# Domestic Homicide Review

## “Louise” who died in March 2020

**LDHR20/MSAR10 Executive Summary 09/02/2022**

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# Contents

# 1 The Review Process

1.1 This summary outlines the process undertaken by the Liverpool Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Louise, who was a resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the victim her partner and others referred to in the review.

| Name and Who | Age and Ethnicity |
|---|---|
| Louise - Victim | 32 – White British |
| Julie – Victim's partner | 41 – White British |
| Jade – Louise's sister | Adult – White British |
| Sarah – Louise's sister | Adult – White British |

1.3 Louise was in a long-term relationship with her partner Julie and there had been a number of domestic abuse incidents in the relationship over the preceding years. On the day Louise died, she had a number of communications with her sister who became concerned about her and contacted the ambulance service. When paramedics went to Louise's address, they found that she had passed away.

1.4 The coroner has already concluded the inquest into Louise's death. The circumstances of Louise's death, described in the record of inquest, are as follows:

"Louise was a 32-year-old lady with a medical history of self-harm, previous overdose, malnourishment and psychosis. On [time and date redacted], the North West Ambulance Service were contacted by Louise's sister advising of her concern that Louise had taken an overdose because of text messages and

phone calls received in the early hours. When the ambulance service attended, Louise was found deceased, slumped against the couch in the living room. Empty blister packets of medication were close by. A Facebook posting stated she had taken a combination of medication. Toxicological analysis revealed the presence of a large amount of alcohol, together with elevated concentrations of quetiapine and a fatal concentration of dihydrocodeine, neither of which were prescribed to Louise. The post mortem examination did not reveal any natural disease contributing to Louise's death. The toxic effects of quetiapine include drowsiness and cardiac arrhythmias. Dihydrocodeine is an opioid painkiller, and the concentration present was more than 12 times the fatal concentration. The main effect of opioid toxicity is respiratory depression, and this taken together with the alcohol which can also reduce the level of consciousness and respiratory depression has resulted in a fatal outcome. It is unclear as to what Louise's intentions were when she consumed the medication and alcohol but taking account the amount, she consumed and in all the circumstances it is more likely than not she has taken them with the intention of taking her own life. The alcohol consumed would have impaired her state of mind when carrying out the act and therefore it is more likely than not Louise has taken her own life whilst the balance of her mind was impaired".

1.5 Following Louise's death, a referral was made to Merseyside Safeguarding Adult Board (April 2020) for consideration of a Safeguarding Adult Review.

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB[1] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

[1] Safeguarding Adult Board

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

On 24 June 2020, the Independent Chair of the Merseyside Safeguarding Adult Board confirmed that the circumstances of the case met the criteria for a Safeguarding Adult Review.

1.6 The 2016 Domestic Homicide Review statutory guidance[2] says:

*'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'.*

1.7 The Community Safety Partnership therefore took the decision at a meeting on 7 July 2020, that a Domestic Homicide Review should be conducted. Thereafter, the Safeguarding Adult Board and Community Safety Partnership agreed that a joint review would be commissioned.

1.8 The start of the process was delayed as a result of agency work pressures in the Covid-19 pandemic and the need to source and commission an Independent Chair and Author. The first meeting of the DHR panel, which took place on 23 September 2020, determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews and the others, short reports. The Chair provided training to Individual Management Review (IMR)[3] authors to assist in the completion of the written reports.

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

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

1.9 In April 2021, Louise's mum provided further information to the police: the police agreed to review and consider whether to reopen their investigation. As a result of this, a decision was made to suspend contact with the family as there was a risk of damaging any future prosecution. That decision was communicated to Louise's mum by her AAFDA advocate. This suspension of contact led to a delay in the DHR, as consultation with Louise's mum could not take place during this period. On 8 June 2021, the DHR chair was informed by the police that a review of evidence had taken place and that there would not be a new investigation.

1.10 Meetings took place using Microsoft Teams video conferencing and the panel met six times. In addition to panel meetings, an online practitioner event, utilising Microsoft Team breakout rooms, took place involving twenty practitioners and managers who had contact with Louise and Julie.

1.11 An advanced draft of the overview report was shared with Louise's mum via her AAFDA advocate in early July 2021. Earlier delays in the progress of the review and challenges in arranging meetings over the summer period meant that it was not possible to for Louise's mum to meet with the panel. Following an extensive period of consultation as a result of which refinements were made to the report the process was concluded on 22 October 2021.

