCC and CPS stalking protocol. Other CPD opportunities are also provided in relation to DVPOs and Harmful Practices that supplement the main ELP events.

Whilst the force investigation strand leads on the project, other strands, e.g., Response and Resolution and Local Policing, are required to ensure that CPD is delivered at a local level to achieve the same aims of quality investigations and ELP. Resources for local events are made available to the force through the force

intranet and include relevant video footage to highlight the voice of the child, ACES, and voice of the victim.

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

Taken directly from IMRs:

14.15.1 **Primary Care**

Though the GP responded to the request from the children's safeguarding unit for a report regarding health information for Jamie, this request was not linked to Sarah's patient electronic record. This resulted in key information, provided by the safeguarding unit, not being considered alongside clinical consultation with Sarah.

The practice has reviewed their safeguarding practice and now hold monthly safeguarding meeting to discuss patients who may be at risk of domestic abuse.

14.15.2 **Safe2Speak**

S2S now completes unannounced visits when attempts are being made to establish contact with a client.

S2S has been attending learning circles and has recognised that Education is a key partner who can help to establish contact when children are known. This approach is not yet routine practice but is included within a single agency action plan.

14.15.3 **Children and Young People Services**

IDVA should have been involved earlier, given that Sarah was initially resistant to acknowledging that she was a victim of domestic abuse.

14.15.4 **Mersey Care**

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

14.15.5 **St Helens and Knowsley NHS Trust**

St Helens and Knowsley NHS Trust has strengthened the process for routine enquiry when staff are referred to the Health Work and Wellbeing Department reporting issues relating to mental health or substance misuse.

14.15.6 **Merseyside Police**

There should be a more thorough review of domestic incidents where there is a 'Treat As Urgent' marker.

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

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

15 Conclusions

15.1 Despite there being lengthy breaks in reporting, Sarah was a victim of domestic abuse for around 20 years. The abuse was inflicted by several perpetrators, including Max's father. Sarah's children witnessed domestic abuse, and although the panel has been unable to speak with them, it is likely that both were significantly affected by this.

15.2 The panel was mindful of the sensitivities associated with exploring Sarah's alcohol use, and whilst it has been articulated within this report, there should be no inference that Sarah's relationship with alcohol attracts any blame for her being a victim of domestic abuse.

Due to a lack of involvement from Sarah's family, it is difficult to establish exactly when Sarah began to use alcohol to excess. Reports as early as 2002 suggest that alcohol was a factor. It is clear that people who knew Sarah well, believed that she suffered with alcohol use disorder. Whilst alcohol was considered a contributary factor in safeguarding issues around both of her children, this was not known to either Sarah's GP or her employer.

15.3 The panel felt that Sarah's alcohol use may have been a coping mechanism for her to escape the abuse; consequently, she may have been reluctant to access support from professionals.

15.4 Sarah's children witnessed domestic abuse within the home, over a prolonged period of time. The panel felt that during the period under review, reported incidents involving Max, demonstrated that they may have normalised such behaviour.

15.5 The panel considered the incidents between Max and Sarah and felt that it was challenging to differentiate disagreements between a parent and child(ren) and domestic abuse. Max's behaviour may have been considered normal for a child transitioning into adulthood.

The police did, however, acknowledge that Max's behaviour was domestic abuse and recorded it as such. Even though Sarah did not make complaints against Max, the lack of recorded discussion with them as to why they behaved in such a way, was a missed opportunity to understand their relationship. The panel felt that greater professional curiosity from the police and Children's Social Care may have identified opportunities to intervene and support Sarah more widely in terms of abuse from her partners, including Jordan.

15.6 Lengthy panel discussion took place around the MeRIT risk assessment tool. The panel thought that although the tool has been used effectively in the past, it may no longer be fit for purpose. Key factors in Sarah's abuse were alcohol use and an accumulative effect of abuse by several partners over many years. Despite the MeRIT assessments being graded correctly in all domestic abuse incidents during the timeframe of the review, these two issues were not identified using the question set within MeRIT.

