Domestic Homicide Review

Overview Report

Westmorland & Furness CSP
Community Safety Partnership

Report into the death of Ella
March 2020

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June 2023

Contents

Glossary 3

Preface 5

1. Introduction and Background 5

3. Domestic Homicide Review Panel 9

4. Independence 10

5. Terms of Reference 10

6. Confidentiality and Dissemination 10

7. Methodology 11

8. Involvement of Family and Friends 12

9. Independent Management Reviews and Chronologies 13

10. Equality and Diversity 36

11. Analysis 39

12. Good practice 54

13. Key findings 54

14. Recommendations 57

15. Section 15 Action Plan .... **Error! Bookmark not defined.**

Glossary

AAFDA – Advocacy After Fatal Domestic Abuse

A&E – Accident and Emergency

CCB – Coercive and Controlling Behaviour

CCG – Clinical Commissioning Group

CMH – Community Mental Health

CPS – Crown Prosecution Service

CSC - Children's Social Care

CSP – Community Safety Partnership

DA – Domestic Abuse

DARA – Domestic Abuse Risk Assessment

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

GDPR – General Data Protection Rules

GP – General Practitioner

HO – Home Office

IDVA – Independent Domestic Violence Advocate

IDVSA – Independent Domestic and Sexual Violence Advocate

LSCFT – Lancashire & South Cumbria NHS Foundation Trust

ICB – Integrated Care Board

IGB – Integrated Governance Board

IMR – Independent Management Review

MARAC – Multi-Agency Risk Assessment Conference

MASH – Multi-Agency Safeguarding Hub

NFA – No Further Action

NHS – National Health Service

NICE – National Institute for Care Excellence

PSED – Public Sector Equality Duty

PTSD – Post Traumatic Stress Disorder

QA – Quality Assurance

SW – Social Worker

TOR – Terms of Reference

UHMBT – University Hospital of Morecambe Bay NHS Foundation Trust

UNODC - United Nations Office on Drugs and Crime

VAWG – Violence Against Women and Girls

VS – Victim Support

WHO – World Health Organisation

DHR Overview Report into the death of Ella, March 2020

Ella's loved one's were able to provide the chair with the following portrait:

> *Ella loved to party, in our teenage years we had a lot of fun, and she was always throwing the best house parties. When we weren't partying, we would just chill together and watch a film or go to the shops, she was so kind and caring and she had a laugh that filled up the room, it was really contagious. We would laugh at Family Guy and SpongeBob, in fact Ella would tend to laugh at pretty much everything. Ella loved the zoo; it was one of her favourite places to visit and she would take the children there when she could. Ella loved her children dearly and she parented them as best as she was able to. We all miss her very much and hope she is at peace now.*

Preface

The independent author, DHR panel and the Westmorland & Furness Community Safety Partnership wish to offer their deepest condolences to everyone who was affected by Ella's[1] death. We extend our further thanks to those who knew Ella and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Independent Management Reviews (IMR), their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of Ella, aged 28, who died by suicide in March 2020.

1.2 Domestic Homicide Reviews (DHRs) came into force on the 13th of April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

[1] Not her real name

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[2].

1.3 The purpose of a DHR is to:

a) 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.

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) 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.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

1.4 Timescales

This report of a death, where domestic abuse was identified, analyses the involvement and responses afforded to Ella, who was a resident in South Cumbria prior to her death in March 2020.

The review will consider agency contact with Ella and her ex-partner Ryan[3] for the period of:

- December 2017 and March 2020

This time frame was agreed to be appropriate by all panel members in March 2022.

The referral from Cumbria Children's Services was sent to the CSP on the 10 November 2021. The delay in referral for consideration of a DHR to the CSP appears to be related to the fact that Ella was not in a relationship at the time of her death. After review, the panel representative for Cumbria Constabulary commented on the difference in 2020 around suicides nationally not being linked to DHRs in the way they are currently. There was some discussion about whether Ella's death should be considered for a Serious Case Review (SCR), but once the information came to light about the domestic abuse Ryan subjected Ella and her children to, the referral was made to the CSP.

The decision to undertake a DHR was made by South Cumbria Community Safety Partnership (CSP) on 24 November 2021. The Home Office was subsequently informed. On

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

[3] Not his real name

25 November 2021 the CSP commissioned a DHR author, but due to unforeseen circumstances the original author had to recuse herself from the process. In August 2022, Dr Shonagh Dillon was commissioned to undertake the role of independent author and chair to the panel and the DHR panel was convened. Due to the change in author and some impact on services due to resources thus the late submission of IMRs, the DHR was delayed.

Since this case and another in the area Cumbria Constabulary have implemented extensive training on crimes of Suicide for Detective Inspector's, and Detective Sergeants to consider DA and sudden deaths. Forms are now utilised ensuring consideration of CCB. In addition, the Suicide and Sudden Death policy has been changed to cover consideration for DA and DHRs in cases like Ella's.

Please note that due to Local Government Reorganisation, on 1st April 2023 South Cumbria CSP became Westmorland & Furness CSP.

The panel members met on the following dates:

- 23rd February 2022
- 15th September 2022
- 9th March 2023
- 30th March 2023

1.5 The overview report and executive summary were presented to the Westmorland & Furness CSP board for approval on 10th July 2023 and submitted to the Home Office on 26th July 2023. The report was considered by the Home Office Quality Assurance Panel on 21st January 2024 and approved for publication on 15th February 2024.

1.6 Cumbria takes the issue of domestic abuse seriously; the area has an exemplary record of prioritising and commissioning innovative services for victims and survivors of domestic abuse. Safer Cumbria Partnership has the following Domestic Abuse Priorities:

- Improve confidence to report domestic abuse
- Ensuring appropriate provision to aid victims to cope & recover
- Reduce repeat incidents of Domestic Abuse
- Develop an understanding of the key drivers and influences of abuse to aid prevention and education.

1.7 People involved in the DHR:

Name	Age at time of death	Relationship with the victim	Ethnicity
Ella	28	Victim	White British
Ryan	30	Ex-Partner and Perpetrator	White British

Ella had three children, her youngest two were fathered by Ryan.

The panel has applied the Home Office guidance and has given the pseudonyms identified above to the offender and the victim. It is hoped this humanises the review process and eases the reading of the report. The friends and family of Ella were happy with the name chosen for her.

1.8 Facts:

Ella met Ryan in 2016. Ella was a single mum to her much loved first child (Child A[4]). Ella was vulnerable when she met Ryan and had a history of mental health issues, she also disclosed to her friends that her previous partner had been abusive. Ella was happy with her child and her own flat, but the relationship with Ryan quickly became abusive. Ella would disclose later to her social worker that within six months of being together, Ryan was already being abusive to her and A, both mentally and physically.

In 2017 Ella fell pregnant and gave birth to her first child with Ryan, (Child B[5]). Within a month of B's birth, the police, and Children's Social Care (CSC) became aware of and involved with the family after a call out to the police, and a subsequent concern raised by the midwife.

Agency involvement with the family continued with both Ella and the children showing signs of distress due to persistent coercive and controlling behaviour from Ryan, alongside physical and sexual violence towards Ella. Ella and Ryan both relied on substances and Ella's mental health deteriorated in the early months of B's life, with a suicide attempt taking place within the first six months after B's birth. Ryan's behaviour in the home extended to his lack of interest in the cleanliness of the house and leaving Ella to do all the housework and childcare. Ryan refused to help, and he urinated in bottles where he sat which distressed Ella and made her feel ashamed. Ella described feeling like a *'slave'*.

In 2019 Ella gave birth to her second child with Ryan, (Child C[6]). Ella struggled to cope, and the domestic abuse Ryan perpetrated against Ella and the children escalated, thus Social Care involvement increased. Intermittently things would improve in the home, and for a short period in 2019 Ella and Ryan separated and there was a notable difference in the house and with the children, everything seemed calmer for the whole family. But Ella still struggled with alcohol, and she described not feeling able to manage without Ryan, and she was fearful that he would talk his way back into her life. They did get back together for another brief period and the abuse continued.

[4] No pseudonym given after QA panel guidance to anonymise sex of children.
[5] No pseudonym given after QA panel guidance to anonymise sex of children.
[6] No pseudonym given after QA panel guidance to anonymise sex of children.

After Ryan and Ella split up for the final time Ella was left on her own with three small children, she suffered acutely from mental health issues and was heavily reliant on alcohol, she also sometimes used drugs. Ella struggled and Ryan continued to abuse her through the separation, offering little support to her with the children, which was a concurrent theme in his parenting choices. It is undeniable that Ella's parenting was neglectful of the children, although her family gave her some support, she could not manage. The combination of her mental health issues, substance misuse and being subjected to long-term domestic abuse exacerbated her ability to provide the children with the care they needed.

In August of 2019 Ella's three children were removed due to a concern for welfare which was raised after she had left all three children alone in the house. The children were immediately removed into foster care, Ella was devastated and although she was permitted supervised contact with her children, she found it hard to keep up with these appointments.

In the final months of her life Ella found out she was pregnant for a fourth time and sought support for the pregnancy in the later stages of the window for a termination. She made appointments and had discussions about having a termination, but due to the timing of her pregnancy this would be a more invasive procedure and could not easily be facilitated in her area. This caused Ella great anxiety and distress.

Within five months of Ella losing her children she had died by suicide; may she rest in peace.

2. Parallel Reviews and Processes

2.1 A post-mortem was conducted and recorded the death as suicide.

2.2 There were no other parallel review processes arising from Ella's death.

3. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies and professionals:

Name	Job Title
Dr Shonagh Dillon	Chair & Author
AngelaRush/Alison Goodfellow	DHR Co-ordinator
Jane Heath	Named Midwife for Safeguarding – University Hospitals Of Morecambe Bay NHS Foundation Trust
Mary-Claire Telford	Domestic Abuse Strategic Lead – Cumbria County Council
Joanne Babic	Specialist Safeguarding Practitioner – Lancashire & South Cumbria NHS Foundation Trust
Lee Evans	Area Manager, Victim Support
Sarah Edgar	Detective Constable – Cumbria Constabulary
Fae Dilks	Detective Inspector – Cumbria Constabulary
Kelly Short	Designated Nurse for Adult Safeguarding – Lancashire & South Cumbria Integrated Care Board

Louise Cavanagh	Domestic and Sexual Abuse Business Coordinator – Children's Social Care
Michelle Southward	Service Manager – Children's Social Care

The Home Office Quality assurance panel suggested a representative from public health and or suicide prevention should have been included in the panel. Since this review, public health and suicide prevention are now represented at all DHR panels.

4. Independence

4.1 The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Ella or Ryan.

5. Terms of Reference

5.1 The full terms of reference, which were agreed at the first panel meeting and reviewed at the subsequent meetings are included in Appendix A of this report.

6. Confidentiality and Dissemination

6.1 Confidentiality

The IMRs will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018[7].

6.2 Dissemination

Whilst it is essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office quality assurance group.

[7] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Once clearance has been approved by the Home Office quality assurance group, the dissemination of the overview report will be published on the Westmorland & Furness website and will be widely disseminated including, but not limited to:

- Members of the Westmorland & Furness Community Safety Partnership
- DA Commissioner England and Wales

The Westmorland & Furness Community Safety Partnership will be responsible for monitoring the implementation of recommendations.

7. Methodology

7.1 Following the decision to conduct this DHR, Cumbria Constabulary provided the panel with a timeline of the investigation. Subsequently, several other statutory and voluntary sector agencies were asked to return a chronology of their involvement to help the panel understand and analyse any interactions agencies had with Ella and Ryan during the specified review period.

Having considered the chronologies, the following Individual Management Reviews (IMRs) were requested:

a) Cumbria Constabulary
b) Children's Social Care
c) Lancashire & South Cumbria NHS Foundation Trust
d) Lancashire & South Cumbria Integrated Care Board (LSC ICB) formally known as Morecambe Bay Clinical Commissioning Group
e) Recovery Steps: Substance Misuse Service (formally known as Unity)
f) Victim Support
g) University Hospitals of Morecambe Bay NHS Foundation Trust

7.2 The Terms of Reference guidance set out the purpose and the scope of the review and the panel focused specific questions to each agency whilst undertaking the analysis of their involvement. The questions were as follows:

1. What knowledge or information did your agency have that indicated Ella was a victim of abuse, coercive control or domestic violence and how did your agency protect her? How did your agency assess the risk that her ex/partner posed? What referrals did your agency make?
2. If your agency had information that indicated that the victim might be at risk of abuse, coercive control or domestic violence was this information shared? If so, with which agencies or professionals?
3. What knowledge or information did your agency have that indicated her ex/partner might be violent, abusive or controlling and how did your agency respond to this information?

4. Did Covid-19 have an impact on the support that was offered or provided to the victim? This might include early measures, restrictions, planning or sickness.
5. How did your agency triangulate the information that was provided by the perpetrator? Was the information he gave simply taken at face value? How did your agency explore this information with the victim? How were her views sought?

The authors of the IMRs are independent in accordance with the Home Office guidance[8].

The full Terms of Reference are available in Appendix A of this report.

7.3 This report is based on:

- The findings of the IMRs
- Further requested information and analysis resulting from the IMRs
- Interactions with a friend of Ella's and one of her family members

The IMRs are set out below (see section 9). Each IMR author offered single agency recommendations which are presented in section 14 of the report. The panel have reflected and amended where they felt that single agency actions needed further clarity.

