Domestic Homicide Review (DHR)

Safer North Tyneside Partnership

Executive Summary

‘Ali’

July 2021

Julia Greig

Date: December 2023

# Contents

## 1.0 The Review Process

1.1 This summary outlines the process undertaken by the Safer North Tyneside Partnership domestic homicide review panel in reviewing the suicide of Ali who was a resident in their area.

1.2 The pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members.

1.3 Ali was twenty-five when she died. She was white British. Ali had two children with whom she lived. Ali's children have not been provided with pseudonyms and have been referred to simply as Ali's children throughout. The perpetrator of Ali's abuse was white British and also twenty-five years old when Ali died. Whilst Ali and perpetrator had been in a relationship, they were not living together at the time of her death. The perpetrator was the biological father of her youngest child.

1.4 A Pre-Inquest Review was held in early February 2023. A draft report was shared with His Majesty's Coroner in advance of the Pre-Inquest Review with a caveat that it must not be allowed to enter the public domain before the Home Office has ratified the report. The inquest was held in late July 2023 and recorded a narrative verdict that *'The deceased took her own life whilst under the influence of alcohol having suffered an acute deterioration in her mental health condition.'*

1.5 The review process began with an initial meeting of the DHR Core Group on 16th September 2021 and the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Ali, her children and/or the perpetrator prior to the point of death were contacted and asked to confirm whether they been involved with them. Nine of the agencies contacted confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

## 2.0 Contributors to the Review

2.1 The agencies that contributed to the review are as follows:

- North Tyneside Council (NTC) Adult Social Care - IMR
- NTC Housing - IMR
- NTC Children's Services - IMR
- NTC 0-19 Service (Health Visitors) - IMR
- North Tyneside Clinical Commissioning Group (now North East and North Cumbria Integrated Care Board) - IMR
- Cumbria Northumberland, Tyne and Wear NHS Foundation Trust - IMR
- Northumbria Police - IMR
- Northumbria Healthcare NHS Trust - IMR
- Harbour – IMR

2.2 IMR authors were independent with no direct involvement in the case, or line management responsibility for any of those involved.

## 3.0 The Review Panel Members

3.1 The DHR panel members were as follows:

| Name | Role | Agency |
|---|---|---|
| Lindsey Ojomo | Resilience and Community Safety Manager | Safer North Tyneside |
| Shona Priddey | Independent Reviewer – DHR Chair | Independent |
| Julia Greig | Independent Reviewer – DHR Author | Independent |
| Trish Grant | Deputy Designated Nurse Safeguarding children and Lead Nurse Safeguarding Adults | North Tyneside Clinical Commissioning Group |
| Sheona Duffy | Acting Team Manager Safeguarding and Public Protection / Named Nurse Safeguarding | Cumbria Northumberland, Tyne and Wear NHS Foundation Trust |
| Jackie Butson | Advanced Customer Support Senior Leader | Department for Work and Pensions |
| Lesley Hill | Preventions Worker | Harbour |
| Paula Shandran | Associate Director of Professional Standards and Safeguarding | Northumbria Healthcare NHS Trust |
| James Killgallon | Safeguarding Adult Advisor | North-East Ambulance Service (NEAS) |
| Mel Baxendale<br>Kelly Hindhaugh | Safeguarding Nurse Lead<br>Safeguarding Nurse Lead | North Tyneside Council 0-19 service |
| Ellie Anderson | Assistant Director, Business & Quality Assurance | North Tyneside Council – Adult Social Care |
| Abby Waites | Senior Manager Social Care Practice | North Tyneside Council – Children's Services |
| Ian Callaghan | Detective Inspector - Strategic Innovation Partnership Safeguarding | Northumbria Police |
| Liz Archer | Head of Housing Operations | Housing, North Tyneside Council |
| Sue Pearce | Chief Executive Officer | Rape Crisis Tyneside and Northumberland |

3.2 Independence and impartiality are fundamental principles of delivering DHR and the impartiality of the independent chair and report author and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel

members, had direct involvement in the case, or had line management responsibility for any of those involved. The panel met on four occasions.

## 4.0 Chair and Author of the Review and Overview Report

4.1 The Safer North Tyneside Partnership appointed Shona Priddey to Chair the DHR. Shona acts as an independent Chair and Author for DHR's. Her background is within the Criminal Justice System both academically and professionally. She is a justice of the peace in both Criminal and Family courts and holds the position of trustee for the domestic abuse charity 'Stand Up To Domestic Abuse'. Shona is independent of all the agencies involved in this case and has never worked in North Tyneside or for any of its agencies.

4.2 Julia Greig was appointed to author the Overview Report. She is a registered social worker and has extensive social work experience in statutory and independent sectors working with adults. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by AAFDA and is an accredited reviewer using the Serious Incident Learning Process. Julia is independent of all the agencies involved in this case, she has never worked in North Tyneside or for any of its agencies.

## 5.0 Terms of Reference for the Review

5.1 Statutory Guidance (Section 2.7) states the purpose of the DHR Review 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 coordinated 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;
- Highlight good practice.

### Specific terms of reference set for this review

- Was Ali able to access the help and support needed to improve her physical and mental wellbeing? Was that support enough considering the disclosures of Domestic Abuse and Violence?

- Did agencies recognise the abuse by the perpetrator? If so, did they take the appropriate steps to support and intervene where they could have?

- Did child contact facilitate further control in this case?

- Did agencies share information and if they did, what did they share?

- Did any agency join the dots? If they did was it done correctly and in a timely manner? What more could have been done by agencies?

- Was there a history of abusive behaviour towards Ali and was this known to any agencies?

- Was there a history of mental health problems for Ali and if so, was this known to agencies or multi agency forums?

- Were family or friends aware of any abusive behaviour to Ali prior to her death? Did family or friends experience any barriers in reporting abuse? Did agencies communicate effectively with the family and friends?

- Could improvement in any of the following have led to a different outcome: Communication and information sharing between services; Information sharing between agencies regarding the safeguarding of adults; Communication within services; Communication and publicity to the general public and unknown specialist services about the nature and prevalence of domestic abuse and available local specialist services.

- Was the work undertaken by services in this case consistent with each organisations professional standards and any domestic abuse policy procedures and protocols?

- Has any learning already been identified? If so, has anything been implemented since Ali's death?

- Does your agency have policies and procedures in place for identifying domestic abuse, training, management and supervision, working in partnership with other agencies and resources?

- Identify good practice where responses may have been over and above the required standards.

- Was consideration given to any equality and diversity issues that appear to be pertinent to the victim and alleged perpetrator, e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

## 6.0 Background and Summary Chronology

### Background information and history

6.1 On a day in July 2021 Ali was found deceased at home by her father. The police were contacted, and an ambulance was dispatched. Ambulance crew confirmed her death at 13:11; Ali had died by hanging. Text messages on Ali's phone indicated a fear of fighting alcoholism. Services were notified of Ali's death. The perpetrator notified children's services the following morning; he stated that Ali had died two days previously in the evening. It is not known how the perpetrator came to know about the exact date of Ali's death.