# 2 Contributors to the Review

| Agency | Contribution |
|---|---|
| Merseyside Police | IMR |
| Liverpool Clinical Commissioning Group | IMR |
| Merseyside Community Rehabilitation Company | IMR |
| North West Ambulance Service | IMR |
| Liverpool Adult Social Care | IMR |
| Local Solutions (IDVA service) | IMR |
| PSS UK Women's Turnaround | IMR |
| We Are With You | Short report |
| Housing Options | Short report |
| Fylde Coast Women's Aid | Short report |
| Mersey Care NHS Foundation Trust | Short report |
| Liverpool University Hospitals NHS Foundation Trust | Short report |

# 3 Members of the Domestic Homicide Review Panel

3.1

| Members Name | Position |
|---|---|
| Ged McManus | Independent Chair and author |
| Carol Ellwood Clarke | Support to Chair and author |
| Angela Clarke | Domestic Abuse Lead, Liverpool City Council |
| Michelle Lesbirel-Jones | Merseyside Safeguarding Adult Board |
| Beverley Hyland | Chief Inspector, Merseyside Police |
| Esther Lucas | Careline Adult Services Manager, Liverpool Adult Social Care |
| Carmel Hale | Designated Safeguarding Adult Nurse, Liverpool Clinical Commissioning Group |
| Karen Rooney | Community Director, Merseyside Community Rehabilitation Company |
| Susan Hewitt | Safeguarding Practitioners, North West Ambulance Service |
| Kate Scott | Public Mental Health/Suicide Prevention |
| Kerry Dowling | Local Solutions, IDVA |
| Kari Rude | Support to panel |
| Sharon Cooper | Service Manager, PSS UK |

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 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, set out the requirements for review Chairs and Authors.

4.2 Ged McManus was chosen as the DHR Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside) and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England (not Merseyside). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

4.3 The Chair was supported by another independent practitioner, Carol Ellwood Clarke. She retired from thirty years public service (British policing, not Merseyside) during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

4.4 Between them, they have undertaken over sixty reviews including the following: child serious case reviews; Safeguarding Adult Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have also completed accredited training for DHR Chairs, provided by AAFDA[4].

4.5 Neither of them has worked for any agency involved in this review.

# 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.

[4] Advocacy After Fatal Domestic Abuse.

(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 1 December 2017 to Louise's death in March 2020.

5.3 **Case Specific Terms**

**Subjects of the DHR**

Victim: Louise, aged 32 years

Louise's partner: Julie, aged 41 years

## Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[5] did your agency identify for Louise?

2. How did your agency assess the level of risk faced by Louise from the alleged perpetrator and which risk assessment model did you use?

3. What knowledge did your agency have that indicated Louise could be at risk of suicide as a result of any coercive and controlling behaviour?

4. Did your agency consider that Louise could be an adult at risk within the terms of the Care Act 2014?

5. What consideration did your agency give to any mental health issues or substance misuse when identifying, assessing, and managing risks around Louise?

6. What mental capacity assessment(s) were completed by your agency and what was the outcome?

[5] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

7. Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?
8. What services did your agency provide for Louise and/or Julie; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?
9. Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?
10. How did your agency ascertain the wishes and feelings of Louise and Julie about Louise's victimisation and Julie's alleged offending, and were their views taken into account when providing services or support?
11. How effective was inter-agency information sharing and cooperation in response to Louise and Julie, and was information shared with those agencies who needed it?
12. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Louise and Julie?
13. What did your agency do to establish the reasons for Julie's alleged abusive behaviour, and how did it address them?
14. Was there sufficient focus on reducing the impact of Julie's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?
15. 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?
16. Do the lessons arising from this review appear in other reviews held by this Community Safety Partnership?
17. What knowledge did family, friends and employers have that Louise was in an abusive relationship, and did they know what to do with that knowledge?
18. Were there any examples of outstanding or innovative practice?
19. What learning did your agency identify in this case?

# 6 Summary Chronology

## 6.1 Information prior to the timeframe of the review

6.1.1 Louise was the middle child of five siblings. She was a shy child but also loyal and very caring. She was a joker and enjoyed playing practical jokes on her family and friends. Her mum said that Louise could be feisty and was not someone to cross lightly, as she would easily make her feelings known.

6.1.2 Louise liked writing poetry as a teenager, and it was whilst reading Louise's work that her mum came across a letter that Louise had written which disclosed sexual abuse by her father. This ultimately led to a crown court case where Louise gave evidence. During the course of cross examination, Louise was questioned about things that she had said during counselling sessions. This caused her to leave the witness box and she did not continue with her evidence.

6.1.3 Louise's father was subsequently acquitted of the charges that had been brought. The case caused a split in the family and meant that Louise no longer saw her extended family on her father's side and did not see her father again.