15.7 Sarah suffered with anxiety and depression for many years, and throughout the timeframe of this review, was prescribed medication by her GP. Sarah was also issued with not fit for work notes frequently, and the panel felt that increased professional curiosity around the root cause of Sarah's reasons for needing time off work, may have presented an opportunity to consider domestic abuse and more fully explore the risk of suicide.

15.8 The panel acknowledged that the police took proactive action following the first incident involving Jordan in March 2022. They identified that Jordan presented a significant risk to Sarah, considered a DVDS to be an appropriate response, and delivered it within the national 35-day guideline. However, as Sarah did not immediately agree to engage with the police in respect of the DVDS, it was not pursued further by them until it was actioned at a strategy meeting in May 2022 – as part of child protection measures in respect of Jamie.

The panel felt that the DVDS may have been more impactive, had it been delivered soon after the initial incident in March 2022, rather than in May 2022 when Sarah and Jordan's relationship had become more established.

15.9 This report outlines the 42-hour delay in the police attending Sarah's address, following the second incident involving Jordan in June 2022. Merseyside Police explained that the reasons for the delay was the fact that Jordan had left the address; therefore, the risk of harm was not immediate. This resulted in the incident not being as high a priority as other live incidents that required the police resources at that time.

The panel felt that as a long-standing victim of domestic abuse, plus considering Jordan's history as a perpetrator of domestic abuse, Sarah deserved better.

The panel agreed that the delay in attending, resulted in Merseyside Police missing an opportunity to quickly arrest Jordan and pursue a prosecution, whilst Sarah was still supportive. The panel also considered the handwritten notes found in Sarah's address at the time of her death, and the panel felt that the delay may have resulted in Sarah losing confidence in the police's ability to protect her.

16 LEARNING

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

16.1 Narrative

Agencies do not have a consistent understanding of MeRIT and are not confident that the current question set effectively assesses risks to victims.

Learning

Domestic abuse incidents should be assessed using a common tool that is fit for purpose, understood by all agencies, and applied consistently.

Panel recommendation 1 applies

16.2 Narrative

Agencies did not fully explore the relationship between Sarah and Max, which restricted their ability to identify domestic abuse.

Learning

Domestic abuse involving parents and their children, needs to be acknowledged as domestic abuse and dealt with according to established policies and processes.

Panel recommendation 2 applies

16.3 Narrative

Agencies had information that suggested that Sarah may have used alcohol excessively, was suffering with poor mental health, and was in a high-risk occupation in terms of domestic abuse. The panel thought that research linking domestic abuse with use of alcohol and drugs, mental health, and high-risk occupation groups, was not understood by agency staff.

Learning

Knowledge of the link between domestic abuse and use of alcohol and drugs, mental health, and high-risk occupation groups, will enable professionals to formulate appropriate risk assessments and risk management plans.

Panel recommendation 3 applies

16.4 **Narrative**

Agencies had information that Sarah had been a victim of domestic abuse for many years by several perpetrators. The panel thought that research linking domestic abuse to the risk of suicide, was not well known by staff in their organisations.

Learning

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

Panel recommendation 3 applies

16.5 **Narrative**

Professionals did not facilitate the disclosure of information to Sarah about Jordan's previous abusive behaviour in a timely manner.

Learning

Established procedures to manage and deliver DVDS disclosures promptly, will enable agencies to provide effective services to domestic abuse victims.

Panel recommendation 4 applies

17 RECOMMENDATIONS

DHR Panel

17.1.1 St Helens Community Safety Partnership should widely canvass its agencies in order to establish the effectiveness and suitability of MeRIT as a risk assessment tool for domestic abuse cases and consider using alternative risk assessment tools if appropriate.

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

17.1.3 St Helens Community Safety Partnership should produce a briefing note to be disseminated to all agencies involved in the review. The briefing note should outline the links between domestic abuse, risk of suicide, mental health, high-risk occupations, and heavy alcohol and drug use by both offenders and victims. All agencies should provide assurance that operational staff have received the briefing material and that it has been embedded into mandatory domestic abuse training.

17.1.4 All agencies involved in the review should provide St Helens Community Safety Partnership with evidence that they have effective processes in place to facilitate DVDS disclosures by the police in a timely manner.