6.2 Within a few weeks of Ali's death, the perpetrator moved, with both children, to another local authority area and the children moved school. The perpetrator quickly established a new relationship and the couple now have a child together. Ali's mother has had a family court case, alongside the DHR process being undertaken, in order to gain and formalise consistent access to the children.

### Summary Chronology

6.3 The review considered agency involvement with Ali, her children and the perpetrator from August 2017 to the date when Ali died in July 2021. The Panel agreed that this period reflected the issues identified through scoping and contact with agencies in respect of these.

6.4 In November 2017 Ali fell pregnant with Child 2. Ali described her relationship with the perpetrator as 'friends with benefits' and said that he was supportive. During 2017 Ali had contact with her GP practice on approximately eleven occasions for both her mental and physical health including treatment for two urinary tract infections (UTIs).

6.5 In 2018 Children's services completed a Single Assessment following news of Ali's pregnancy. Both Ali and the perpetrator were observed to interact positively with Child 1 and speak positively about the pregnancy. No issues of domestic abuse were identified and children's services ended their involvement. Ali gave birth to Child 2 in July.

6.6 Following the birth, Ali requested a referral to mental health which was completed by the GP on the 23rd July. CNWT saw Ali in August. A Bipolar disorder diagnosis was discounted, concluding emotional instability. No mental health problems were identified but further review was agreed. On the 30th August Ali reported during a medical review with the Perinatal Team in August 2018 that she had not previously shared the extent of her mental health problems and self-harm ideation for fear of Social Services involvement. She was prescribed antidepressants. Ali did not attend any of her scheduled medical reviews and later confirmed she had stopped taking her medication.

6.7 In November Ali requested sterilisation. The referral was rejected by gynaecological services on the basis that they did not offer sterilisation to those under thirty years of age.

6.8 The Health Visitor visited Ali on two occasions. No concerns about Ali's mental health or domestic abuse were reported. During 2018 Ali had contact with Surgery A on approximately thirty-three occasions and Surgery B on two occasions for both her physical and mental health, including five UTIs and an injury of bruised ribs, back,

bottom and leg sustained when Ali reported that she had slipped down a few stairs. In December Ali's changed GP surgery to Surgery B and she was seen for a new patient screening. It was reported that Ali changed surgeries as she did not feel listened to at the former surgery.

6.9 By late 2018 Ali was in arrears for her rent by approximately £1000.

6.10 In January 2019 Ali reported to CNWT drinking 2-3 energy drinks a day but no alcohol. She reported no self-harm or suicidal thoughts. Ali disclosed being raped as a teenager by an unknown individual. Ali was advised to cut down energy drinks. Counselling for the sexual assault was agreed. Ali was discharged from the service in September 2019, Ali was not happy about her discharge from mental health services and told her GP that her mental health was not good, and that she needed help.

6.11 Between February and July 2019 Ali had multiple appointments with a peer support worker, looking at anxiety management and developing a Wellness Recovery action Plan. Ali was offered Dialectal Behavioural Therapy (DBT) but she did not attend the group sessions.

6.12 In late May 2019 Ali reported to police that her ex-partner (the perpetrator) had taken Child 1 out and was refusing to return him. A DASH was completed and Ali was assessed as standard risk. A Child Concern Notification (CCN) was raised, with Police stating that the children were being used a "bargaining chips." The CCN was triaged by the Multi-agency Safeguarding Hub (MASH) and it was agreed that the health visitor would follow up.

6.13 During a consultation with the surgery nurse in September 2019 Ali reported suicidal thoughts and that she was drinking a bottle of wine daily, more if she was feeling stressed. Ali reported to her GP a difficult relationship with her ex-partner and arguments over nursery fees but said they were no longer living together.

6.14 On the 28th October 2019 Ali contacted 999 reporting intent to suicide. Ali had attempted an overdose but was stopped by the perpetrator, she then cut her wrists. Ali left her property and said she still intended to suicide. An ambulance was dispatched, and she was transported to A&E. Safeguarding Referrals were submitted to Adult Social Care in relation to Ali and her two children. In response, adult social care took no further action and children's services MASH agreed that support would be offered from Early Help.

6.15 Ali was assessed by the psychiatric liaison team; she denied any abuse. Ali declined many offers of help and could not say what help she did want. She accepted home treatment. A referral to NTRP for alcohol use was declined.

6.16 Ali had contact with the health visitor on five occasions (four in person home visits). The perpetrator was present during at least one of these visits. During a visit in November she reported that her ex-partner was harassing her and he lived over the street. Ali reported this is why she attempted to take her life. In response the health visitor provided a housing support letter.

6.17 From the 31st October to the 18th November 2019 Ali received home based treatment visits, during which, she reported derogatory texts from the perpetrator and his withdrawal of support with childcare. A self-referral to Harbour was suggested.

6.18 On the 13th November 2019 Ali's housing application was closed as she had not responded within the time limit.

6.19 Ali saw her GP surgery on ten occasions during 2019 due to injuries and pain as a result of various falls and an assault by unknown persons at the local pub in March. She also attended for postnatal depression and to request sterilisation, which was declined. In June she reported experiencing panic attacks and in August reported post coital bleeding and abdominal pain for which she attended the Accident and Emergency Department.

6.20 In April 2020 Ali aggression from perpetrator to police and abusive texts. A DASH was completed as standard risk. A CCN was raised as the children had been present. This was triaged in MASH and passed to early help support to follow up. Children's services spoke to Ali who reported that the perpetrator had been living with her during lockdown and that he had used cannabis. It was determined that support was to be offered via Early Help and the school were made aware through Operation Encompass1.

6.21 On the 30th August Ali reported to police that she had had an argument with the perpetrator, and he had hit her with a glass before leaving with her house key and her son's mobile phone. Ali refused to support a prosecution or make a statement. Ali further disclosed that during their relationship, the perpetrator had been controlling and jealous, had threatened to take the children from her and had pinned her against the wall by her throat. Ali told Police that he used cannabis and was in a lot of debt. Ali was assessed as medium risk and referred to Harbour, although they were unable to contact her and the case was closed. A CCN was raised as the children had been present. This was triaged in MASH and passed to the allocated social worker. MASH was unable to contact Ali and therefore a letter of support was sent but no further children's services action taken. The school were made aware.

6.22 On the 8th September 2020 Ali presented to Housing Advice Team (homelessness service), due to domestic violence. She reported the incident that had occurred the previous week and that she did not want to press charges for fear of repercussions. Ali advised there had been previous incidents that were reported to police. Ali reported to housing that she had rent arrears of more than £2000 and despite a repayment plan was unable to make payments as the perpetrator was taking money from her. A DASH was completed and a plan was agreed with her. Housing referred to their Domestic Abuse Officer. The referral was not accepted by the Domestic Abuse Officer as it was identified that Ali had been referred to MARAC. The information was shared with police who assessed Ali as medium risk using the DASH. Police notified children's services who progressed the matter for an assessment.