6.1.4 Louise's mum said that it was after the court case that Louise started to self-harm. She was detained under a section of the mental health act on two occasions. She refused to have counselling because of her previous bad experience during the court case. During one of her hospital admissions, Louise asked her mum for permission to take her own life saying, "ten minutes pain for a lifetime of freedom".

6.1.5 Louise was active on social media and formed friendships online rather than in person. It was in 2013 that she met Julie online. Julie lived in the South-East of England and travelled to Liverpool to meet Louise in person. The couple formed a relationship and lived together in Liverpool for two years before moving to the South Coast, where they lived in a caravan on a holiday park.

6.1.6 Louise's mum related a number of incidents which had happened whilst the couple were living at the South Coast. Louise was on her own for much of the time, as she didn't like Julie's friends so didn't often go out with Julie, and Louise began to drink excessively. Louise's benefit money was paid into Julie's bank account and Louise had to ask for anything if she needed it. Louise's mum told her that this was wrong, and it was controlling behaviour by Julie, but Louise thought it was not a problem. For a few months, Louise arranged for her money to be paid into her mum's account. However, Louise found this difficult and went back to having her money paid into Julie's account, as she said it was easier.

6.1.7 After several months, the couple had to leave the caravan as rent had not been paid, for a while they were living in a car. On one occasion, Louise spoke to her mum on the phone, she said that she was in the car outside a house that Julie was visiting for a meal, but that she was not allowed inside.

6.1.8 On another occasion, Louise contacted her mum, sending pictures of her body with bite marks and bruising. Louise's mum went to visit her and confronted Julie about the injuries, but Julie denied any wrongdoing, stating that the injuries had been caused by the couple's dogs. Louise's mum did not think this was a plausible explanation given the severity of the injuries and the fact that Louise had no marks on her hands or face. After an episode of self-harm, Louise's sister, Jade[6] picked her up and took her back to Liverpool, where Louise lived with Jade, for a while. During this time, Louise and Julie were reconciled and moved into their own property towards the end of 2017.

[6] A pseudonym agreed with Louise's family

## 6.2 Information during the timeframe of the review

6.2.1 On 21 December 2017, Louise attended at a hospital Accident and Emergency department (Liverpool University Hospitals NHS Foundation Trust) following her taking an overdose of medication, which was said to belong to Julie. She was treated and seen by the Psychiatric Liaison Team (Mersey Care) before being discharged. Louise referred to Julie as her ex-partner and said that "Julie puts her down and tells her how pathetic she is".

6.2.2 On 22 February 2018, the police were called after Louise had left home (living with Julie) indicating that she was going to take her own life following an argument with Julie. Louise was found nearby and taken to hospital. A VPRF1 was submitted, and a referral was made to Adult Social Care. There is no record of her being seen by medical staff on this occasion. No action was taken by Adult Social Care.

6.2.3 On 16 March 2018, the police were called to an incident at Louise and Julie's home. Julie, who was heard shouting "I'm going to have you", was arrested for threats to kill, Common Assault and possession of an offensive weapon against another family member at the scene. A VPRF1 was submitted by the officers and a Merseyside Risk Identification Toolkit, (MeRIT – see paragraph 14.2.1 for full details) risk assessment was completed, which was graded bronze. Louise made a written statement saying she had not been assaulted, and that her injury resulted from hitting her head on the wall. In her statement, she said that although her relationship with Julie had its ups and downs, Julie had never shown violence towards her or behaved in a controlling manner. Julie was seen in custody by the Criminal Justice Liaison Team (Mersey Care). The VPRF1 submitted to Adult Social Care was shared by them with Louise's GP practice.

6.2.4 On Friday 23 March 2018, Julie appeared at magistrates' court in relation to the incident of 16 March 2018. An incident occurred in the court building between Louise and her sister, Jade, following which Louise was asked to leave the building. Over the course of the next few months, whilst the occurrence of 16 March 2018 was investigated, a number of incidents of threats and damage were reported by Louise's family: they indicated that Louise and Julie were responsible for them.

6.2.5 On 15 April 2018, in the early hours of the morning, Louise phoned the police stating that Julie had set a dog on her and assaulted her. Officers quickly arrived but Louise then denied that she had been assaulted and said a bruise on her head had been caused by falling over. Louise did not make a statement and was taken to Aintree Hospital as she wanted to speak to the mental health team. However, she left before being seen. A MeRIT risk assessment was completed and graded as silver. A VPRF1 was submitted, Adult Social Care were notified and took no action.