17.2 Single Agency Recommendations

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

Appendix A

Action Plan

Panel Recommendations							
No	**Recommendation**	**Scope: local or regional**	**Action to take**	**Lead agency**	**Key milestones achieved in enacting recommendation**	**Target date / expected outcomes**	**Completion date and outcome**
1	St Helens Community Safety Partnership should widely canvass its agencies to establish the effectiveness and suitability of MeRIT as a risk assessment tool for domestic abuse cases and consider using alternative risk assessment tools if appropriate.	Local	Survey of all agencies currently using MeRIT.	Domestic Abuse Partnership Board	Understand the level of confidence and understanding in the MeRIT form.	01 March 2024 Domestic Abuse Partnership Board will have a greater understanding of the effectiveness of MeRIT and should use that to consider the most effective risk assessment tool.	Heard at the DAPB 13.5.24. For multi-agency discussion. Merseyside Police have recently concluded a review of risk assessment tools. The partnership is awaiting an official update.

2	All agencies involved in the review should provide St Helens Community Safety Partnership with assurance that training has been provided to staff to enable them to recognise and act upon all aspects of domestic abuse within the definition contained in the Domestic Abuse act 2021.	Local	Agencies to check and feedback to the CSP Executive meeting, that appropriate training is provided to staff.	St Helens Community Safety Partnership	Ensure staff have the knowledge to be able to recognise domestic abuse within the definition contained in the Domestic Abuse Act 2021.	01 January 2024 St Helens Community Safety Partnership will understand the level of knowledge held by agency staff and should use this to support agencies learning and development strategies in support of domestic abuse.	Previous discussion around training at the DAPB in 2023. Heard at the DAPB 13.5.24 assurance requested that training is in place.
3	St Helens Community Safety Partnership should produce a briefing note to be disseminated to all agencies involved in the review. The briefing note should outline the links between domestic abuse, risk of suicide, mental health, high-risk occupations, and heavy alcohol and drug use by both offenders and victims. All agencies should provide assurance that operational	Local	Briefing note to be tabled at CSP Executive meeting for dissemination to all staff. Agencies to assure that all staff have received the briefing at following CSP	St Helens Community Safety Partnership	Ensure staff have the knowledge to be able to recognise the additional risk of suicide linked to domestic abuse, mental health, high-risk occupations and heavy drug/ alcohol use.	01 March 2024 Increased awareness will enable operational staff to identify domestic abuse and consider indicators of increased risk more effectively.	Domestic Abuse Prevention Officer to create 2-page briefing note, to be presented at future DAPB. Resource will also be

	staff have received the briefing material and that it has been embedded into mandatory domestic abuse training.		Executive meeting.				published on the Safer St Helens website.
4	All agencies involved in the review should provide St Helens Community Safety Partnership with evidence that they have effective processes in place to facilitate DVDS disclosures by the police in a timely manner.	Local	Creation of an effective process, to ensure DVDS disclosures are made in a timely manner.	Domestic Abuse Partnership Board	Ensure process is in place. Reducing the risk to victims.	01 March 2024 All agencies will have a shared responsibility to effectively support each other when attempting to make DVDS disclosures.	Merseyside Police to update on the DVDS process at future DAPB. Other agencies to confirm current DVDS policy at same meeting.

Single Agency Recommendations

No	Recommendation	Scope: local or regional	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date / expected outcomes	Completion date and outcome
Primary Care							
1	Any report requests or information shared by the children's safeguarding unit to be added to parent/next of kin patient record.	Local	Comms with all practice staff. Update of safeguarding policy.	Practice Manager	Evidence of comms to practice staff. Updated safeguarding policy and evidence read by all practice staff. Potential future audit once new process is embedded into practice.	30/3/23 Information regarding safeguarding concerns is contained on all relevant patient records. To enable safeguarding information to be considered during patient contact with the practice.	Completed 30 May 2023
2	Domestic Abuse Audit (Joint action between ICB and Safe2Speak).	Local	Conduct audit and address any actions from learning.	ICB and Safe2Speak	Domestic abuse support information: - Safe2Speak IDVA service and domestic abuse information to be added to GP practice websites - Safe2Speak posters to be displayed in all GP practices - QR code to be added to display posters – so patients can	May 2023 Increasing visibility of domestic abuse support information.	Completed 1/5/23