6.23 On the 28th September 2020 Ali told police the perpetrator had borrowed £300 and was refusing to pay the last £50 back. She was advised that the recovery of money was a civil matter. Ali was assessed as standard risk. A CCN was raised and triaged in MASH. This was passed to the allocated social worker. Ali was advised by the health visitor that Harbour could support her with a non-molestation order[2].

[1] Operation Encompass ensures that there is a simple telephone call or notification to a school's trained Designated Safeguarding Lead /Officer (known as key Adult) prior to the start of the next school day after an incident of police attended domestic abuse where there are children related to either of the adult parties involved.

[2] A non-molestation order is typically issued to prohibit an abuser from using or threatening physical violence, intimidating, harassing, pestering or communicating with the victim. An order could prevent the abuser coming within a certain distance of the victim, their home address or attending their place of

6.24 Between 23rd September and 23rd November 2020 Children's services completed an Assessment. Other professionals (School/ nursery/ health visitor/ housing) were contacted during the assessment. Harbour support was discussed with Ali, but she stated she did not feel she needed this support. The Single Assessment did not identify any ongoing role for children's services and the case was closed.

6.25 By October 2020 Ali had rent arrears of £2,652.48 and therefore ineligible to bid for rehousing. AI was to be considered for a property via the 'direct let' process, due to domestic abuse.

6.26 On the 10th November 2020 Ali reported to police a verbal argument with the perpetrator, that he had mentally and financially abused her and no longer wanted contact. A DVN was raised and Ali was assessed as medium risk. A CCN was raised and triaged in MASH and passed to the allocated social worker.

6.27 On the 12th November 2020 Ali told the health visitor she was struggling financially and was in significant arrears for Child 2's nursery fees, and therefore no longer attends. She said she was really struggling with the perpetrator as he wants to be in a relationship with her and she does not want this as he is very controlling and described him as horrible. Ali said he cares for Child 2 when she is working but will not leave the home when she returns from work. Ali said she had accepted a referral to Harbour.

6.28 In 2020 Ali had fifteen consultations with GPs and nurses at her surgery. Reasons related to both her mental and physical health including, request for sterilisation (which was declined), musculoskeletal pain, heavy bleeding and abdominal pain, UTI, and anxiety, thoughts of self-harm and intrusive thoughts. Ali further disclosed panic attacks if touched and gave an example of the perpetrator cuddling her, she said that despite this she did not experience anxiety when hugging her children. In December, the GP referred Ali to the Community Treatment Team for negative intrusive ideas of self- harm.

6.29 On the 17th January 2021 Ali reported to police that the perpetrator was refusing to leave her home. He could be heard shouting in the background, stating that if he were arrested the children should not be left with Ali as she was drunk. Upon police attendance Ali was observed to be sober. Ali was assessed as high risk on the DASH Risk Assessment and referral was made to MARAC. A CCN was raised, triaged in MASH and passed to early help support. Ali further disclosed to a Domestic Violence Officer that the perpetrator had raped her approximately 18 months ago. Ali refused to engage and did not want the perpetrator spoken to as it may inflame the situation.

6.30 Harbour received a referral on the 18th January 2021. The IDVA contacted Ali, Ali said she was frightened of the perpetrator as his abusive behaviour was happening more frequently. She had been offered new accommodation and the incident had occurred because she would not tell him where she was going.

---

work. An order will also prevent an abuser from instructing or encouraging others to do any of those actions. A non-molestation order can protect a victim against behaviour that by itself may not be a criminal offence or in situations where the police have responded to a 999 call but then taken the view that there is insufficient evidence to charge the abuser with a criminal offence such as assault. With a non-molestation order in place, the police can arrest the abuser for the offence of breaching that order. A non-molestation order is usually granted for six to 12 months, although in certain circumstances, it could be granted for a longer period. An order can also be extended.

6.31 Ali was heard at MARAC on the 26th January 2021. MARAC identified the following positive factors: Ali had no intention of reconciling with the perpetrator and was due to move to an address unknown to him, Children's services were not involved because she had acted appropriately to keep herself and her children safe and she was engaging with her Health Visitor and had engaged with the DVO. It was further noted that Ali had not attended appointments with Harbour for initial assessment, and that she had bi-polar and was an active patient of the community treatment team. MARAC agreed for markers to be added to Ali's new address and her phone number to be linked, and for the health visitor to make an unannounced visit to Ali to ascertain if the perpetrator was living at her property. MARAC information was shared with CNTW and Ali's GP.

6.32 On the 28th January 2021 Ali moved to her new home.

6.33 The IDVA undertook an assessment with Ali on the 2nd February 2021, which recorded the following. Ali was in a relationship with the perpetrator for 4 years. The relationship ended over 12 months ago but he used the child contact times to perpetrate abuse. In the past he had raped her and had hit her in the face with a glass. Ali said when they were still in a relationship, he was physically abusive including strangulation. When she ended the relationship and refused him child contact, the perpetrator took Ali's son and refused to return him until she granted him access to his daughter. The perpetrator had previously attempted suicide by taking an overdose. Ali said she used to use alcohol as a coping mechanism when she was with the perpetrator, but since they have split up, she only drinks two glasses of wine in an evening.

6.34 Ali confirmed she had moved house and the perpetrator did not have her new address. Before she moved, he would turn up uninvited and would wait on the doorstep until she came out of the property. Ali felt he was stalking and harassing her. Since she has moved home, she has stopped the perpetrator's contact with the children. He was harassing Ali by sending constant abusive messages to her. He was also threatening to get the children removed from her care. The IDVA advised Ali to report the abusive messages to the police.

6.35 Ali reported considerable rent arrears because of the financial abuse from the perpetrator. She accepted the offer for referral to Citizen's Advice to look at a debt relief order. The IDVA completed a DASH with a score of 18 and an alcohol audit[3] which scored 7, indicating a low risk. All information from the assessment was shared with MASH.

6.36 On the 3rd February 2021 Ali reported to police constant calls and texts from the perpetrator over the past few weeks. Ali also disclosed that during an argument in 2019, the perpetrator had grabbed her throat. A crime of stalking was raised regarding the phone calls. Ali gave police screenshots of the texts and initially supported a prosecution; however, after the report was made a non-molestation order was granted by the court on the 8th February 2021 (to expire 8th August 2021) and Ali withdrew her support. Ali was assessed as medium risk. The police signposted Ali to Harbour and a CCN was raised and triaged in MASH with a request for Early Help.

