The Safer St Helens Community Safety Partnership

Domestic Homicide Review

Overview Report

Carol

Died November 2023

Chair and Author: Ged McManus

Supported by: Carol Ellwood-Clarke QPM

Date: April 2025

INDEX **Page**

1 Introduction

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

1.2 Carol and John had been married for over 30 years and lived together in social housing in St Helens. The couple were not widely known to services in St Helens in recent years; however, historically there had been many calls to the police from both Carol and John – each making complaints of domestic abuse against one or the other. Children's Social Care was involved with the family when the couple's now adult children were young. Prior to Carol's unlawful death in 2023, there had been no calls to the police since 2017.

1.3 In early 2022, the couple notified the Department for Work and Pensions, and their housing provider, that they had split up. By October 2022, medical records show that the couple were living together again.

1.4 On a date in November 2023, John strangled Carol to death in their home. John laid Carol's body out and then went to the local police station to confess to killing her.

1.5 Carol and John are pseudonyms chosen by the DHR panel from a list of names. Their family did not wish to contribute to the review.

1.6 John was charged with Carol's murder and pleaded guilty to manslaughter. A trial on the murder charge went ahead, with John being found not guilty of murder. During the trial, John claimed that he had been provoked by verbal abuse from Carol (who was drunk) and that he lost control, strangling her to death. The DHR panel wish to state that Carol was the victim in this review, and John's narrative is victim blaming. However, the panel chose to include John's claim because there is so little other information with which to provide context around Carol's unlawful death.

1.7 Sentencing John to six years' imprisonment for Carol's manslaughter, the sentencing Judge said:

'*I am satisfied that the correct basis for sentence is that you did have the necessary intention for the offence of murder, but that the killing was the result of your loss of control in circumstances where there was a sufficient trigger and your response was justifiable.*

I do not accept that there was, in the circumstances, a very high degree of provocation. Carol [name redacted] was, to an extent, a vulnerable, slightly built, [comment redacted] who represented no threat to you and who was killed in her own home'.

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

1.9 The review considers agencies' contact and involvement with Carol and John from 1 January 2021 until Carol's death in November 2023. This time period was chosen in order to provide a proportionate review period, as there had been no evidence of domestic abuse in recent years prior to Carol's death. The DHR panel considered that this period of almost three years was proportionate and potentially capable of producing learning relevant to contemporary services in St Helens.

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

1.11 **Note:**
It is not the purpose of this DHR to enquire into how Carol died: that is a matter that has already been examined during John's trial.

2 Timescales

2.1 This review began on 2 June 2024 and was concluded on 19 March 2025.

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

3 Confidentiality

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

3.2 Pseudonyms have been used in the report to protect the identity of the subjects of the review.

4 Terms of Reference

4.1 The purpose of a DHR is to:

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

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

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

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

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

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

4.2 Time frame Under Review

The DHR covers the period from 1 January 2021 until Carol's death in November 2023.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Carol, aged 62 years

Perpetrator: John, aged 68 years

Specific Terms

1. What indicators of domestic abuse were your agency aware of that could have identified Carol or John as a victim of domestic abuse, and what was the response?

2. What knowledge was your agency aware of that indicated John might be a perpetrator of domestic abuse against Carol, and what was the response? Did that knowledge identify any controlling or coercive behaviour by John?

3. How did your agency assess the level of risk faced by Carol and John? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How effective was inter-agency information sharing and co-operation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider cross-border information sharing.

5. How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Carol and John?

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

7. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

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

9. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to COVID-19.

10. What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?

11. Are there any examples of outstanding or innovative practice arising from this review?

12. What learning has emerged for your agency?

13. Does this learning appear in other Domestic Homicide Reviews commissioned by St Helens Community Safety Partnership?

5 Methodology

5.1 On 27 November 2023, Merseyside Police made a referral to St Helens Domestic Abuse Partnership Board for the case to be considered for a DHR. On 31 January 2024, the Safer St Helens Community Safety Partnership agreed that the circumstances of the case met the criteria for a Domestic Homicide Review and recommended one should be conducted. The Home Office was informed of the decision to undertake a review on 11 February 2024.

5.2 On 25 April 2024, Ged McManus was commissioned as the Independent Chair of the review. Due to other commitments, he was unable to start work on the review until June 2024.

5.3 The first DHR panel meeting took place on 20 June 2024. DHR meetings took place using Microsoft Teams video conferencing: the panel met six times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 19 February 2025, after which minor amendments were made to the report that were agreed with the panel by email. The report was then proof read before being finalised.

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

6.1 Family

6.1.1 Carol and John's adult children were supported by a Victim Support Homicide Worker. The Chair wrote to them, inviting them to contribute to the review, and included appropriate Home Office leaflets. Through their support worker, they indicated that they wished to contribute to the review, and a meeting was arranged. On the day of the meeting, one of the siblings contacted their Victim Support Homicide Worker and said that they no longer wished to contribute to the review. Although arrangements for the meeting continued in the anticipation of the second sibling attending, they did not attend. When contacted, they stated that they had a family emergency and were unable to attend the meeting that day. Victim Support were unable to engage with them after that.

6.1.2 Towards the end of the review, the Safer St Helens Community Safety Partnership wrote to Carol's children to offer a further opportunity to be involved in the review or receive a copy of the report. No reply was received.

6.1.3 Merseyside Police provided statements made by Carol and John's children for the purposes of the investigation into Carol's death. The statements are summarised below.

6.1.4 Adult child 1

Adult child 1 recalled, as a child, a history of domestic abuse between Carol and John. There were regular arguments and sometimes both of them received injuries from the other. Carol would generally be more verbally aggressive and loud whilst John would be quieter and try to stay out of the way. Although John would generally be quiet, he could sometimes snap and then things would escalate.

Carol would drink alcohol excessively. Carol did not work, and John provided the money from his work as a warehouse manager. Adult child 1 described Carol as a functioning alcoholic.

Adult child 1 left the family home aged 17 and kept in contact mainly by telephone.

6.1.5 **Adult child 2**

Adult child 2 described the difficulties of growing up with Carol, whose life was dominated by alcohol. They described Carol as a violent alcoholic who assaulted both children and John. They also described assaults on Carol by John. Adult child 2 left the family home at the age of 15, as they could not tolerate their parents' behaviour.

Adult child 2 had no contact with Carol for over 10 years prior to her death: this was following an argument over contact with a grandchild.

6.1.6 **John's siblings**

John has three siblings. They were not in regular contact. One of the siblings made a statement to the police for the purposes of the investigation into Carol's death. They stated that they became aware that John was in hospital in March 2023 and visited him three times with their other siblings. During the visits, John said that Carol had told him not to go back to the marital home, and he was looking for somewhere else to live. The siblings had no further contact with John after visiting him in hospital.

6.2 **Neighbours**

6.2.1 Merseyside Police provided the statements made by neighbours for the purposes of the investigation into Carol's death.

6.2.2 Neighbours 1 and 2 lived next door to Carol and John and described a cordial relationship as neighbours. However, they were aware of regular arguments between Carol and John, which could be heard almost every day. Mostly, this was Carol shouting at John and John telling Carol to 'Shut up'.

6.2.3 Neighbour 3 said that they often gave John a lift to the doctors' surgery, as he struggled with walking. Neighbour 3 would often hear Carol shouting at John when walking the dog past the couple's house. When John was asked why he did not leave, he said: 'Where would I go?'.

Friends

6.2.4 The DHR panel was unable to identify friends with which it could seek engagement.

6.3 **Employer**

6.3.1 Carol did not work and was reliant on benefits. John was a retired warehouse manager.

6.4 **John**

6.4.1 The Independent Chair of the review wrote to John, inviting him to contribute to the review. His prison offender manager gave him the letter and explained it to him. John declined to contribute to the review.

7 Contributors to the Review / Agencies Submitting IMRs[1]

7.1.1	**Agency**	**Contribution**
	Merseyside Police	Report with historic information
	NHS Cheshire and Merseyside Integrated Care Board – GPs	IMR
	Mersey Care NHS Foundation Trust	IMR
	St Helens City Council Adult Social Care	IMR
	Mersey and West Lancashire Teaching Hospital NHS Trust	IMR
	Liverpool University Hospital NHS Foundation Trust	IMR
	Safe2Speak	IMR
	North West Ambulance Service	IMR
	Torus Housing [Carol and John's landlord]	IMR
	St Helens Adult Social Care	IMR
	St Helens Children's Social Care	Report with historic information

[1] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Carol and/or the perpetrator.

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

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

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

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

7.2 Information About Agencies Contributing to the Review

7.2.1 Merseyside Police

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

7.2.2 NHS Cheshire and Merseyside

NHS Cheshire and Merseyside – an Integrated Care Board – holds responsibility for planning NHS services, including primary care, community pharmacy, and those previously planned by clinical commissioning groups.

7.2.3 Mersey Care NHS Foundation Trust

The Trust provides specialist inpatient and community services that support mental health, learning disabilities, addictions, brain injuries, and physical health in the community.

7.2.4 St Helens Borough Council Adult Social Care

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

7.2.5 Mersey and West Lancashire Teaching Hospital NHS Trust

The Trust provides acute and community healthcare services at St Helens and Whiston Hospitals: both of which are modern, high quality facilities. Community Intermediate Care services are delivered from Newton Community Hospital in Newton-le-Willows. The Trust also provides the urgent treatment centre, operating from the Millennium Centre, which is in the centre of St Helens. Alongside these community and secondary care services, the Trust also provides primary care services from the Marshalls Cross Medical Centre, which is situated inside St Helens Hospital. In addition, all St Helens community services were transferred to the Trust in April 2020.

7.2.6 North West Ambulance Service

North West Ambulance Service NHS Trust are emergency responders, patient transport providers, and NHS 111 urgent care and advice givers.

NWAS provides urgent and emergency care in Cumbria, Greater Manchester, Lancashire, Cheshire, and Merseyside.

Patient Transport Services are provided in Cumbria, Greater Manchester, Lancashire, and Merseyside.

7.2.7 Safe2Speak

Safe2Speak is the locally commissioned domestic abuse service for the St Helens borough and has been providing this service since 2011. Safe2Speak is an inclusive service in recognition that anyone can be a victim of domestic abuse, regardless of gender, age, ethnicity, socio-economic status, sexuality, or background.

Safe2Speak offers a client-led, trauma-informed support, including specialist safety advice and advocacy, assisting victims to explore their options, and implementing short to long-term support plans. Practitioners collaborate with partner agencies with the aim to reduce risk for those experiencing abuse, which includes representing the voice of high-risk victims in the local multi-agency risk assessment conference (MARAC). The service supports victims of domestic abuse – risk assessed as at high, medium, and standard risk of serious harm and/or homicide.

Safe2Speak offers the following victim focused services:

- Safe2Speak Refuge Accommodation
- Safe2Speak 24hr Helpline
- Safe2Speak Programme
- Safe2Speak Community Based Support – Domestic Abuse Outreach & IDVA services

Safe2Speak also delivers professional training within the borough: including a course raising awareness of the local domestic abuse referral pathways and role of St Helens MARAC.

7.2.8 Torus Housing

One of the North West's largest landlords, Torus is a well-established housing group with deep roots in Liverpool, St Helens, and Warrington – and a total footprint encompassing 11 local authority areas.

The group mission of 'growing stronger communities' drives the four arms of the group to work together and deliver homes and services for those who need them most. The landlord function sits at the heart of Torus and works to provide affordable homes and housing services that support people to live securely and independently. The development company, Torus Developments, builds new homes across a range of tenure types, and the commercial contractor, HMS, is the building and maintenance contractor. The charitable arm, Torus Foundation, invests the income generated by Torus Developments and HMS, together with additional income that it attracts into services that improve wellbeing, skills, and

quality of life – breaking down barriers, unlocking potential, and making communities more resilient.

7.2.9 NHS University Hospitals of Liverpool Group (UHLG) – Operator of Aintree Hospital

NHS University Hospitals of Liverpool Group (UHLG) was formed on 1 November 2024: born from a shared aim to improve the care provided to our communities.

The group operates from four hospital sites: Aintree University Hospital, Broadgreen Hospital, Liverpool Women's Hospital, and the Royal Liverpool University Hospital, alongside a host of community services.

It is one of the largest employers in the region, with over 16,800 colleagues who are dedicated to caring for their communities – from birth and beyond.

For the 630,000 people across Merseyside, it is their local NHS. It provides general and emergency hospital care, alongside highly specialised regional services that extend to more than two million people in the North West.

Aintree University Hospital is the single receiving site for adult major trauma patients in Cheshire and Merseyside, and it hosts a number of regional services, including an award-winning stroke facility. Broadgreen Hospital is home to several elective surgical, diagnostic and treatment services, together with specialist patient rehabilitation. Liverpool Women's Hospital specialises in the health of women and babies, delivering over 7,200 babies in the UK's largest single site maternity hospital each year. The Royal Liverpool University Hospital is the largest hospital in the country to provide inpatients with 100% single en-suite bedrooms, and it mainly focuses on complex planned care and specialist services.

8 The Review Panel Members

8.1	Ged McManus	Chair and Author
	Carol Ellwood-Clarke	Support to Chair and Author
	Alan Nuttall	Detective Chief Inspector, Merseyside Police
	Michael Andrews	St Helens Borough Council, Community Safety Team Manager

Sarah Platt	Operational Manager, St Helens & Knowsley Probation
Francesca Smith	St Helens Borough Council, Head of Safeguarding Adults
Lindsay McAllister	NHS Cheshire and Merseyside, Designated Nurse Safeguarding Adults
Hanna Roslund	Mersey Care NHS Foundation Trust, Named Professional Safeguarding Adults
Lisa Forshaw	St Helens & Knowsley Teaching Hospitals NHS Trust, Named Nurse Safeguarding Children
Donna Birch	St Helens Borough Council, Housing Options & Advice Team Manager
Martine McLear	Change Grow Live (CGL), Quality Lead – panel expert on alcohol issues
Jennie Grayson	Safe2Speak, Domestic Abuse Service Team Leader
Bev Jonkers	St Helens Borough Council, Community Safety Team
Brendan Doherty	Legal Adviser to the panel, St Helens Borough Council Legal Services
Jane Lauchlan	Torus Housing
Rachel McKernan	Chief Executive Officer, Mid Mersey Age UK
Dave Roberts	Safeguarding Senior Lead, NHS University Hospitals of Liverpool Group (UHLG)
Susan Hewitt	Safeguarding Practitioner, North West Ambulance Service NHS Trust

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

9 Author and Chair of the Overview Report

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

9.2 Ged McManus was chosen as the DHR Independent Chair and wrote the report. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside or an adjoining authority).

9.3 Carol Ellwood-Clarke supported the Independent Chair. She retired from public service (British policing), 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[2].

9.4 Both practitioners served for over 30 years in different police services (not Merseyside) in England. Neither of them has previously worked for any agency involved in this review.

9.5 Between them, they have undertaken over 70 reviews, including the following: Child Serious Case Reviews; Safeguarding Adults 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[3] and have been awarded certificates in chairing a DHR from the Open College Network, London.

[2] https://safelives.org.uk/
[3] Advocacy After Fatal Domestic Abuse

10 Parallel Reviews

10.1 The coroner opened an inquest after Carol's death. The inquest was closed without a hearing, following John's conviction for manslaughter.