The full recommended action plan is presented in section 15 of this report.

The conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

8. Involvement of Family and Friends

8.1 **Ella**

Ella's family were referred by the Domestic Abuse coordinator at South Cumbria CSP to specialist advocacy services, including Victim Support and Advocacy After Fatal Domestic Abuse (AAFDA).

The chair of the panel initially wrote to Ella's Mother, Denise[9], in December 2022. Contact was made and agreed by the previous lead for Domestic Homicide Reviews in South Cumbria Community Safety Partnership and through Cumbria Constabulary after they had previously informed Denise that a DHR would be taking place.

Although there was initially no reply to the chair from Denise, another letter was sent at the end of January 2023. On this occasion Denise facilitated a friend and family member to contact the chair.

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[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (Section 7)

[9] Not her real name

Throughout the analysis section, and at the end of the report, the views of Ella's loved one's on specific incidents and aspects of the case will be referenced from their perspective and from their knowledge of her.

The panel were incredibly grateful for the time Ella's loved one's took in responding to this review, without their input, the report and the work agencies need to reflect upon would have been considerably less impactful.

8.2 **Ryan**

The chair of the panel wrote to Ryan in February 2023. There was no response to this correspondence. The police attempted to deliver the letter in person three times, and they also texted Ryan and tried three separate mobile numbers they had on file for him. A copy of the Chair's letter was finally handed to Ryan in May 2023, the panel waited a further two weeks to enable Ryan to consider whether he wanted to contribute to the review, but Ryan made no contact with the chair.

The chair of the review thanks Cumbria Constabulary for going to considerable effort to reach Ryan for his input.

Ella's family and friends were unable to provide much insight into Ryan as he did not interact with them. They noted his control whenever they saw Ella with him and the reflect these views within the analysis section 11. Every attempt was made to gain the perspective of Ryan and any others who knew him for this review, but due to the lack of information this review is limited on its analysis from the perspective of the perpetrator.

9. Independent Management Reviews and Chronologies

Significant dates for Ella and Ryan included the following:

- 2016 – relationship begins, Ella already had her first child A from a previous relationship
- December 2017 – B Born
- January 2019 – C born
- June 2019 – Ryan and Ella separated for final time
- August 2019 – Children removed and placed in foster care
- January 2020 – Ella discloses fourth pregnancy
- March 2020 - Ella died by suicide

It is normal standard practice to complete a Domestic Abuse Stalking and Harassment[10] (DASH) risk assessment with victims:

> *DASH is a risk multi agency risk assessment tool, designed to manage risk for victims and co-ordinate safety plans and services. A DASH is completed by a professional who asks the victims a list of between 24 or 27 questions, the information given by the*

10 https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

victim is then used to assess the risk the perpetrator presents to the victim and facilitate a safety plan for the to safeguard against further abuse and violence.

The risk category assigned to the DASH is as follows[11]:

- Standard - Current evidence does not indicate the likelihood of causing serious harm
- Medium - There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
- High -There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. (Cumbria identify 14 positive responses as High Risk, and victims can also be referred as high risk on professional judgement).

When a victim is assessed as high risk after completing a DASH, they are referred to a multi-agency risk assessment conference (MARAC), where agencies discuss the case and share information, aiming to reduce the risk of serious harm or murder from the perpetrator to the victim.

There are a number of references to DASH risk assessments and MARAC in the following IMR data.

9.2 Independent Management Review – Cumbria Constabulary

Key Incident Timeline:

9.2.1 Cumbria Constabulary had little interaction with Ella or Ryan prior to them living together. Although there were some interactions with Ella as a child this was noted to be largely in reference to her mental health, but there was nothing of significance.

9.2.2 The first significant interaction for the police was in late 2017 shortly after B was born when they were called to an incident at the address by a neighbour who heard a woman shouting, “get the police” and a man coming out of the house holding a young baby. Police attended and spoke to both Ella and Ryan separately and the accounts taken were that Ella was tired having recently had a baby and she was frustrated that there were too many visitors to the house. On this occasion a DASH was completed with Ella, and she was graded as standard risk.

9.2.3 Referrals were made to children’s services, and information shared with the health visitor due to the age of B.

9.2.4 Very shortly after this, in early 2018, the police were notified by the community midwife that she had been unable to gain entry to Ella and Ryan’s home on a routine appointment. Ella had answered the door in a distressed state and visibly upset, Ella disclosed that she had been arguing with Ryan. On this call the midwife informed the police that Ella had previously told her that Ryan had assaulted her. Police attended the address and spoke to Ella separately; she denied the assault and the police checked that the children were safe and well. Another DASH was completed, and Ella was graded as standard risk. Referrals were made to the Safeguarding Hub.

[11] https://academic.oup.com/bjc/article/59/5/1013/5518314 (p.1017)

9.2.5 Police attended a strategy meeting as a result of this incident and information was shared about previous disclosures that Ella had made about being assaulted by Ryan.

9.2.6 A further incident was discussed at this meeting where the social worker had seen Ella with a blackeye, and she disclosed that Ryan had done this on valentine's day. Ella took photos of this injury and shared them with her mother, Denise. When Denise asked why, Ella stated: *"it's evidence for you just in case he kills me"*

9.2.7 An investigation was undertaken into the above incident and Ryan was interviewed under caution. Ella stated that Ryan had accidentally poked her in the eye. The investigation was no further actioned (NFA), due to Ella not wanting to proceed to court. A DASH was completed, and the risk posed to Ella from Ryan was assessed as medium. Further safeguarding referrals were made and the police did speak to Ella about safeguarding. Police recognised that Ryan was the primary perpetrator, and that Ella was struggling to manage the stresses of keeping the family home appropriately clean for the children. Police also spoke to Ryan separately about the safeguarding of the children and they noted that he was flippant about the state of the house and blamed Ella for being lazy.

9.2.8 Police attended the initial child protection conference in March 2018, where A and B were placed on a Child Protection Plan due to witnessing Domestic Violence and Abuse (DVA) and parental substance misuse.

9.2.9 In May 2018 police attended the property in the early hours of the morning. Ella had attempted suicide and was very upset. Both children were in the house but were asleep and safe. Ella was taken to hospital on this occasion. Referrals were made to Adult Social Care, Children's Social Care and Victim Support. A DASH was completed and graded as standard.

9.2.10 The next incident the police attended was in July 2018 at Ella and Ryan's property. A neighbour had reported shouting and screaming from Ella and the neighbour disclosed that it happened all the time. When police attended Ella was very distressed and Ryan was polite and receptive. Both were spoken to separately and the accounts to the police were the same; namely that Ella was in the early stages of pregnancy, and she was very hormonal and sensitive. Ella was upset that the family were meant to be going on an outing that day and they had promised the children, Ryan had talked about not going that day and this caused an argument. The police left the property and submitted a DASH form that graded the risk from Ryan to Ella as 'standard'. Children's services were made aware, but no other organisations were informed.

9.2.11 There were no further calls to the police during 2018.

9.2.12 The next report was in February 2019 which was another 999 call from a neighbour who heard the couple arguing. Ella explained that she had wanted to take her own life and Ryan had tried to stop her. Ella told officers she was struggling with her mental health and the officers contacted mental health support on her behalf. The officers at this incident graded the DASH risk from Ryan to Ella as High and she was referred to MARAC and the Independent Domestic Violence Advocate (IDVA) service at Victim Support. The case was heard at MARAC in March 2019.

9.2.13 In April 2019, one of Ella's friends contacted the police to ask for a welfare check on her. This was due to Ella saying that Ryan was being abusive and the fact that Ella always had unexplained bruises on her. Police attended and Ella said that Ryan needed some support with his mental health, but that the argument was verbal and not physical. There is no record of police asking Ella about the claim from her friend about the unexplained bruising. The officer graded the risk to Ella from Ryan as standard. The safeguarding referrals were made, but no link was made between this incident and the previous high-risk incident.

9.2.14 In June 2019 (during a period of separation) Ella reported Ryan to the police for coercive and controlling behaviour (CCB). When officers attended the property Ella disclosed a long history of physical and emotional abuse, including historical rapes that Ryan subjected her to. An investigation was handed over to the safeguarding team within the police. A DASH was completed and graded Ella at being of medium risk from Ryan. Referrals were made to adult and children's safeguarding and also the Independent Domestic and Sexual Violence Advocacy (IDSVA) service at Victim Support.

9.2.15 As a result of the above report a safeguarding strategy meeting was held for the children and the police attended this. Children's Social Care were in the process of seeking legal advice around the removal of the children and the police would continue with the investigation into Ella's reports against Ryan.

9.2.16 In July 2019, Ryan made a counter-allegation against Ella to the police. He disclosed CCB, and physical and sexual abuse from Ella towards him. A DASH was completed with Ryan, and he was graded as at medium risk from Ella. Referrals were made to adult safeguarding and the IDVA service.

9.2.17 Both Ella's and Ryan's reports were investigated separately and presented to the Evidential Reviewing officer together. It was deemed that Ella was the victim and Ryan the perpetrator. The case against Ella was no further action (NFA). However, it was decided that there was insufficient evidence to support a prosecution and the case against Ryan was also NFA.

9.2.18 In August of 2019 a call, from what is thought to be a friend of Ella's came into the police reporting that Ella had gone out drinking and left the three children alone in the house. The police attended the property and found the children unattended and very distressed. They were immediately removed and put in a place of safety. Ella was subsequently arrested on suspicion of child neglect. The report was submitted to adult and Children's Social Care and the health visiting service. The children were placed in foster care.

9.2.19 During various interviews with the police mental health concerns were raised with regards to Ella. On the second interview in September 2019, the officer noted that Ella's behaviour was very strange and concerning. Although she was deemed to be medically fit for interview.

9.2.20 In early March 2020 a letter was sent to Ella informing her of charges to be issued to her in respect of neglect of her three children. Ella was also charged with possession of cannabis. The allocation for the court date was early April 2020. NB: It is normal in these cases for charges to be sent by post.

9.2.21 There were no other contacts or reports of either Ella or Ryan until mid-March 2020. Ella's Mother, Denise, called the police as she was concerned about having not heard from Ella for a period of time. Denise said that Ella had been upset recently due to a friend of hers dying and that she had also been a victim of domestic abuse from Ryan.

9.2.22 Police attended Ella's address and discovered she had died by suicide. May she rest in peace.

Learning Points:

The IMR author raised several learning points in reference to the specific questions posed within the TOR (see appendix A):

9.2.23 The IMR author noted that safeguarding referrals were all made appropriately. However, the DASH risk assessments completed were not always graded appropriately or accurately, with due consideration to the context of the circumstances. The IMR author further notes that there was only one referral to MARAC and there were opportunities to use professional judgement and refer to Ella's case to MARAC on more than one occasion.

There was a total of seven DASH risk assessments completed with Ella and one DASH completed with Ryan after his counter-allegation. The picture of the dates and grading of these DASHs were as follows:

Ella DASH Timeline

- DASH 1 Dec 2017: Standard
- DASH 2 Jan 2018: Standard
- DASH 3 Feb 2018: Medium
- DASH 4 May 2018: Standard
- DASH 5 July 2018: Standard
- DASH 6 Feb 2019: High
- DASH 7 June 2019: Medium

Ryan DASH Timeline

- DASH 1 for Ryan – July 2019 Medium risk

The panel agree with the above observation from the IMR author with regards to inaccuracy on DASH grading, and the review author discusses this issue further in analysis section 11.1, having noticed a similar trend in other DHRs she has undertaken in other parts of the country.

9.2.24 The IMR author notes that the police could not evidence triangulating the information given to them from Ryan in respect of Ella self-harming. Although this information was corroborated by Ella herself, the IMR author asserts that there were missed opportunities to explore with Ella the reasons why she was self-harming.

9.2.25 The IMR author further notes that in the interview where Ella was under investigation for child neglect the officers noted she was behaving strangely. Agencies were aware of the history of mental health issues Ella suffered from and this should have prompted an adult safeguarding referral, or referrals to mental health services, as the loss of Ella's children was a very difficult and stressful time for her.

9.2.26 In addition, the IMR author noted that the postal charges could have been done in person, and this could have potentially been followed up by a mental health assessment. Police were, however, unaware that Ella was under the care of the mental health team at the time. Had they known they may have delivered the child neglect charge to her differently.

9.2.27 The IMR author astutely points out that despite Ella's mental health issues this did not pose a barrier to her reporting. Moreover, the IMR author referenced that Ryan used Ella's mental health as an excuse and she was blamed for the DVA. The IMR author noted that the police have taken Ryan's word at face value.

9.2.28 The IMR author felt that Ella's wider family could have been spoken to in relation to Ella's reports about CCB and rape.

Developments and Good Practice:

9.2.29 Cumbria Constabulary have undertaken Domestic Abuse (DA) Matters and DA Champions training with SafeLives[12]. Through the evaluations post training they have noticed an increased understanding for officers in CCB. In addition, senior officers are undertaking Sustain the Change workshops[13] to help embed the training and maintain the learning.