[3]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684823/Alcohol_use_disorders_identification_test__AUDIT_.pdf

6.37 On the 16th February 2021, the Health Visitor carried out an unannounced visit to Ali. Both children were present, and no concerns were identified. Ali denied any involvement with the perpetrator and denied that she was living with him. She said he did not know where she now lived, she had not told him, and a non-molestation order was in place. Ali felt things are going well and she was very happy to have moved. The health visitor had no concerns around Ali's ability to care for her children.

6.38 Ali did not attend her mental health appointments with CNTW on the 2nd, 15th and 19th February 2021 and was therefore discharged from the service. The GP was informed.

6.39 On the 23rd February 2021 Ali reported to police the perpetrator had breached his non-molestation order. It was established that there had been no breach as Ali and the perpetrator's mother had been arranging child access and the phone was on speaker, there had been no direct contact with Ali. She was assessed as standard risk. A CCN was raised, triaged in MASH and passed to early help.

6.40 The IDVA reviewed Ali's support Plan and DASH on the 8th March 2021, the score had reduced from 18 to 6. Ali said she did not feel she needed anymore support and the case was closed.

6.41 On the 31st March 2021 Ali self-referred to NTRP for support to reduce alcohol use. Ali reported drinking up to 3 bottles wine in an evening. Ali denied suicidal thoughts and reported she had good support from the children's father. Later that day Ali contacted the Crisis Team reporting suicidal ideation and expressed an imminent plan to overdose. The Crisis Team requested a police welfare check. Officers attended and found Ali safe and well, although she had been drinking alcohol and had consumed a bottle of wine. An ACN was raised and reviewed in MASH. It was recorded that Ali had support in place and her GP was notified. Following telephone triage and Crisis Team assessment, home based treatment was agreed.

6.42 MASH spoke to Ali and confirmed that the children were with the perpetrator. Further discussions took place with Ali and the perpetrator on 1st April 2021, and it was agreed that the children would remain with him temporarily. Ali explained that he had fortnightly contact, facilitated by a third party (Ali's friend 'T') due to the non-molestation order. Ali had contacted him on 31st March due to feeling very low in mood. The contact was progressed to a Referral and Single Assessment.

6.43 Ali told the health visitor that she did not drink 3 bottles of wine per night but does drink 2-3 glasses on a night-time to chill out when the children were in bed. She said she told NTRP the most she has ever drank is around 3 bottles. Ali's safety was considered as it was the easter weekend, she had the crisis team visiting daily and had a good friend and family network to support her especially over the next few days. Following a period of daily visits and review by CNTW, Ali was discharged from the Crisis Team on the 5th April 2021.

6.44 On the 18th April 2021 Ali contacted police reporting that the perpetrator had the children's school uniforms and was refusing to return them. On attendance she was found to be intoxicated. She stated that the perpetrator had breached his non-molestation order by making contact and sending threatening messages; however, when her phone was checked she had initiated the contact and had sent aggressive messages, it was therefore determined there had been no breach. A DVN was raised

and Ali was assessed as medium risk. A CCN was raised and triaged in MASH. This was passed to the allocated social worker.

6.45 On the 29th May 2021 Ali attended NSECH following suicidal ideation and self-harm. She was reviewed by the Psychiatric Liaison Team and reported a decline in mental state starting weeks prior following an incident with her son and issues with the perpetrator around derogatory texts and refusing to return children. Ali was informally admitted to inpatient care. An incident report was completed with regards her vulnerability from abuse and a copy sent to Children's Services. The Police were also contacted to confirm the report of verbal abuse and withholding children.

6.46 On the 30th May 2021 Ali reported to police that she had slashed her wrists and was going to take all of the tablets that she had in the house. Officers attended and found her with a minor cut to her wrist and no tablets or alcohol in the house. Ali declined assistance and was verbally abusive to officers, telling them to leave multiple times. Ali was given to number for the Crisis Team and advised to contact them if she needed to. Later that morning a call was made to police from Ali's friend who was concerned for Ali's welfare. A DVN was raised and Ali was assessed as standard risk. A CCN was raised and passed to the allocated social worker. A further 999 call was received by the ambulance service from Ali who stated she was suicidal and intoxicated with access to medication. Police confirmed she had no access to medication in the house but had left scene. An ambulance was arranged and she was taken to NSECH, A&E. Ali was admitted as an informal patient and the GP was informed.

6.47 Ali requested discharge from hospital the following day. A review found that suicidal thinking remained present, with hopelessness and lack of protective factors. Ali was detained subject to a Mental Health Act assessment and a referral for such was made. It was agreed that staff would supervise the perpetrator's visit to the ward with children, to support Ali. At a multi-disciplinary meeting it was thought unlikely that Ali was consuming the self-reported level of alcohol due to no visible withdrawal symptoms. Ali's emotional personality disorder made it more difficult for her to regulate her emotions and that the recent incident with her son had been very difficult for her. There was no mention of her relationship with the perpetrator. The meeting agreed that a period of stabilisation was required before Ali could return home. Ali was detained under section 2 of the Mental Health Act 1983 on the 4th June 2021. The social worker for Ali's children was informed.

6.48 On the 8th June 2021 Ali informed ward staff that she was subject to abusive texts from the perpetrator. A DASH was completed, and whilst Ali declined to contact police she agreed to consider. The Children's Social worker was informed.

6.49 Between the 9th and 23rd June 2021 Ali engaged in treatment offered by psychology, nursing, medical staff and exercise therapy. An improvement to mood with reduced self-harm and suicidal ideation was noted and discharge planning commenced**.** Ali identified that she wanted the children returned to her care on the day of her discharge and was aware of support services upon discharge. Children's services spoke to the perpetrator about how the children would be returned to Ali's care if she was discharged over the weekend. He asked about how to get more money from Ali for the care of the children. Ali then called children's services to report that the perpetrator had contacted her to say he would not be returning the children to her care when she is discharged.

6.50 On the 25th June 2021 Police received a call from staff at adult social care; Ali had disclosed that the perpetrator had sent her texts telling her to kill herself and there was a potential breach of the non-molestation order. When officers spoke to Ali, she did not support a prosecution as she believed that it would make the situation worse. A victimless prosecution was considered but not proceeded with due to concerns for Ali's mental health. The crime was finalised as undetected. Ali was assessed as medium risk. A CCN was raised and passed to the children's allocated social worker. The ward stated they would refer to MARAC. The section 2 was rescinded, and Ali agreed to stay on the ward over the weekend. On the 28th June she was discharged from inpatient care.

6.51 On the 29th June Ali was visited at home by the Crisis Team for the purpose of seven day follow up. She reported a resurgence of low mood and self-harm ideation since discharge. Further home-based treatment was agreed to offer continued support. Ali appeared sedated/ intoxicated with children in her care the following day.