10.2 There are no other parallel reviews in this case.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process.

11 Equality and Diversity

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

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**

- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’I faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines ‘disability’ as:

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

11.2 Carol was a 62-year-old white British woman. She was heterosexual and had been married to the perpetrator, John, for many years. In 2006 and 2007, Carol was diagnosed by her GP with mixed anxiety and depressive disorder. Carol was not fit for work for extended periods during this time. During the review period, Carol was diagnosed with acute sciatica and a disc bulge in her back. She was also seen by a GP for other routine appointments.

11.3 The DHR has seen evidence, from several sources, that Carol misused alcohol for many years. This is reflected in historic entries in her GP record. The review has not seen evidence of a formal diagnosis of alcohol dependence or other such condition, and there is no evidence that Carol was referred to or engaged with alcohol services.

11.4 The Equality Act 2010 (Disability) Regulations (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.5 In February 2022, Carol was assessed as having limited capability to work. This meant that Carol did not have to actively seek work in order to receive Universal Credit payments. From June 2022, Carol was in receipt of Personal Independence Payment (PIP) as a result of her medical conditions. Carol said that she did not get out much and was unable to attend appointments with the DWP. Her claims and assessments were dealt with on the phone.

11.6 The panel discussed Carol's medical conditions and concluded, on balance, that she was disabled within the meaning of the Act.

11.7 **Intersectionality**

1. **Age and Gender**: Older women often face societal stereotypes and discrimination related to both their gender and age. Older women may encounter ageism in healthcare, media, and social spaces, where they are sometimes marginalised or seen as less capable. Gendered expectations around ageing, such as pressure to maintain youthfulness or conform to specific societal roles, may also affect older women's mental health and substance use patterns. For example, older women may experience higher rates of loneliness or isolation, which can contribute to higher alcohol consumption as a coping mechanism.
2. **Disability**: Disability, whether physical, cognitive, or mental, adds another layer of experience. Disabled individuals often face accessibility issues, discrimination, and stigma that can compound their difficulties. For older women with disabilities, these barriers may be heightened. They may experience physical limitations in accessing healthcare, support networks, or alcohol treatment programmes. Additionally, women with disabilities may face unique pressures or social isolation, which can lead to substance use as a form of self-medication.
3. **Alcohol Use**: Alcohol consumption among older women with disabilities may be influenced by various factors, including chronic pain, mental health struggles, or a lack of social support. Additionally, the ageing process can affect how alcohol is metabolised, leading to increased health risks. Women

with disabilities may face specific challenges in accessing resources for alcohol abuse treatment, as many addiction services are not tailored to the needs of older adults or people with disabilities.

4. **Healthcare and Support**: Healthcare systems may fail to address the intersectional needs of older women with disabilities who struggle with alcohol use. Many addiction recovery programmes do not account for the specific physical or psychological challenges older individuals, or those with disabilities, face. Older women with disabilities might not receive the same level of care, attention, or resources as their younger or non-disabled counterparts, leading to higher rates of untreated alcohol dependency or related issues.

11.8 John is a white British man who was 68 years old at the time of Carol's death. Between April and June 2008, John consulted his GP for anxiety and work-related depression. He was not fit for work during this time. In 2011, John consulted his GP for depression. He was not fit for work for four weeks. During the review period, he suffered from leg ulcers, resulting in a number of medical treatments and a period in hospital.

11.9 Domestic homicide and domestic abuse predominantly affect women – with women making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. According to the Office for National Statistics homicide report 2021/22[4], there were 134 domestic homicides in the year ending March 2022.

Of the 134 domestic homicides: 78 victims were killed by a partner or ex-partner; 40 were killed by a parent, son, or daughter; and 16 were killed by another family member.

Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect.

Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.

[4] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

11.10 In November 2023, the Office for National Statistics published the following data – 'Domestic abuse in England and Wales overview':[5]

- The Crime Survey for England and Wales estimated that 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) experienced domestic abuse in the year ending March 2023.
- There was no significant change in the prevalence of domestic abuse experienced in the last year compared with the previous year.
- The police recorded 889,918 domestic abuse-related crimes (excluding Devon and Cornwall) in the year ending March 2023, a similar number to the previous year.
- There were 51,288 domestic abuse-related prosecutions in England and Wales for the year ending March 2023, compared with 53,207 in the year ending March 2022.
- In the year ending March 2023, the victim was female in 73.5% of domestic abuse-related crimes.

12 Dissemination

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

5 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies and material gathered by the police during their investigation following Carol's death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

Risk assessments – contextual note

Merseyside Police assess each domestic abuse incident using the Merseyside Risk Identification Toolkit, or (MeRIT), on a Vulnerable Person Referral Form (VPRF). It consists of 40 questions designed to assess the extent to which the relationship has broken down, a brief social assessment, and a violence assessment. The answers inform a score that is graded bronze, silver, or gold accordingly. The results are conveyed to the Multi-Agency Safeguarding Hub (MASH), via the VPRF, and to the custody officer in cases where there has been an arrest. If urgent measures are needed, the matter is escalated to the senior officer on duty. In every case, a secondary risk assessment is undertaken at the police's Vulnerable Persons Referral Unit. Here, assessors correct any obvious errors and gather additional information: providing an opportunity for the grade to be adjusted, according to professional judgement. The final grade informs the appropriate level of intervention and determines the necessary referrals.

Not all agencies in Merseyside use MeRIT. Some health agencies use the DASH risk assessment. In this case, only MeRIT was used.

13.1 Relevant History

13.1.1 From August 1993, Carol and John were joint tenants in the family home rented from Torus Housing and its precursor organisations.

13.1.2 Between 2004 – 2012, there were over 100 incidents involving Carol and John where police were called to verbal arguments. When officers attended, neither would pursue any complaint and neither had any injuries. They were both recorded as suspect and victim during incidents. Carol was often intoxicated by alcohol when spoken to by police officers.

13.1.3 Carol, John, and their two children were known to Children's Social Care from 1999 to 2007. Due to the age of the events, not all records were available to the review. Those records available to the review are summarised as follows.

The concerns in the main were as a result of the police being called regarding domestic abuse involving Carol and John, or Carol acting harmfully towards the children. Often, John raised concerns regarding Carol's drinking and hitting one of the children. On occasion, Carol would ring the police to ask for John to be removed from the property. There were periods of intervention by Children's Social Care where support was offered to the family and issues settled down; therefore, services were withdrawn. Carol's use of alcohol seemed to be a trigger for the ongoing repeat episodes of social care intervention and reports of domestic abuse.

13.1.4 In June 2004, Carol was seen by her GP for alcohol use. It was recorded that she was a heavy drinker. Carol stated that there were marital problems, and she had been assaulted by John the previous week. Carol had further GP appointments for stress-related disorder.

13.1.5 In 2005, Carol received an 18-month community order for an assault on her then teenage daughter.

13.1.6 In 2006 and 2007, Carol was diagnosed by her GP with mixed anxiety and depressive disorder. Carol was not fit for work for extended periods during this time.

13.1.7 Between April and June 2008, John consulted his GP for anxiety and work-related depression. He was not fit for work during this time.

13.1.8 In 2011, John consulted his GP for depression. He was not fit for work for four weeks.

13.1.9 In May 2012, Carol reported to the police that John had tried to strangle her. Carol stated that she was drunk, and John was sober. A VPRF MeRIT risk assessment, showing Carol as the victim, was graded bronze. There was no further action.

13.1.10 In November 2012, John reported to the police that Carol had smashed the house door with a hammer. On police arrival, the front door had damage to its window. Carol was arrested for breach of the peace. A VPRF MeRIT risk assessment, showing John as the victim, was graded bronze. No further action was taken.

13.1.11 In July 2015, Carol phoned the police, stating that John was aggressive, shouting at her, and had pushed her. When officers attended, Carol refuted the allegation of assault. John went to stay elsewhere for the night. A VPRF MeRIT risk assessment, showing Carol as the victim, was graded bronze. No further action was taken.

13.1.12 In April 2017, Carol phoned the police following an argument with John. On officer attendance, this appeared to be an argument about Carol drinking alcohol. John left to stay elsewhere for the night. A VPRF MeRIT risk assessment, showing Carol as the victim, was completed and graded as bronze.

13.1.13 In August 2017, Carol phoned the police and stated that John had held a knife to her throat the previous night. When officers attended, Carol was under the influence of alcohol. Her account was recorded on body worn camera, where she stated that John had grabbed her around the throat and threatened her with a butter knife. John had left the premises with a suitcase. A VPRF MeRIT risk assessment was completed: this showed Carol as the victim and was graded as silver. Carol did not wish to take the matter further, and there was no further action.

13.1.14 In December 2017, the police received a complaint from a neighbour that Carol had threatened them after the neighbour had complained about a disturbance, as Carol and John were screaming at each other.

The above incidents are provided by way of context to Carol and John's life and do not form part of the analysis of the review.

13.2 Information within the review time frame

13.2.1 On 18 February 2021, John had a telephone consultation with a GP for shoulder pain. A not fit for work note was issued until 20 March 2021. Following further consultations, this was diagnosed as mild osteoarthritis of the joint – on 21 April 2021.

13.2.2 On 5 March 2021, John's state pension claim was opened. His state pension was paid from 28 March 2021.

13.2.3 On 10 March 2021, Carol had a telephone consultation with a GP for back pain.

13.2.4 On 7 April 2021, Carol and John made a joint claim for Universal Credit. The bank account declared on the claim was in John's name.

13.2.5 On 7 April 2021, Carol attended an Urgent Treatment Centre [Mersey and West Lancashire Teaching Hospital Trust]. Carol had a wound to the thumb caused by trying to open a tin with a knife two days previously. Carol smelled strongly of intoxicants but denied drinking. She was prescribed antibiotics. No alcohol referral was made because Carol denied drinking.

13.2.6 Between 9 April 2021 and 7 May 2021, Carol was reviewed by a GP nine times due to back pain. Carol was diagnosed with acute sciatica (a pain in your bottom, leg, or foot caused by irritation or compression of the sciatic nerve).

13.2.7 On 20 April 2021, Carol uploaded a fit note to the couple's Universal Credit journal, stating her health conditions as severe pain in lower back and hips. Carol stated that the medical conditions restricted her ability to work or look for work.

13.2.8 Between 7 June 2021 to 28 June 2021, Carol was reviewed by a GP for a number of ailments, including bleeding from the nose and dizzy spells. Medication was prescribed for folate deficiency (a condition caused by low levels of folate, a B group vitamin, in the body).

13.2.9 On 29 June 2021, Carol had an initial assessment with Musculoskeletal services [Mersey Care NHS Foundation Trust]. She was diagnosed with a disc bulge and nerve compression. She was advised on activity and exercise.

13.2.10 On 7 July 2021, Carol called Musculoskeletal services to ask about painkillers. She was signposted to her GP. Carol stated that she had tried the exercises, but they were too painful. Also, she requested face-to-face appointments. Carol did not attend a face-to-face appointment on 23 August 2021 and was discharged from the service.

13.2.11 On 13 December 2021, Carol had a physiotherapy review for lower back pain. An MRI scan showed disc bulges and age-related changes. It was recorded that Carol lived with her husband and did the housework. She had previously worked as a cleaner but had stopped work due to poor health. Carol stated that she didn't go out of the house, except for appointments, because she was frightened in case she couldn't walk or got dizzy.

13.2.12 On 16 January 2022, the DWP closed John and Carol's joint Universal Credit claim, as they were no longer living together. The claim was transferred to a single claim for Carol only.

13.2.13 On 3 February 2022, Carol had a Work Capability Assessment via telephone.

Medical Conditions listed in the report were back problem, vitamin D deficiency, alcohol dependency, and anxiety and depression.

The report states that Carol's alcohol dependency has improved as '*she does not drink everyday anymore and she has not done this for the past month*.'

Regarding anxiety and depression, the report states that it had been worse for the past 12 months and '*especially over the last month due to stress, relationship breakdown and financial issues*.'

The report further states that she has no self-harm intent, however '*She will think of ending her life as nothing is worth living for, everything is going wrong and she can't cope. No specific thoughts, plans, intent and never attempted. Protective factors in her family. GP aware.*'

13.2.14 On 3 February 2022, Carol made a claim for Personal Independence Payment (PIP). Health conditions declared on the questionnaire were lower back and hip problems and stress/anxiety/panic attacks.

13.2.15 On 4 February 2022, John rang Torus Housing [landlord of family home] to inform them that he had split up from Carol and had left the property. He was concerned that Carol would struggle to pay the rent on her own.

13.2.16 On 7 February 2022, Carol attended a physiotherapy review.

'Lower back pain review also discussed/recorded.
Did contact GP about stress, was supposed to be prescribed citalopram (antidepressant) – noted on urgent care letter, however, patient did not receive prescription, but also doesn't want to take them as feels they may make her worse, would prefer to have somebody to talk to about it instead. has not had any talking therapy.

'Patient feels very stressed, reports not getting on with husband due to financial difficulties. This is making stress worse, finding it hard to switch off, not sleeping, waking up early morning and worrying about things. Asked patient regarding suicidal thought, reports she has had some thoughts of not wanting to carry on and not wanting to be here but has not wanted to act on them. Not suicidal at present.

'Discussed with patient how stress and mental health issues will adversely affect pain levels, patient agreed that she needs to improve mentally before she can

focus on physical health. Advised on how she can get help from think wellbeing for this and given patient the phone number to self-refer – she does not access the computer.

'Discussed with patient how social prescribing might be able to help signpost to services for financial problems – given phone number for patient to contact St Helens wellbeing service for this.

'Also advised need to speak to GP re stress and mental health, has appointment already booked with GP tomorrow – will send note to him regarding this, patient happy.

'No further appointment made but patient can return to me if requires further input once Mental health issues addressed, patient happy with plan'.

13.2.17 On 8 February 2022, Carol had a telephone consultation with a GP.

'Mixed anxiety and depressive disorder (Review)

'To discuss mental health and sick note request.
Patient stressed out with financial difficulties – difficulty with paying bills/rent.
Has been assessed by Department of Work and Pensions for Universal Credit – awaiting outcome of panel.
Worrying about outcome of Universal Credit panel and longstanding low back pains and general physical health.
Anxiety and worries affecting sleep, staying awake most nights, feeling tired in the morning.
Mood is low most days.
Previously had intrusive thoughts of not wanting to be here anymore.
Denies suicidal ideation or self-harm thoughts presently, insists she won't do anything to herself.
Family main protective factor.
Lives with husband, daughter and grandchildren check on her regularly.
Previously prescribed citalopram for low mood – states had bad side effects – felt worse, adamantly refuses to try alternative antidepressants, feels she doesn't need this.

'Given contact numbers for Think wellbeing and social prescriber yesterday at Teleconsultation – plans to call later today.
Requesting sick note for Universal credit.

'Good rapport, engages well, no abnormal perception, normal speech tone rate volume, good insight.

'Agreed sick note extension – previous note ends 24th Feb 2022 – fit note can be extended when old one runs out.
Discussed medications – patient adamantly declined antidepressants.
She is keen to engage with talking therapies/counselling and Cognitive Behavioural Therapy for anxiety and low mood.
Crisis team number given to patient today to contact if worsening intrusive thoughts or self-harm or suicidal ideation – follow up in 3 weeks'.

13.2.18 On 15 February 2022, Carol received her first Universal Credit payment.

13.2.19 On 15 February 2022, John rang Torus Housing to discuss removing himself from the tenancy of the family home.

13.2.20 On 18 February 2022, John saw an advanced nurse practitioner at his GP surgery. He was referred to the community COPD team and did not attend appointments.