9.2.30 In respect of the missed opportunities to refer to MARAC there has been a change of process within the Safeguarding Hub. DVA incidents involving children are now triaged within 24hrs of the incident. This allows for earlier intervention and referrals. MARACs are now held in Cumbria weekly in three separate areas and professionals are able to refer cases based on their judgement rather than on the number of positive ticks on the risk assessment form.

9.2.31 There were a number of areas of good practice noted by the IMR author on behalf of Cumbria Constabulary in this case:

- Ella and Ryan were always spoken to separately on attendance to incidents
- Appropriate adult and children's safeguarding referrals were made
- After the incident in February 2019 which prompted the MARAC referral, some positive actions were made, and Ella and Ryan were flagged on a bulletin system. As a result, a force liaison and diversion worker, from Cumbria Northumbria Tyne and Wear NHS Trust, engaged with Ella and made some really good progress with her.
- The correct protocol was followed after Ella's death

The review author further noted good practice:

- The counter-allegation by Ryan after Ella had bravely disclosed numerous crimes, he subjected her to, including rape, were dealt with transparently and appropriately. The review author and panel would like to note the good practice on how this was dealt with.

Recommendations:

The IMR author offered a series of single agency and multi-agency recommendations which were all accepted by the panel and are referenced in section 15 of this report.

The panel would further recommend that the liaison and diversion worker is commended for their work with Ella.

There are a number of multi-agency recommendations which incorporate Cumbria Constabulary, and these are reflected in section 14.3 of the report.

[12] https://safelives.org.uk/training/police/about
[13] https://safelives.org.uk/training/police/about

9.3 Independent Management Review – Children's Social Care (CSC)

Key Incident Timeline:

To avoid repetition the incidents noted in Cumbria Constabulary's Key Incident Timeline (see 9.1), were all known to Children's Social Care. The timeline below reflects any further information pertinent to the review that was known to Children's Social Care.

9.3.1 Children's Social Care were involved with the family due to concerns around domestic abuse being perpetrated by Ryan against Ella; substance misuse issues for both Ella and Ryan; Ella's mental health issues; and ultimately their combined challenges in parenting A, B, and C.

9.3.2 Between the review period the children had four separate social workers. One social worker was reallocated to work with the family to ensure continuity for the parents. In addition, a child and family worker were working with the family during 2019.

Disclosures and observations:

Perhaps more important than the incident log the IMR for Social Care carefully highlights the disclosures Ella made to social workers and the observations from professionals regarding visits and interactions

9.3.3 Disengagement from interventions to support their parenting were frequent.

9.3.4 In addition, there is reference in the child protection conference minutes that both parents declined to work with services around their substance misuse.

9.3.5 Ella described in detail how Ryan would never help around the home. He urinated in bottles where he sat and then stored them in the kitchen rather than use the toilet. Ella explained to Social Care that she felt like a "slave". Notably the IMR author observed that the history of Ella's childhood and socialisation was explored with regards to her ability to parent, but Ryan's was not.

9.3.6 On occasions where Ella and Ryan were meant to be separated, the social worker (SW) noted that Ryan was frequently at the property, and they had suspicions that he had moved back in. This appears to have been a regular pattern during 2018/19. This was challenged by SW at the time.

9.3.7 There were disclosures from Ella about Ryan's consistent emotional physical and sexual abuse against her. Social Care was aware of the detailed report she made to the police in 2019.

9.3.8 Social workers noticed that Ella struggled to bond with C and paid him very little attention. Following the report to the police in 2019, Ella disclosed that C was conceived through a rape Ryan subjected her to.

9.3.9 Children's Social Care were involved with the family for a period of 13 months prior to issuing legal proceedings to remove the children.

9.3.10 After removal of the children, Ella was facilitated to maintain contact with them by Social Care and financial support was offered. Contact was sporadic from both Ryan and Ella, and they frequently did not attend and or cancelled appointments. When Ella did attend sessions, she was very loving towards the children and was frequently observed giving them lots of hugs and kisses and telling them they were beautiful.

Learning Points:

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.3.11 Ella often shared information about Ryan that was not discussed in any detail with Ryan. Although there was some challenge to Ryan, there could have been more robust and direct challenge to him, both in terms of his behaviour in the home with regards to cleanliness, his parenting skills and most importantly, his abuse towards Ella and the children.

9.3.12 Ryan was not always present at statutory visits and discussions and plans were completed with Ella, and less so with Ryan. The reasons given for Ryan's absence was that he was either at work or at his mother or grandmother's house. Although the SW did visit Ryan at his mother's address it was noted that further visits could have been arranged, and this would have facilitated direct work to be undertaken with Ryan.

9.3.13 The IMR author noted that the couple struggled to make changes in the parenting of their children. Although some discussions took place about the impact Ryan's abuse was having on the children; Ryan was not always present for these discussions.

9.3.14 The IMR author noted that Social Care did not work collaboratively with Ella and Ryan. In addition, they did not talk directly to Ella about a lot of the things that Ryan was saying about Ella. Information from other agencies often contradicting what Ryan said, in addition, social workers did notice some disguised compliance from Ryan.

9.3.15 Ella's mental health did not act as a barrier to her disclosing. Social workers did encourage Ella to engage with Community Mental Health (CMH) Services, due to the obvious distress she was showing at times of increased self-harm.

9.3.16 However, the IMR author does note that Ella's diagnosed mental health issues, alcohol use and the fact she was being subjected to domestic abuse affected her thought processes, including how she felt about Ryan and her relationship. Ella expressed that she knew that Ryan did not treat her "right", but she said she struggled when she was not with him.

9.3.17 It was noted that Ella had a lot of support from her family, and they were very active in trying to assist her with the children. Her family members also disclosed a lot of the abuse Ryan was subjecting Ella to.

9.3.18 Referrals and interventions from partner agencies were regularly actioned by Social Care, but engagement was sporadic. Information was generally shared very well from SW to other agencies.

9.3.19 After the final breakup from Ryan in June 2019, there was a steady decline in Ella's presentation and ability to care for the children.

9.3.20 The IMR author notes that earlier intervention would have been more appropriate for Ella. Domestic abuse work, through CSC, only began when the couple had separated and by this stage Ella was very stressed and dealing with her children being removed.

9.3.21 Social Care became aware of Ella's fourth pregnancy via community mental health services. At that stage Ella was 16 weeks gestation.

9.3.22 Children's Social Care did assist Ella to visit the children as soon as they were removed from her care. Conversations were had with Ella on how she would cope going forward. Ella was also offered support each time she had supervised contact with the children. In addition, the social worker attempted to visit Ella on several occasions by visiting and texting her, but the contact was not responded to by Ella.

9.3.23 There were concerns raised about Ella's behaviour and presentation prior to her death and the IMR author noted that contact should have been made with Ella's GP and the community mental health team.

9.3.24 Just prior to Ella's death the community mental health team did contact the social worker to confirm a diagnosis of personality disorder. Ella had missed a series of appointments and when she did attend in late February there was evidence of self-neglect, coupled with distressed behaviour and restlessness. In addition to this Ella was advised that if she failed to attend another appointment with the community mental health team she would be discharged. Ella told them if they did that, she "may as well kill herself". Ella explained that she needed to prove to the courts that she was trying, and she had attended sessions required around domestic abuse. The IMR author noted that not having the children in her care, coupled with her fourth pregnancy made Ella considerably more vulnerable. Ella had explained to Social Care that it was her children who *"kept her going"*.

9.3.25 Records showed that Ella was not only missing her contact sessions with her children but also her appointments with her mental health team. Ella's presentation was declining, and she was pregnant. The IMR author notes that this would have been the opportunity to come together and have a care planning meeting. This could ensure continuation of support once children are removed from the care of parents.

9.3.26 The IMR author queries the information sharing from Cumbria Constabulary to Children's services and notes that transfer of intelligence was not always swift.

Developments and Good Practice:

9.3.27 Social Care are involved in the SafeLives review of domestic abuse systems and the MARAC in Cumbria. This will include a review of children's safeguarding systems.

9.3.28 There were a number of areas of good practice from social workers. Risk was identified, through conversations the social worker had with Ella, and safety plans were put into place.

9.3.29 There was support offered around improving the family home and on direct work offered for Ryan and Ella.

9.3.30 There was good information sharing from Social Care to other agencies, and social workers chased up information from other agencies.

Recommendations:

The IMR author offered a series of single agency and multi-agency recommendations which were all accepted by the panel and are referenced in section 15 of this report.

The panel offer further multi-agency recommendations reflected in section 14.3 of the report.

9.4 Independent Management Review - Lancashire & South Cumbria NHS Foundation Trust (LSCFT)

Key Incident Timeline (Ella only):

9.4.1 Ella was referred to adult safeguarding, initially via her health visitor after B's birth due to her mental health presentation at the time. Domestic abuse was highlighted as a contributing factor. On initial assessment Ella's risk of suicide was low and she had not self-harmed for some months.

9.4.2 On the police referral in February 2019, it was noted that a report of a domestic incident had been called in via a neighbour, who overheard Ella say she was considering ending her life and Ryan telling her to "go ahead and kill herself".

9.4.3 Ella proactively disclosed domestic abuse from Ryan. The domestic abuse that Ella was being subjected to was treated as a trigger for her mental health deterioration.

9.4.4 A practitioner recognised the risk of domestic abuse in Ella's relationship with Ryan and offered to refer her to the MARAC, which Ella declined.

Learning Points:

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.4.5 The IMR author notes that although the MARAC referral was offered there was no evidence of a DASH being undertaken with Ella, in addition there were no referrals or signposting to specialist domestic abuse support agencies. A DASH risk assessment would have identified the risk Ryan posed to Ella and could have fostered further discussions with the safeguarding team as to how to proceed.

9.4.6 The panel would further note that the MARAC does not require consent from the victim, it is a mechanism to refer to after a DASH has been completed. This will further be discussed in the analysis section 11.1. The one MARAC referral to discuss Ryan's risk towards Ella, a representative from the acute mental health team did attend and shared information.

9.4.7 The IMR author noted that Ella's children were cited as a protective factor in her risk of suicide and self-harm, but there is growing evidence[14] that children as a protective factor should be viewed with caution. Other means of support should be explored in relation to suicide, in addition to the increased risk of suicide as a result of DVA.

9.4.8 The IMR author noted that there were a number of missed appointments in Ella's records, these were followed up with further appointments offered.

9.4.9 After Ella's children were removed the community mental health team did attend Ella's address to complete a risk assessment. It was only at this stage that they became aware of Ella's alcohol and drug use, as no information had been previously shared. After this assessment Ella's risk of suicide was elevated to medium. Ella reported having daily thoughts of suicide, but she was focused on getting her children back.

9.4.10 In addition to the overreliance on Ella's children being a protective factor[15] and Ella doing everything she could to get them back, the IMR author noted that there was no consideration of the impact of the combination of alcohol and substance misuse and domestic abuse and the impact this had on Ella's mental health.

9.4.11 Ella did disclose that she would be attending drug and alcohol recovery services and that she hadn't told practitioners that she had been drinking to excess for months. The IMR author noted that liaison with drug and alcohol services may have provided an opportunity for some joint work and a better support plan for Ella.

[14] https://learning.nspcc.org.uk/media/3160/learning-from-case-reviews_parents-with-a-mental-health-problem.pdf

[15] https://learning.nspcc.org.uk/media/3160/learning-from-case-reviews_parents-with-a-mental-health-problem.pdf

9.4.12 The IMR author also noted that routine enquiry is best practice and Ella should have been asked at every contact whether she was experiencing domestic abuse.

9.4.13 In February 2020 Ella disclosed that she was pregnant for a fourth time and was seeking support around a termination. Ella expressed her desire to continue with therapy as she *“had to for her children”.*

9.4.14 During the same appointment Ella requested support regarding her suicidal thoughts and told them she didn’t feel supported. The care coordinator suggested weekly appointments to provide additional support.

9.4.15 There was no evidence that the father of Ella’s pregnancy was discussed and the IMR author notes that this could have facilitated further support and referrals to domestic abuse support services, given that DVA increases during pregnancy.

9.4.16 On her final booked appointment Ella cancelled stating that she could not attend as she was isolating due to having COVID19 symptoms (this was at the very early stages of the pandemic). The IMR author notes that no follow up appointment was provided to Ella; this is against the policy and practice of the mental health team which requires direct contact back after a cancelled appointment.

9.4.17 There was good liaison with the health visitor and an open dialogue noted within the records. However, the safety plan undertaken by Community Mental Health Services in February 2019, minimised the domestic abuse, the rationale being that Ryan and Ella had separated. The IMR author astutely points out that separation increases the risk to the victim in domestic abuse cases, but there was no evidence of referral to DA services.

9.4.18 The IMR author notes that there is a lack of clarity on whether consideration was offered to Ella’s additional complexities after removal of her children, and how she would maintain contact and attend her court appearances.

9.4.19 There is also a lack of evidence to suggest that aside from the MARAC input, mental health services attended or were invited to any multi-agency meetings in relation to either Ella or the children. Although information was shared, the attendance at these meetings could have ensured that Ella’s mental health risks were considered throughout assessments.

9.4.20 There is evidence in the mental health records to show that a conversation was had with Ella regarding attending appointments. She was informed that if she didn’t attend her next appointment she may be discharged from the service. There was no corroborating evidence of Ella stating that if she was discharged ‘she might as well kill herself’. This will be discussed further in analysis section 11.5.