6.52 On the 30th June Ali reported to the children's social worker, further abusive messages from the perpetrator. She was advised to contact the Police if there was further contact from the perpetrator, or he attended the home. The Social worker noted that Ali's speech appeared slow and unclear which Ali and her friend said was due to the medication. The Social worker spoke to the hospital who confirmed that the medication could impact upon Ali's speech and presentation. The Crisis team and Children's Social Worker discussion regarding Ali's presentation, apparent sedation and care for the children following planned visit. Concerns were shared regarding Ali's presentation the day prior and Ali playing inappropriate music in front of children on the previous day. The Crisis Team observation that evening was that she appeared sedated/ intoxicated but denied the use of alcohol.

6.53 In early July, the Crisis Team reported concerns about Ali to Children's Service as she had informed them that she had been drinking since discharge from hospital. Children's services made an unannounced visit to Ali. The home was untidy, and children not dressed. Empty wine bottles were observed. Ali reported hearing voices and having feelings of self-harm. Due to her presentation and concern that she may have taken an overdose, she was asked if she would agree to the children going to stay with the perpetrator, she agreed, the children to remain in the perpetrator's care until 12th July. The Crisis Team and Ambulance were contacted and Ali was taken to hospital. The social worker contacted the Crisis Team to ensure Ali was offered support over the weekend. She was discharged home that evening following Psychiatric Liaison Team assessment at A&E.

6.54 The next day, the perpetrator contacted police concerned for Ali as she had called him to say goodbye. Police attended Ali's home. Entry was forced and she was found with superficial cuts to her arm. She appeared dazed and disclosed that she had drunk two bottles of wine that morning. A member of the Crisis Team also attended the address following contact from the perpetrator, the Crisis Clinician contacted the ambulance service prior to attendance as Ali had confirmed imminent intent to suicide. The Ambulance crew attended Ali's address. She stated Social Services removed her children yesterday to the perpetrator's address. Ali was experiencing auditory hallucinations. She was transported to NSECH, A&E where her wounds were treated. Ali declined a psychiatric liaison assessment and was deemed to have mental capacity to make that decision. The ambulance service submitted a Safeguarding Referral to

Social Services requesting a full assessment of Ali's needs and support with her mental health. The Police raised an ACN and forwarded to the allocated social worker with Ali's consent.

6.55 The Crisis clinician visited Ali at home. Her father was in attendance. Ali was reflective of her earlier distress and reported she had been under the influence of alcohol and planned no further alcohol that evening, planning to spend the evening at her parents' home. Ali said she had been using alcohol since discharge, at times 8 bottles of wine per day. She reported plans to engage with NTRP to reduce alcohol use. Ali reported suicidal thinking had reduced.

6.56 The following day Ali's friend called 999 concerned for her welfare. An ambulance was dispatched. Ali, I did not wish to travel to hospital or speak to the Crisis Team. She was drinking alcohol, but not threatening to harm or suicide. Ali stayed at home with her ex-partner staying with her until she went to stay at sister's house.

6.57 At 9:10am the next morning Ali sent a text to a children's services social worker which stated: "*if anything happened to me over the weekend make sure [the children] stay together, they are a credit to me and I love them so much and make sure they know that. [the perpetrator] can take custody of them both*."

6.58 Ali was found deceased at home by her father. The police were contacted, and an ambulance was dispatched. Ambulance crew confirmed death at 13:11. An Adult Concern Notification from police stated that AIi had hung herself after consuming seven bottles of wine and that she had apparently been chatting happily with ex-partner by phone.

6.59 The following day, a MARAC referral was received from CNTW with accompanying DASH risk assessment[4]. The referral noted that contact from the perpetrator was having an increased impact on Ali's mental wellbeing and contributing to risk related behaviour (self-harm and alcohol).

## 7.0 Key Issues Arising from the Review

### Access to physical and mental health services

7.1 Ali was proactive in seeking support from her GP surgery with regards her physical and mental health and appropriate onward referrals were made, particularly with regards to her mental health. However, her contact with the surgery during the scoping period was significant. With the benefit of hindsight, the reasons for contact with the surgery and the complaints Ali presented with could have indicated wider issues including the potential for domestic abuse. For example, Ali presented with a number of urinary tract infections and gynaecological issues, requests for sterilisation, and a number of minor injuries reportedly caused by slips, trips and falls. However, at the time, these were not a trigger for further investigation by GP services. It is also evident that Ali was able to self-refer to agencies for support, such as NTRP.

[4] 19 'yes's

7.2 However, there were a number of offers to refer, and signpost, to other agencies. On many occasions Ali did not agree to onward referrals or support from other agencies, and a number of appointments made for her she did not attend. There is no evidence of consideration by agencies as to why she either did not wish to engage or did not attend. Ali was a single mother with two young children with employment to maintain which would likely have made it practically difficult for her to attend and engage with services. There is no reference or exploration of her previous experiences with services, although she did disclose downplaying her mental health for fear of children's services involvement. Her experience of being separated from Child 1 when he was a baby would undoubtably have had an impact on her and therefore she would have been mindful of the repercussions of engaging with certain agencies and services, especially in the context of the perpetrator using threat of having the children removed from her care.

7.3 With regards to Ali's mental health specifically, she often stated that she did not think treatments and support were helpful yet there was no further exploration as to why these did not work for her.

## Domestic Abuse: Recognition and Response

7.4 Agencies appeared to recognise the domestic abuse Ali was experiencing, particularly the police who assessed the risk in response to every contact made. Domestic abuse was first identified by police following her first contact with them in May 2019. Ali's first disclosure to mental health and the 0-19 services was in October 2019. She disclosed domestic abuse to housing in September 2020, to NEAS in November 2020 and to NTRP in March 2021. Ali only referred to her relationship whilst in contact with GP services on two occasions, whilst her disclosures were not as explicit as with other agencies, further probing may have uncovered the domestic abuse Ali was experiencing. There was a MARAC/domestic abuse marker on file from January 2021 yet her contact with the GP lessened from that period of time onwards.

7.5 As mentioned above, Ali presented to her GP with a number of urinary tract infections and gynaecological issues and made three requests for sterilisation. The GP stated that although Ali presented with symptoms of a UTI, tests was often negative. The GP commented on the presentations in respect of a UTI and in her opinion, Ali did not have recurrent UTI and the frequency of symptoms was common for a person of her age. With regards Ali's requests for sterilisation, the GP commented that Ali was having unprotected sexual intercourse throughout the chronology and had a number of pregnancy tests completed by the GP. Her request for sterilisation was declined by specialist services in the first instance due to her age. It is possible that Ali's requests for sterilisation stemmed from being poor at remembering to use oral contraceptives and not finding a long-acting contraceptive she liked. Ali had had a couple of pregnancy scares and a termination and she was a young single mother to two children who struggled financially. Ali had experienced post-natal depression on three occasions and so maybe did not want to go negatively impact her mental health again and did not want the stress and worry of remembering to take contraception.