13.2.21 On 1 March 2022, Carol had a telephone appointment with a GP. She complained of pain in her hips and back and was referred to the pain clinic.

13.2.22 On 22 March 2022, Carol contacted Torus Housing to ask for John to be removed from the tenancy, as they were not living together anymore. Carol did not return the paperwork, and the request was not progressed.

13.2.23 On 22 April 2022, Carol contacted Torus Housing to ask for John to be removed from the tenancy, as they were not living together anymore. The completed application form was received back on 27 May 2022, and a property inspection took place on 28 June 2022. Carol signed a tenancy agreement for the property in her sole name on 11 July 2022.

13.2.24 On 12 May 2022, Carol contacted the DWP because they were paying only half of the amount needed for rent for her home. On investigation, this was because John was shown as a joint tenant. This was resolved on 15 July, after which the full payment was made.

13.2.25 On 31 May 2022, following her medical assessment via telephone on 13 May 2022, PIP received Carol's health assessment report.

Regarding back and hip pain, the report states that Carol has not had a formal diagnosis and that her symptoms cause shooting pains and burning pain in both her legs.

Regarding stress, anxiety, and panic attacks, the report states that: '*She has been offered medications, but she will not take tablets due to family reasons. Her dad was on a lot of medication when she was younger and due to this she does not like medication. Refused medications*.'

The report further disclosed that Carol was alcohol dependant, although this had not been formally diagnosed. Carol reported that she had been drinking a large amount of alcohol every day for a '*very long time'* and that '*she would drink 2 bottles of wine a day if she could afford it.*' She had previously attended Alcoholics Anonymous but was not attending at the time of the assessment.

The report also stated: '*She reports that sometimes she will feel as if life is not worth living, she will speak to the Samaritans on these days, this is not every day - 2-3 times a month. She is not having suicidal thoughts but reports low mood and giving up. No thoughts of self harm and overdose. GP is aware.*'

Carol stated that she lived alone in social housing.

13.2.26 On 16 June 2022, Carol was informed (via letter) that she was entitled to Personal Independence Payment at the standard daily living rate and standard mobility rate – from 3 February 2022 to 12 November 2024. The money was paid into a bank account in Carol's name.

13.2.27 On 12 August 2022, Carol left a message on her Universal Credit journal regarding an extra bedroom request: '*xxxx or xxxx stays three to four nights per week to ensure that I am safe, as I am forgetful in making sure my home is safe and secure. In the morning they help with making sure I have breakfast, and my exercises to ensure I do not have a fall*.' The claim for extra housing costs for an extra bedroom was granted.

There is no evidence that the people named in the journal entry stayed at the property.

13.2.28 On 18 August 2022, Carol was assessed at a face-to-face appointment at the Musculoskeletal service. Following assessment in clinic, a shared decision was made, and it was decided that Carol was going to take a self-management approach. Her diagnosis was discussed in detail, including the fact that chronic low

back pain is by nature multifactorial with no specific structure to blame. Carol was reassured that her scan showed nothing sinister or concerning. Carol declined referrals to other services and did not want to take painkillers. During the appointment, Carol disclosed that in an average week, she drank two full bottles of brandy and four bottles of wine.

13.2.29 On 12 October 2022, John was seen by a district nurse regarding an ulcer of his lower leg. He attended with Carol. John was referred to a GP. John was prescribed pain relief and referred to a dermatologist.

13.2.30 On 16 October 2022, Carol rang the ambulance service because the odour from John's leg ulcer was making her unwell. The attending crew spoke to and assessed John. John stated that he was aware that the odour was bothering Carol. Carol denied any mental health issues or suicidal thoughts. The attending crew contacted the GP out of hours service. The crew advised Carol to also speak to her own GP around how she was feeling.

13.2.31 On 16 October 2022, Carol had a telephone consultation with the out of hours GP service regarding her anxiety. Carol declined medication. She accepted a referral to the Think Wellbeing Service.

13.2.32 On 26 October 2022, Carol rang the ambulance service in relation to John's leg ulcers. It was reported that John had failed to attend an appointment the previous day and had dressed his own legs. Carol was advised to contact the treatment centre and reschedule the appointment. Carol advised that she was willing to do this, and the ambulance response was cancelled. A referral was made to the GP in respect of this contact. Worsening advice and analgesia were discussed. An ambulance attended, and John was left at home with the understanding that he would be seen by his GP the following day.

13.2.33 On 17 November 2022, Carol rang the ambulance service because there was a smell in the house making her nauseous. Carol was alone in the house. Carol was left at home.

13.2.34 On 21 November 2022, Universal Credit system notes record that, during a phone call with Carol, she disclosed that:

`her husband is coming to the house and forces his way in. She said the house still smells from when he left and she has told him she does not want him there.'

The Universal Credit agent advised Carol to call the police if she felt threatened. Carol then informed that:

`*there has been domestic violence in the past and the police have been involved therefore she does not want to call them. She hung up the phone when I was talking.'*

The Universal Credit agent called Carol again, but there was no answer. The agent left a message on Carol's Universal Credit journal, providing her with the National Domestic Abuse Helpline number.

13.2.35 On 7 December 2022, Carol called an ambulance for John regarding his leg ulcer. Carol advised that she could not cope with the ulcer, and it needed looking at. John advised that Carol had been anxious with the district nurses, and his ulcer was being looked after. John was seeing the district nurses the following day and was happy to be left at the house with self-care advice.

13.2.36 On 8 December 2022, a referral for Carol was received by St Helens Talking Therapies from the GP out of hours service.

13.2.37 On 9 December 2022, Carol completed an Initial Assessment with St Helens Talking Therapies. The following is a copy of Carol's initial assessment:

'Presenting problem:
Carol has had a series of significant losses in 2022:
January – Sister died suddenly from diabetes
March – Best friend died of cancer
May – Mum died.

'Carol has also been extremely stressed recently with her husband's medical condition which sounds like a leg ulcer that isn't healing despite regular dressings from District Nurses. Carol complained that the foul smell from the wound is affecting her particularly at night i.e., whereby she struggles to sleep.
Carol reported that she gets quite agitated with her husband because he didn't seek medical intervention sooner and therefore the wound is proving difficult to

heal now.

'Carol has stopped doing activities like reading which she used to do a lot. She stated that she used to talk to her neighbours a lot prior to the pandemic but people on the street don't seem to come out and chat as much anymore.

'What does the client want help with?
Carol stated that she is really stressed, anxious and low in mood and would like help in managing these symptoms.

'Goals for therapy:
Reduce stress levels
Learn strategies to boost her mood and reduce anxiety levels.

'Risk / safeguarding:
• Confidentiality statement agreed.
• Self – Carol was quite adamant she has no thoughts, plans or intent to kill herself. It appears to be something she doesn't agree with. She did however mention that she has at points in the last year thought 'What is it all about, why am I here' but it has never got to a point where she contemplates ending her life.

• History – None
• Protective factors – Carol's main protective factor appears to be a belief that it isn't the right thing to do. She made references to praying to God at times during the assessment so appears to have strong religious beliefs about how wrong suicide is.
She also has a son and daughter that she cares about.

• Risk Management Plan – Willing to accept safety plan letter with relevant contact numbers.
• Forensic History – None.

'Current alcohol and substance use:
Drinks 3 miniature bottles of brandy per week.
No illicit drug use.

'Personalised care: e.g., Mobility / interpreter / access requirements.
Has arthritic hip so would prefer not to have to travel for appointments.

'Other treatment: No previous psychological therapy.

'Medication: None.

'Agreed plan: I have discussed the case with one of our services' counsellors and it was felt that Carol would be better served undergoing step 2 low intensity CBT at present in line with the service model'.

13.2.38 On 3 January 2023, Carol called an ambulance for John regarding his leg ulcer. On arrival, the crew were met by Carol, who was verbally abusive and screaming at them to take John. John is documented to have had capacity. John had an infection of his ulcer and had recently undergone a biopsy and stitches. The crew applied a temporary dressing. He had taken paracetamol but reported that he had run out of his prescribed oramorph[6]. An Early Help concern was raised by the attending crew with consent for John, and the concerns were documented on the patient report form handed over at the emergency department.

13.2.39 On 3 January 2023, Adult Social Care received a referral for John from NWAS. It was assessed that no action was required at that time, and John's case was to be tracked to monitor any future attendances at the emergency department.

13.2.40 On 4 January 2023, Adult Social Care attempted to call John. There was no answer, and no facility to leave a message. A letter was sent to John the following day advising where to contact for an assessment if it was required.

13.2.41 On 10 January 2023, Carol had an appointment with St Helens Talking Therapies.

The following has been taken directly from Carol's record:

'Session 1 – assessment

'Attended on time. Confidentiality and exclusions discussed. PWP role explained. DNA policy explained, including late cancellations. Value of regular attendance and completion of intersession work discussed.

'Risk: PHQ9 Q9 score: 0**.
Carol was adamant that she had not experienced any current thoughts of suicide or self-harm, as such has no intent to act and has not made any plans or preparations.
History: denied any history of attempted suicide.
Carol denied any recent thoughts or plans to self-harm.
Protective factors: not wanting to end her life.

[6] Oramorph is a liquid form of morphine: a drug which is often used as a pain killer.

Safety plan: Good support network identified. Advice given on how to contact The Samaritans, the crisis team and attending A&E if risk levels increased.
No risk to or from others was disclosed. No safeguarding concerns were discussed.

'Medication: reports doesn't take any tablets. Carol stated that she does not take any tablets and reported being proud of this.

'CONTEXT: Carol reports being stressed and worried. Husband has a condition with his leg which she states has been 'going on for months'. Carol seemed very agitated with her husband for not seeking medical attention for this sooner. Carol states she has had to deal with the smell from her husband's leg ongoing and this has been causing her stress.

'Carol states she has a son and a daughter. Carol states Daughter lives in [redacted] and son has his own family so she does not see them often but they do speak on the phone.
'Carol states she has Limited mobility due to hip pain, but is able to mobilise around her home and do housework. I asked Carol on several occasions about whether she goes out of the house but she kept referring that she is expecting a delivery of blinds at the moment.

'During the call it was quite difficult to understand Carol and she was often repeating about the smell and dealing with the stress from this and seemed to struggle to answer some of the questions I asked. It was therefore quite difficult to obtain information for a formulation.

'CURRENT: smells in the house due to husband's leg seems to be Carols main issue currently. [Carol] reported that before this became an issue she was coping well and was able to do more things for herself.
Currently [Carol] reports that she doesn't get time for herself to do things that she enjoys. Used to enjoy reading and was able to relax but now spends most of her time cleaning and doing housework.
Has told her husband to leave. Reports staying in for months.

'Autonomic symptoms: struggling to sleep at night due to worrying, biting teeth at nighttime has a mouth guard for this.

'Behaviours: shouting and screaming, keeps a clean and tidy house, gets up very early due to worrying.

'Cognitions: worrying.

'TREATMENT GOALS: "I don't want all this smell; I just want a nice house like we had before"'.

13.2.42 On 17 January 2023, Carol had an appointment with St Helens Talking Therapies.

The following is taken directly from Carol's record:

'Called Carol for telephone session, Carol answered and stated she knew I was calling and immediately asked me to "get her some home help". Carol reported still feeling stressed regarding her home situation. Carol did not want to continue with the session and kept requesting me to get her some home help. Agreed to make a referral to contact cares, consent gained. Referral sent immediately following the call'.

A referral for a Care Act 2014 Assessment was made to Adult Social Care and received the same day.

13.2.43 On 24 January 2023, Carol had an appointment with St Helens Talking Therapies. She did not answer her telephone. Carol was discharged from the service on 31 January 2023 when she did not make contact after being sent a letter asking her to re-engage with the service. This is in line with standard policy.

13.2.44 On 26 January 2023, Adult Social Care spoke to Carol on the telephone. Carol was asked what help was needed, and she stated: 'anything and everything'. Carol said that her husband's legs smelled really bad and had been going on for a year. Carol stated that she could not sleep with the smell and wanted John to go into a care home. The line went dead during the call and attempts to call back had no answer.

13.2.45 On 29 January 2023, following further unsuccessful calls, Adult Social Care closed the referral.

13.2.46 On 31 January 2023, Carol rang the NWAS 111 service because she was struggling looking after John. She reported that she could not stand the smell, and he did not shower or attend to his own personal hygiene needs. Carol was documented to be screaming down the telephone, and John was spoken too. John said that he had his bandages changed the day before and had walked there and back. Carol was slurring and admitted that she had drank a large glass of brandy.

111 spoke to the GP surgery and were put through to the on-call GP. It was agreed that the GP would undertake a home visit. Carol was offered a safeguarding

concern: this was refused because she said she did not want social services coming to her door.

An Early Help concern was raised for John with consent. The Early Help document records that Carol was advised that she could take her husband to hospital, as she said that he was feeling suicidal; however, she stated that they couldn't go anywhere.

13.2.47 On 1 February 2023, the GP surgery called Urgent Community Response and spoke to a member of staff who accepted the details.

Urgent Community Response recorded a referral from the GP surgery on 3 February 2023 – to assess for grab rails and a bed lever. John had already been contacted by occupational therapy and had declined equipment. No further action was therefore taken.

13.2.48 Adult Social Care was also informed of the Urgent Care Referral on 1 February 2023, and, as a result, a telephone call was made to Carol that day. Carol stated that John had his wounds dressed twice weekly, there was a terrible odour, and health had advised an urgent assessment of needs. Carol was advised to take John to A&E, as she said that he felt suicidal. Carol stated that they couldn't go anywhere.

John didn't want to go into a care home, but Carol felt that it was best for both of them.

As a result of the telephone call, a visit to John and Carol (at home) took place the same day by the Adult Social Care Crisis Response team. Both Carol and John were present. It was found that John was struggling with personal care, and a reablement package of daily care visits was therefore arranged. Carers visited John every day from 2 – 8 February.

13.2.49 On 5 February 2023, Adult Social Care Spoke to Carol. She advised that reablement had been brilliant, and John was doing really well. Carol was told that only the first week was free, with ongoing support being chargeable. Carol said they didn't wish to pay for care and agreed the last call would be 8 February 2023.

13.2.50 On 10 February 2023, an ambulance attended to John for a swollen foot.

John was transported to Whiston Hospital [Mersey and West Lancashire Teaching Hospital Trust]. The attending crew documented that there was some social

services' input the previous week, and carers had attended until five days ago. John reported that Carol had pushed him down two stairs.

The handover documentation to hospital recorded details of the above. John said that he had not been seen by his GP or nurse for two weeks and had been dressing his leg himself.

13.2.51 On 13 February 2023, John's case was reviewed by the Adult Social Care Safeguarding Later Life manager, and a decision was made that the case was to be allocated for Section 42 Care Act Enquiries [safeguarding].

13.2.52 On 14 February 2023, Mersey and West Lancashire Teaching Hospital Trust Safeguarding Team attended to see John on the ward after a disclosure was made in A&E regarding domestic abuse from his wife.

John disclosed that Carol was alcohol dependent and drank brandy all day. John disclosed that Carol emotionally abused him by telling him he was a 'load of shit' and 'not worth fuck all'.

John stated that since his leg ulcers had deteriorated, he had 'not been thinking properly', which led to him not tidying up as much as he usually would. John described Carol as being 'house proud', and she had therefore been shouting at John for not cleaning up. John reported that Carol had not visited him in hospital because she was 'annoyed' that the bedroom was messy.