Developments and Good Practice:

LSCFT have proactively made eleven improvements in areas of practice as a result of this case. The panel commend them for this robust action and support their work to move this forward. The list of improvements is referenced in section 14.1 of this report.

In terms of good practice, there were a number of areas the IMR author highlighted.

9.4.21 There was good communication between the GP, health visitor and mental health services.

9.4.22 The community mental health team acknowledged and escalated the increased risk to Ella’s mental health issues. This included home visits and an increase in frequency of interventions.

9.4.23 Ella’s views and request for support were acknowledged and actioned.

Recommendations:

The IMR author offered a series of single agency and multi-agency recommendations which were all accepted by the panel and are referenced in section 15 of this report.

9.5 Independent Management Review - Lancashire & South Cumbria Integrated Care Board (formally known as Morecambe Bay Clinical Commissioning Group) CCG on behalf of Primary Care

Key Incidents Timeline (Ella only):

9.5.1 Ella was well known to the GP practice, when she moved the practice made the decision to keep her registered at the surgery, despite the change of catchment area. This is due to the complexities of Ella's needs and her vulnerabilities. The GP practice wanted to ensure continuity of care for Ella.

9.5.2 Ryan was not known to the practice and only attended with Ella on one appointment, which was in January of 2018.

9.5.3 The GP surgery gave relevant information on the chronology report further back than the requested review period. This information in its totality meant the IMR author was able to note twelve missed opportunities to ask Ella directly about domestic abuse, the review author also noted a further six possible opportunities.

Learning Points:

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.5.4 The GP records show a good level of record keeping and information sharing between agencies about the risk of Ryan perpetrating domestic abuse towards Ella and the children.

9.5.5 There were onwards referrals that recognised the escalation of domestic abuse towards her, the deterioration in her mental health and substance misuse. Where Ella was asked about or disclosed domestic abuse there were some very open and transparent conversations with the GP. However, following these discussions the IMR author observed the lack of risk assessments and referrals to specific DVA services, nor were these options discussed or offered to Ella. Given there were a number of other opportunities to discuss the abuse which Ella was being subjected to, the review author would suggest that it is possible that because all agencies knew about the domestic violence within the household, this meant Ella was not always asked about it in depth; following the first draft of the report being sent to the GP surgery the review author was able to establish that the practice was unaware of the extent of Ryan's behaviour towards Ella.

9.5.6 In addition to the above the IMR author noted that there is a lack of evidence to suggest that alerts from child protection plans were inputted onto Ella's medical records to show that she was a victim of DVA.

9.5.7 The IMR author notes that there was no information shared with the GP surgery about the discussion held at the MARAC meeting about Ella, either prior to the meeting to

request information from primary care, or after the meeting to share the minutes and actions.

9.5.8 Although the IMR author could evidence that discussions were held with Ella about her vulnerabilities, on occasion the recording of Ella's wishes and feelings were not always recorded clearly on the system, alongside this there was a lack of record keeping on what support was offered.

9.5.9 During their involvement with Ella there were frequent periods where she did not attend appointments. This was especially prevalent after her children were removed and she had disclosed her fourth pregnancy. There is now an updated policy for patients who are 'high risk' of vulnerabilities in place. This was initiated in Ella's interactions with the GP surgery, but the policy was put in practice a month prior to Ella's death, therefore we cannot know if the policy had been available sooner whether it would have helped her.

9.5.10 An anomaly on the note sharing system was flagged by the IMR author which had a direct impact on the care that Ella received. Due to a database change that means GPs cannot now see midwives' notes, this means that Ella's GP was not aware of her late-stage pregnancy and that Ella was not engaging in her antenatal care. Due to this there was a delay in the GP being alerted to this issue for Ella.

9.5.11 The IMR author noted that the removal of Ella's children was detailed specifically in the notes as an increased vulnerability in terms of her mental health. Records evidence that information was given to Ella about who to contact and self-refer to. The review author will discuss the appropriateness of this (see section 11.3 trauma informed practice) and the likelihood of a self-referral occurring given that Ella also disclosed she was coping with very heavy alcohol use and vastly increased mental health symptoms at the time.

9.5.12 During the IMR review the author took the opportunity to speak with Ella's GP, who has an interest in personality disorders. It was observed by the IMR author that this diagnosis is often complex and challenging for professionals to manage. The GP explained that personality disorders are further amplified by substance misuse. In addition to this information the GP confirmed that suicidal ideation and self-harm were a risk factor for Ella for a number of years.

9.5.13 There is clear evidence of the high number of referrals to local mental health services. One of the frustrations expressed by the named GP for Ella is how frequently she was discharged by specialist mental health services and then referred back to the GP practice if she did not engage with services (this will be further discussed in section 11.3 trauma informed practice).

9.5.14 Despite the above there was generally good communication between mental health services and the GPs surgery.

9.5.15 The GP surgery were aware of Ella's mental health being exacerbated during her pregnancies and as such they allocated her a mental health midwife to support her during her pregnancy with C. During her pregnancies Ella was particularly concerned about any medication she was taking having an impact on her unborn child.

9.5.16 Given her difficulties and clear vulnerabilities the GP surgery showed great care in balancing Ella's wishes in her fourth pregnancy with her vulnerabilities.

9.5.17 Given the late stage of Ella's fourth pregnancy the termination would have needed to be some distance from where she lived. There is no evidence to suggest that Ella was offered any financial support to get to this appointment.

9.5.18 Although COVID19 did not have an impact directly on the delivery of services from primary care the IMR author astutely points out an important factor for the panel and all agencies to consider:

"In mid-March a national lockdown was announced. At this time Ella's children were placed in foster care in another part of the county, with limited contact with her. During the initial lockdown, external travel, and unnecessary journeys were not advised, social bubbles were not in place at the time of her death, therefore potential for no/even further limited contact with her children (or perceived potential). Ella was therefore facing the national lockdown with an abusive ex-partner, isolated from her children, unsure of her pregnancy, with an enduring unstable personality disorder massively impacting on her mental health during this period leading to her death." (IMR author LSG)

Developments and Good Practice:

9.5.19 The MARAC in Cumbria has now been commissioned to be reviewed and includes the recommendation of correspondence to primary care.
9.5.20 The continuity of care in keeping Ella engaged with the same GP surgery was noted as best practice.
9.5.21 It is clear from the chronology that Ella trusted her GP and they treated her with empathy and care. The GP practice held a safeguarding meeting just prior to Ella's death due to the increase in her vulnerability. This was the first agency she informed of her fourth pregnancy and her excessive alcohol consumption since losing her children.
9.5.22 The practice was well connected with agencies around the children's child protection plan.
9.5.23 There was recognition of the difficulty of the enduring mental health and personality disorder which Ella was facing.
9.5.24 Access to medical records and different systems posed challenges at times.
9.5.25 Maintaining robust records, and flagging systems requires review and strengthening.

Recommendations:

The IMR author offered a series of single agency and multi-agency recommendations which were all accepted by the panel and are referenced in section 15 of this report. The recommendation regarding professionals' knowledge, management and understanding of people with personality disorders will be extended to a national recommendation by the panel.

9.6 Independent Management Review – Recovery Steps (Substance Misuse Services – formerly Unity)

Key Incident Timeline:

9.6.1 Ella was known to addiction support services, Unity, for her alcohol use from early 2018. The service received two referrals for Ella and had one phone call with her where she apologised for not being able to attend. During 2018, Unity was unable to make any meaningful engagement with her.
9.6.2 Unity has a policy where patients are discharged from their service if they do not attend two consecutive appointments.

9.6.3 After the last discharge in 2018 Unity did not receive another referral for Ella until a just over a year later.

9.6.4 During 2019 there were a further two referral points for Ella after some engagement and then discharging from the service when Ella did not attend.

9.6.5 Aside from the brief interludes of discharging Ella from the service, Unity had her case open for a period of six months from mid-2019 until January 2020. But Ella's last meaningful contact with Unity was in the November of 2019.

9.6.6 In total Ella had 9 direct contacts with Unity over the review period, some of these were phone calls and the rest were assessments or direct work. There were six occasions where Ella was seen in person and two of these occasions were when Ella attended a group work programme.

Learning Points:

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.6.7 Unity was not made aware of the fact that Ella was experiencing DVA from Ryan until she informed them herself at an assessment in 2019. This was after she had separated from Ryan. There is no record of a DASH being undertaken with Ella at this session or any referral on to specialist domestic abuse support services.

9.6.8 Alongside the fact that there are no records to state that referring agencies informed Unity that DVA was a contributing vulnerability for Ella and or that Ryan used substances too; there is also no record that Unity services asked Ella about domestic abuse either.

9.6.9 After Ella pro-actively disclosed the abuse, Ryan was subjecting her to, with Unity. Unity began to have contact with the allocated social worker after the social worker contacted Unity. The social worker confirmed that domestic abuse was an identifying feature in Ella's life.

9.6.10 Ella also disclosed in another assessment appointment that she had a diagnosis of Post-Traumatic Stress Disorder (PTSD) from the abuse that she had experienced. Ella also disclosed that she was open to community mental health services.

9.6.11 There is no record that Unity ever spoke to community mental health services. The focus in partnership working was on child safeguarding and substance misuse, and although Ella's mental health and diagnosed conditions were reviewed in her contacts with Unity there was a lack of multi-agency working undertaken around Ella's mental health care.

Developments and Good Practice:

9.6.12 Since this case there has been significant development relating to safeguarding practice across Addictions services. Many of these have been prompted by the recommissioning of services to a new care provider (Recovery Steps) and some have been a result of the learning from internal and external incidents and reviews.

9.6.13 An Integrated Governance Board (IGB) has now been developed across Addictions services to support oversight, review and learning from all incidents across the service.

Within the IGB structure, a specialist Safeguarding Practice Subgroup has been set up, which is supporting the development of safeguarding practice and ensuring learning identified from internal and external reviews is embedded within future practice.

9.6.14 Addictions Services have identified Safeguarding and MARAC Leads within each locality. These leads provide specialist advice and support to staff regarding domestic abuse. Specialist safeguarding supervision is available to all Addictions service staff on a monthly basis, whereby staff can discuss complex safeguarding cases.

9.6.15 Within the service transfer on 01/10/2021, Addictions services have implemented a clinical recording system that has a designated safeguarding function, inclusive of domestic abuse. This is aimed at supporting effective safeguarding oversight and documentation within service users care record.

9.6.16 In terms of good practice, the partnership working between Unity and the allocated social worker was timely and detailed.

9.6.17 In addition, although disclosures of domestic abuse were not explored enough by professionals and opportunities were missed, it is clear that when Ella was able to have meaningful contact with Unity, she felt able to discuss her vulnerabilities and the trauma she had been subjected to by Ryan with professionals.

Recommendations:

The IMR author offered a series of single agency and multi-agency recommendations which were all accepted by the panel and are referenced in section 14 of this report.

The panel will make a further recommendation in relation to the discharging policy Substance Misuse services, this recommendation is linked to ensuring victims of domestic abuse are not penalised for being unable to attend or engage with services. In addition, policies on domestic abuse within addiction services should be triangulated to adhere to best practice in trauma informed services for victims of domestic abuse.

9.7 Independent Management Review - Victim Support (domestic abuse provider):

The majority of interventions for Ella and Ryan centred around the Turning the Spotlight (TTS) programme provided by Victim Support in Cumbria[16]. The programme is aimed at couples who "*are having problems with their relationships, leading to arguments, an unhealthy relationship, and abuse. We work with both victims and perpetrators of abuse.*"[17]

Key Incident Timeline (Ella):

9.7.1 Ella was first referred by Cumbria Constabulary to Victim Support (VS) in March 2018 after Ryan had assaulted her (see 9.1.4).

9.7.2 VS did try to call and text Ella, but after no response they contacted her health visitor and the Officer in Charge of the case. Due to this incident being graded as standard risk VS require consent from the victim to make contact (this is in line with data protection duties for all DVA services across the UK). As Ella had not given consent Victim Support had to close the case.

[16] https://www.victimsupport.org.uk/cumbria/turning-the-spotlight/

[17] https://www.victimsupport.org.uk/cumbria/turning-the-spotlight/

9.7.3 Later in March 2018 Ella was referred to VS again, this time from the support service within Children's Social Care. The case was re-opened and after a number of attempts to contact Ella texted her VS worker back to say she did want support to complete the partner programme.

9.7.4 Contact with Ella was sporadic. The VS advocate was able to do a home visit with Ella, and Ryan was present in the home at the time, he confirmed he would be attending the healthy relationship sessions.

9.7.5 Ella was never able to attend the partner programme. Although she did often let her VS advocate know she wasn't attending. On occasion this was due to child sickness and at other times Ella explained that the sessions clashed with child safeguarding meetings.

9.7.6 On one occasion a home visit was organised, but Ella requested that this was changed to when Ryan was not at the address and the advocate rearranged to another day.

9.7.7 Unfortunately, the advocate was unable to meaningfully engage Ella in support, although she did make every effort to do so, Ella was unable to attend the programme and did not attend meetings arranged with her advocate.

9.7.8 Ella's case was closed again in August of 2018.

9.7.9 The third referral was received in November 2018, via Children's Social Care. The referral graded the risk from Ryan to Ella as 'standard'. Consent was sought on this occasion.