6.2.6 On 16 April 2018, Louise returned home. Julie phoned the police claiming that Louise was assaulting her and had threatened to harm herself with a knife. When officers attended, Julie did not wish to pursue a prosecution. However, both Julie and Louise were arrested in connection with matters arising from the incident of 16 March 2018. A VPRF1 was completed for the domestic incident, recording Julie as the victim; she was signposted to the National Centre for Domestic Violence. Louise was seen in custody by the Criminal Justice Liaison Team. She reported having suicidal thoughts but no plans to act upon them and was given alcohol referral information. Adult Social Care received the VPRF1 and took no action.

6.2.7 On 11 May 2018, Julie was convicted of Common Assault on Louise's sister, Jade, following the incident of 16 March 2018. She received a suspended sentence order, and a restraining order was also imposed to prevent Julie approaching Jade and other family members. The case was transferred to Merseyside Community Rehabilitation Company (MCRC) and the case assigned to a case manager. Notes were added to the case management system denoting that Julie was diagnosed with bi-polar disorder and PTSD. Suicide and self-harm risk markers were applied to the case, as Julie reported a recent suicide attempt.

6.2.8 On 15 May 2018, Louise was admitted to hospital having taken an overdose of medication with alcohol. She had an existing mental health appointment the following week and after the liaison between the two services, Louise left hospital with the plan to keep the existing appointment. She kept the appointment for an assessment on 24 May and was referred to the early intervention team. Information was shared with Adult Social Care who shared it with Louise's GP practice.

6.2.9 On 21 May 2018, an initial assessment and sentence plan was completed with Julie by MCRC and shared with PSS UK Women's Turnaround. In working with women, MCRC contracts the PSS UK Women's Turnaround to deliver women-specific interventions in order to reduce reoffending. The teams are co-located, and all women subject to probation supervision are given a PSS UK Women's Turnaround keyworker. The risk management and sentence plans are routinely shared, which is considered good practice.

6.2.10 On 2 July 2018, Louise attended a hospital A&E department: she had a head injury following an alleged assault. She was treated and discharged. It is unknown how Louise came by this injury as she declined to discuss it.

6.2.11 On 11 July 2018, Louise's sister, Sarah[7], called the police to report that Louise had been assaulted by Julie. On arrival, officers found that both sisters had been drinking. Louise said that her injuries were from hitting herself on the head and falling over: she made a signed statement that she had not been assaulted. Louise was taken to hospital for treatment to her injuries. A MeRIT risk assessment was completed and graded as silver. A VPRF1 was submitted, Adult Social Care were notified and took no action.

6.2.12 On 25 July 2018, Louise's sister contacted the police. She was concerned for Louise's safety as Louise had telephoned her saying that she had taken an overdose of tablets. Police officers forced entry to Louise's home and found her awake and surrounded by tablets, although she denied taking any. She was taken to hospital by ambulance, a VPRF1 was completed and followed up with a referral to Mental Health Services. Louise was discharged from hospital following treatment. She did not give her consent for Adult Social Care to share information with her GP and there was no further action taken by Adult Social Care.

6.2.13 On 8 August 2018, police officers were called to an incident involving Louise and Julie in Liverpool city centre. Both were very drunk, and Louise was arrested because of her behaviour. She later received a caution. A MeRIT risk assessment was completed and graded as bronze, showing Julie as the victim. A VPRF1 was submitted to Adult Social Care, they took no action.

6.2.14 On 9 September 2018, Louise contacted the police stating that she was on her way to the bus station to leave the city and thought that Julie was going to stop her. Officers found Louise in the street and took her to hospital after she stated she wanted to speak to the Crisis Team. Julie was not present. A VPRF1 was completed and a referral to Adult Social Care was made for Louise. Adult Social Care took no action.

[7] A pseudonym agreed with Louise's family

6.2.15 In September 2018, members of Louise's family were arrested and questioned about serious criminal offences. They were released and no charges were ever brought. The family blamed Julie for providing what they consider to be malicious information to the police, which caused them to be arrested. Following this, Louise and her mum were not in contact with each other.

6.2.16 On 7 October 2018, Louise telephoned the police reporting that Julie had hit her with the Hoover. When officers attended, Louise was drunk and stated she had been watching a TV programme and became confused about what was happening due to her mental health issues: she denied Julie had assaulted her. Julie said that Louise had been drinking all day and there had been no domestic abuse incident. Louise was abusive and uncooperative and was arrested to prevent a breach of the peace. A MeRIT risk assessment was completed and graded as bronze. A VPRF1 was completed, and a referral sent to Adult Social Care for Louise. Adult Social Care took no action.

6.2.17 On Monday 8 October 2018, Louise's sister, Jade, contacted the police reporting malicious communications from Louise. Louise was arrested for this on 7 November 2018 and later convicted. A restraining order was issued.