John also described that, on 9 February 2023, he was talking in his sleep and was woken up by Carol at 4 am. She was 'shouting, screaming and punching' him because he had woken her up. John stated that he then stood up to go and sleep on the couch and fell over. He reported that he felt Carol may have pushed him, but he couldn't be certain.

No injuries specific to this incident were noted.

A MeRIT risk assessment was completed, which was graded as silver.

A referral was made to Safe2Speak – John stated that he felt safe to return home when he was medically fit for discharge.

John was an inpatient from 10 February 2023 until 15 February 2023, when John was transferred to Aintree Hospital vascular team for ongoing medical management.

Safeguarding information was handed over to Aintree Hospital [Liverpool University Hospitals NHS Foundation Trust], on discharge from Whiston Hospital.

13.2.53 On 17 February 2023, Adult Social Care contacted Aintree Hospital. Notes of the conversation record that John was an open safeguarding case with St Helens Adult Social Care. Adult Social Care requested John remain in hospital until seen by a social worker, as they were concerned that discharging him before a social worker review may place him at risk.

13.2.54 On 21 February 2023, John had surgery on his leg at Aintree Hospital.

13.2.55 On 21 February 2023, Safe2Speak processed the referral from Mersey and West Lancashire Teaching Hospital Trust. A Risk Identification Officer attempted to contact John by telephone. The call was unsuccessful.

13.2.56 On 23 February 2023, the assigned social worker attempted to visit John in hospital. John was not able to be seen due to receiving medical treatment. An arrangement was made to visit John on 28 February. Hospital staff were asked not to discharge John home under any circumstances until a review had taken place, as he was at potential risk of harm at home.

13.2.57 On 23 February 2023, whilst at Aintree Hospital, John discussed safeguarding concerns with a member of staff. John stated that Carol was an alcoholic and had abused him in the past. They had a long history of abuse in the relationship and were both abusive to one another in the past. Pre-admission, Carol had physically and mentally abused him. Carol had not contacted John since he had been an inpatient. John was asked if he felt safe at home, and he was unsure where he wanted to be discharged to.

13.2.58 On 27 February 2023, John discussed his situation with a physiotherapist at Aintree Hospital. John discussed his fear of going home, feeling vulnerable when not able to care for himself independently, stating that Carol was a physically abusive alcoholic, and that he feared he may hurt her if provoked to retaliate.

13.2.59 On 28 February 2023, John was seen at Aintree Hospital by a social worker from the Later Life team. John discussed domestic abuse going back 40 years. Both him and his wife were victims, and the police had been to the property many times. John demonstrated mental capacity and said that the abuse was the result of alcohol misuse.

John advised that he no longer drank, but he had lost his job due to home commitments and the children. John blamed Carol's alcohol misuse. John said that he didn't want to return home and didn't want Carol to know where he went. John stated that he and Carol were in debt, as he paid all the bills. He asked for support with housing and rehabilitation.

13.2.60 On 6 March 2023, Adult Social Care received a telephone call from a woman who stated that she was John's ex-partner. The ex-partner stated that John did not want to return home. Adult Social Care called back but were unable to leave a message. The ex-partner called again on 9 March and confirmed that John did not want to go home.

13.2.61 On 15 March 2023, Adult Social Care called Aintree Hospital to speak to John. John was not on the ward because he had been taken by a relative to view a shared property. John arrived back during the call and declined a social care assessment or further support. The identity of the relative was not recorded.

13.2.62 On 15 March 2023, Safe2Speak contacted John by telephone. He stated that he was open to support from Safe2Speak and was provided with information by text. His case was allocated to a domestic abuse outreach practitioner.

13.2.63 On 16 March 2023, John contacted the Safe2Speak helpline, stating that he was resuming the relationship with Carol, moving back into the family home, and wanted the case closing. The helpline staff confirmed his wishes. They then informed the allocated outreach officer, after which the case was closed.

13.2.64 On 17 March 2023, John contacted the Safe2Speak helpline, stating that he had no recollection of the call on 16 March and did not know who could have made the call because he was still in hospital. He was hoping to reconcile his relationship with Carol, but she would not allow him to return home until he was medically fit.

13.2.65 On 22 March 2023, John told ward staff at Aintree Hospital that when he was discharged, he would like to go back to his home address with Carol. John was asked whether or not the domestic abuse would continue when he went home. He was confident it wouldn't, and he was happy. The Trust safeguarding team were notified of John's wishes.

13.2.66 On 24 March 2023, during a physiotherapy appointment at Aintree Hospital, John said that Carol did not want him to return home until his leg was 'all healed' and had no dressings/scars. John said that he was still going to try and find somewhere else to go on discharge.

13.2.67 On 4 April 2023, Aintree Hospital recorded that John went to view shared living accommodation. It was noted that he was happy with his choice; however, it may not be ready until the end of April.

13.2.68 On 12 April 2023, John informed staff at Aintree Hospital that he wanted to go home to live with Carol. Staff spoke to the safeguarding team for advice, and a ward sister spoke to John. John was clear that he wished to go home and thanked staff for their concern.

On the same day, Adult Social Care spoke to John on the telephone. John confirmed his wish to go home, and that Carol was supportive.

13.2.69 On 15 April 2023, a nurse at Aintree Hospital completed a mental capacity assessment with John. John was deemed to have capacity to make the decision to go home to live with Carol.

13.2.70 On 16 April 2023, John was discharged from Aintree Hospital to the home address with Carol.

13.2.71 On 28 April 2023, Adult Social Care [Later Life Safeguarding Enquiry Practitioner] spoke with John. When asked why he had decided to go home, John stated that he and Carol 'are fine now'. John declined support with housing and did not want the safeguarding process to progress any further. An arrangement was made to meet John the following Tuesday, away from the family home.

John was aware of MeRIT/MARAC, Emergency Duty Team numbers were given, and he was advised to call the police if there were any problems. John declined the numbers for domestic abuse services.

13.2.72 On 2 May 2023, John did not attend an agreed meeting with Adult Social Care (away from the family home). John did not answer telephone calls.

13.2.73 On 30 May 2023, Adult Social Care telephoned John's ex-partner. She stated that John was living with his daughter.

13.2.74 On 4 July 2023, a GP called John: this was following a letter from the Adult Social Care Later Life team (dated 4 May 2023). John denied feeling low in mood and said: 'Everything's okay and I feel fine'.

13.2.75 On 26 July 2023, following a management discussion, Adult Social Care closed the safeguarding referral for John, as he was understood to be living with his daughter.

13.2.76 On a date in November 2023, John strangled Carol to death in their home.

14 Analysis

14.1 What indicators of domestic abuse were your agency aware of that could have identified Carol or John as a victim of domestic abuse, and what was the response?

14.1.1 Prior to the review period, there were many times when Carol and John came to the attention of agencies. Between 2004 – 2012, the police were called to the family home over 100 times to verbal disputes between Carol and John. Neither pursued any complaints, and there was no evidence of injuries. None of these disputes between Carol and John progressed to a criminal investigation or conviction.

14.1.2 In 2015, Carol made one call to the police, and in 2017, a further two calls. During the last call in August 2017, Carol stated that John had held a knife to her throat the previous evening but then stated it was a fork. When officers attended, John had already left to stay elsewhere. A VPRF and MeRIT risk assessment was completed: graded as silver. Carol did not support a prosecution, and there was no further action.

14.1.3 The police received no further calls to incidents between the couple after August 2017. The historic incidents are included here to provide background and context but are not analysed in any detail, as they were not within the formal review period.

14.1.4 Carol attended St Helens Urgent Treatment Centre [Mersey and West Lancashire Teaching Hospital NHS Trust] on 7 April 2021, due to a thumb wound. However, a clear history was provided from Carol as to how she sustained the injury, and she reported that she did this when opening a tin with a knife. No domestic abuse concerns were raised during the attendance. Furthermore, as there was no domestic abuse alert on Carol's record, no further action was required at that time. Concerns were documented during this attendance in relation to Carol smelling strongly of alcohol. This was explored by staff at the time. [see paragraph 14.5.1].

14.1.5 On 7 February 2022, Carol had a physiotherapy review where she reported not getting on with John due to financial difficulties. The GP was updated, and advice was given on financial issues and mental health. As Carol had reported not getting on with John, this was an opportunity to explore whether Carol felt safe at home and ask questions about domestic abuse. The following day, Carol had a telephone

review with a GP regarding anxiety and depression. This was a further opportunity to explore any domestic abuse, given the disclosure of the previous day.

14.1.6 NWAS had seven Patient Emergency Services (PES) contacts with Carol and nine contacts with John. Not all contacts resulted in John or Carol being taken to hospital or seen in person (face to face).

In reviewing the totality of NWAS contact with Carol and John during the review period, the underlying issues appear to be Carol's difficulties in coping with her John's health issues and her increasing distress. As time progressed, the relationship appeared to be more strained. Carol expressed her concerns whilst John appeared to be more accepting and played down his condition. Whilst this is apparent in hindsight, it would not have been so at the time to individual members of staff.

14.1.7 During 2022, Carol had a number of medical and Talking Therapies appointments, during which she explained that financial pressures were causing her stress. Carol and John split up in early 2022, with John moving to live elsewhere. It took several months for benefits payments to be amended.

14.1.8 The Review Panel discussed Carol and John's financial situation and, in doing so, took cognisance of the following definitions, as detailed by the UK charity Surviving Economic Abuse:[7]

Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy. Economic abuse can include exerting control over income, spending, bank accounts, bills, and borrowing. It can also include controlling access to and use of things like transport and technology, to allow an individual to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs.

Financial abuse is controlling finances, stealing money, or coercing someone into debt. Economic abuse and financial abuse involve similar behaviours, but it is helpful to think of financial abuse as a subcategory of economic abuse.

[7] https://survivingeconomicabuse.org/about-us/what-we-do/
Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

14.1.9 The panel also discussed the possibility that financial pressures may have contributed to John and Carol's decisions. John was retired, and Carol was in receipt of benefits. Neither had easy options to increase their income. The couple's exact financial circumstances are not known. The panel did not feel that it could come to a conclusion that there had been financial or economic abuse on the information available to it.

14.1.10 The panel noted that Carol and John's joint Universal Credit claim was initially paid into John's bank account. This was amended later, and money was paid direct to Carol. The panel noted that after Carol was awarded Personal Independence Payment in June 2022, she did not repeat concerns around finances. The panel did not see evidence that Carol was a victim of financial or economic abuse and thought that Carol's worries about money were likely to be a consequence of John leaving the martial home in early 2022.

14.1.11 In November 2022, the Department for Work and Pensions' records show that during a telephone call, Carol disclosed that John was coming to the house and forcing his way in. When prompted to call the police, if necessary, Carol stated a reluctance to do so and then hung up the phone. DWP called Carol back but did not receive an answer. The agent left a message on Carol's Universal Credit journal, providing her with the National Domestic Abuse Helpline number. The panel thought that this was a reasonable response in the circumstances.

14.1.12 From 2 – 8 February 2023, John received care visits from the Adult Social Care reablement team. Records show that no care was provided. John was washed and dressed and had taken care of his own care needs on all visits. The records do not contain any reference to domestic abuse concerns or concerns around alcohol consumption.

14.1.13 On 10 February 2023, John disclosed to NWAS staff that Carol had pushed him down two steps. John was taken to hospital, and the information was shared with hospital staff. This was the only direct disclosure of domestic abuse to NWAS staff.

14.1.14 Following his admittance to Whiston Hospital on 10 February 2023, John repeated his disclosure to NWAS to staff at the hospital. Following admittance to a ward, staff contacted the Trust's safeguarding team for advice. A member of the Trust's safeguarding team attended the ward to speak to John, and a MeRIT risk assessment was completed. This is further analysed at 14.3. A referral to Safe2Speak domestic abuse service was also completed. A safeguarding alert was raised with Adult Social Care, which resulted in an enquiry in accordance with Section 42 of the Care Act 2014. From February 2023, Adult Social Care was aware that John had reported domestic abuse.

14.1.15 On 15 February 2023, John was transferred to Aintree Hospital [Liverpool University Teaching Hospital NHS Trust]. The disclosure that John made to NWAS and Whiston Hospital staff was passed appropriately to Aintree Hospital, and staff there knew from the outset of the issue John had reported.

14.1.16 The disclosure by John was not reported to the police by John or any agency. The police were unaware of domestic abuse issues during the review period.

14.2 **What knowledge was your agency aware of that indicated John might be a perpetrator of domestic abuse against Carol, and what was the response? Did that knowledge identify any controlling or coercive behaviour by John?**

14.2.1 The MeRIT risk assessment completed by Whiston Hospital staff, and shared with Safe2Speak, documented that John had disclosed that he had previously perpetrated domestic abuse towards Carol.

John's admittance into hospital provided an opportunity for Carol to be risk assessed as a potential victim of abuse. There is no evidence to show this was considered by Safe2Speak or that this information was shared with other agencies or that checks were made to establish if Carol was open to other services. This is a learning point for Safe2Speak, which leads to a single agency recommendation.

A home visit to Carol could have been facilitated by the Torus neighbourhood team, had checks been made by Safe2Speak on the internal case management system to identify the couple lived in a Torus property. There is no evidence that this information was checked on the case management system by relevant Safe2Speak staff.

14.2.2 During a discussion with staff whilst at Aintree Hospital on 27 February 2023, John stated that: 'Carol was a physically abusive alcoholic and he feared he may hurt her if provoked to retaliate'. The panel acknowledge that this is a victim blaming comment but decided to include it as a contemporaneous record of John's disclosure.

14.2.3 No other agency had information during the review period that John was a perpetrator of domestic abuse towards Carol. The panel was clear that John's act in strangling Carol to death was domestic abuse. Prior to that, the only overt indicator of domestic abuse in the period under review was John's disclosure of abuse from Carol.

14.2.4 The panel considered whether there was evidence of coercive control by John towards Carol. In doing so, the panel referred to the Crown prosecution Service guidance.

14.2.5 The Crown Prosecution Service Guidance on Coercive Control [updated 23 April 2023], states:[8]

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

- isolating a person from their friends and family
- depriving them of their basic needs
- monitoring their time
- monitoring a person via online communication tools or using spyware
- using digital systems such as smart devices or social media to coerce, control, or upset the victim, including posting triggering material
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep – this can be intertwined with the suspect saying it is in their best interests, and 'rewarding' 'good behaviour' e.g. with gifts
- depriving them of access to support services, such as specialist support or medical services
- repeatedly putting them down, such as telling them they are worthless
- enforcing rules and activity which humiliate, degrade or dehumanise the victim
- forcing the victim to take part in criminal activity, such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- economic abuse, including coerced debt, controlling spending/bank accounts/investments/mortgages/benefit payments
- controlling the ability to go to school or place of study
- taking wages, benefits or allowances
- threatening to hurt or kill
- threatening to harm a child
- threatening to reveal or publish private information
- threatening to hurt or physically harming a family pet
- assault

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

- physical intimidation e.g. blocking doors, clenching or shaking fists
- criminal damage (such as destruction of household goods)
- preventing a person from having access to transport or from working
- preventing a person from learning or using a language or making friends outside of their ethnic or cultural background
- family 'dishonour'
- reputational damage
- sexual assault or threats of sexual assault
- reproductive coercion, including restricting a victim's access to birth control, refusing to use a birth control method, forced pregnancy, forcing a victim to get an abortion, to undergo in vitro fertilisation (IVF) or other procedure, or denying access to such a procedure
- using substances such as alcohol or drugs to control a victim through dependency, or controlling their access to substances
- disclosure of sexual orientation
- disclosure of HIV status or other medical condition without consent
- limiting access to family, friends and finances
- withholding and/or destruction of the victim's immigration documents, e.g. passports and visas
- threatening to place the victim in an institution against the victim's will, e.g. care home, supported living facility, mental health facility, etc. (particularly for disabled or elderly victims)'.