					access Safe2Speak websites independently. Professional curiosity: - 7-minute briefing to be developed and shared with all GP practices, regarding primary care, domestic abuse and professional curiosity. - Attend Clinical Directors (primary care) meeting. To share findings of audit, DHRs and Safe2Speak service. Clinical Directors to share information to all practices. - Primary care training to incorporate key themes identified from recent Domestic Homicide Reviews, including professional curiosity when a patient presents with changes to their mental health or mood. As well as	June 2023 Incorporated into training package for 2023/24 pack. Planned completion December 2023. Primary care practitioners to ensure professional curiosity and consider domestic abuse as a factor when patients present with stress or changes to their mental health.	Completed 28/6/23

					Information in regard to Safe2Speak. - Safe2 Speak to attend primary care PLT.		
Safe2Speak							
1	Promote and monitor impact of primary care work and embed as standard IDVA work.	Local	Regular briefings to primary care services. Promotion of the Safe2Speak service via websites and visibility of posters.	Anna Lock (Team Leader)	Safe2Speak IDVA service and domestic abuse information to be added to GP practice websites. Anna Lock provided an overview to Lindsay McAllister, who confirmed that the information has been added. (Completed). Safe2Speak posters to be displayed in all GP practices. QR codes have been added to display posters – so patients can access Safe2Speak websites independently. (Completed June 2023). Safe2Speak to attend primary care Protected Learning Time (PLT) sessions – Anna Lock has contacted Neil Rotherham, who will be responding with sessions we can support. (Ongoing).	To be reviewed June 2023. Track referrals from primary care setting. Aim to see an increase each quarter, starting from April 2023.	Number of referrals have increased from Primary Care. Recording source of initial referrals still ongoing Content that action is completed

					Team asked to log source of self-referral on Mainstay case management system to capture if we have received an increase in referrals from primary care.		
2	Improve process around partner agency checks.	Local	Engage with pastoral leads and Early Years to develop and strengthen links. Invite on MeRIT/MARAC training.	Anna Lock (Team Leader)	Identify key partners. Anna Lock sourced a list of the education and pastoral leads for all schools within the St Helens borough. 14/4/23 – an email was sent to all the education leads with information on the Safe2Speak service, including website details and all upcoming training dates on MeRIT/MARAC and DA: impact on the child. 19/5/23 – a meeting was held by Anna Lock via Microsoft Teams and all education leads invited. A presentation was provided giving an oversight on the Safe2Speak service and a Q and A session facilitated. The presentation was sent out on 23/5/23 for the staff who were unable to attend, providing contact details on our service / DA awareness	To be reviewed June 2023. Increased referrals from Early Years / Education. Aim to see an increase each quarter, starting from April 2023.	Local school designated safeguarding leads and points of contacts shared with the team, to utilise in case work. Close working relationship established with MARAC Education & Early Years representative. Education are attending Safe2Speak

					and the service offer Safe2Speak provide, including referral pathways. 25/5/23 – Anna Lock sent out a list of contact details for pastoral / education leads to the Safe2Speak service to enable joint working and collaboration. 9/6/23 – Anna Lock highlighted the issue to Merseyside Police that school information for children is not consistently recorded or shared by officers.		professional s training and able to book on via the local safeguarding partnership training calendar. Content that action is completed.
3	Develop client led options for direct contact.	Local	Consultation with staff. Consultation with clients. Liaise with health and safety team (Torus).	Anna Lock (Team Leader)	Consultation session arranged for the 22/6/23 to seek client feedback on preferred method of communication / appointment and general feedback. Staff who complete outreach visits have had risk assessments and sky guard devices issued. This is to further support the ability to complete cold calls (unannounced visits) safely. Anna Lock delivered a	To be reviewed June 2023. The feedback will ask around preferred method of communication/ visit to inform service delivery. The service will ask to be scored from 1-10: this will be repeated every 6 months to measure and build on customer satisfaction and	This action is still on-going due to capacity /resources and attendance at face-to-face programme s