6.2.18 Later in the day, on Monday 8 October 2018, the police received an anonymous 999 call to a disturbance at Louise and Julie's home. Louise was outside the flat with a minor cut to her arm, and the glass in the front door was broken. She was intoxicated. Julie said that she had just returned home to find Louise in that condition, and no domestic incident had occurred. Louise was taken to hospital to see the mental health Crisis Team, and have her wound dressed. She left before she could be seen by a mental health practitioner. A MeRIT risk assessment was completed and graded as silver, with Julie as the victim and Louise as the perpetrator. A VPRF1 was completed and referrals to Adult Social Care were made for both Louise and Julie. Adult Social Care sent a letter to Julie signposting her to support agencies.

6.2.19 On 6 February 2019, Julie told a MCRC case manager that Louise was not staying with her for the time being and was staying with her sister, as a result of Louise drinking again. Julie felt that she couldn't be around Louise when she was drinking.

6.2.20 On 4 March 2019, the ambulance service was called to a park in Liverpool where Louise had cut her wrists and taken an overdose. She was taken to hospital where she was admitted for treatment. Louise stayed in hospital until 8 March 2019, when she was discharged. A VPRF1 was completed, and Adult Services were notified of the incident. On her release from hospital, Louise was arrested for an outstanding court warrant: she had failed to appear at court in answer to the malicious communications charges (para no 13.27 – 8 October). Adult Social Care shared the information with Mersey Care.

6.2.21 On 15 March 2019, Louise appeared at North Liverpool Community Justice Court for an offence of Harassment (against her sister Jade). A Pre-Sentence Report, prepared by probation, noted that Louise described a good relationship with her partner, Julie, and denied that Julie was in any way abusive towards her: contrary to the beliefs of her family members. The report recommended that the domestic situation be monitored. The report noted that Louise had attempted to take her own life in recent weeks. The author proposed that Louise be made subject of a Community Order with an Alcohol Treatment Requirement and a Rehabilitation Activity Requirement (RAR). Louise received a Community Order of 12-months duration with a 15 days RAR and a 15-week curfew. A Restraining Order was also imposed, preventing contact with Louise's mother and sister. Furthermore, the court imposed a curfew requirement. This requirement necessitated Louise remaining in their home address, with Julie, during her curfew period.

6.2.22 On 27 March 2019, a MCRC offender manager completed a risk assessment and sentence plan for Louise. This was shared with PSS UK Women's Turnaround. The plan noted that Louise was engaging with Royal Liverpool University Hospital alcohol clinic and had been prescribed Librium. She was waiting to be prescribed mirtazapine. The assessment noted that there were no current concerns in Louise's relationship, that Louise denied Julie was in any way abusive towards her, and that concerns were fabricated by her family. She also stated that accommodation was not a problem. Louise was assessed as a suicide risk, and as such, a risk flag was applied to the case. She was not considered a risk to others, and as such, a Risk Management Plan was not completed. Her sentence plan included the improvement of thinking and problem-solving skills, enhanced emotional management, and continued abstinence from alcohol.

6.2.23 On Thursday 16 May 2019, Louise contacted the police via social media, reporting that Julie was threatening to throw her out of their home. Louise was concerned she would be in breach of her curfew as her residence there was a condition imposed by the court. She was reluctant for an officer to attend to ensure she was safe and well. There was no report of a domestic incident, and an officer spoke to her several times on the phone, indicating she was free to use her phone should she need to do so in an emergency. Louise agreed to an appointment at a police station on 22 May, and she was advised to contact her probation officer the following day regarding the accommodation issue.

6.2.24 On 20 May 2019, Louise told her offender manager that she and Julie had been arguing and were separating. She was remaining at the property for now as that was where she was required to live by the court order. She was advised that she should leave the property if she felt at risk.

6.2.25 On 20 May 2019, the ambulance service was called to Louise and Julie's home by Louise, who said that she had taken an overdose and stabbed herself. Julie told a police officer that Louise had self-harmed because she was distressed at being convicted of harassment and being on a tag. A VPRF1 was completed, and a referral was sent to Adult Social Care requesting support for Louise's alcohol abuse. Louise was taken to hospital by ambulance and admitted for treatment.

6.2.26 On 22 May 2019, a police officer contacted Louise as she did not attend a police station appointment. Louise asked for support for her alcohol abuse and mental health problems and stated she did not feel she was receiving either (Louise was in hospital at this time). A VPRF1 was completed with this information and a referral sent to Adult Social Care. No action was taken by Adult Social Care

6.2.27 During this admission to hospital, discussions took place with Louise about moving into crisis accommodation, provided by Mersey Care, when she was medically fit for discharge. Louise discharged herself and left the hospital before this could be arranged.