9.7.10 Ella responded to messages and stated again that she would like to complete the partner programme with VS, and her advocate visited her at home.

9.7.11 Ella explained that she was feeling a lot better since she had moved closer to her family and Ryan was working. She stated they were both keen to engage with the partner programme and the healthy relationships programme. Ella further explained that she found groups really hard to attend due to her anxiety, so the VS advocate arranged to do the programme with her on a one-to-one basis.

9.7.12 Shortly after these meetings Ella gave birth to C. The VS advocate made attempts to contact but no further meetings with Ella occurred. In early February 2019 the VS advocate contacted Children's Social Care and explained that Ella was not engaging with VS. At this stage Children's services were initiating legal proceedings with regards to the children. The VS advocate planned to continue to try and make contact and attend the MARAC meeting to hear Ella's case in March 2019.

9.7.13 The VS advocate was able to contact Ella and she was keen to engage. A home visit was arranged and when the VS worker attended, Ryan was there, as was Ella's Mum, Denise. The house was very busy with the children also present and there was little quiet space, so the VS worker and Ella ended up sitting in the car. Ella disclosed that Ryan was not pulling his weight with the children and the household chores. She told the VS worker that she hoped the Healthy Relationships course would help Ryan as he was of the opinion that Ella should do all the cooking and cleaning in the home. Ella explained that she saw this as the last chance for her relationship with Ryan and that if things didn't change then she saw little future together.

9.7.14 Unfortunately, it was difficult to meet with Ella after this. Appointments and contacts were sporadic. The VS worker did note that Ryan was giving conflicting information to Ella. VS staff continued to work in partnership and share information with Children's Social Care.

9.7.15 During February and March, the VS worker was only able to complete two face-to-face sessions with Ella, although Ella did not respond to some texts and phone calls, she did stay in contact with the VS worker intermittently and often explained why she wasn't attending appointments.

9.7.16 At the second face to face session, Ryan was in the home and told the VS worker that he would be attending the healthy relationships programme later that day.

9.7.17 During April and May no face-to-face appointments were achieved. Ella did reply to texts and gave reasons for not attending appointments.

9.7.18 The VS worker noted that Ryan had not attended any appointments and that he was at this stage not meant to be in the property, but Social Care had noted that he was often there when they went to visit, under the premise that he was there to see the children.

9.7.19 In June VS closed Ella's file.

9.7.20 Ella was re-referred to VS later in June after her report to the police for historic abuse from Ryan, including rape. Ella was referred to the Independent Domestic and Sexual Violence Advisor (IDSVA).

9.7.21 The case was graded on referral as medium risk in terms of the DASH grading system (see 9.1.14 and 9.1.23 – DASH 7)

9.7.22 Attempts were made to contact Ella during June 2019, but none were successful. The VS advocate did go back to the referring officer to check she had the right details and was informed that Ella and Ryan had separated.

9.7.23 Further attempts were made through to September 2019, but unfortunately VS were unable to engage Ella. Her case was closed again in October 2019 and no further referrals were received.

Key Incident Timeline (Ryan):

9.7.24 Ryan was first referred to VS in March 2018, by CSC, for the healthy relationship course, to address the issues in his relationship with Ella and his behaviour towards her.

9.7.25 Despite numerous attempts to engage Ryan to attend the sessions during March, April and into May, the VS worker was unable to get him to come to the arranged group session. Ryan did engage in text with the VS worker and had one assessment over the phone, he expressed a motivation to attend the course and to address his behaviour.

9.7.26 In May 2018 the VS worker contacted CSC to explain that Ryan appeared to be motivated on the phone but was not engaging in the group programme, repeatedly cancelling at the last minute and or not attending arranged appointments. The social worker informed the VS worker that Ryan had stated he had met with VS. The social worker stated that her belief was that Ryan was very controlling.

9.7.27 The VS worker explained that Ryan had missed the opportunity to attend the current group but offered to meet him to discuss the programme with him and reassure Ryan of any anxieties he had around it.

9.7.28 In June 2018, a requirement of the child protection plan was for both Ella and Ryan to work with VS separately.

9.7.29 No further response was forthcoming from Ryan, so the VS case was closed to him in mid-June 2018.

9.7.30 Alongside Ella, Ryan was re-referred to VS in November 2018 after escalating concerns from the children's social worker.

9.7.31 At that point Ella was pregnant with her third child C and VS were aware that both Ella and Ryan used alcohol and substances. VS were also aware of Ella's diagnosed mental health conditions.

9.7.32 In February 2019 VS were finally able to meet with Ryan at his and Ella's house. The reason for the delay for the meeting was due to Ryan reporting he had a difficult working pattern. A date was set for Ryan to attend a meeting to be assessed for the group programme. Ryan did not attend that appointment.

9.7.33 Two further face to face meetings were arranged with the VS worker, but Ryan did not attend. He did text after a reminder was sent apologising and saying he forgot, and on the second occasion he stated he couldn't make it.

9.7.34 Finally, Ryan attended his assessment appointment in late February 2019, at the session he was open about his relationship with Ella. He stated he was ready to start the group programme in March 2019.

9.7.35 Ryan did not attend the first session of group in March 2019, he had told Ella's VS worker that day that he was attending the evening group class (see 9.6.16), but when he did not attend, he told his VS worker that he had forgotten.

9.7.36 Ryan did not attend the second session, stating he couldn't attend because it was a family members birthday. The VS worker informed the social worker of Ryan not attending group and in total missing three arranged appointments.

9.7.37 On the third group session (April 2019), Ryan was sent a text reminder to attend group that evening, he told his VS worker that he had not had any sleep due to being arrested and being in custody. This incident was reported to the police via Ella's friend to say that she had been assaulted by Ryan. Ryan stated he was not going back to Ella's and would come to group the next time. An appointment was arranged for a face-to-face appointment.

9.7.38 Ryan attended the face-to-face session; this was two days after his arrest. He stated he was back with Ella, and she had apologised, but he didn't know if he had done the right thing in going back to her. Ryan described Ella as controlling and jealous. He said he was glad she was getting help with her mental health. Ryan stated the reason he didn't attend the previous sessions was because Ella wasn't supportive and didn't want him attending. Ryan said he would speak to Ella and agreed to attend the next group session (session 4).

9.7.39 Ryan did not attend the next group session.

9.7.40 Following on from this the VS worker updated CSC, the social worker informed her that legal proceedings had moved further forward, and Ryan had stated to the social worker that he did not feel he needed any help with his attitudes towards women or his abusive behaviour towards Ella.

9.7.41 After this conversation in late April 2019, two more attempts were made to engage Ryan in the group programme. He did not respond to either message.

9.7.42 In May 2019, VS closed the case with Ryan and updated the child protection conference about his lack of engagement.

Learning Points:

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.7.43 After a thorough search of case systems, the IMR author noted that during the second phase of engagement with Ella, in late 2018, there was a missing DASH form on the VS system. The IMR author did have a conversation with the VS advocate, and she recalled completing a DASH and that Ella had not scored high risk; it is likely a human error that the form was not scanned in on that occasion.

9.7.44 In addition, the MARAC minutes from early 2019 could not be analysed because of automatic deletion under GDPR regulations[18]. However, the IMR author was able to provide a copy of the MARAC referral form for the one meeting that Ella was referred to and the observations from the IDVA recorded the last three attempts to contact Ella as well as a request for support to reach out in writing to Ella.

9.7.45 The IMR author felt that communication across different teams within VS could have been better on occasion as Ella had some different caseworkers.

9.7.46 The IMR author observed that Ella's case evidenced a need for professionals to have a greater understanding of risk assessments, and the high-risk nature of coercive and controlling behaviour (CCB) and the feature of CCB in domestic homicides.

9.7.47 In addition, the IMR author highlighted need for more robust assessment processes for perpetrators presenting as victims.

Development and Good Practice:

9.7.48 Since late 2019 VS Cumbria integrated specialist case workers into one multi crime hub model. Allowing increased joint working and information/skills sharing across the different teams.

9.7.49 VS in Cumbria have worked with Professor Jane Monkton Smith to merge the Homicide[19] and Suicide Timeline[20] into VS risk assessment processes. This was not incorporated into VS work when Ella was using the service. The suicide timeline is in its infancy but could have been used as an indicator to inform multi-agency interventions for Ella, particularly if used correctly and in conjunction with the interactions VS had with Ryan (this will be further discussed in 11.4 and 14.1).

9.7.50 The review author noted the exemplary practice of VS staff in pro-actively contacting both Ella and Ryan. It was clear from the chronology that VS used different means of engaging victim/survivors and perpetrators.

9.7.51 MARACs have moved to weekly meetings in Cumbria, thus facilitating quicker access to risk markers and interventions for victims and perpetrators.

Recommendations:

9.7.52 The review author suggests VS review home visits where the perpetrator is present or living at the address, as this can be unsafe for victim and staff. Ella had suggested herself that she had wanted to meet when Ryan was not there and on occasion the house had been so busy that the VS worker and herself had to sit in the car. Multi-agency partners should have enabled facilitation of Ella attending appointments ensuring that the children were looked after and that she had a space to go to that was safe, quiet and trauma informed.

9.7.53 The IMR author has suggested the use of the DASH by external agencies is patchy. Sometimes the referrals VS receives have missing information on the DASH or sections not completed. In addition, on referral some professionals do not know what the DASH is. At the time of Ella receiving support, it was VS policy that the service will only take referrals with an up-to-date DASH and the IMR author recommends requirement for referring agency risk grading's to be accurate & risk assessments

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[18] https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/

[19] https://www.youtube.com/watch?v=lPF_p3ZwLh8

[20] https://eprints.glos.ac.uk/10579/

provided upon referral into VS services. The review author and IMR author offer other reflections on this recommendation, and this is further discussed in section 11.4 and 14.1 of the report.

9.7.54 There were a further two multi agency recommendations put forward by VS which were accepted by the panel and are referred to in section 14.3 of this report.

9.8 Independent Management Review - University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT):

Key Incident Timeline (Ella only):

9.8.1 Ella was previously known to midwifery services for her son A.

9.8.2 When Ella was seen by a midwife for her pregnancy with B, she disclosed having diagnosed mental health issues and stated she was not drinking or taking any drugs. Ella was supported with an antenatal wellbeing assessment.

9.8.3 Ella was asked by midwives about domestic abuse at her antenatal appointments and she disclosed emotional abuse but said that things were *“much improved”* since Ryan had been working. Ella also insisted that Ryan would not hurt her son A.

9.8.4 After B was born, Ella disclosed to the midwife that Ryan had accused Ella of doing nothing all day whilst he went out to work. Ella told the midwife that Ryan had pushed her over a few times, and this was shared with the specialist midwife and health visitor.

9.8.5 On the next visit Ella did not let the midwife into the property, she was visibly upset and stated that she and Ryan were having an argument. The midwife returned to the office and reported the incident to the police and CSC (see 9.1.4).

9.8.6 Following on from this the midwife and health visitor attended the property the next day and Ella was very nervous. She admitted to the midwife that both her and Ryan were drinking and using cannabis. This was shared with CSC.

9.8.7 In May 2018, five months after B’s birth, Ella was taken to the emergency department by ambulance after attempting suicide (see 9.1.9). She disclosed that her relationship with Ryan was troubled and that he *“makes her feel bad all the time”*. Ella disclosed that she had previously attempted suicide three years earlier. The crisis team supported Ella to stay in the hospital as she was keen to get back to Ryan because she was concerned, he would hurt himself. Referrals were made to Community Mental Health team, GP and the Safeguarding Hub.

9.8.8 Ella did consider a termination of her pregnancy with C, her youngest child, but decided against the procedure.

9.8.9 There were some missed appointments during her pregnancy with C, but Ella did engage honestly with her midwife when she saw her and spoke openly about her mental health diagnosis and the medication, she was taking for it. Ella was referred to a specialist mental health midwife.

9.8.10 Ella also disclosed that Children’s Social Care was involved with the family and the midwife was already in contact with the children’s social worker. After attending Ryan and Ella’s address the midwife fed back to the social worker further concerns about Ryan’s coercive and controlling behaviour and the impact on the children.

9.8.11 After this there were a series of missed antenatal appointments with Ella between July and October 2018. The midwife kept in contact with CSC during this time and attended child protection meetings.

9.8.12 A and B remained on the child protection plan and C was placed on the plan with them as an unborn.

9.8.13 The midwife noted in the core meeting for the child protection plan in November 2018, that Ryan lacked understanding of the seriousness of the children being placed on the register and blamed Ella for this.

9.8.14 Ella attended an antenatal appointment alone in November 2018 and was asked about domestic abuse by the midwife, on this occasion she did not disclose any issues.

9.8.15 There are reports of improvement in the care of the children in December 2018 and an agreement by both Ryan and Ella to engage with VS after C was born.

9.8.16 Ella went into labour with C naturally in January 2019. At the hospital it was noted that both Ella and Ryan were unkempt and lacked personal hygiene. Ella was noted to have bruising on both her legs and an old healing bruise under her right eye. Ella was attentive to C, but Ryan was inattentive to both C and Ella. At one point Ryan and Ella were heard to be arguing and the midwife told Ryan to leave. He did so but mentioned that Ella would accuse him of having affairs if he went home.