7.6 Expert advice sought from Rape Crisis North Tyneside (RCNT) stated that their service was familiar working with women who experienced domestic abuse and have additional needs, and their fear of disclosing the extent of mental health issues and

self-harm ideation for fear of losing children. They also stated that when working with women who are in an abusive relationship but not reporting the abuse, problems such as UTIs and post coital bleeding can often be present. Women will often say this is a health problem when practitioner suspects ongoing rape. RCNT also thought that the repeated requests for sterilisation may have been a possible indicator of an abuser who was trying to control a woman through pregnancies.

7.7 Agencies acknowledged that domestic abuse was not always fully explored following disclosure which may indicate a lack of understanding and recognition. It is proposed that the incidents of domestic abuse Ali was experiencing were also minimised by the other issues being reported such as childcare, alcohol use and mental health. There was also evidence of a lack of triangulation of information and professional curiosity. Domestic abuse was identified by agencies as was Ali's need for mental health services and support. However, the presenting issues were treated in isolation and there did not appear to be any consideration of how the domestic abuse and coercive control Ali was experiencing was impacting upon her mental health and latterly upon her alleged alcohol use, and a lack of recognition and understanding of how the perpetrator used the children as a means to control and coerce Ali.

### Coercive and controlling behaviour

7.8 The chronology evidenced that agencies recognised domestic abuse yet it is unclear whether they recognised the coercion and control that Ali was subjected to by the perpetrator, yet in a review of DHRs, coercion and control was identified as an aggravating factor in 65% of cases[5]. The perpetrator primarily used the children to coerce and control her. He failed to pay nursery fees which meant that she became reliant on him to provide childcare. He used the children to threaten Ali, he refused to return the children, threatened to have them removed from her care and utilised contact time to maintain his control over her. When contact via a third party was put in place, he sought to meet directly with Ali to facilitate contact, when he was unable to do so he resorted to directing abusive messages towards the friend who was facilitating the family time.

7.9 The perpetrator discussed with Children's Social Care his concerns about returning the children to Ali's care if she remained unwell, which is an appropriate and understandable response in the situation. However, it is unclear if this was considered through the lens of controlling behaviour rather than just the response of a concerned parent.

7.10 On the occasions that the children were placed in the perpetrator's care it was with the agreement of Ali, it is likely she felt she had no choice. Children's social care had no concerns about the perpetrator's ability to care for the children and there were no concerns raised or observed. From Children's Social Care's point of view he had parental responsibility for Child 2, Ali stated that she wanted the children to go to him when she was unwell, the children did not appear to be fearful of him, and there was no evidence of harm. However, these observations are contrary to the perceptions of family and friends, yet no enquiries were made with friends and family about the abuse that Ali was experiencing. Furthermore, children are considered victims of domestic

[5] DHRs_Review_2019-2020_Report_Final_Draft.pdf

abuse, whether witnessed or not, and this is now formalised in law.[6] Child contact is used by perpetrators to legitimise contact with ex-partners therefore, when considering the safety of the victim and children, it is important to discuss informal contact and family routines in order to identify when victims and their children may be at risk.

7.11 As a result of the perpetrator using the children to maintain control over Ali, she could not remove herself from the source of abuse. There are references to Ali having capacity to make decisions about pursuing offences. Whilst Ali may have had mental capacity in accordance with the Mental Capacity Act 2005 there was no consideration was given to undue influence, whether she was making truly free and informed decisions or whether she was making decisions in fear of retribution from the perpetrator.

## Risk assessment

7.12 Despite numerous disclosures to agencies only four agencies formally assessed the risk in relation to domestic abuse[7]. During the scoping period fourteen risk checklists were completed, nine of which were completed by the police. The outcomes of these risk checklists are provided in Table 1.

7.13 The overview provided in Table 1 illustrates a number of things. It firstly demonstrates an escalation from August 2020 through 2021, despite Ali moving to a new home and securing a non-molestation order, in January and February 2021 respectively, reports of domestic abuse continued to be made and risk remained. The Table also demonstrates how checklists were completed in isolation, they did not take into consideration previous reports and checklists completed, the risk increased and decreased across the checklists completed without any conceivable reason. The level of risk identified through the checklist was based on number of ticks without consideration of escalation and without the application of professional judgement.

| Date | Agency | Risk Level |
|---|---|---|
| May 2019 | Police | Standard |
| 5th April 2020 | Police | Standard |
| 30th August 2020 | Police | Medium |
| 11th September 2020 | Housing | *Not known* |
| 16th September 2020 | Police | Medium |
| 28th September 2020 | Police | Standard |
| 10th November 2020 | Police | Medium |
| 17th January 2021 | Police | High* |
| 2nd February 2021 | Harbour | High |
| 3rd February 2021 | Police | Medium |
| 23rd February 2021 | Police | Standard |
| 8th March 2021 | Harbour | Standard |
| 18th April 2021 | Police | Medium |
| 8th June 2021 | CNTW | High* |

***Table 1*** - * referred to MARAC

[6] Domestic Abuse Act 2021, s #
[7] Police, Housing, Harbour, CNTW

7.14 There is also an indication of lack of consistency in application of the checklist when comparing the checklist completed by Harbour on the 2nd February and by police on the 3rd February. This inconsistency is likely to be based upon the information known to and shared with the professional undertaking the checklist and therefor highlights both the importance of sharing information and taking time with the victim to complete the checklist. In this case it would have been beneficial to share the checklist completed by Harbour with MARAC as this appeared to be the most comprehensively completed checklist with Ali sharing a considerable amount of information about her experiences of domestic abuse.

7.15 The checklists completed resulted in two referrals to MARAC, although only one took place. As a result of an apparent delay in referring to MARAC following the checklist completed in June 2021 the referral was not received by MARAC until the day after Ali died. There was also an apparent miscommunication and misunderstanding in September 2020 when Housing completed a checklist but no further action was taken based upon a misapprehension that a referral had already been made to MARAC.

7.16 The MARAC held in January 2021 identified Ali's move to an address unknown by the perpetrator as a positive factor. Although Ali had ended the relationship sometime prior, the perpetrator was still able to exert his control over her, which would account for the increase in reports from August 2020. Ali's move to a new home indicated a more definitive separation which would result in a lessening of control for the perpetrator. Separation is a high-risk factor, with an increased likelihood of violence. Forty-one percent (37 of 91) of women killed by a male partner/former partner in England, Wales and Northern Ireland in 2018 had separated or taken steps to separate from them. Eleven of these thirty-seven women were killed within the first month of separation and twenty-four were killed within the first year.[8]

7.17 In terms of risk assessment for mental health CNTW's internal review identified significant findings and areas for learning for the Crisis Team with recognition that the service did not evidence robustly how risks were appraised and treatment plan outcomes were measured or reviewed at the end of June, beginning of July 2021, following Ali's discharge. It was noted that the Community Care Coordination Care/Risk management Plan and risk assessment did not give a contemporaneous record of the complexities of Ali's family circumstances.