6.2.28 On 19 June 2019, during an appointment with her offender manager, Louise said that she and Julie had been arguing lately, and she was keen to source her own independent accommodation. The offender manager advised that if the situation became volatile, she should leave the property and contact police (this in the context of a curfew order). Louise stated that her money was going into Julie's account and that she was applying for ID to enable her to set up her own. She claimed to have reduced her alcohol use, and whilst feeling low, she had not had any suicidal thoughts. The offender manager instructed Louise to attend Mersey Care's mental health drop-in to discuss how she could be medicated until she registered with a new GP. Louise was given money so that she could attend the Housing Options Service to complete a housing assessment. Louise did attend at the service but did not wait long enough for an assessment to be completed. There is no record of Louise attending the mental health drop-in.

6.2.29 On 17 July 2019, Louise attended at a hospital A&E department and stated that she had taken an accidental overdose. She left before receiving treatment.

6.2.30 On 9 August 2019, Louise appeared at Sefton Magistrates Court in relation to a Breach of Community Order. This followed warnings after failing to attend sessions (e.g., alcohol key worker). She was fined and the order was to continue.

6.2.31 On 3 September 2019, Louise telephoned a MCRC case manager. Louise sounded drunk and said that Julie had asked her to leave her home and she had slept in a 24-hour McDonalds. The case manager contacted MARS Riverside (a housing provider) who tried to contact Louise, without success.

6.2.32 On 5 September 2019, Louise texted a PSS UK Women's Turnaround worker to say that Julie had "battered her". This prompted a series of texts in which Louise said that she had left the house, was safe, and was staying with a friend. Louise would provide no further details. She was offered safety advice and support to link in with PSS UK domestic abuse services and other agencies. These offers were repeated over the following two weeks during appointments. Louise said that she had left the relationship and was fine. MARS Riverside and the Housing Options Service made a number of attempts to contact Louise, but all were unsuccessful.

6.2.33 On 2 October 2019, following MCRC management oversight of the case, Louise's risk of harm level was increased to medium: this was a result of multiple domestic abuse incidents and alleged continued harassment.

Later in the day, an MCRC case manager received a text message from Louise informing that she had taken an overdose the day before, had called an ambulance, and had then discharged herself from hospital (Louise left before she could be treated). She said she was now back at Julie's house. The case manager called Louise and advised her that she must visit her GP urgently and re-engage mental health services. The case manager contacted Mersey Care to request an appointment and referred Louise to We Are With You. In addition, Louise was referred to the Rotunda College (with whom MCRC contracts) for counselling. Multiple attempts were made by Mersey Care to engage with Louise, but she did not engage with them and did not attend the appointments offered.

6.2.34 On 9 October 2019, Louise started a voluntary alcohol treatment programme with We are With You. Her attendance was sporadic, but she made progress and completed the course by January 2020. Louise had identified her triggers and, through this, had learned to control her drinking. It was noted that in the last meeting, Louise's personal presentation and mood was significantly improved.

6.2.35 On 7 January 2020, Louise contacted the police to report a dispute with Julie over ownership of a dog. Louise stated their relationship had ended some six months before and Julie was refusing to hand over the dog. An officer attended and advised that this was a civil matter. Julie alleged that Louise, who was intoxicated, had slapped her across the face. She was not in need of medical attention and declined to make a complaint of assault. Louise agreed to leave the premises and was transported to the YMCA in Liverpool. A VPRF1 was completed, with Julie as the victim. Also, a MeRIT risk assessment was graded as bronze.

6.2.36 On 1 March 2020, the police received a call from a member of the public reporting a disturbance when Louise was involved in a fracas with a number of people, including Julie's adult son, and Julie. Julie's son was arrested on an unconnected matter. A VPRF1 was completed, with Julie as the victim. Also, a MeRIT risk assessment was graded as bronze.

6.2.37 On 10 March 2020, Louise attended for her final appointment with her MCRC case manager. She said that she was taking sertraline and quetiapine daily and was feeling much better. She stated that she was grateful for all the support she had received and felt she was unlikely to offend again, given that she was no longer drinking. She was financially independent and stable, with her own bank account, and understood that she could maintain contact with her keyworkers if necessary.

6.2.38 On 12 March 2020, Louise contacted the police and an officer attended to speak to her. Louise said that Julie had subjected her to coercive and controlling behaviour during their 10-year relationship. Julie was, at this time, away in the South East. Louise was informed of her options and given reassurance about the support that could be provided. A MeRIT risk assessment was graded as gold and a VPRF1 was completed. Referrals to IDVA, MARAC and Adult Social Care were made.