'This is not an exhaustive list, and prosecutors should be aware that a suspect will often tailor the conduct to the victim, and this conduct can vary to a high degree from one person to the next. Prosecutors should consider the conduct of the suspect in each individual case to assess whether it discloses controlling or coercive behaviour. There is plainly overlap with stalking and harassment.

'There might be confusion about where the "appropriate" dynamic of a relationship ends and where unlawful behaviour begins. One way of considering this is described by The College of Policing Authorised Professional Practice on Domestic Abuse,[9] which sets out that: "In many relationships, there are occasions when one person makes a decision on behalf of another, or when one partner takes control of a situation and the other has to compromise. The difference in an abusive relationship is that decisions by a dominant partner can become rules that, when broken, lead to consequences for the victim".

[9] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse

'Prosecutors should consider the impact on the victim of following, or not following, rules imposed upon them within the wider context of the relationship, where this type of behaviour has occurred within the relationship. It is not necessary for the prosecutor to prove that consequences follow, not least because the fear of consequences is just as powerful. This is intended as a tool by which to recognise a controlling or coercive relationship, rather than a "point to prove"'.

14.2.6 The panel did not feel that it had information with which it could conclude that Carol was a victim of coercive control.

14.2.7 The panel discussed the couple's relationship in the context of Johnson's[10] 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.

[10] Michael Tim 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 30 years.

14.2.8 Given the opposing evidence that the panel reviewed the panel were unable to come to a conclusion on which category of domestic abuse was prevalent in this case.

14.3 **How did your agency assess the level of risk faced by Carol and John? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?**

14.3.1 Whiston Hospital staff completed a MeRIT risk assessment, with John shown as the victim of domestic abuse. The assessment was graded as silver and resulted in appropriate referrals.

14.3.2 Safe2Speak received a referral for John from Whiston Hospital safeguarding team, who attached a copy of the MERIT risk assessment that they had completed. The MERIT was reviewed upon receipt and uploaded on the Safe2Speak Mainstay Case Management System for the allocated practitioner's review and reference. The allocated domestic abuse outreach worker reviewed the MERIT risk assessment and the accompanying referral form when they were allocated John's case.

14.3.3 Following John's transfer to Aintree Hospital, information was shared about the MeRIT assessment, and appropriate staff were informed. There was liaison between ward staff and the allocated Adult Social Care social worker. John stayed in hospital until 16 April. This was some way beyond the time when he was medically fit for discharge on 31 March and was facilitated in order to allow John to find somewhere to live, as he did not originally intend to go home to Carol. The panel reflected that the decision to not discharge John as soon as he was medically fit was good, given the outstanding safeguarding concern at that time.

14.3.4 Although John stayed in hospital to allow time for him to find somewhere to live, there is no evidence of a referral or signposting to Housing Options, which may have helped him find somewhere to live. Adult Social Care was aware of John's housing situation and that a relative had taken him to view a property. The panel could see no further evidence that John was assisted by any agency in dealing with his accommodation issues prior to leaving hospital. The panel discussed whether the response would have been the same had it been a female victim of domestic abuse in hospital who had had housing needs: it concluded that it would not. The panel thought that a female victim of domestic abuse would have been given more support with potential access to a refuge space if necessary. The panel was informed that whilst there is refuge provision for men, it is very limited, and none would have been available locally. There is no evidence that such provision was discussed with John by any professional. The panel was told that local refuge

provision accepts male victims. If there was no space available locally then the nearest available space would have been offered.

14.3.5 On 12 April 2023, John informed ward staff that he wanted to go home to live with Carol. Staff discussed the circumstances with John, asking if he felt safe to go home, and John confirmed that he did. A senior member of staff conducted a mental capacity assessment with John regarding his decision to go home and assessed that John had capacity to make the decision and understand the consequences. The panel thought that the discussions staff had with John and carrying out a mental capacity assessment were useful. The panel also thought that conducting a further MeRIT risk assessment prior to John's discharge would have been helpful in assessing risks at that point. This is a learning point for LUFT and leads to a single agency recommendation.

14.3.6 Adult Social Care was involved with John after receiving the domestic abuse notification from Whiston Hospital. Records show that a MeRIT risk assessment was completed. However, it has not been possible to find a copy of this risk assessment, and the risk grading [bronze/silver/gold] is unknown. Adult Social Care records show that John commented:

"that he was afraid the domestic abuse would escalate one day and he would just 'snap'".

There does not appear to have been any professional curiosity to determine what this meant, or whether John had previously snapped or been a perpetrator of domestic abuse. John's comment provided an opportunity to enquire further into the couple's background, for example, by requesting information from the police. The panel thought that the risks to Carol could have been considered at this point, for example, by speaking to Carol in person to see how she felt about John returning home and with the potential to have completed a MeRIT risk assessment for Carol. The rationale for not speaking to Carol was that John was reported to be the victim of domestic abuse, which was mainly verbal. This is a learning point that leads to panel recommendation 1.

14.4 **How effective was inter-agency information sharing and co-operation in response to the subjects of this review, and was information shared with those agencies who needed it? N.B. Please also consider cross-border information sharing.**

14.4.1 On 3 January 2023, NWAS shared an Early Help concern (for John) with Adult Social Care. This was received and prompted monitoring of John's case for any future admissions, etc.

14.4.2 On 17 January 2023, St Helens Talking Therapies service [Mersey Care NHS Foundation Trust] completed a referral to St Helens Adult Social care for a Care Act 2014 assessment. This resulted from a telephone consultation in which Carol was stressed and asked the practitioner to get her 'some home help'.

There is no evidence in the records of the outcome being communicated back post referral. Given that Carol disengaged after initial Talking Therapies sessions and was subsequently discharged from the Trust services, there was no further opportunity to review her needs for support.

14.4.3 On 31 January 2023, the NWAS 111 telephone service was contacted by Carol, who was struggling to cope. An Early Help concern was submitted for John, and the 111 service spoke to John's GP practice.

14.4.4 Information was appropriately and quickly shared following John's disclosure of domestic abuse in February 2023. NWAS staff passed on the disclosure to staff at Whiston Hospital. Following a MeRIT risk assessment, Whiston Hospital shared information with Safe2Speak, Adult Social Care, and Aintree Hospital. All those charged with caring for John were aware of the necessary information.

14.4.5 John's GP practice received a discharge summary from Aintree Hospital that outlined that there were safeguarding issues and Adult Social Care involvement. The Adult Social Care Later Life team wrote to John's GP when they were unable to contact John after his discharge from hospital. This prompted the GP to telephone John, who confirmed that he was well and was not low in mood.

14.4.6 As outlined at 14.3.4, Adult Social Care's records show that a MeRIT risk assessment was completed. John declined consent for this to be shared with other agencies. Adult Social Care could have requested information from the police to inform the risk assessment for John.

14.4.7 From a Safe2Speak perspective, both the Safe2Speak risk identification officer and domestic abuse outreach practitioner could have liaised with the referrer. The risk identification officer should have liaised with Whiston Hospital as the referrer to determine the most safe and efficient routes to reach John and to seek confirmation if John remained an inpatient. This information could have then been utilised to support more timely contact with John and enabled the allocated DAO

practitioner to have a professional inter-agency point of contact. This is evidenced by the fact that telephone contact was attempted with John on the day that he had an operation and was therefore most unlikely to be successful.

14.4.8 Safe2Speak should have communicated with Whiston Hospital / Aintree Hospital when John declined the Safe2Speak service and on the subsequent case closure – to inform them that John had not wished to access Safe2Speak services. This would have been beneficial to inform the hospitals' care, holistic support offered to John, and risk management as an inpatient disclosing domestic abuse.

14.4.9 On receipt of the referral, the risk identification officer should attempt initial contact within the recommended timescales for the risk level and, if initial contact was unsuccessful, commence wider agency enquiries, in addition to liaison with the original referrer. In this case, initial contact was attempted by telephone on 21 February 2023: the same day that John had an operation on his leg.

Wider agency enquiries, at the time this case was referred to Safe2Speak, should have included correspondence with the following key partner agencies – Police, Adult Social Care, Children's Services, and CGL. This enquiry would be to try and identify if John was known and/or open to these key local agencies – to broaden routes to safely establishing contact with him to offer specialist domestic abuse support. There is no evidence that alternative contact options or contact with the referrer were attempted in this case.

14.4.10 Initial contact was made by Safe2Speak with John on 15 March 2023, when he was still in Aintree Hospital. On that date, John said that he was open to receiving services from Safe2Speak. On 16 March, John contacted Safe2Speak and said that he was reconciling with Carol and no longer needed Safe2Speak. On 17 March, John again contacted Safe2Speak and was unable to recall the conversation of 16 March.

14.4.11 At that point, it would have been beneficial for Safe2Speak to have shared that information with Aintree Hospital and seek their input on John's capacity, any recommendations on his wellbeing, and how to best approach an offer of domestic abuse support dependent on his health needs.

14.4.12 When John was discharged from Aintree Hospital on 16 April 2023, Safe2Speak was not notified. It is unclear if this was an oversight or if Aintree Hospital staff were simply unaware that John was in contact with Safe2Speak. Aintree Hospital predominantly serves the Liverpool area, and staff have good knowledge of Liverpool domestic abuse agencies but perhaps less so of those for St Helens. Safe2Speak was not in touch with John whilst he was in Aintree Hospital, and the

panel concluded that had there been ongoing contact with John, it would have been much more likely that Safe2Speak would have been informed of John's discharge from hospital.

14.4.13 Adult Social Care was still involved with John after his discharge from hospital. There is no evidence that information sharing with Safe2Speak was considered

14.5 **How did your agency respond to any mental health issues, substance misuse, and/or self-neglect when engaging with Carol and John?**

14.5.1 During a St Helens Urgent Treatment Centre attendance in April 2021, staff documented that they could smell a strong smell of alcohol from Carol. This was explored with Carol, but as she denied that she had been drinking, no further action was completed. Had Carol disclosed a significant history of alcohol use, then a community referral could have been considered with relevant signposting for support.

14.5.2 From February 2022 onwards, both Carol and John expressed concerns to their landlord [Torus Housing] regarding the impact of their separation on their individual finances. There were four emails from Carol stating that she was worried about rent arrears and that this was impacting her stress levels and health issues. Torus Housing has no record of what Carol's health conditions were.

14.5.3 In February 2022, John rang Torus to say that he and Carol had split up and that Carol was worried that she was going to lose her home because she was struggling financially.

A property inspection was carried out by the Neighbourhood Officer, as part of the tenancy change process June 2022. Carol presented well and did not display any signs of self-neglect. There were no issues observed regarding the condition of the home or repairs that may have indicated domestic abuse or other support needs.

The panel has seen evidence that Carol made claims for Universal Credit to the Department for Work and Pensions, which resolved Carol's financial worries. There were no significant rent arrears.

14.5.4 Both Carol and John had received support, regarding anxiety and depression, on several occasions. During the review time frame in 2022, Carol spoke with a physiotherapist, GP, and out of hours GP services regarding low mood. This was reportedly due to financial difficulties. Carol was offered medication, which she declined, and was signposted to mental health services. On 24 November 2022, Carol was seen by the out of hours service and was offered a Think Wellbeing referral, to which she was happy to be referred.

14.5.5 On 3 January 2023, the NWAS 111 service spoke to the GP to share concerns around Carol and John. Carol was reportedly struggling to deal with the smell from John's leg. There was a concern that Carol had been drinking, and she acknowledged having a glass of brandy with water earlier. The GP arranged for Urgent Community Response to review the case the next day. The patient records do not give detail of what was requested from Urgent Community Response.

There was no exploration by the GP practice of Carol's use of alcohol, and the opportunity to signpost or refer her to alcohol services was missed. This is a learning point that leads to a single agency recommendation.

14.5.6 St Helens Talking Therapies service was involved with Carol; however, she disengaged from the service after two sessions. The appropriate assessments were completed, but it was noted that Carol struggled to answer some questions and therefore making it difficult to complete a formulation.

St Helens Talking Therapies service and Musculoskeletal services – both provided by Mersey Care NHS Foundation Trust – recorded concerns about Carol's alcohol use during their consultations with her. There is no evidence of any discussion, signposting, or referral to an alcohol service. This is a learning point that leads to a single agency recommendation.

14.5.7 On 1 February 2023, following a series of concerns being raised by partner agencies, the Adult Social Care Crisis Response Team visited Carol and John at home. As a result of that visit, a reablement care package was provided for John. This meant that carers visited him every day until 8 February. The Crisis Response Team did not note any concern regarding substance use. Although carers visited John on a daily basis from 2 – 8 February, records show that no care was provided. John was washed and dressed and had taken care of his own care needs on all visits. The records do not contain any reference to domestic abuse concerns or concerns around alcohol consumption.

14.5.8 On 14 February 2023, when a MERIT risk assessment for John was completed at Whiston Hospital, he shared concerns regarding Carol's drinking. This information was added to the MERIT and shared with Safe2Speak for further exploration when the referral was submitted.

14.5.9 On receipt of the MeRIT risk assessment, Safe2Speak recognised that there were references to mental health and substance misuse issues for Carol. However, as John was the identified victim in the referral, contact was not made with Carol by Safe2Speak.

14.5.10 Panel discussions identified that there had been a professional expectation or assumption that Adult Social Care explored issues around mental health or substance misuse for Carol. This did not happen, and the service response was focussed entirely on John, who was seen as the primary victim. The panel thought that there was a lack of professional curiosity around the reasons for domestic abuse in Carol and John's relationship. This meant that the opportunity to discuss any concerns with Carol was not taken.

14.5.11 As identified earlier in the report, Safe2Speak was unable to maintain engagement with John. Had meaningful engagement been achieved with John, tailored safety planning advice and guidance could have been provided to John regarding risks associated with Carol's alleged mental health issues and substance misuse, exploring it in more depth. This would have also provided the opportunity to inform John of the local and national support services accessible to people impacted by mental health and substance misuse, as well as local and national support services available to family members of those experiencing mental health issues and/or substance misuse.

14.5.12 Neither Carol nor John was known to Change Grow Live – the local provider of drugs and alcohol treatment services.

14.5.13 A report by the Institute for Alcohol Studies[11], 'Alcohol, domestic abuse and sexual assault', states

> Alcohol has been found to be associated with victimisation, with research finding victims of domestic assault to have higher alcohol consumption that non-victims, and that the risk of violence increased with levels of consumption.
>
> There are many reasons why victims of domestic abuse may drink. Amongst those caught up in long-term domestic abuse, there is evidence that they may use

[11] https://www.ias.org.uk

alcohol to cope with the effects of domestic abuse. Indeed, one study found that women who suffered domestic abuse from their partners were twice as likely to drink after the abuse as their violent partner.[12]

14.5.14 Alcohol Change have published the following information on their fact sheet "Alcohol and Domestic Abuse"

The links between alcohol and domestic abuse

1. Drinking and domestic abuse often occur at the same time

Many abuse incidents occur when one or both people involved has been drinking, and alcohol is more commonly involved in more aggressive incidents [13]. It is not just being intoxicated that can increase risk; lack of access to alcohol can make someone irritable or angry which can, in turn, create a trigger point.