9.8.17 Ella explained that she wanted to sort out her relationship with Ryan and that he was controlling and never helped with the children. The midwife did inquire about the bruising, but Ella said it was A when he had a tantrum.

9.8.18 The midwife visited Ella at home most days for the 10 days after C's birth. On one occasion Ryan was seen to be shouting and swearing at the children and the house was very busy with the children crying and running around. Ella wasn't answering many questions.

9.8.19 On another occasion the midwife visited, and Ella was very distressed due to her eldest son having tantrums. Support was given to Ella from the midwife and the health visitor who was also present, and she was advised to speak to her GP about how she was feeling and also for advice on A. The midwife noted a large bruise on Ella's upper arm, and she reported this was because she had "*fallen into a wall*" the night before.

9.8.20 The midwife visited Ella the next day and she seemed a lot brighter. She did state that her and Ryan had been arguing a lot because they were stressed, and she would prefer it if the next child protection conference was postponed, as she didn't feel she had been able to complete everything that CSC had asked her to do.

9.8.21 The midwife and health visitor agreed to work together through the child protection plan to support Ella. This was especially important Ella's ability to cope with three children and Ryan being back at work, exacerbated by the domestic abuse he was subjecting her to and her mental health issues.

9.8.22 Midwifery stayed in contact until February 2019.

9.8.23 A year later, in February 2020, midwifery came into contact with Ella again due to her fourth pregnancy. Ella disclosed that she was in an abusive relationship and didn't want her partner to know about the pregnancy or the planned termination. Unfortunately, due to system error (see ***) Ella's scan was missed and she was not contacted for a few weeks in March 2020.

9.8.24 At her final appointment Ella was seen by a radiographer and was confirmed as approximately 22 weeks pregnant.

<u>Learning Points:</u>

The IMR author raised a number of learning points in reference to the specific questions posed within the TOR (see appendix A):

9.8.25 When the midwife received a positive disclosure of domestic abuse from Ella, she referred her to the specialist domestic abuse midwife, but there is no record to state whether this referral was acted upon.

9.8.26 On the second occasion that Ella disclosed emotional abuse, but described that things were *"much improved"* this was acted upon. The midwife contacted the Safeguarding Hub to have a professional discussion with a view to referral. However, it was deemed that the threshold for the referral had not been met. The IMR author notes that she would have expected more to be done on both occasions but adds that this was in 2017 and processes have significantly improved since then (see developments and good practice below).

9.8.27 Although there was good information sharing between practitioners that Ella was a victim of domestic abuse from Ryan, there was a delay in referring the children to Social Care after B was born in 2017. There was a delay of a week in referring the children to Social Care after Ella had disclosed, she had been subjected to physical abuse from Ryan.

9.8.28 Although information was shared with CSC on Ryan's behaviour, including witnessed incidents of abuse, there was nothing on the records to evidence the risk that Ryan may pose to Ella.

9.8.29 The IMR author noted that Ella was heavily involved with Community Mental health during her second pregnancy with B, but this was not replicated in her pregnancy with C. Ella's nonattendance at a lot of antenatal appointments meant that triangulation with mental health services did not occur in the way they should. The IMR author further notes that the focus for child protection appeared to be on domestic abuse and the mental health team were not present. This is despite the fact that there was an increased risk of self-harm during pregnancy as this had previously occurred during B's pregnancy when Ella had tried to take her own life. The midwifery notes do not appear to have considered the above.

9.8.30 Although Ella did disclose, she was a victim of domestic abuse from Ryan, it is not clear whether she detailed what he was doing to her, there is no record of these conversations and no risk assessment undertaken on file.

9.8.31 The review author also notes that there were numerous occasions where evidence of physical violence in the form of bruising on Ella were witnessed by health staff. There appears to be a lack of professional curiosity and about how much this was explored with Ella.

Developments and Good Practice:

9.8.32 Very positively the IMR author was able to report the following to the panel:

"There has been a number of changes and improvements to practice made since 2017/2018, but these were made prior to Ella's contact in February/March 2020. An audit of Routine Enquiry was undertaken in 2017 and this showed that only 35% of women had routine enquiry at least twice within the maternity episode. There was a new training package developed for domestic abuse training for maternity unit staff which was delivered to all staff over the course of the next 12 months. The next audit in 2019 showed that this figure had increased to 77% of women and the following year 85% of pregnant women had been asked at least twice in the maternity episode. The findings from the audit were shared with the maternity teams and domestic abuse was a focus for safeguarding supervision and for the regular safeguarding bulletins published by the Safeguarding Specialist Midwife. This year the audit has found that

100% of pregnant women are asked about domestic abuse at least twice during their maternity episode with some women having been asked 17 times during the pregnancy." (IMR Author, UHMBT, 2022)

9.8.33 As with the IMR for LSCFT the system failure on Ella's fourth pregnancy where she was not contacted for a scan. This has now been rectified.

9.8.34 The review author noted good practice on professional curiosity from midwives with Ella. It was especially good to see Ella being asked the routine enquiry question more than once. There was also good partnership working between Ella's midwifery team and Social Care.

9.8.35 The review author was able to gain further insight into the care and attention of the GP surgery when interacting with Ella and her fourth pregnancy. After liaising with the panel representative of primary care and the GP's surgery, the review author understood how affected they were by Ella's death. There was a keen sense of urgency on supporting Ella through the termination of the fourth pregnancy and when the practice learnt of Ella's death, they were deeply impacted by it. The review author will discuss this issue further in section 11.7.

Recommendations:

The formal single agency recommendations have been completed by UHMB and are reflected in section 15. The panel note that it is positive to see a more enhanced support midwifery service where women with vulnerabilities can gain access to specialist support that meets their needs in a trauma informed care setting.

The IMR author also noted some formal multi-agency recommendations were needed in regard to further better liaison between midwifery care and community mental health teams. The panel agree and have reflected on this in the recommendation section 14 and extended this further with other partner agencies.

10. Equality and Diversity

10.1 The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All the protected characteristics have been considered throughout this process with mental health being addressed under 'disability'. Services must adhere to the Public Sector Equality

Duty (PSED)[21] and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

There are generally three aims[22] under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Ella had a formal mental health diagnosis, therefore the relevant characteristics applied to her case is her sex, her disability, and her pregnancy.

10.2. The sex of the victim is relevant. Females are disproportionately the victims of homicide in domestic abuse cases. According to new data released by the United Nations Office on Drugs and Crime (UNODC), research shows that an average of 137 women across the world are killed by a partner or family member every day, the research further evidence that 58% of women who are murdered, are murdered by a partner or family member[23]. In addition, through the work of Karen Ingala Smith[24], we know that in the UK 1,425 women have been murdered by men over the ten-year period between 2009 and 2018[25]. That equates to one woman being murdered every three days by a man and one woman every four days by a man she knows. Ella shares many of the same experiences and characteristics as the other women murdered, however, the overriding factor they all have in common is their biological sex.

10.3 With respect to this DHR the conclusion is that the protected characteristic of sex should be known and understood much better by service providers and commissioners in relation to domestic abuse. The analysis and recommendations set out in the Femicide Census[26], ten-year report provide more detail.

Protected characteristics and the discrimination people face because of them often intersect. This was true for Ella as it is for many women who experience domestic abuse and have multiple complex needs.

Research[27] evidence that death rates from suicide are consistently higher for men, and thus many interventions to reduce the suicide rate amongst populations are aimed at men. Although this good work should not be undermined, it means that women's experience of suicidal ideation is often side-lined. Given that women are significantly more likely than men to attempt suicide[28], responding to women's suicidal ideation should also be a priority:

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[21] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty

[22] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty

[23] https://www.bbc.co.uk/news/world-46292919

[24] https://kareningalasmith.com/counting-dead-women/

[25] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[26] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[27] https://journals.sagepub.com/doi/full/10.1177/0269758018824160

[28] https://journals.sagepub.com/doi/full/10.1177/0269758018824160#bibr15-0269758018824160

The role of traumatic experiences, such as being subjected to domestic abuse, as a precursor to suicidality has already been formally recognised at national (Department of Health, 2012) and international (WHO, 2014) levels. However, the scale, dynamics and complexity of this intersection, and the ways in which positive interventions may be secured, remain significantly under-researched, particularly in the UK.[29]

Women's experiences of suicide need to be featured and prioritised within research, particularly within the context of domestic abuse. As previously mentioned, the work of Agenda Alliance highlights this issue. All services need to be able to understand and respond better to the links between domestic abuse and suicide in women. Failure to prioritise resources for female victims' experiences of suicide does not pay due regard to their protected characteristic of sex or as with Ella her protected characteristic of disability. If services and responses for suicide reduction are aimed at men, women are indirectly discriminated against.

In addition, the GP astutely noted that understanding on personality disorders is lacking amongst professionals. It is a complex diagnosis for people to manage and if professionals are not supported with the knowledge of the diagnosis and skills to respond then interventions can indirectly discriminate due to the processes being inaccessible for people with this type of diagnosis.

10.4 Ella had three pregnancies during the review period, the last of which resulted in a traumatic time for her as a result of her existing children being taken into care, whilst she was facing prosecution for neglect. Understandably Ella was considering a termination for her fourth pregnancy. The links between the escalation of domestic abuse whilst a woman is pregnant is well established in research[30]. Throughout the world the feature of domestic abuse in pregnancy is noted as a prevalent feature[31], and it is both a serious health concern as well as a breach of women's human rights[32]. Accessing general health services is a fairly routine act during a woman's pregnancy and there were multiple opportunities for agencies to note Ella's relevant protected characteristic during these periods in her life. The reality of the intersection of her compounding vulnerabilities should have meant professionals were alert to the further potential for oppression from an abusive partner.

Pregnant women retain a privileged public position in society, but the frequent violence some are subjected to within their homes suggests discordance in their status in public and private spheres. Officially, we are deeply offended at the image of a pregnant woman being choked or kicked in the abdomen, but this instinctive distaste produces a strong taboo, and it is perhaps this which prevents us from rigorously screening and offering intervention to this vulnerable group.[33]

It is not just health professionals that need to be alert to this risks of DA for pregnant women, Ella had contact with numerous agencies during her pregnancies, and combined with the vulnerable issues she was already dealing with this should have afforded professionals an

[29] https://journals.sagepub.com/doi/full/10.1177/0269758018824160
[30] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/
[31] https://europepmc.org/article/med/16972587
[32] https://dspace.ceid.org.tr/xmlui/bitstream/handle/1/93/ekutuphane4.1.6.4.pdf?sequence=1&isAllowed=y
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/

opportunity to be curious in order to advance equality of opportunity to services under the PSED.

11. Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and or intervention for Ella. This analysis is based on information provided in the IMRs and, perhaps more importantly, Ella's friends provided a focus for the panel to understand a more holistic perspective of the situation.

Chair Summary:

Having reviewed a vast amount of data given to the chair by each agency it offers a stark picture when you are able to place yourself in the shoes of a victim of domestic abuse like Ella. Ella had multiple and complex needs, she used substances as a coping mechanism, and she had a diagnosed mental health condition which made her very vulnerable. Ryan clearly took advantage of Ella's vulnerabilities.

We can see that Ella did try and engage in support offered (although sporadic) and that she was honest and open about what was going on for her. Ella did willingly disclose the abuse Ryan was subjecting her too. She tried to engage in services including Domestic Abuse (DA) services, mental health services, substance misuse services and she tried to adhere to some elements of the child protection plan. In the final nine months of her life, she bravely reported historic rape, physical abuse and CCB from Ryan towards her.

In stark contrast Ryan never meaningfully engaged in any interventions, moreover he would manipulate the system, telling Social Care that he would engage in the work with VS about his behaviour, and then telling VS he was too busy, or he would simply not turn up. On the only occasion he did have contact he spent the time blaming Ella. Substance misuse services had never heard of Ryan, and he was often not at appointments with Social Care, including on appointments where his abusive behaviour was being challenged and the affect that he was having on the children - these conversations were aimed at Ella, not Ryan. Ryan engaged in some sessions on his abusive behaviour after he and Ella separated but these were noted as 'disguised compliance'; it appears from his last conversation with the social worker prior to VS disengagement that he never had any intention of changing his behaviour.

The Quality Assurance panel for the Home Office noted the unconscious bias towards Ella throughout some of the IMR data, particularly in relation to the changes in child protection plans. Some of these actions from agencies could have constituted victim blaming and would have undoubtedly been exacerbated by Ella's feelings of being overwhelmed, particularly in the context of her own vulnerabilities and mental health issues.

When Ella and Ryan did finally split up, she was left to cope with the three children. It is obvious that their parenting combined was inadequate and that they were both culpable in the neglect of their children. It is also clear that CSC made a lot of effort to enable them both

to improve the care of the children. However, after Ryan left, Ella drastically spiralled, and her drinking increased. She was left with the trauma of having been subjected to systematic abuse for years, an increasing alcohol issue and a mental health diagnosis that was exacerbated by substance misuse and trauma. When the children were finally removed and placed in foster care, Ryan was nowhere to be seen. All agencies were still involved with Ella at this time, including the police, Social Care, her GP, and the community mental health team, noted a rapid decline in her presentation and her mental wellbeing.

