St Helens Community Safety Partnership

Executive Summary

Domestic Homicide Review

'Sarah'

Died June 2022

Chair and Author: Dan Bettison

Date: 28 July 2023

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1 The Review Process

1.1 This summary outlines the process undertaken by the St Helen's Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Sarah, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, her children, and partner, in order to protect their identities.

Name	Who	Age	Ethnicity
Sarah	Victim	46	White British
Max	Sarah's child	19	White British
Jamie	Sarah's child	Secondary school age	White British
Jordan	Sarah's partner	47	White British

1.3 Sarah was single and had two children. She was 46 years old when she took her own life. At the time of Sarah's death, one of her children (Jamie) was of secondary school age, and one (Max) was an adult. Jamie lived with Sarah in a privately owned property in St Helens.

1.4 An inquest was held on 15 February 2023.

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

1.5 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][1] and recommended one should be conducted. The Home Office was informed on 1 May 2023.

1.6 Sarah reported being a victim of domestic abuse from as long ago as 2002.

[1] 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.

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

In 2022, Sarah reported 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.

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.

1.7 Sarah, Max, Jamie, and Jordan were made subjects of the review, and the timeframe was from 1 September 2019 until Sarah's death in June 2022.

This timeframe 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 ensured that relevant interactions with support agencies were captured.

1.8 The first meeting of the DHR panel took place on 1 December 2022. Meetings took place in person and using Microsoft Teams video conferencing. The panel met five times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final panel meeting took place on 26 May 2023, after which, minor amendments were made to the report: these were agreed with the panel by email.

2 Contributors to the Review

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 NHS Foundation Trust	IMR
St Helens and Knowsley NHS Trust	IMR
North West Probation Service	Short report
We Are With You (formally Addaction)	IMR
Merseyside Police	IMR
Children and Young People Services (Referred to as Children's Social Care throughout the report)	IMR

3 Members of the Domestic Homicide Review Panel

3.1	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

3.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and Author of the Overview Report

4.1 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.

5 Terms of Reference

5.1 '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)

5.2 **Timeframe under Review**

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

5.3 **Case 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?

6 Summary Chronology

6.1 Background

6.1.1 Prior to the timeframe of the review, the 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[2] for support following domestic abuse.

6.1.2 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.

6.1.3 Between 2012 and 2019, Sarah reported one incident of domestic abuse to the 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.

6.1.4 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.

6.1.5 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.

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

6.1.7 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

[2] 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.

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.

6.1.8 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.

6.1.9 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.

6.1.10 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.

6.1.11 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.

6.1.12 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, has been supported by Children's Social Care.

6.1.13 The panel considered observations made by Sarah's sibling, who 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.

6.1.14 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.

6.1.15 Therefore, the panel 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.

6.1.16 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 Max, 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.

6.1.17 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)[3] 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.

6.1.18 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.

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

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

6.2 Relevant Events

6.2.1 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.

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

6.2.2 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.

6.2.3 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.

6.2.4 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 medication to treat anxiety and depression, and she was absent from work due to the deterioration of her mental health.

6.2.5 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.

6.2.6 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[4]) in relation to domestic abuse by Sarah against her former partner. They graded the risk as bronze[5].

6.2.7 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

[4] 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.

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

being shared with other agencies. The police signposted Sarah to the Merseyside Police website page to find information about domestic abuse.

6.2.8 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.

6.2.9 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 they did. Max was in possession of cannabis, and the police issued them with a warning. A VPRF 1 was completed, and the risk was graded as bronze.

6.2.10 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.

6.2.11 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 them. 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.

6.2.12 On 17 February 2022, Sarah reported to the police that her partner had been assaulted by Max and that they were 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.

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

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

6.2.15 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.

6.2.16 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.

6.2.17 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)[6] 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.

6.2.18 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.

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

6.2.20 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.

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[6] 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.

6.2.21 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.

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

6.2.23 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.

6.2.24 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.

6.2.25 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)[7], and a Domestic Violence Protection Order (DVPO) was granted at court on 13 June 2022.

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

6.2.27 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.

6.2.28 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.

[7] A DVPN is an emergency non-molestation and eviction notice which 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 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.

6.2.29 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.

6.2.30 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.

6.2.31 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.

6.2.32 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.

7 Conclusions

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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.

7.9 There was a 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.

8 LEARNING

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

8.1 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

8.2 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

8.3 **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

8.4 **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

8.5 **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

9 RECOMMENDATIONS

DHR Panel

9.1 St Helens Community Safety Partnership should widely canvass it's 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.

9.2 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.

9.3 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.

9.4 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.

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

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.

Appendix A

Action Plans

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

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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 access Safe2Speak websites independently. Professional curiosity: - 7-minute briefing to be developed and shared with all GP practices,	May 2023 Increasing visibility of domestic abuse support information. June 2023 Incorporated into training package for 2023/24 pack. Planned completion	Completed 1/5/23 Completed 28/6/23

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					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	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.	

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					or mood. As well as 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 –	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.

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					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). 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	Anna Lock (Team Leader)	Identify key partners. Anna Lock sourced a list of the education and pastoral	To be reviewed June 2023.	Local school designated safeguarding leads and

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			develop and strengthen links. Invite on MeRIT/MARAC training.		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	Increased referrals from Early Years / Education. Aim to see an increase each quarter, starting from April 2023.	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 professionals training and able to book on via the local safeguarding partnership

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					awareness 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 sourced by officers and that it will help us proactively reach out education from efficiently as per DHR recommendations.		training calendar. Content that action is completed.

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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 workshop on 2/3/23 to the Safe2Speak team to discuss more varied attempts to establish contact with clients.	To be reviewed June 2023. The feedback will ask around preferred method of communicati on/ 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 ensure	This action is still on-going due to capacity /resources and attendance at face-to-face programmes.

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						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).	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	Joint working improved, co-location put on pause, due to resources but this will start monthly again in August. Content that action is completed.

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					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 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.	every quarter. Collect data on joint visits / contact with the police as part of case work. To be repeated every quarter.	

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					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 focused time to attending	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.	Ongoing.

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			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.				

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			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.	Ongoing.
Mersey Care							
1	Review domestic abuse training packages.	Local / Regional (due to	Learning to feed into Named Safeguarding	Hanna Roslund, Named Professional	Learning to feed into Named Safeguarding Leads Lessons Learned forum, as well as into	April 2023 Increase the knowledge	Yes, this action is completed (or as much as it

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		Trust footprint)	Leads Lessons Learned forum, as well as into Safeguarding Training Assurance Group then to Safeguarding Training Development Group.	Safeguarding Adults, Mersey Care NHS Foundation Trust	Safeguarding Training Assurance Group then to Safeguarding Training Development Group. New training roll-out for year 2023/24.	within MCFT workforce around domestic abuse, suicide risk, as well as child to parent abuse.	possibly can be as it will always be 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 Well Being Department consider the possibility that domestic abuse may be a contributory factor to	Local	Routine enquiry will be utilised.	STHK	Action completed.	30/06/2023	Completed.

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	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 incident and now education may have changed response and knowledge.	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'