2. When alcohol is involved, abuse can become more severe

Alcohol can affect our self-control and decision-making and can reduce our ability to resolve conflict. Global evidence shows that alcohol use can increase the severity of a violent incident [14]. Home Office analysis of 33 intimate partner domestic homicides in 2014-15 found that 20 of these involved substance use[15].

3. Controlling access to alcohol can become part of the abuse

A perpetrator may exert control over another person by withholding alcohol from them, or preventing them from buying it. For someone who is dependent on alcohol, this could be extremely distressing and even dangerous, if they experience withdrawal symptoms.

4. People who experience domestic abuse may drink to try to cope

Living with domestic abuse can be extremely frightening, distressing or exhausting. This can cause some people to drink alcohol to try to cope with the physical and mental health impacts of domestic abuse. Research shows that women who experience extensive physical and sexual violence are more than twice as likely to

[12] Galvani, S. 'Grasping the Nettle: alcohol and domestic violence'

[13] https://academic.oup.com/bjc/article/59/5/1035/5486457
[14] https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

have a problem with alcohol than those with little experience of violence and abuse [16].

Alcohol use can also leave someone more vulnerable to further abuse, especially if drinking prevents survivors from accessing support or makes their mental health worse.

14.5.15 Whilst John was in Aintree Hospital in 2023, there were no concerns for his mental health. A mental capacity assessment was completed to assess whether he was capable of making the decision to go home to Carol on discharge from hospital, and it was concluded that John did have capacity. There is no evidence that Carol visited John whilst he was in hospital, and there is no record of hospital staff having any interaction with her.

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

14.6.1 As identified at paragraph 14.5.7, John had a short-term reablement care package in February 2023, which was provided in a timely manner. After five days, Carol was informed (in a telephone call) that the service was free only for the first week and there would be a charge after that. Carol therefore cancelled the daily care visits. There is no evidence that there was any exploration of a financial assessment in order to assist with the decision. The service, in fact, may not have been payable depending on Carol and John's finances at that time. It is highly likely that the fear of paying for the service is what motivated Carol to cancel it. The panel noted that John was admitted to hospital on 10 February, two days after the last care visit. The panel was assured that all relevant Adult Social Care staff have been reminded of the need to explore financial issues fully.

The panel reflected that as the service was being provided to John, then it was inappropriate for the cancellation of the service to be discussed with and decided by Carol. This is a learning point for Adult Social care that leads to a single agency recommendation.

[16] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-nature-and-impact-of-domestic-abuse/

14.6.2 Carol was not provided with support at this point, for example, a carer's assessment because she was not identified by Adult Social Care as John's carer. Given the number of contacts with services in January 2023, when Carol clearly expressed that she was struggling to cope with John's medical condition, the panel thought that this was a missed opportunity. This is a learning point that leads to a single agency recommendation for Adult Social Care.

14.6.3 When John was admitted to Whiston Hospital on 10 February 2023, his disclosure of domestic abuse was acted upon promptly and within the Trust's policies. Both a domestic abuse referral to Safe2Speak and a MeRIT risk assessment were properly recorded, and copies were placed in John's records, as well as being recorded on a database held by the Trust safeguarding team.

14.6.4 On John's transfer to Aintree Hospital, information about the disclosures was properly shared. The information was considered throughout John's stay in hospital. John stayed longer in hospital than was necessary in order to allow him to explore accommodation options before he decided to go home to live with Carol.

14.6.5 The referral from Whiston Hospital for John to Safe2Speak was processed outside the expected timescales for an outreach service referral. As a result, there were five working days between receipt of the referral and the case being formally uploaded onto the case management system. Domestic abuse outreach referrals should be processed, and initial contact attempted within 48 – 72 hours of the referral being received. Due to staff changes, it has not been possible to identify specific reasons for this delay; however, it is acknowledged that the service was under significant workload pressure at the time.

When it was not possible to contact John at the first attempt, other contact options or liaison with Whiston Hospital should have been considered. As referenced at paragraph 14.4.7, the first contact was on the same day that John had an operation. Contact with the hospital would have enhanced Safe2Speak's understanding of the situation.

Successful contact was established with John at the second attempt. However, the second contact attempt with John was made significantly outside the expected timescales, resulting in a 16 working day gap between the first and second attempt and 21 days from the date the referral was initially received. This gap is outside the expected and acceptable time frames and generated an avoidable delay in offering John specialist domestic abuse support.

14.6.6 Although the Safe2Speak service to John was limited, he was provided with full Safe2Speak contact information, including 24-hour helpline details that he did utilise. He was also provided with information regarding his housing circumstances and a recommendation he seek support from hospital staff to reach out to St Helens Housing Options. The practitioner provided reinforcement to John that what he had disclosed did amount to abuse.

14.6.7 Following John's discharge from hospital, he was spoken to on the telephone by Adult Social Care and stated that he and Carol were 'fine now'. Arrangements were made to meet John on his own (away from the family home), but he did not attend the meeting. John's case was later closed after information was received from a third party that he was living with one of his adult children. A letter was sent to John's GP, which resulted in contact by the GP with John when he said that he was fine and declined services. The closure by Adult Social Care of John's case, in July 2023, was appropriate – given that he was no longer engaging, and concerns were not being reported at that time.

14.6.8 There was ongoing social work support after the safeguarding referral. It was known that John was being supported by a relative – to identify alternative accommodation – following his hospital discharge. John later declined support from Adult Social Care in relation to housing at the point of discharge from hospital because he intended to go home to live with Carol. In relation to John being a victim in his own right, the service was fit for purpose. John was seen in hospital on his own, away from Carol. Later, there were opportunities created for John to meet with the social worker away from the family home, so he had a safe place to talk; however, he did not attend the meetings.

14.7 **When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?**

14.7.1 In early 2022, it seems that Carol and John split up. Both the Department for Work and Pensions and Torus Housing (the couple's landlord) were notified. Carol and John both indicated to Torus that John should be taken off the joint tenancy for their rented property, with the tenancy remaining in Carol's sole name.

14.7.2 In June 2022, a Neighbourhood Officer from Torus carried out a property inspection during the tenancy change procedure. Carol was seen alone and asked if she would like a referral into the Torus Tenancy Sustain Team. Furthermore, discussions took place around changes to her finances and if she would struggle

financially now that John had left the property. Carol declined the offer of additional support. During this visit, Carol was also asked if she would like to downsize to a smaller property but again declined. She stated that it was her family home, and she wished to stay there. The process for changing the tenancy was handled within a reasonable timescale and considered both Carol and John's wishes. Torus has identified a learning point in that a tenancy change such as this, due to relationship breakdown, presents an opportunity to engage with the tenants around domestic abuse. This has already been actioned by changes to the forms that need to be completed by Torus staff, which now include prompts to ask appropriate questions around domestic abuse.

14.7.3 It is apparent from medical records that by October 2022, John was back living in the family home. This was not reported to the Department for Work and Pensions or Torus, who were unaware that John was back living with Carol.

14.7.4 John's disclosure of domestic abuse was treated appropriately by NWAS and Whiston and Aintree Hospitals. Referrals were correctly made to Safe2Speak and Adult Social Care. Whilst in Aintree Hospital, there was a lot of discussion with John around his safety and his feelings about returning home or identifying an alternative place to live. John had identified a property but then decided he wanted to return to the home address.

14.7.5 John's wishes and feelings were clearly documented by Adult Social Care in relation to the safeguarding referral. John was given choices in terms of services he could access. As outlined at paragraph 14.6.8, John was not supported by any agency in relation to housing but was supported by an unknown relative to view at least one property.

14.7.6 Carol and John were both registered at the same GP practice. Records show that their wishes and feelings were considered. They were both offered support, advice, and signposted to appropriate services when applicable. Carol was signposted to Talking Therapies, which was accessible to provide support in relation to her mood, and she did engage with the service to some extent.

14.7.7 John's case was originally closed to Safe2Speak in acknowledgement of John's wishes and feelings, as he advised he wished for no further contact with Safe2Speak. As the Safe2Speak domestic abuse outreach service is client led and consent based, the case was closed.

14.7.8 Further contact was then made with John in response to him reaching back out to the service the following day. The Safe2Speak practitioner spoke with John, actively listening to his wishes and feelings. John was provided with information on

his options and choices regarding not wishing to return to his home address. John was signposted to St Helens Housing Options, and it was recommended that he seek support from staff at the hospital in order to do so.

14.7.9 Due to John's presentation on the call, and his circumstances, Safe2Speak should have explored with John how easy he would find contacting St Helens Housing Options whilst as an inpatient, and who was leading on his care. It would have been proportionate and trauma-informed for Safe2Speak to seek John's consent – for assistance from Safe2Speak – to share his information and refer him to St Helens Housing Options to support him accessing specialist housing advice and guidance.

14.7.10 St Helens Talking Therapies and Musculoskeletal services – both provided by Mersey Care NHS Foundation Trust – recorded concerns about Carol's alcohol use during their consultations with her. There is no evidence of any discussion on signposting or referral to an alcohol service. This is a learning point for Mersey Care NHS Foundation Trust and leads to a single agency recommendation.

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

14.8.1 The MeRIT risk assessment for John, conducted by Whiston Hospital, was recorded as a silver risk. Only gold (high risk cases) are referred to MARAC, and the case was correctly referred for support to Safe2Speak.

14.8.2 Adult Social Care's records show that a MeRIT risk assessment was completed by Adult Social Care, but it has not been possible to find a record of the assessment. The record shows that John had declined consent to share with MARAC. There is no information available about the risk score or grading. The Adult Social Care IMR author thought that this reflected a need for additional training for practitioners and managers in this important area of work.

14.8.3 The panel reflected that it was unlikely (although not impossible) that the practitioner would have assessed the risk to John as being higher than when he first went into hospital and made a disclosure. It is therefore likely that the reference to declining consent – to share information with MARAC – is anomalous or based on a misunderstanding of process. The St Helens MARAC policy is clear that consent is not required to refer Gold – high risk cases to MARAC.

The panel was told that further MERIT risk assessment training sessions are scheduled for 2025, and there has been a request to the Organisational Development team to ensure that social workers get refresher training.

14.8.4 The panel discussed that the St Helens Domestic Abuse Strategy is soon to be updated. As part of that update, the panel thought that the provision of information for professionals – on the services available to victims and perpetrators of domestic abuse – should be considered.

14.8.5 Torus Housing identified that their agency policies were followed. However, since Carol's death, the procedure around tenancy changes (joint to sole requests) has been reviewed to create opportunities to explore issues around domestic abuse and provide opportunities for disclosure.

14.8.6 In the month prior to Carol's death, Torus launched a new Domestic Abuse Housing Service, consisting of two specialist domestic abuse housing officers. The team work with victims of domestic abuse identified via internal colleagues, referrals from external support services, direct disclosure, and MARAC. Had domestic abuse been identified, a case would have been created for the Domestic Abuse Housing team. The team provide housing-related support to victims of domestic abuse.

14.9 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to COVID-19.**

14.9.1 At the start of the review period, 1 January 2021, the United Kingdom was still experiencing a number of COVID-19 related restrictions. This undoubtedly affected the type of service that was offered in some instances. Hospital, GP, and ambulance services were still affected by COVID-19 working practice during the early part of the review period. However, it is clear that both Carol and John were able to access services as required and had a number of medical appointments during this time.

There is evidence that some face-to-face services were available when requested. For example, in June 2021, Carol requested a face-to-face physiotherapy appointment, and this was facilitated.

14.9.2 Safe2Speak had issues in relation to capacity and resources that affected the ability to provide the appropriate level of service and oversight for John, as well as limitations on the ability to work as proactively and robustly with other agencies as Safe2Speak would aim to do.

At the time John was referred to Safe2Speak – from 1st January 2023 to 31st March 2023 – there were 367 new referrals added to the Mainstay Case Management System. 139 of these were domestic abuse outreach referrals, with only two DAO practitioners for all incoming medium and standard risk referrals.

Following the rapid review completed – relating to this case in December 2023 – Safe2Speak caseload numbers were detailed within the Torus safeguarding register and categorised as high risk. Issues in respect to capacity and resources have been an ongoing area of concern for the service, and a recent peer review described Safe2Speak as a service under pressure.

Safe2Speak recently presented a report to the St Helens Domestic Abuse Partnership Board. The report identified the capacity and resource issues for Safe2Speak, as the locally commissioned domestic abuse service. Within this report, it was communicated that Safe2Speak practitioners' caseloads remain high, with the average case load at the point of producing the report being 60 clients per practitioner. This is 140% higher than the SafeLives recommended case load for domestic abuse practitioners. The panel was informed that although there has been a slight reduction in caseload, volumes remain high. Some additional resource has been provided through the Safer St Helens Partnership, and commissioning discussions with partners are ongoing.

14.9.3 Other agencies did not identify resource issues that had affected the provision of services.

14.9.4 The panel acknowledged that COVID-19 restrictions may have had an impact on Carol and John's relationship, for example, 'lockdown' may have meant that the couple spent significantly more time together. This had the potential to increase tension, especially in a household where relationships were already strained.

14.9.5 Domestic homicides didn't appear to increase dramatically during the pandemic – with 163 recorded in the 12 months to 31 March 2021. This was very similar to the

previous year's figure of 152 and was in line with the 15-year average,[17] according to the Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, and College of Policing.

14.9.6 The Project found that COVID-19 acted as an 'escalator and intensifier of existing abuse' in some instances, with victims less able to seek help due to COVID-19 restrictions. It also concluded that COVID-19 had not 'caused' domestic homicide, but it had been 'weaponised' by some abusers, as both a new tool of control over victims and – in some cases – as an excuse or defence for abuse or homicide of the victim.

14.9.7 Monk et al. (2023)[18] conducted a study on alcohol consumption during the COVID-19 pandemic, which is relevant to the period under review. They inferred from their findings that there was a general trend of increased consumption, at the population level, during the COVID-19 pandemic.

14.9.8 The panel discussed whether access to services was restricted, as Carol was signposted to some services rather than a referral being made. For example, she was signposted to Talking Therapies and a social prescriber. There is no evidence that she made contact with those services. The day after she was signposted to them, a GP checked with Carol, who said that she planned to contact the services that day. Carol was able to engage, to some extent, with services over the telephone, for example, Talking Therapies and physiotherapy. However, she did request face-to-face physiotherapy because she did not get on well with doing her own exercise, as directed in a telephone appointment. Overall, the panel did not see that access to services was restricted but noted, as discussed at paragraph 14.5, that Carol could have been referred to Change Grow Live for help with alcohol consumption.

14.10 **What knowledge did family, friends, and employers have of any incidents of domestic abuse, including coercive control, and did they know what to do with that knowledge?**

14.10.1 The panel has been unable to engage with Carol and John's family. Attempts were also made to identify the person who identified themselves to Adult Social Care as

[17] Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, and College of Policing.

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10096461/

'John's ex-partner'. Only a telephone number was known for this person, and that number is no longer in use.

14.11 Are there any examples of outstanding or innovative practice arising from this review?

14.11.1 The panel did not identify outstanding or innovative practice that it wished to highlight.

14.12 What learning has emerged for your agency?

14.12.1 Adult Social Care

In all domestic abuse cases, a discussion needs to take place with the police to determine if there have been previous reports. It is unclear whether this had not been checked because John was a male victim and had indicated that it was mainly verbal/emotional abuse.