					workshop on 2/3/23 to the Safe2Speak team to discuss more varied attempts to establish contact with clients.	ensure we are survivor led.	
4	Improve links with the police for partnership working contact when children are known.	Local	Co-location at the police station. Link in with the police to complete cold calls and home visits. Monthly meetings with the police and Safe2Speak.	Anna Lock (Team Leader)	Co-location at police station (Safe2Speak team's information has been sent to the police and they are in the process of vetting before co-location can progress). Link in with the police to complete cold calls and home visits. (Ongoing). The team have completed two joint visits with the police in the past two months. Monthly meetings with the police and Safe2Speak are held to discuss and highlight issues and best working practice. (Ongoing). DVDS process – to unify and strengthen the partnership working with the police: it has been agreed that we will support DVDS disclosures moving forward. Meeting held with Colin Briscoe (DI Merseyside Police). The police will actively email Safe2Speak to ask if we have	To be reviewed June 2023. Less time delay between the receipt of the referral and engagement with the client. Dip check of a sample of 20 cases received between April- June, to measure the above. To be repeated every quarter. Collect data on joint visits / contact with the police as part of case work. To be repeated every quarter.	Yes joint working improved, co-location put on pause, due to resources but this will start monthly again in August. Content that action is completed.

					contact with clients to support with establishing engagement when they are struggling to do so. We will be in a position to book an office space at Helen Central to offer a neutral and safe space if this is the client's preference. The police will contact Safe2Speak to ask for our support with facilitating disclosures. If the case is open, then the case worker to support with the disclosure. If the case is not open to the service, this appointment will be picked up by the duty officer to offer safety planning advice and guidance to the client after receiving the information.		
CYPS							
1	All social workers will have accessed all DA training and have a clear understanding.	Local	DA training to be mandatory. Leaders to ensure all service areas dedicate	Practice Improvement Team / Senior managers (Heads of Service)	Rolling programme of delivery and review through SLT. Review quarterly.	Improved practice, response and support to those families experiencing DA.	Progress update sought. Due 30 April 2024

			focused time to attending training and further identify any learning needs analysis to develop wider training. Mental health – understanding triggers to suicide – what can we learn. Nominate a DA senior leader champion. Practice improvement team to support development of safety planning and focus across services. Improving joint training and working with the police by facilitating working together session with social care				

			and police managers.				
2	Learning from the review to be shared across children's services.	Local	SLT develop briefings to all staff / deliver through staff engagement events.	SLT (Heads of Service), AD/DCS		August 2023 All professionals to be aware of the wider learning from Sarah's DHR.	Progress update sought. Due 30 April 2024
Mersey Care							
1	Review domestic abuse training packages.	Local / Regional (due to Trust footprint)	Learning to feed into Named Safeguarding Leads Lessons Learned forum, as well as into Safeguarding Training Assurance Group then to Safeguarding Training Development Group.	Hanna Roslund, Named Professional Safeguarding Adults, Mersey Care NHS Foundation Trust	Learning to feed into Named Safeguarding Leads Lessons Learned forum, as well as into Safeguarding Training Assurance Group then to Safeguarding Training Development Group. New training roll-out for year 2023/24.	April 2023 Increase the knowledge within MCFT workforce around domestic abuse, suicide risk, as well as child to parent abuse.	Yes, this action is completed (or as much as it possibly can be as it will always been an ongoing matter of raising awareness and training our workforce).
St Helens & Knowsley NHS Trust							
1	Ensure that staff working within the Health Work and	Local	Routine enquiry will be utilised.	STHK	Action completed.	30/06/2023	Completed.

	Well Being Department consider the possibility that domestic abuse may be a contributory factor to mental health or drug and alcohol issues.						
Merseyside Police							
1	Ensure level and identification of risk and DA is reiterated to JCC staff.	Local	Speak to member of staff dealing with the call in the first instance.	Police	Due to the intensification period between the incident and the time of completing the IMR, staff knowledge has changed, but has still been addressed by means of staff briefing.	30/03/2023 More efficient knowledge in the recognition of risk and getting to the victim at a time when they are co-operative, and to increase confidence in the police.	Completed. JCC supervisors have received a briefing entitled 'Concern for Safety', which has been cascaded to all staff.

End of Overview Report 'Sarah'