6.2.39 On 13 March 2020 (Friday), the referral from the police to the IDVA service was actioned and Louise was contacted by telephone. The IDVA who spoke to Louise agreed to look into the possibility of hostel accommodation. No places were available in Liverpool and Louise was not considered suitable for the only refuge space available in the North West that day (Fylde Coast Women's Aid). Louise also had three dogs, which she was concerned about. It was agreed that Louise was safe where she was because Julie was away and not expected back for several days. Another refuge in the North West indicated that it may have space on Monday and would contact Louise then. Louise remained concerned and contacted Careline (Adult Social Care) to seek advice following her being declined accommodation by Fylde Coast Women's Aid. It was confirmed that she was currently safe, and she was asked to speak with the IDVA service again on Monday.

6.2.40 Louise was found deceased before the case could be followed up.

# 7 Conclusions

7.1 Louise and Julie had been in a relationship since 2013. Louise's family say that she had suffered abuse for much of the relationship. In 2017, after a period living in the South East, the couple returned to Liverpool.

7.2 Over the following years until her sad death in March 2020, many incidents involving the couple were reported to agencies. Whilst information was shared between agencies, little was done to pull together an overall picture of the relationship and the risks to both Louise and Julie. If all the available information had been drawn together, opportunities existed for a multi-agency meeting to be convened to consider if a safeguarding enquiry or a referral to MARAC would have been appropriate. This would have allowed for multi-agency information gathering and sharing, and oversight and action planning to reduce the risk. Those opportunities were not grasped.

7.3 Louise did not easily accept help. A bad experience in court as a teenager made her reluctant to engage with the criminal justice system and counselling. This was not known by professionals who dealt with Louise during the timeframe of the review. On the occasions that Louise reported domestic abuse to the police, she withdrew her allegations and there was insufficient evidence for the police to act. Other than engagement with Merseyside Community Rehabilitation Company and their partner Women's Turnaround, which Louise had to engage with, she typically only engaged with services when she was in crisis, and then quickly withdrew. She often did not attend follow-up appointments. Louise's reasons for non-engagement were never fully understood by professionals.

7.4 The nature of Louise and Julie's relationship was not easily understood by agencies. Both were recorded as victims and perpetrators of domestic abuse to each other, although this was not known to all agencies.

7.5 The panel discussed the couple's relationship in the context of Johnson's[8] typology of intimate partner violence. This divides domestic abuse (intimate partner violence) into four categories:

The panel discussed the couple's relationship in the context of Johnson's typology of intimate partner violence. This divides domestic abuse (intimate partner violence) into four categories:

**Intimate terrorism**, or coercive controlling violence, occurs when one partner in a relationship, typically a man, uses coercive control and power over the other partner, using threats, intimidation, and isolation. Coercive Controlling Violence relies on severe psychological abuse for controlling purposes; when physical abuse occurs, it too is severe. In such cases, one partner, usually a man, controls virtually every aspect of the victim's, usually a woman's, life. Johnson reported in 2001 that 97% of the perpetrators of intimate terrorism were men.

**Violent resistance**, a form of self-defence is violence perpetrated by victims against their partners who have exerted intimate terrorism against them. Within relationships of intimate terrorism and violent resistance, 96% of the violent resisters are women.

**Situational couple violence**, also called common couple violence, is not connected to general control behaviour, but arises in a single argument where one or both partners physically lash out at the other. This is the most common form of intimate partner violence, particularly in the western world and among young couples, and involves members of both sexes nearly equally. Among college students, Johnson found it to be perpetrated about 44% of the time by women and 56% of the time by men.

**Mutual violent control,** is a rare type of intimate partner violence occurring when both partners act in a violent manner, battling for control.

[8] Michael Paul Johnson is emeritus professor of sociology, women's studies and African and African American studies at Penn State university, USA, having taught there for over thirty years.

7.6 The panel also considered whether there had been bi-directional violence. The term has been generated to capture relationships in which both parties use violence and/or abusive behaviour. The term suggests that a single primary aggressor cannot be identified.

7.7 The panel thought that on the balance of information available, it was likely that Louise had suffered intimate terrorism and had responded on occasions by violent resistance. The panel acknowledged that whilst it is possible to categorise the abuse Louise suffered in hindsight, it was difficult for individual practitioners dealing with single occurrences to do so

7.8 The 2018 Changing Lives report 'Too complex for complex needs', focusses on the successes of assertive outreach work for victims of domestic abuse who have needs such as substance misuse, poor mental health and domestic abuse combined. The panel thought that Louise could be seen as part of that group. The report asks, and answers the question:

***Where might we have intervened earlier?***

It is difficult, with such a small sample, to identify definitively any obvious opportunities for early intervention with these women. However, the women's stories suggest it would be helpful to refer women for more intensive support:

at the second or third referral to MARAC

on eviction from a refuge

on refusal of a refuge space on the grounds to 'complex needs'

7.9 Louise was refused refuge space because the only space available was unsupervised outside core hours and it was thought unsuitable for her given her recent history of self-harm. She had drinking problems and a history of overdose and self-harm. It is possible that Louise may have been helped by consistent supportive outreach if it had been available. The existing services in Liverpool were unable to consistently engage with her.