Although the MERIT risk assessment training has been provided, it needs to be fully embedded in practice and the referrals progressed. Some work is required in relation to information sharing without consent when a risk has been identified.

Earlier this year, there were some professional curiosity training sessions held. It is therefore difficult to determine the impact of this, or whether there would have been any bearing on this case.

14.12.2 Aintree Hospital – NHS University Hospitals of Liverpool Group (UHLG)

Prior to discharge where there are safeguarding concerns, all involved partner agencies should be contacted prior to the patient leaving the hospital.

The Trust should ensure that where domestic abuse concerns have been raised during a patients stay in hospital, a domestic abuse risk assessment [MeRIT/DASH] is completed before the patient discharge – to inform any further actions or referrals necessary.

14.12.3 Mersey Care NHS Foundation Trust

In February 2024, MCFT Domestic Abuse Policy SA12 was updated and now provides clear step-by-step expected responses to domestic abuse, which has been

set out in a Practice Guidance. Mersey Care are complementing this policy and practice guidance with Toolkit sessions, focusing on practical advice and 'how to' do certain things (such as asking the question about domestic abuse). The aim of this is that to identify domestic abuse early on during a contact, then provide appropriate services, which will include risk assessments, take domestic abuse into account, and use the DASH/MeRIT to help practitioners understand and contextualise the domestic abuse. It is important to think of DA risk assessments as broader functions than just a vehicle for referral to MARAC, as the risk assessment will help facilitate a conversation about domestic abuse and, hopefully, elicit details supporting accurate risk assessments. The practice guidance also highlights the trauma-informed approach required with domestic abuse.

In contacts with Carol, Mersey care refer to asking about 'Safeguarding concerns' but what this entails is not detailed, and it is also a broad question/area. With routine enquiry, Mersey Care aims to be specific about domestic abuse and so if service users do tell disclose abuse, appropriate steps can be taken.

Mersey Care could have provided Carol with information about substance misuse services and how to access them.

14.12.4 **Primary Care – GP**

Ensure that when a patient reports that they are not getting on with their spouse/partner, the reasons for this are explored in full, including consideration of domestic abuse and the findings are documented.

Ensure any requests for another service to visit (UCR) are provided, and that patient records are updated in detail of what is being requested and of any feedback given following the visit.

Ensure any concerns raised regarding alcohol use are explored, that findings are documented, and that referrals to alcohol support services are offered, if needed.

14.12.5 **Safe2Speak**

Following the notification of Carol's death, a rapid review of Safe2Speak's involvement was conducted.

As a result, learning has emerged from this case, in the following areas:

- Structure required for contact attempt timescales.
- Inter-agency information sharing – wider agency enquiries process to be structured upon new referrals being received into the Safe2Speak service.
- Improvement required in the case supervision and case audit support afforded to practitioners by line management.
- Case management practice within the service.
- Ensuring support is tailored to the individual and their presenting needs.
- Importance of professional curiosity when completing assessments and providing services.
- The need to establish business critical activities for periods of increased demand/reduced capacity.
- Enhance the reporting infrastructure and improve data collation and activity reporting.

14.12.6 **Torus Housing**

Torus Housing can play a key role in terms of identifying domestic abuse during all contact points with tenants, including requests for changes/amendments to tenancy agreements as identified in this case. It is important that colleagues feel confident to create safe opportunities for victims or perpetrators to disclose abuse and/or concerns about their own behaviours and that we respond appropriately and safely.

14.13 **Does this learning appear in other Domestic Homicide Reviews commissioned by St Helens Community Safety Partnership?**

14.13.1 Primary Care – DHR Ben 2014. Alcohol concerns to be explored, documented, and referrals offered. The current DHR highlights that further work is needed on this area. A relevant single agency recommendation has been made.

14.13.2 Adult Social Care MeRIT/MARAC training – this was made mandatory following DHR Gill in 2020. The current review shows that further work may be needed to embed that training. A relevant single agency recommendation has been made.

15 Conclusions

15.1 The panel was clear that Carol was a victim of domestic abuse when John strangled her to death in November 2023. There had been historic domestic abuse, with both John and Carol being recorded as victims of each other. However, prior to the review period, there had been a significant gap in agency contact with the couple. There were no reports to the police of domestic abuse after August 2017, when Carol told the police that John had left the house with a suitcase. Contact with Adult Social Care in 2023, by a person who stated that they were John's ex-partner, led the panel to believe that John may have lived away from the family home for some time. In April 2021, the couple submitted a joint claim for Universal Credit and stated that they were living together at that time.

15.2 In January 2022, Carol informed Universal Credit that John was no longer living with her. Both went on to confirm this to their housing provider. In October 2022, there is evidence from medical records that the couple were living together in the family home again.

15.3 From this point, Carol complained that she was struggling to deal with John's care needs and the smell from his leg ulcer. This led to brief interventions from Adult Social Care, for example, reablement visits from carers. However, two days after the last care visit, John was admitted to hospital and disclosed domestic abuse by Carol.

15.4 John's disclosure led to the involvement of Safe2Speak and Adult Social Care. Safe2Speak's interaction with John was brief, and they did not provide ongoing support. Adult Social Care provided John with limited support whilst in hospital and attempted to communicate with him when he left hospital, with little success.

15.5 No agency attempted to speak to Carol about the couple's situation because she was perceived as a domestic abuse perpetrator due to John's disclosure. There was no contact with the police to elicit historic information. This was relevant because John also disclosed that he had previously been a perpetrator of domestic abuse. The panel acknowledged uncertainty about what information the police could have provided to partner agencies, given the historic nature of that information.

15.6 The gathering of further information and contact with Carol may have given a greater understanding of the couple's relationship and enabled the offer of appropriate services to both Carol and John. The panel noted that there was very little interaction with any agency, by either Carol or John, after John left hospital in April 2023. Although John stated to professionals that he was happy to go home to Carol, there is no evidence that Carol was asked for her views. The fact that

neither John nor his family have engaged in the review means that the panel was unsighted on what was happening during that time.

15.7 The panel would like to reiterate its condolences to Carol's family.

16 Learning

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

16.1 Narrative

After John's disclosure of domestic abuse, services were aimed at John. Carol was not spoken to, and historic information was not gathered. A comprehensive understanding of the couple's situation was not achieved.

Learning

When dealing with domestic abuse in people with care and support needs, and who are in long-term relationships, the strict compartmentalisation of victim and perpetrator may be unhelpful. Understanding the background and dynamics of a long enduring relationship is more likely to lead to the offer of appropriate services and enhance the chances of a more successful outcome.

16.2 Narrative

Professionals did not establish whether Carol or John was the primary perpetrator in the relationship.

Learning

Establishing who is the primary perpetrator in a relationship enables professionals to have informed discussions and provide appropriate services to those involved.

16.3 Narrative

Domestic abuse in older people may be complicated by a range of issues, including carer stress and physical and mental health of both parties.

Learning

Domestic abuse in older people may present additional complexities for professionals, which are not always understood

16.4 **Narrative**

The full range of domestic abuse services and accommodation options available were not utilised in this case.

Learning

Providing professionals with information in relation to the full range of services and accommodation options open to victims and perpetrators of domestic abuse is likely to lead to enhanced take up of services.

17 Recommendations[19]

DHR Panel

17.1.1 The Safer St Helens Community Safety Partnership / Domestic Abuse Partnership Board and Safeguarding Adults Board should collaborate to produce a pathway for dealing comprehensively with safeguarding referrals that feature domestic abuse in people with care and support needs in long-term relationships. This should include, as a minimum, communication with both parties and an assessment of their needs.

17.1.2 The Safer St Helens Community Safety Partnership should adopt the SafeLives toolkit for professionals – to aid in their assessment in identifying the primary victim and perpetrator.

17.1.3 The Safer St Helens Community Safety Partnership should produce a briefing for staff regarding domestic abuse in people with care and support needs, especially those in long-term relationships. [Age UK may be able to assist with this].

17.1.4 The new St Helens Domestic Abuse Strategy should consider how information on the full range of domestic abuse services, for victims and perpetrators, can be provided to professionals, and it should set out a timeline for doing so.

17.2 Single Agency Recommendations

17.2.1 Adult Social Care

Reinforce that consent should not be a barrier to safeguarding and progressing MERIT risk assessments.

[19] Implementation of recommendations will be overseen by the Domestic Abuse Partnership Board on behalf of the Community Safety Partnership

Safeguarding team to request the police's historical information if there is a domestic abuse element to the concern.

St Helens Safeguarding Information Sharing Agreement with appropriate teams (already on the SAB website).

Professional curiosity training has been facilitated previously. During National Safeguarding Adults Week, there is a session on this subject – 18th Nov.

Consultation should be undertaken directly with the service user before reablement visits are discontinued.

ASC staff should consider whether a carer's assessment would be helpful during their interaction with older people.

17.2.2 Aintree Hospital – NHS University Hospitals of Liverpool Group (UHLG)

The Trust should ensure that where domestic abuse concerns have been raised during a patient's stay in hospital, a domestic abuse risk assessment [MeRIT/DASH] is completed before the patient discharge – to inform any further actions or referrals necessary.

The outcome of this DHR and its learning are to be shared through the organisation's governance process and Safeguarding Vulnerable People Group.

A review of current training provision.

17.2.3 Primary Care – GP

Ensure any disclosures by a patient that they are experiencing anxiety or issues with their mood, and/or that they disclose they are having difficulties in their relationship with their spouse/partner, are explored. Practice staff to ensure professional curiosity and seek clarity on the causes and if domestic abuse is a possible factor.

Ensure any requests for another service to visit (UCR) are provided, and that patient records are updated in detail of what is being requested and of any feedback given following the visit.

Ensure any concerns raised by another service regarding alcohol use are explored, that the findings are documented, and that referrals to alcohol support services are offered, if needed.

17.2.45 **Mersey Care NHS Foundation Trust**

Further work to be made on implementing Routine Enquiry around Domestic Abuse.

Ensure information is provided to service users on how to access substance misuse services, if this is an identified need/concern.

17.2.5 **NWAS**

NWAS safeguarding practitioner for Cheshire and Mersey will ensure that there is a general discussion point at the local Cheshire & Mersey Learning Forum around the impact of long-term health conditions on the whole family and the need to unpick any patient comments around pushing or shoving by family members. The discussion will also link to carers' strain. The forum is attended by Advanced Paramedics and has representation from the NWAS Clinical Hub, which provides support to crews who are dealing with live incidents.

17.2.6 **Safe2Speak**

Contact framework to be embedded within the service to provide structure and consistency to the initial contact. Further contact and wider agency enquiries practitioners should completed upon being allocated a new case.

Development of the Mainstay Case Management System to further support the KPI monitoring and case audit functions.

Enhance the reporting infrastructure and improve data collation and activity reporting.

Safe2Speak practitioners to notify referrers, and any known involved partner agencies, upon case closure.

All incoming referrals to have the address cross referred on the internal Torus QL case management system to identify if the address is a Torus property.

Review of referral forms to ensure that the referrer has the opportunity to capture Adult Social Care and other agency involvement.

Safe2Speak should consider how it can assist clients to engage with Housing Options.

Mersey and West Lancashire Teaching Hospital NHS Trust

Review of referral forms to ensure that engagement with Adult Social Care, and other agencies, is captured if information is available.

Appendix A Action Plan – Carol DHR – St Helens Community Safety Partnership

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
St Helens Community Safety Partnership							
1	The Safer St Helens Community Safety Partnership / Domestic Abuse Partnership Board and Safeguarding Adults Board should collaborate to produce a pathway for dealing comprehensively with safeguarding referrals that feature domestic abuse in people with care and support needs in long-term relationships. This should include, as a minimum, communication with both parties and an assessment of their needs.	Local	A draft pathway process needs to be developed	Adults Safeguarding	Draft pathway to be developed. Pathway to be shared and understood by the CPS/ DAPB/ SAB.	October 2025	Completed October 2025. The Safeguarding Adults Board have agreed a 7-minute briefing for informal carers - we already have a system in place for an adult with care and support needs to be spoken to when they are a victim of domestic abuse. The carers briefing takes this further as there is an expectation that both the person in receipt of support and their carer are offered assessments and

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							spoken to as part of the enquiry regardless of who is the victim.
2	The Safer St Helens Community Safety Partnership should adopt the SafeLives toolkit for professionals – to aid in their assessment in identifying the primary victim and perpetrator.	Local	Invitation to be extended to SafeLives to present the toolkit to the DABP. If endorsed to be cascaded in all organisations. Safe2Speak to incorporate toolkit into training package	Domestic Abuse Partnership Board	On the agenda for board in August 2026, for assurance that the toolkit is now part part of working practice - GL 2/7/26.	December 2025	Commenced.
3	The Safer St Helens Community Safety Partnership should produce a briefing for staff regarding domestic abuse in people with care and support needs, especially those in long-term relationships. [Age UK may be able to assist with this].	Local	Consult with Age UK to create briefing note for the partnership	Community Safety Team/ Age UK	Contact to be made with Age UK. Confirmation of content of briefing note. Share with Adult Social Care		Commenced.
4	The new St Helens Domestic Abuse Strategy should consider how information on the full range of domestic abuse services, for victims and perpetrators, can be provided	Local	Creation of DA Services Directory	Domestic Abuse Partnership Board	Creation of DA Services Directory	September 2025	Completed July 2025. Document available at https://www.sthelens.gov.uk/article/13

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	to professionals, and it should set out a timeline for doing so.						283/Domestic-Abuse-Helplines-and-Support-Services
Single Agency Recommendations							
Adult Social Care							
1	Reinforce that consent should not be a barrier to safeguarding and progressing MERIT risk assessments.	Local	To discuss at the safeguarding team meeting. To liaise with heads of services and ensure the same message is being shared in their team meetings.	ASC	Discuss with heads of service at safeguarding team meeting. Dissemination amongst teams	July 2025	Completed July 2025. Issue has been addressed within the department.
2	Safeguarding team to request the police's historical information if there is a domestic abuse element to the concern.	Local	Team meeting.	ASC	Teams to be briefed on requirement to contact Police when DA is a concern. Results to inform risk assessment and ensure that potential victims are identified.	July 2025	Completed July 2025 Discussion with the team to advise that in domestic abuse cases (for adults with care and support needs), Police should be contacted to determine if there are any previous allegations.

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3	St Helens Safeguarding Information Sharing Agreement with appropriate teams (already on the SAB website).	Local	Share with appropriate heads of service and share on the Adult Social Care Training Hub (Sharepoint).	ASC	Email sent to HOS to share and discuss the Organisational Development team to add on the Hub. All MERIT risk assessment documents will be shared to the appropriate services.	October 2025	Completed October 2025.
4	Professional curiosity training has been facilitated previously. During National Safeguarding Adults Week, there is a session on this subject – 18th Nov.	Regional	Communications promoting the sessions as are Liverpool, Sefton, Wirral and Knowsley.	ASC	Staff to complete training	October 2025	Completed October 2025.
5	Consultation should be undertaken directly with the service user before reablement visits are discontinued.	Local	Discuss recommendation with Head of Reablement	ASC	Matter discussed and agreed with Head of Reablement Dissemination amongst teams	July 2025	Completed July 2025.
6	ASC staff should consider whether a carer's assessment would be helpful during their interaction with older people.	Local	Briefing in relation to Carers and Domestic Abuse	Community Safety Team/ ASC.	Briefing in relation to Carers and Domestic Abuse agreed at Safeguarding Adult Board. 7 Minute briefing to be shared during Principal Social Worker briefing	October 2025	Commenced.