From a domestic abuse perspective Ryan's narrative was always that Ella was to blame for everything, including the children's neglect, and that he was not responsible. There is no suggestion that any agency ever made the same insinuation to Ella, and it is clear that Ryan was never considered able to care for the children himself, but we can predict that the message that Ryan had consistently told Ella was that she was a bad person and a bad parent (this was subsequently backed up by conversations with Ella's loved one's). As professionals we cannot underestimate the loudest voice in the mind of a victim is that of the perpetrator, even when the perpetrator is not there anymore. It takes years to recover from the trauma of psychological and physical abuse. It is up to us as professionals to ask the right questions, foster empathy, and to support and enable victims to understand the dynamics of coercive and controlling behaviour, especially at a time of crisis.

Of course, there is no question that the children should have been removed, Ella was unable to care for them. But with the benefit of hindsight, we can see how the narrative of a manipulative perpetrator who had told Ella she was to blame for everything, came true when in fact she did lose the children. This would have hugely impacted on her mental health and increased risk of substance misuse and suicide. It is at that point that the manipulative narrative of Ryan came to fruition, and it would not be outside the realms of possibility to claim that Ella was using substances more and spiralling out of control to deal with the trauma of having to unpick that narrative, whilst also coping with the loss of her children.

We also know that Ella was pregnant with her fourth child, and pregnancy always increased Ella's mental health symptoms, she was struggling to cope with the decision to go through with a late-stage termination and in the week prior to her death she had received a letter to inform her that she was being taken to court for neglecting her children. Ella was still residing in the family home alone when the national lockdown was announced, although no agencies noted that COVID19 impacted on their care of Ella, it may have isolated her further and changed her thought patterns and perceptions.

The stark facts are that Ella was incredibly vulnerable and a catalyst of events would undoubtedly have led to feelings of hopelessness in a woman who had long had issues with self-harm and suicidal ideation. There is no one reason for suicide, but a combination of factors. As professionals we need to reflect on where our interventions and the systems, we use may have made a difference to women like Ella, so that we can reduce the risk of serious harm/suicide and homicide, particularly where the actions of perpetrators of domestic abuse, add to and exacerbate victims' circumstances and influence or control their choices.

The following analysis aims to reflect on where agencies can better develop our responses to victims like Ella, and equally as importantly prevent collusion with perpetrators and hold them to account.

It is because of the conversations that the chair was able to have with Ella's loved one's that enabled the analysis to be much more illuminating, their thoughts are represented throughout the following section and in section 13.5.

11.1 Coercive Control

Coercive control legislation came into effect in the UK on the 29th of December 2015 and was therefore in force as a crime when Ella and Ryan were in a relationship. Thus, it is important to analyse this as a factor in their relationship. Therefore, the following analysis section is presented by the author with the dynamic of Ryan subjecting Ella to his coercive and controlling behaviour. To understand domestic abuse holistically we must understand that coercive and controlling behaviour acts as the backdrop to physical and or sexual violence[34].

The cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress.[35]

Ryan was controlling, almost right from the start of their relationship. Ella told professionals this information and her friends and family witnessed it:

> *Ryan used to make it difficult for me to see Ella, even if I saw them in the street, he would make it awkward and he would be hurrying Ella along. If ever I went to their address, he wouldn't even look at me, I think he knew what I thought of him. (Family Member)*

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[34] https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf

[35] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

> *Ryan made me cut contact with her, I wasn't allowed to see her much at all. If I saw her on the street, he made sure to stand back and, keep telling Ella to hurry up. She originally lived in another area with him and, I know she felt far away from friends and family there. Eventually she moved to across the street from me, if she saw me without Ryan, she would run up to me so we could have a catch up. She got a job at a shop, and he would wait outside for her to finish. Wherever she was I wasn't allowed time with her. She felt trapped with him and, would try different ways to communicate with me by turning her phone off with him so, when it was on, she could text back or talk to me through her PlayStation. (Friend)*

In essence their relationship was fairly short in length (approx. 3 ½ years) but it was prolifically abusive, in every sense, and the control and abuse Ryan exerted over Ella was rapid. The impact on that for Ella would have reduced her autonomy and ability to make rational choices. Coercive control is designed to isolate a victim, exploit them and reduce their independence:

> *Expert in CCB, Professor Evan Stark, likens coercive control to being taken hostage. As he says: "the victim becomes captive in an unreal world created by the abuser, entrapped in a world of confusion, contradiction and fear."*[36]

Ryan used various methods to control and degrade Ella. She talked about how he made her feel like a "*slave*", and his opinion was that she should do all the cooking and cleaning in the house. We also know that he performed degrading acts like urinating in bottles where he sat and expecting Ella to clean up after him. When taken in the context of coercive and controlling behaviour, these aren't just routine acts of a 'lazy man'; they were designed to denigrate and shame Ella. When the person you love reduces you to the depths of what feels like slavery that is very hard to lift your head up from, especially when combined with physical and sexual abuse and dealing with a diagnosed mental health issue that exacerbates a sense of worthlessness.

Ryan was good at blaming Ella for the involvement of agencies, he was, like many perpetrators, incredibly adept at never taking any responsibility for his actions, this is an extension of the coercive and controlling behaviour, displayed in his interactions with professionals. The victim can see that their perpetrator has the ability to spin and twist the narrative to make himself the victim and her the problem. He frequently told professionals that she was to blame for various things or that she was the problem:

- He blamed Ella for the child protection involvement,
- He would reference her self-harm and mental health issues using it as an excuse to explain away arguments between them; the goal achieved in this was painting the issues in their relationship as being a result of Ella's 'madness' and draw sympathy to him for having to cope with her.
- He stated that she was jealous and controlling and wouldn't let him attend group work with victim support; he told the hospital that if he left, she would accuse him of having affairs (this was just after Ella had given birth to C, she had visible bruises on her legs and face)

[36] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

- When police attended an incident in July 2018, Ella was 'very distressed', and Ryan was 'polite and receptive'. Ryan expertly navigates the presentation of Ella as 'problematic' in this incident.

When we know who the perpetrator is in a relationship, which in the case of Ryan and Ella was well established, we as professionals simply cannot take the perpetrators narrative at face value. Moreover, we should treat every conversation with them as an extension of the abuse that is happening in the relationship. Often their narrative is a small window for professionals to peer through, and to view what is being said to the victim within the relationship. Research published in July 2022[37] also evidences that:

> *…perpetrators of abuse in suicide cases were three times more likely to have engaged in coercive and controlling behaviour than those in intimate partner homicides.*

In this sense coercive and controlling behaviour isn't something that we assume is going on behind closed doors, perpetrators display it in plain sight and professionals need to be supported to appropriately challenge perpetrators on this, not just directly with them, but also in front of victims (especially where there are multi-agency child protection meetings with both parent's present). We do this in order that we model to victims our understanding of the tactics of a controlling perpetrator, and that the behaviour is designed to make the victim look, and feel, bad. Moreover, we prove to the abusive person that are not going to let their behaviour go unchallenged.

11.2 <u>Multiple and complex needs and domestic abuse</u>

We are aware that Ella used alcohol and sometimes drugs; this featured in all the IMR reports submitted to the panel. Substance misuse in victims can increase their vulnerability and may also mask the seriousness of the violence[38] perpetrated against them. Ella also had a diagnosis of borderline personality disorder. The combination of these factors alongside domestic abuse resulted in Ella having multiple complex needs:

> *A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing. Such needs typically interact with and exacerbate one another leading to individuals experiencing several problems simultaneously. These needs are often severe and/or long standing, often proving difficult to ascertain, diagnose or treat. Individuals with complex needs are often at, or vulnerable to reaching crisis point and experience barriers to accessing services; usually requiring support from two or more services/agencies.[39]"*

There are many barriers to accessing support for victims of domestic abuse but one of the key factors for victims like Ella is their ability to meet the requirements of lots of separate

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[37] https://warwick.ac.uk/fac/soc/law/research/projects/999368_law_domestic_violence_main_research_report_final_final_pre-print.pdf

[38] World Health Organization (2006). 'Intimate Partner Violence and Alcohol', p1-10. Retrieved from fs_intimate.pdf (who.int)

[39] The All-Party Parliamentary Group on Complex Needs and Dual Diagnosis (APPG) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf

agencies. We can also see throughout the IMR information that the community mental health team did not at the time liaise well with other agencies. This has since been rectified and the system in Cumbria is a great deal more robust.

Exclusion is a common theme for individuals, and they may find their needs labelled too complex – or too challenging – for the service they are trying to access. 'Complex' is often equated with 'difficult'. Those with complex needs are frequently considered challenging or difficult to work with whereas in reality, they challenge our *way of working*. This is a good thing[40]. The extent to which individuals are treated with dignity and respect by services will directly impact on their engagement going forward.

Ella was a very sociable woman, her character meant that she liked to be around people and in the last few months of her life she was very alone, confined to her home:

> *She loved to socialise, even if it was nothing exciting, she enjoyed company (Friend)*

There is a lot of evidence to suggest that agencies, particularly Social Care, victim support and midwifery services went to Ella's address whilst she was with Ryan. However, despite some effort to engage in contact Ella, there are much fewer visits to her once Ryan had left and she had lost her children.

> *When you have health issues the last thing you want to do is leave the house and, try and sort it. If she wasn't happy or had to face something she didn't like she would avoid the situation to not get more heartache… My advice for professionals is to be more sympathetic and, to stop treating people who need help like they have to do it all themselves, if you're that hopeless how can you, with no motivation? (Friend)*

It is essential that all agencies understand the added barriers for victims with multiple and complex needs. The individual's presenting issues (for example, drug use, domestic abuse, mental health issues) may 'mask' other complexities (for example, childhood trauma, cognitive impairment, low levels of literacy and so on).

We can see from the IMRs that not every agency had all the information at one time, for example:

- Community mental health (CMH) practitioners were unaware of Ella's alcohol use, and only found out a few weeks before her death.
- Liaison between community mental health and Social Care was fairly late into the interventions and the social worker was unaware that Ella was under the care of CMH or of her mental health diagnosis.
- Substance misuse services had no idea about the domestic abuse that Ella was being subjected to until 2019 when Ella told them herself. They were also unaware that Ryan used substances too.
- Cumbria Constabulary noted that they missed opportunities to assess Ella better when she was in custody after having her children removed. In addition, the IMR author noted that the police would have delivered the charging decision differently if they had been aware she was under the care of CMH.

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[40] Complex needs capable, defining complex needs, 2013, http://www.complexneedscapable.org.au/why-be-complex-needs-capable.html#defining

- Both Cumbria Constabulary and CSC noted that during that time there were missed opportunities to intervene for Ella, particularly when professionals noticed a decline in her mental health, with her behaviour and presentation in the months leading up to her death. A care plan and multi-agency meetings could have been facilitated.
- Aside from the MARAC meeting there is no evidence to suggest that CMH attended any multi-agency meetings or routinely spoke to other agencies about Ella's care.
- After the first draft of this review was sent to the GP surgery, they commented on the fact that they were unaware of everything that Ella was going through. The lead GP noted that Ryan's behaviour was far worse than they had anticipated.

The reality is that when dealing with women with multiple and complex needs each issue needs to be prioritised with equal parity. If organisations 'treat' their speciality in silo and do not share information appropriately or understand the complexities of what is going on for a victim like Ella, work with them will be sporadic and hard to move forward.

For victims who have complex needs they are often seen as problematic by agencies, but the perpetrator will use their vulnerabilities as leverage against them[41].As previously stated in section 11.1, Coercive and Controlling Behaviour, Ryan appears to have used Ella's vulnerabilities to his advantage and it is imperative to acknowledge the linked behaviour of perpetrators; they will use substance misuse, and or mental health issues to their advantage and professionals must be alert to this when dealing with victims and survivors of domestic abuse.

This leads onto the importance of training for trauma informed practice.

11.2 Trauma Informed Practice

Trauma Informed Practice across multi-disciplines is being rolled out for professionals. There is a wealth of information regarding the need for services to respond in a trauma informed way to their service users.

The six guiding principles[42] to trauma informed care are as follows:

1. Safety
2. Trustworthiness & transparency
3. Peer support
4. Collaboration & mutuality
5. Empowerment & choice
6. Cultural, historical & gender issues

With regards to domestic abuse victim's trauma informed practice is of paramount importance to foster trust, engagement, and disclosures. Although practitioners engaging with Ella have done so with empathy, the systems, and processes that organisations operate under are not supportive of trauma informed work, this is particularly relevant to victims with multiple and complex needs:

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[41] http://www.ncdsv.org/images/WomensSubAbusewheelNOSHADING.pdf
[42] https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

1. Process: Substance misuse services have a policy of discharging clients if they do not show for two separate appointments

   Reflection for Trauma informed policy approach: A blanket policy like the above means that victims who are unable to attend due to the perpetrator making it difficult for them, equates to the care they have pro-actively punishes them for the abuse they are being subjected to.

2. Process: Community Mental Health team informed Ella that if she failed to attend another appointment she would be discharged from the service. This was at a point that Ella had lost her children, her substance misuse was at its worst, and she was pregnant. Ella told CMH that if they discharged her, she "may as well kill herself".

   Reflection for Trauma informed policy approach: Although it is understandable that organisations have to set boundaries and ensure resources are used appropriately, with a client like Ella the approach to how the policy is imparted, needs to be empathetic, creative and the reasons of non-attendance understood holistically and in the round in terms of all her issues, not just her mental health.