7.10 Louise was judged to have capacity to make decisions in relation to accessing services and whether to accept offers of help. The panel recognised the challenges that professionals can face when there is a known risk to individuals, whether through self-harm or suicidal ideation; however, there was no evidence available that would have justified implementing sections of the Mental Health Act to safeguard Louise and remove her liberty.

7.11 On the day prior to her death, Louise had been in contact with professionals and disclosed a 10-year history of coercive control from Julie. Louise was deemed to have been safe, given that Julie was living outside of the area and was not anticipated to return. The panel acknowledged that this distance was not necessarily a safety barrier as coercive control within the Serious Crime Act 2015 (Section 76), states that victim's only need to 'fear' that violence will be used. With no available refuge accommodation that was accessible to Louise, due to her risk of suicide, the panel acknowledged that there were no alternative options but for Louise to remain at home, with planned further agency engagement after the weekend. The potential for Louise's risk of self-harm to increase at this point was not understood or recognised by those who had contact with her.

The inquest did not establish any third-party involvement in Louise's death. The panel acknowledged the tragic circumstances of this case and again offer their condolences to Louise's family.

# 8 Learning Identified

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

8.1 **Narrative**

Training for staff on suicide awareness and prevention is inconsistent across the partnership.

**Learning**

The availability of free training resources to agencies should enable them to provide information and advice to staff on suicide prevention.

Panel recommendation 1 applies.

8.2 **Narrative**

The link between domestic abuse and suicide is not well known or understood.

**Learning**

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

Panel Recommendation 2 applies.

8.3 **Narrative**

This case illustrates the challenges faced by professionals in achieving effective engagement with victims of domestic abuse. As stated earlier in the report, there are multiple reasons why victims feel unable to engage.

**Learning**

Some victims of domestic abuse find engagement with agencies especially difficult. This may be particularly the case when a victim such as Louise has suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma-informed way.

8.4 **Narrative**

There is a shortage of refuge accommodation for people who have complex needs.

**Learning**

The absence of safe accommodation can lead to further risk.

8.5 **Narrative**

The panel felt it possible that unconscious bias affected the considerations of agencies in this case.

**Learning**

Improved awareness of abuse in same sex relationships may help to eliminate unconscious bias.

8.6 **Narrative**

Louise and Julie's circumstances were not referred to MARAC as incidents were not assessed as Gold. The high volume of incidents did not generate a referral on professional judgement.

**Learning**

Cases where there is a high volume of repeat domestic abuse incidents, combined with other risk factors, should be recognised as high risk and generate a MARAC referral.

# 9 Panel Recommendations

9.1 All agencies involved in the review should provide Liverpool Community Safety Partnership with evidence of the training and information provided to staff on suicide prevention. The Community Safety Partnership should assess the information received and consider whether a multi-agency training package for Liverpool is required.

9.2 Agencies involved in the review should provide Liverpool Community Safety Partnership with evidence that information has been provided to staff on the links between domestic abuse and suicide. The learning from this review should be used to assess whether a city-wide multi-agency package, to inform practitioners of the links between domestic abuse and suicide, is required.

9.3 Agencies involved in the review should provide Liverpool Community Safety Partnership with assurance that their training plans take into account the need to train staff in trauma-informed practice. The Community Safety Partnership should assess whether a city-wide multi-agency approach to trauma-informed practice is required.

9.4 The Domestic Abuse Act 2021 (section 57) requires all Local Authorities to:

(a)assess, or make arrangements for the assessment of, the need for accommodation-based support in its area,

(b)prepare and publish a strategy for the provision of such support in its area, and

(c)monitor and evaluate the effectiveness of the strategy.

The assessment and strategy for Liverpool should take into account the learning from this case.

The panel further recommends that the Home Office encourage all local Authorities to ensure that their assessment and strategy for accommodation-based support takes into account people with complex needs, including the risk of suicide.

9.5 Agencies involved in the review should provide Liverpool Community Safety Partnership with assurance that staff are trained in relation to the possibility of unconscious bias and domestic abuse in same sex relationships.

9.6 Guidance for professionals on what factors should be taken into account in making a professional judgement referral to MARAC should be developed.