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Aintree Hospital – NHS University Hospitals of Liverpool Group (UHLG)							
1	The Trust should ensure that where domestic abuse concerns have been raised during a patient's stay in hospital, a domestic abuse risk assessment [MeRIT/DASH] is completed before the patient discharge – to inform any further actions or referrals necessary.	Local	Training is being provided/delivered by Safeguarding Team Specialist Nurse for Domestic Abuse around DASH/Merit and MARAC process	LUHFT Safeguarding Team	Sessions that take place are recorded names of staff attended documented	Rolling programme	Ongoing.
2	The outcome of this DHR and its learning are to be shared through the organisation's governance process and Safeguarding Vulnerable People Group.	Local	Safeguarding team to develop in-house leaning event to disseminate outcome of DHRs SARs, etc. and required changes to current practice.	LUHFT Safeguarding Team	Agenda and recorded minutes of meetings and events. Safeguarding team will work with the governance team to facilitate the event.	December 2025	Completed December 2025. LUHFT staff to have clear understanding of safeguarding processes and any lessons learnt.
3	A review of current training provision.	Local	Currently under review and will include outcomes and links to completed DHRs/SARs/SCRs and recommendations. With an emphasis on 'professional curiosity and routine enquiries'.	LUHFT Safeguarding Team	Adaptations to the current package. Realignment of staff to the most appropriate level of training.	December 2025	Completed December 2025. An Increase in compliance as determined in the organisation's KPIs.

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Primary Care							
1	Ensure any disclosures by a patient that they are experiencing anxiety or issues with their mood, and/or that they disclose they are having difficulties in their relationship with their spouse/partner, are explored. Practice staff to ensure professional curiosity and seek clarity on the causes and if domestic abuse is a possible factor.	Local	Comms with all practice staff. Posters on domestic abuse placed in the practice to encourage patients to seek support.	Lead GP Reception Supervisor	Evidence of comms to practice staff. Domestic abuse awareness poster to be placed in patient areas in the practice.	31/11/24	Completed January 2025. Any disclosures by a patient that they are experiences anxiety or issues with their mood and that they disclose they are having difficulties in their relationship with their spouse/ partner. Practice staff to ensure professional curiosity and seek clarity on the causes and if domestic abuse is a possible fact
2	Ensure any requests for another service to visit (UCR) are provided, and that patient records are updated in detail of what is being requested and of any feedback given following the visit.		Comms with all practice staff.	Lead GP	Evidence of comms to practice staff.	6/1/25	Completed January 2025. Any requests for another service to visit (UCR), that patient records are updated in detail of

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							what is being requested and any feedback given following the visit.
3	Ensure any concerns raised by another service regarding alcohol use are explored, that the findings documented, and that referrals to alcohol support services are offered, if needed.		Comms with all practice staff.	Lead GP	Evidence of comms to practice staff.	6/1/25	Completed January 2025. Ensure any concerns raised by another service in regard to alcohol use are explored and findings documented and referrals to alcohol support services offered if needed.
Merseycare NHS Foundation Trust							
1	Further work to be made on implementing Routine Enquiry around Domestic Abuse.	Local	Safeguarding team will undertake a scoping exercise with all teams around current practice around this and ensure each risk assessment used contains a section on routine enquiry. Safeguarding service will roll out Toolkit sessions, focusing on 'asking the	MCFT Safeguarding Service	Service users consulted so that support offer can be personalised. Staff can identify substance misuse and sign post to support services.	End of 2024/25 financial year	Completed April 20205. Each service user is asked about domestic abuse, and so early support services can be offered, and risk assessments can be informed.

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			question' in October/November 2024.				
2	Ensure information is provided to service users on how to access substance misuse services, if this is an identified need/concern.	Local	MCFT safeguarding team to engage with operational teams to scope current expected practice and identify any gaps.	MCFT Safeguarding Service	Develop new briefing note for staff.	End of 2024/25 financial year	Completed April 2025. A briefing has been created and shared with all teams about how to signpost individuals to substance misuse services and the importance of doing so.
NWAS							
1	NWAS safeguarding practitioner for Cheshire and Mersey will ensure that there is a general discussion point at the local Cheshire & Mersey Learning Forum around the impact of long-term health conditions on the whole family and the need to unpick any patient comments around pushing or shoving by family members. The discussion will also link to carers' strain. The forum is attended by Advanced Paramedics and has representation from the NWAS	Local	The Advanced Paramedics who attend Learning Forum can provide safeguarding advice and discuss safeguarding with crew as part of contact shifts.	NWAS	Discuss at CAM learning forum	February 2025	Completed February 2025. The discussion was held at CAM Learning Forum on 20/2/25.

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	Clinical Hub, which provides support to crews who are dealing with live incidents.						
Safe2Speak							
1	Contact framework to be embedded within the service to provide structure and consistency to the initial contact. Further contact and wider agency enquiries practitioners should completed upon being allocated a new case.	Local	Review existing practice and approaches to client contact. Consult with Safe2Speak practitioners on contact structure. Produce a contact framework for Safe2Speak practitioners that is standardised across service offers and includes wider agency enquiries and provides set timescales for tasks within a 7-day working window. Mainstay Support Plan to be updated to reflect the new contact framework.	Safe2Speak	Staff briefed in person and in writing with new contact structure and informed this is the new approach for client contacts and wider agency enquiries. Contact Framework produced. Contact Framework incorporated into Safe2Speak case audit tool and process to enable monitoring and performance management. Meeting with Mainstay has taken place to discuss proposed changes.	November 2024	Completed November 2024. Framework is now in place. Team consulted and briefing provided to launch the framework into practise. All practitioners are required to follow the Safe2Speak Contact Framework – provides standardised approach upon new referrals being received in the service. Framework includes associated timescales for attempts across a 7-day working

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					Existing Mainstay support plan reviewed, and new support plan content proposed/drafted.		window. It also incorporates requirement for practitioners to make liaison with partner agencies, original referrer and ensuring a proactivity and professionally curious approach to establishing contact with a newly referred victim of domestic abuse.
2	Development of the Mainstay Case Management System to further support the KPI monitoring and case audit functions.	Local	Review of existing Mainstay Case Management functions available to the Safe2Speak service. Draft new support plan design, including updated goal areas, intervention lists, and task templates. Schedule 6 weekly case audit dates. Mainstay to implement changes to case management system.	Safe2Speak Mainstay	Case Management System and existing support plans/case files reviewed by team leader. Draft new support plan produced and updates to wider areas of the case management system identified. Consultation with Safe2Speak practitioners completed on the proposed updates of the case management system.	January 2025	Completed October 2025. I can confirm all the actions relating to the Safe2Speak case management are completed within the parameters of what was possible. Unfortunately, the new support plan and task templates that were drafted could not progress to implementation

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			Embed changes to the case management system into the case audit tool and process. Refresher training to be provided to Safe2Speak practitioners on utilising the Mainstay Case Management System effectively and robustly.		Demonstration by team leader to Safe2Speak practitioners on functionalities available on the case management system to improve efficiencies and prevent case drift and practitioner accountability. Meeting completed with Mainstay to discuss the proposed changes and seek their input on the possible changes. Staff training also discussed and confirmation received from Mainstay this will be accessible upon changes being made to the system.		in its entirety due to Mainstay developer's restrictions and advising it would not be possible; as a result an alternative approach was implemented as an interim measure and there are future plans for autumn 2026 to design a safety planning form to replace the existing support plan. We continue to have a proactive relationship with Mainstay as our case management provider and they implement changes for us upon request and we have the ongoing flexibility to adapt the system and evolve our reporting functions, and data collection.

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
3	Enhance the reporting infrastructure and improve data collation and activity reporting.	Local	Development of a Safe2Speak Service Dashboard. Reports to be submitted to St Helens Domestic Abuse Partnership Board.	Safe2Speak/ Torus Performance Management Team	Meeting has taken place with Torus Performance Management to scope project and development of a Safe2Speak Service Dashboard. Mainstay access has been progressed for Torus performance management staff supporting on dashboard development. Production of report and presentation of data/activity has commenced by Safe2Speak at St Helens Domestic Abuse Partnership Board.	March 2025	Completed July 20205. Reporting infrastructure has been enhanced – including: · Consultation with Mainstay – resulting in automation & receipt of specifically designed monthly reports from Mainstay case management system · Development and changes made to Mainstay case management system to enhance the detail recorded & reported upon: 1. S2S Client Form – redesigned and additional data/information incorporated for recording 2. Case Closure Tab – redesigned and aligned to ensure

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							information recorded is relevant to the data returns required by commissioners 3. Additions and amendments made to existing case management support plan to ensure collating data relevant to data returns for commissioners/funding streams · Amendments made to spreadsheet used to record incoming referral volumes & categories · Data Spreadsheet produced and in place to enable all monthly data to be recorded and data collated is used to inform activity reporting – this includes data relevant to referrals but also in respect of caseloads across

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							service, diversity of clients etc. · Safe2Speak producing report using data collated for St Helens Domestic Abuse Partnership Board & other multi-agency forums strategically and operationally as required. · Safe2Speak management and service commissioners established meeting structure and to support these meetings the enhanced data collation will be used to produce a report for each meeting. · Members of Torus Performance team now have accounts/access to Mainstay Case Management System to support

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							their input and expertise. Although this action has been completed, in doing so it has identified a further aspiration for the Safe2Speak service to have a reporting dashboard that can use data and convert this automatically to provide statistics and visually inform of activity across service. This requires future support from the Torus performance team and their advice as to how this can be facilitated internally and if the data, they have now had sight of for an extended period can be digitalised.
4	Safe2Speak practitioners to notify referrers, and any known involved	Local	Safe2Speak practitioners to be informed that this is	Safe2Speak	Staff informed individually during their case supervision session about	November 2024	Completed November 2024.

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	partner agencies, upon case closure.		required as part of case closure process. Distribution of template case closure email to practitioners for their use. Incorporate this element within new case management procedure. Mainstay to implement changes to case management system. Embed changes to the case management system into the case audit tool and process.		the additional step/intervention being required at point of case closure. Template case closure email distributed to Safe2Speak practitioners for their use. Team wide briefing provided in Safe2Speak team meeting to reinforce this new aspect of the case closure process		All practitioners informed and aware of the expectation that upon a case closing to the Safe2Speak service, they need to notify the original referrer, and any relevant professionals involved with the case at point of case closure. A template case closure email was produced, circulated and remains an accessible resource to the team. The closure email does prompt partner agencies to ensure they are routinely exploring domestic abuse when safe to do so with the victim has been closed, and it also promotes the ongoing accessibility of support from

No	Recommendation	Scope i.e., Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
							Safe2Speak & the local domestic abuse referral pathway.
5	All incoming referrals to have the address cross referred on the internal Torus QL case management system to identify if the address is a Torus property.	Local	Risk identification officer to be informed this is required as part of the risk identification process. Task to be added to case management system as intervention necessary at point of uploading new cases. Risk identification officer to record on the case file the Torus internal colleagues associated with the property address for Safe2Speak practitioners use Incorporate this element within new case management procedure. Embed this within case audit tool and process. Practitioners to utilise referral pathway to Torus	Jennie Grayson	Risk identification officer informed of the need to complete this as routine within the risk identification process and triaging a new referral. Team-wide briefing, provided in Safe2Speak team meeting, to advise this will be routine practice and their practitioner accountability to ensure they are utilising Torus Housing colleagues in their case management and making referrals with the clients' consent to the Torus Domestic Abuse Housing Team and/or wider Torus in-house services as identified, as needed.	November 2024	Completed November 2024. This is the responsibility of the Safe2Speak risk identification officer who processes all new referrals into the service. As part of the RIO triage process, it is requirement for RIO to review the internal Torus QL system to cross reference the address provided. Outcome of this should be recorded within RIO's triage notes on the case as well as recorded with the Safe2Speak client form. Within Safe2Speak contact framework, clear

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			Domestic Abuse Housing Team if required and with victims' consent. Practitioners to utilise liaison and inter-agency contact with Torus Housing colleagues for no contact cases or cases where a client may have become disengaged.				reference is made to the expectation that where a property is identified as Torus, that it should be routine practise to liaise and link in with Torus Housing to share information, explore safe contact opportunities. Team have been briefed around the expectations of partnership working with Torus Housing and more broadly social landlords where a client is identified as having a social tenancy. Safe2Speak practitioners, where the victim is a Torus tenant, will make internal referrals to Torus in-house services and work in partnership with Torus colleagues

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							across different departments.
6	Review of referral forms to ensure that the referrer has the opportunity to capture Adult Social Care and other agency involvement.	Local	Review of existing Safe2Speak Domestic Abuse Outreach form Make amendments and additions to the referral form Communicate to partner agencies sharing updated referral form Update Safe2Speak website with the updated DA Outreach referral form.	Safe2Speak	Review of existing Safe2Speak Domestic Abuse Outreach form Identified benefit of completing a full redesign Safe2Speak Domestic referral form as current formatting and layout requires improvement, as well as actioned enhancements	October 2026	Commenced. This project has had to be further deferred due to the capacity issues, but it remains tracked internally within Torus DHR progress monitoring/action tracker and will progress forward for completion in the coming months. Realistic completion timescale may be October 2026. As an interim measure, due to the context for the action prompting the changes, the Risk Identification Officer is ensuring safeguarding is queried with referrers where it is not explicitly referenced on the

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							submitted forms as part of quality assurance.
7	Safe2Speak should consider how it can assist clients to engage with Housing Options.	Local	Revisit importance of exploring need for Housing Options advice/referral with newly referred clients with the full Safe2Speak IDVA & outreach team. Template Housing Options Referral Email to be re-circulated to practitioners Recirculating the safety & support planning guidance to practitioners	Safe2Speak	Service users risk assessed with regards to housing. Referral/ support to access relevant housing offered. Refresh for staff on safety and support planning.	July 2025	Completed July 2025. Upon initial contact with a victim, Safe2Speak practitioners are required to explore the individual's immediate safety and security at home. If the victim identifies as not feeling safe to return home or to remain in their present address, options of emergency crisis accommodation should be shared & support to access refuge provision, including a referral to St Helens Housing Options for advice & guidance. This forms part of

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							the Safe2Speak target hardening process as well as the safety and support planning session process. As part of wider safety & support planning, Safe2Speak will make referrals to Housing Options services where a victim needs advice regarding their housing rights and options – this includes victims who may have concerns regarding private landlord, joint tenancy etc. Practitioners will also liaise with Housing Options on client's behalf were identified as a support need or wish of the client. Actions are recorded, and a template email is in place that

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							practitioners can amend & use when making a referral to St Helens Housing Options, and as part of this they should consult with the victim for their contact preferences and list their preferred safest point of contact. This has been re-circulated with the team. Safe2Speak team leader has also liaised with strategic management to seek their support to lead on arranging an opportunity for Safe2Speak and Housing Options service to meet with the view to enhance understanding of each other's services, roles & responsibilities & discuss

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							opportunities for reciprocal training for staffs on both teams.
1	Review of referral forms to ensure that engagement with Adult Social Care, and other agencies, is captured if information is available.	Local	Trust Domestic Abuse referral form to be updated to include involvement/referrals to other services including adult social care.	Mersey West Lancs	Referral form to be updated.	July 2025	Completed March 2025. Trust referral form and Domestic Abuse Policy updated.