## Adult safeguarding

7.18 MARAC is not a substitute for a section 42 enquiry in terms of abuse or neglect and it serves a different purpose to a section 42 enquiry. Whilst it is positive that domestic abuse was recognised, the MARAC process considers a number of cases, with the focus specifically on high-risk domestic abuse. A safeguarding enquiry under section 42 of the Care Act allows a multi-agency holistic focus on the individual, usually including the individual, and seeks to put a safety plan in place that encompasses all areas of vulnerability.

7.19 Ali had care and support needs in respect of her mental health and alcohol use, and there was evidence that she was not able to protect herself from abuse and neglect as

[8] (Femicide Census, 2020)

a result of these issues, meaning that safeguarding concerns should have been referred and enquiries instigated in respect of Ali's disclosures.

7.20 Referrals made to ASC focused on a request for mental health support. No safeguarding concerns were raised with ASC by any of the agencies involved.

7.21 With regards to the abusive texts being sent to Ali, there is evidence that ASC were informed that the CNTW safeguarding team were taking this forward. It was positive that ASC ensured that the police were informed of the disclosure from Ali and that ASC followed up with the CNTW safeguarding department to ascertain what was happening. However, once there was a response that CNTW had only referred back into MARAC there was no consideration of further action under safeguarding procedures.

7.22 A safeguarding enquiry was started for the purpose of informing the police but was closed down without a strategy discussion or meeting because the police had been informed, Ali was deemed to have capacity and CNTW safeguarding were progressing the matter within their safeguarding processes.

7.23 ASC can request other agencies to take a lead on safeguarding processes where this is appropriate, but in Ali's case there is no evidence to show that ASC required CNTW to report back on the efficacy of any safety plan put in place. There is no evidence that the safeguarding actions took account or consulted with Ali about what her desired outcomes were. This should have been followed up by ASC to ensure that this was undertaken.

7.24 When further concerns were received about Ali from the ambulance service and from the police, ASC officers took action to ensure that partners were informed and to ascertain that Ali was linked into services but there is no evidence that any further consideration was given to using the safeguarding process to co-ordinate the actions being taken and to ensure a cohesive safety plan was in place.

### Non-molestation order

7.25 A six-month non-molestation order was granted in February 2021 and agencies involved with Ali were aware of this. Whilst it is difficult to be exact, the chronology suggests that the perpetrator breached the order on at least eight occasions. However, there was no consequence to him doing so. On one occasion Ali was incorrectly told that the perpetrator had not breached the order as she had initiated contact, on another occasion the matter was not pursued in the interests of Ali's mental health. In early July 2021 police were contacted with concerns for Ali's welfare and were satisfied that she had her ex-partner staying with her. At the most the perpetrator was spoken to and reminded about the presence of the non-molestation order.

7.26 Violations of criminal or civil orders may be associated with an increased risk of future violence. Similarly, previous violations of contact or non-contact orders may be associated with an increased risk of future violence. Such violations can indicate both a disrespect for authority and commitment to commit an offence. Victims, such as Ali, who have experienced breaches of bail/court orders in the past may not have had a positive experience of how the police or the courts responded to these. If this is a reality for the victim, they may be very reluctant to pursue these options. In Ali's case she saw no benefit to the non-molestation order as the perpetrator continued to breach without consequence and thus, she was likely reluctant to peruse the matter whilst in hospital, particularly given that the children were in the perpetrator's care at the time.

## Communication and Information Sharing

7.27 There are many examples of good information sharing between agencies. Whenever the police engaged with Ali, they shared information with Children's Social Care who in turn, on many occasions, shared information with the 0-19 service and with the school via Operation Encompass. There was also evidence of collaboration between psychiatric liaison and NHCFT health staff within the hospital when Ali presented. However, when information was shared with other agencies, such as Adult Social Care, the emphasis was upon Ali's mental health.

7.28 There were many instances of a lack of triangulation of information, and information being taken at face value, which had been shared by either Ali with agencies or between agencies. There are examples where this led to confirmation bias such as Ali's use of alcohol. On one occasion it was recorded that she had reported drinking three bottles of wine a night, Ali subsequently clarified this with the health visitor and said she only drank two to three glasses night, the most she had ever drunk was three bottles. Despite this clarification there was continued emphasis on her alcohol problem. In addition, following her admission to hospital in June 2021 there were no signs of alcohol withdrawal which would indicate such a significant use of alcohol. There was, however, evidence of triangulation post discharge when Ali appeared intoxicated but Children's Social Care were able to verify with the hospital that this was an effect of medication.

7.29 Ali also stated that she had self-referred to support agencies when this was not the case. Further to this, whilst Ali was signposted to other support agencies no one made any referrals on her behalf, save to the referral to Harbour following a high-risk checklist.

7.30 There were missed opportunities to share information. Safeguarding concerns were not shared with Adult Social Care, Housing did not share the outcome of their checklist outside of their agency, and Harbour did not feedback the outcome of their interventions and checklist to the MARAC. No information was shared with Ali's GP, the agency that she had the most significant contact with during the period under review. Following the MARAC agencies were advised to flag and tag their systems but the information omitted detail on the person causing the risk.

7.31 In addition, over the four and half years in scope, there were only two multi-disciplinary/agency for a held to discuss Ali, one was a discharge planning meeting and the other was the MARAC held in January 2021. It was evident that each agency held a piece of the puzzle, no one agency held all the information available. In addition, when information was shared it was considered and responded to as a standalone event with no collective consideration of the wider picture and recent history.

7.32 With regards to information sharing and communication with the family, the only agency to communicate with the family was adult social care in relation to their duty to contact the nearest relative following admission under the Mental Health Act 1983 and limited communication between Children's Social Care and Ali's family.

7.33 The CNTW internal review following Ali's death identified that opportunities to include her family in her care and treatment were not taken, as would be expected. There was no evidence that information had been sought or shared with Ali's parents at pertinent points of her care, including admission and discharge planning whilst in inpatient care,

nor by Crisis clinicians during home-based treatment. This was identified as an area for learning in the CNTW internal review.

7.34 There would, of course, be issues of confidentiality and consent but there are no records of consent being sought from Ali to liaise and share with family members. Despite this, the only communication with family by any of the agencies was with the perpetrator.

## 8.0 Conclusions

8.1 Ali was subject to domestic abuse, coercive and controlling behaviour and harassment at the hands of the perpetrator for a period of at least three years. There were a considerable number of high-risk factors in this case which included: isolation, victim's mental health ill-health and suicidal ideation, separation, presence of children and conflict over child contact, pregnancy and maternity, control, escalation, use of objects to cause harm and injury, attempt to strangle/choke, sexual assault (rape), financial issues, perpetrator drug use, perpetrator threats to suicide, and perpetrator's breach of orders.

8.2 Ali had significant engagement with a range of services and all services were aware of the domestic abuse she was experiencing. Unfortunately, a pattern emerged of each incident being responded to in isolation without consideration of events in the recent past and the corrosive cumulative effect of the perpetrator's controlling behaviour on Ali's mental health and use of alcohol as a coping mechanism.

8.3 Ali struggled with her mental health, which made her particularly vulnerable to coercive control. Agencies must be able to identify vulnerabilities and explore through professional curiosity, whether this vulnerability is being, or could be, exploited by others.

8.4 One of the purposes of a DHR is to prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity. The panel are acutely aware that the perpetrator has moved, with the children, to another local authority area where he has started a new relationship with a woman with whom he has had a child. The panel are also aware that the perpetrator has made it very difficult for Ali's parents to have access to the children and there have been reports that the children are not happy in his care. As such this review will identify lessons and make recommendations in relation to perpetrators who move following a domestic abuse related suicide.

## 9.0 Lessons Identified

### Understanding domestic abuse and coercive and controlling behaviour

9.1 Whilst all agencies were aware of the domestic abuse Ali was experiencing, and some agencies identified that the perpetrator was using the children to exert control over Ali,

agencies need to have a deeper understanding of these issues, the high-risk factors and vulnerabilities that increase risk. Agencies should consider the impact domestic abuse and coercive controlling behaviour can have upon mental health, access to and engagement with services, willingness to pursue criminal prosecution.

9.2 As part of the review the Chair contacted the Local Authority B, where the perpetrator and the children moved to following Ali's death. The Chair spoke with Children's services team manager, for both children, on many occasions. The Chair expressed their concerns about coercive control by the perpetrator towards Ali, and now towards the children. Local Authority B did not share these concerns initially although they did appreciate that they did not know about domestic abuse and coercive control relating to the perpetrator and his past relationship. Local authority B appreciated that things could have been dealt with differently before the children moved to their area and that the case had not been looked at through a domestic abuse lens to fully understand the impact on the children. The factors of the perpetrator's new relationship, moving the children from their schools, family and friends within a few weeks of their mother's death were highlighted by the Chair but Local Authority B did not seem concerned.

9.3 The Chair also spoke to the Head of Children's Service who acknowledged learning was needed regarding coercive control and communication between the areas too. Despite many efforts to do so, the Chair was unable to contact the Local Authority B social worker.

9.4 Training in domestic abuse should therefore include a focus on how particular vulnerabilities can increase the risk of domestic abuse and should highlight the high-risk factors and their basis in evidence.

## Professional curiosity

9.5 Ali presented to primary care services, and other agencies, with regards both her physical and mental health. Many of her physical health issued revolved around recurrent presentations for UTIs and abdominal issues, along with injuries sustained by reported slips, trips and falls. These preceded the MARAC in January 2021 and therefore the GP service was not fully aware of the domestic abuse, yet Ali had referred to a difficult relationship with her partner and furthermore reported anxiety if touched by him.

9.6 There was a lack of professional curiosity, both prior to and after the MARAC, into the underlying factors relating to her decline in mental health, particularly following the sudden escalation in October 2019 when Ali attempted an overdose and self-harmed. There was also a lack of exploration of the physical issues Ali presented with or consideration of the underlying cause of her presentations for UTIs, abdominal pain and other injuries and no exploration of the repeated requests for sterilisation. These issues, considered in a wider context and not in isolation, may have indicated, or allowed disclosure, of domestic abuse.

## Risk assessment

9.7 The DASH risk assessment is not a one-off tick box exercise. The DASH risk assessment is based on research about the indicators of high-risk domestic abuse. It is a structured professional judgement scale. Whilst a threshold of fourteen is considered an appropriate classification as high risk, professional judgement and practitioners' own assessment of risk is also important. Being identified as high risk determines the level of intervention and support services provided to victims and,

therefore, has potentially very real implications. For this reason, practitioners should have a sound understanding of the risk checklist and the reasons why these questions are asked. Practitioners should consider past known information, information that has been shared by other agencies and/or persons known to the victim, in addition to the contributions made by the victim themselves. Completion should consider and build upon any previous checklists completed.

## Public understanding

9.8 Ali's family knew that her relationship with the perpetrator was detrimental, they witnessed a change in her demeanour and mood dependent on the perpetrator's presence in her life. However, Ali's family and friends did not understand coercion and control. As in Ali's case, family and friends can have the best understanding of how their loved ones are affected by negative relationships. For that reason, agencies should engage with the public and raise awareness of coercive and controlling behaviour so that the public can better recognise, name and report the behaviour.

## Safeguarding adults at risk

9.9 Domestic abuse is a category of abuse under the Care Act 2014. The associated Care and Support guidance specifically states that 'If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or the police if they believe or suspect that a crime has been committed.'

9.10 Agencies should be aware of when and how to refer a safeguarding concern to the local authority, and their role in safeguarding adults. Local authorities must make enquiries when the criteria[9] has been met and be aware that they have the power to do so when the criteria are not met.

## Family involvement/support networks

9.11 Friends and family can be an invaluable source of information and support. The review has recognised that Ali's family and friends were not readily engaged by agencies working with her. Whilst there are issues with consent to share information, agencies should seek to establish this consent at the earliest opportunity and confirm who the person would like involved in their care and safety planning.

## Communication and information sharing

9.12 Whilst there were examples of good information sharing there were missed opportunities and a feedback loop of information sharing was not apparent. Agencies should ensure that information is shared with all relevant agencies in a timely manner and maximise opportunities for multi-agency discussion and planning.

## Perpetrators that move area

9.13 When a perpetrator of domestic abuse moves areas there should be systems in place to alert and ensure risk is shared with the new area. This should include an agency-to-agency referral from one area to the new area. Where a DHR is being undertaken and the perpetrator has moved to a new area, representative from the new area should

[9] S.42, Care Act 2014

participate in the review to ensure information is shared and risk is managed in the new area.

## 10.0 Recommendations

- For all agencies to increase competence and understanding of domestic abuse and coercive controlling behaviour including high risk factors and the impact of vulnerabilities.

- For all agencies to improve competence in the completion of DASH checklists.

- For health services to increase the application of professional curiosity in relation to physical and mental health presentations.

- Increase public awareness of coercive and controlling behaviour.

- For all agencies to increase understanding of how and when to raise a safeguarding concern.

- For local authorities to ensure that safeguarding concerns involving domestic abuse are considered for an enquiry in accordance with the Care Act 2014.

- For all agencies to improve the involvement of families, considering appropriateness of that involvement and consent.

- For agencies to consider counselling for child victims of domestic abuse and bereavement.

- Improve information sharing between agencies when there is new and significant information to share and ensuring information is shared with all relevant agencies.

- For the Home Office to consider including a requirement for other local authorities to participate in DHRs when the perpetrator has moved areas. In guidance

- To share the final report with local authority B.