3. Process: Ella was told to self-refer to Mental health services by the GP, at a time when she had lost her children and her alcohol intake was increasing

   Reflection for Trauma informed policy approach: The IMR author noted that the likelihood for self-referral at this time in Ella's life would have been difficult. Although it is understood that motivation is very important for interventions to work, a trauma informed approach would account for the fact that Ella had willingly disclosed her issues but was unlikely to have the motivation to complete paperwork or self-referral actions at that point in her life.

4. Process: Ella was frequently referred into mental health services by the GP only to be referred back when discharged by them.

   Reflection for Trauma informed policy approach: 'Bouncing around' services via referral is not uncommon for victims, especially those with complex needs. A trauma informed approach would incorporate a multi-agency response much earlier in these occurrences, to work alongside the victim to reduce their feelings of being passed around by agencies.

5. Process: Ella was written to about the charging decision by Cumbria Constabulary.

   Reflection for Trauma informed Policy approach: better information sharing between agencies can foster different approaches to how information is imparted. In Ella's case a face-to-face meeting informing her of the charging decision, with mental health workers and Social Care present could have proffered the catalyst for a care plan.

There is a further process and bureaucratic issue that needs to be reflected on with regards to the DASH risk assessment and trauma informed processes, this will be discuss below in section 11.4.

Most importantly as a starting point, organisations working in a trauma informed way will approach a person with the question from *"What's wrong with you?"* to *"What's happened to*

you?"[43]. This simple tactic can shift the thinking and the approach for professionals who are much less likely to view victims as 'non-engagers' and not taking the help offered.

11.3 Accessible Frameworks

Alongside the inaccessibility of the discharging policies of CMH and Substance misuse organisations mentioned above, the DASH as a tool needs to be reflected upon.

The use of the DASH Risk assessment tool is well established across the UK[44]. The tool is designed to allocate a risk category to victims, based on the context of the behaviour of the perpetrator[45]. The tool has become particularly useful in fostering multi-agency working and a common language in understanding what risks a victim is experiencing. However, the DASH is frequently used incorrectly and professionals all too often treat each reported incident as a separate set of facts. Thereby making victims repeat the same assessment multiple times or asking victims to do a DASH on one incident and not another. This is not what the DASH was designed for, and it is imperative that professionals understand its use is to assess the risk posed by the perpetrator, rather than use it to allocate and map out resources to victims.

The IMR author for Cumbria Constabulary noted that on several occasions the grading risk of Ryan's behaviour towards Ella was not correct and the review author would agree with this. Similarly, the final occasion that Victim Support received a referral for Ella having disclosed historic rape, CCB and physical abuse from Ryan, Ella was graded as standard risk; there is no evidence to suggest that this risk level was changed to high, which given the fact that Ella had recently separated from Ryan coupled with her complex needs would have been the most appropriate grading.

Ella was only deemed to be high risk on one occasion and thus referred to MARAC where she was afforded the opportunity of multi-agency intervention. The trouble we have with risk assessments is that they are subjective tools and too often there is an overreliance on these processes, which can sometimes get in the way of the meaningful interventions we offer victims.

On one occasion Ella was asked if she would like to be referred to MARAC by CMH, although that is an incorrect process, we can assume that what the professional was asking Ella was whether or not she wanted to complete a DASH. Ella declined. Which is her right to. The DASH can trigger all sorts of responses in victims, it is a series of intrusive questions, that will be difficult for any victim to go through. However, like most domestic abuse agencies across the UK Victim Support use the DASH with every victim as their main way of assessing what services each victim needs. There is an acceptance that professionals will not always get this assessment right, because of the subjective nature of the DASH; the training received; and whether or not the victim is ready to share or even wants to share details on any given day to the professional completing the DASH.

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[43] https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/
[44] https://www.dashriskchecklist.co.uk/
[45] https://www.dashriskchecklist.co.uk/wp-content/uploads/2022/02/DASH-Practice-Guidance-2016.pdf

The review author agrees that training on DASHs needs to be improved and repeated, and welcomes the College of Policing work with academics, frontline practitioners, and survivors to pilot the use of the Domestic Abuse Risk Assessment (DARA) model, a new risk assessment tool for frontline police officers. Research undertaken by Professor Amanda Robinson[46] evidenced inconsistencies in the way in which first responders used the DASH and subsequently recorded the risk, these issues were compounded by a lack of understanding on Coercive Control.

Victim Support in Cumbria used to have a mandatory requirement of a DASH on referral. This equates to, "no DASH, no service". The review author has the benefit of nearly 30 years in the VAWG sector, she runs a domestic abuse charity herself and has completed numerous DHRs; from this she would surmise that the DV sector, alongside commissioning frameworks, have become over prescriptive and somewhat overzealous on the use of the DASH.

The DASH is one tool, it is not the only means by which we can understand what is going on for victims, and it should not be used as a measure to prevent access to services for victims who do not want to complete it, or professionals who do not understand it. The fact that whole services are now designed around DASH gradings suggests we may have gone too far into process and need to pause and think more about accessibility for victims.

It is especially important that support for victims to access independent domestic abuse organisations should not be restricted to form filling and paperwork. We must ask ourselves what the purpose is of our own processes, and if they are preventing some victims from gaining access to our services, it is our job to reflect on that and amend our provision as necessary.

Of course, needs and risk assessments can be useful tools, especially in liaising with partner agencies. They can be used once we have engaged victims and gained their trust, but their purpose is not to lock victims out of services or to assume that a risk assessment gives us all the answers to what service is right for victims; the use of the DASH has been in operation for 15 years and the femicide rate has not reduced[47].

Academic research in 2019 suggests that the DASH has *"limited value for correctly identifying high-risk victims."*[48]

In addition, the study which looked at 350,000 incidents of domestic abuse between 2011 and 2016 found:

> *Although it is often referred to as an 'evidence-based' tool that 'saves lives',*[1] *there is not much published research estimating the classification error resulting from using DASH. We simply do not know if the classifications made with DASH are good enough (Pease et al. 2014), and we have no evidence either about its crime preventative impact. Some studies have suggested that only a small subset of factors measured by DASH are associated with 'recidivism' (Almond et al. 2017) and that DASH gradings are poor predictors of subsequent homicide (Chalkley and Strang 2017; Thornton*

[46] https://assets.college.police.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-Evidence-review-part-2.pdf
[47] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[48] https://academic.oup.com/bjc/article/59/5/1013/5518314

2017). A recent study concluded the tool is not applied consistently at the frontline and that often enough errors in recording contaminate the process (Robinson et al. 2016). Unsurprisingly, Her Majesty Inspectorate of Constabulary's (HMIC 2014) report on domestic violence recommends that the effectiveness of this approach to risk management be reviewed.[49]

Given the above we should be cautious in over emphasis on a tool that is not yet proven to be effective in the way we may hope it is. That is not to say we should stop using it, but we should not prioritise a DASH over victim's needs, access to services, or the resources afforded to victims based on a predictive grading system that has little evidence of being accurate.

It is incredibly beneficial that Cumbria Victim Support identified the access problems for victims where the DASH is the only referral mechanism. As such they have responded to this issue in an evidence based and appropriate way. This will be further reflected in section 14.1.

The panel will offer further national recommendations on the above in section 15.

They [professionals] should be going to them and, making them open in their own time, instead of sitting down and ticking a list. (Friend)

11.4 Suicide and Domestic Abuse

There are currently 9 DHRs in Cumbria where the victim has died by suicide.

Research published in February 2023 published by Agenda Alliance[50] reveals that:

- *Women who experienced abuse from a partner are three times more likely to have made a suicide attempt in the past year, compared to women who have not experienced abuse.*
- *Women living in poverty are especially at risk.*
- *Sexual abuse puts victims at raised risk of self-harm, suicidal thoughts and suicide attempts.*[51]

It is imperative that organisations across Cumbria and nationally are supported to understand how to approach the suicidal risk of victims of domestic abuse better:

Historically, the focus in suicide prevention has been on men due to their longstanding higher suicide rate. However, this has led to a worrying lack of understanding of the growing rate of attempted suicide and self-harm among women and any link with domestic abuse.[52]

This is particularly important for professionals to understand in terms of domestic abuse victims and the link to suicide. As research states[53]:

…cross-sectional, prospective and retrospective studies have consistently demonstrated that living with a violent intimate partner is a significant contributor to

[49] https://academic.oup.com/bjc/article/59/5/1013/5518314
[50] https://www.agendaalliance.org/about-us/
[51] https://www.agendaalliance.org/news/new-figures-reveal-link-between-suicidal-thoughts-and-domestic-abuse/
[52]
[53] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-98

women's adverse mental health outcomes. The most prevalent sequelae include depression, anxiety and Post-Traumatic Stress Disorder (PTSD). Furthermore, intimate partner violence is strongly associated with suicidality, sleep and eating disorders, low self-esteem, personality disorders, social dysfunction and an increased likelihood of substance misuse…

The UK government's recent Domestic Abuse Action Plan[54] has expressed "concern" about the effects of domestic abuse on suicide, it notes:

"It is devastating to know that those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide".

But as specialist researchers in the field of domestic suicide reviews point out[55]:

"…it is equally important to underscore that this [suicide] is not an inevitability, and there is much that can be done through improved training, risk assessment and support provision tailored to this context."

Increased awareness is being highlighted on victims who die by suicide, for example, in the recent coroner's report after the tragic death of Lauren Murray[56] in Greater Manchester. This case should focus professionals' minds to the potential for victims to die by suicide and or use self-harm as a coping mechanism in dealing with the trauma of domestic abuse.

Multiple disadvantages that exacerbate victims' vulnerabilities including, self-harm, substance misuse and mental health issues are important to highlight. Research commissioned by the Home Office and published in July 2022[57], analysed 32 separate DHRs where the victim had died by suicide. The findings were concurrent with much of Ella's experience, and included:

- *67% of victims who had presented signs of suicidal ideation and / or made prior suicide attempts before their death, also had a history of self-harm.*
- *Where there was alcohol and / or substance abuse documented on the part of the deceased within the DHRs, there were also often signs of consistent self-neglect and deteriorating mental health. 50% of victims had experienced challenges associated with drug and alcohol misuse, and in all cases, this served - in different and sometimes complex ways - to aggravate other vulnerabilities.*
- *Amongst the findings that our sample of DHRs most clearly reveals, then, is that victims were often navigating a variety of complex vulnerabilities and needs, and frequently doing so, moreover, in the plain sight of statutory services. Just over half of the victims had engaged with specialist domestic abuse services, almost two-thirds had engaged with mental health and / or counselling services, and similar proportions*

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54 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064427/E02735263_Tackling_Domestic_Abuse_CP_639_Accessible.pdf

55 https://warwick.ac.uk/fac/soc/law/research/projects/999368_law_domestic_violence_main_research_report_final_final_pre-print.pdf

56 https://bhattmurphy.co.uk/files/SRN%20cases/05.01.23%20SRN.pdf

57 https://warwick.ac.uk/fac/soc/law/research/projects/999368_law_domestic_violence_main_research_report_final_final_pre-print.pdf

had attended hospital or A&E services in conjunction with their abuse, with three-quarters known to have also been in at least relatively regular contact with their GPs. Notwithstanding the higher rates of drug and / or alcohol dependency indicated in the DHRs, less than 30% of victims had accessed support from specialist addiction services.

- *Periods of uncertainty in accessing long term mental health support after speaking with GPs often resulted in a faster deterioration of victim's mental health, and long waiting lists for services were common.*
- *…there was also often evidence of failures to empathise with the barriers to engagement that victims might encounter or to work creatively to overcome them, even where that non-engagement was reflective of worsening mental health or the entrenchment of pre-existing vulnerabilities or abuse. Family Member 1 recounted, for example, that though her daughter's non-engagement with support for her anxiety, depression and alcoholism stemmed from the control she was experiencing from her partner, it was an "automatic strike off" when she failed to attend an appointment. She underscored the profound inadequacy of that approach: "you know, to somebody with a problem like that, where they can't get of the house, the perpetrator doesn't allow them out of the house to know where they're going, and then you don't support them." Part of the problem in these cases lay not only in a tendency to separate mental health concerns from other vulnerabilities, but to demand a particular state of 'readiness' for mental health treatment – reflected, for example, in being drug-free, having stable accommodation or capable of reliably attending meetings at specific times or venues, which was often difficult for victims to achieve.*
- *Where there is a history of domestic abuse, withdrawal from specialist mental health services ought to be treated with caution, as a trigger for exploration, action and engagement, rather than interpreted as an autonomous decision representing victim disinterest or a lack of pressing need.*

Fortuitously the recent research by Agenda Alliance comes with a list of robust recommendations[58] on the links between women experiencing domestic abuse and the increased risk of suicide. The panel support the review of these recommendations for Cumbria, where appropriate, and will further make a national recommendation for the consideration in other areas.

…we lost our close friend to suicide, and this had always impacted our friend group. She [Ella] thought about it a lot, the first time she mentioned it was a few weeks after he passed in 2011, she wondered what it felt like and how did he feel…She did have mental issues and struggled with her self-worth. She had another occasion where in a taxi she opened the door on a road and, chucked herself out of it. She had metal put into her elbow. Nothing was really done then, she was self-harming from a young age, I never shouted at her for this as, I didn't want her to hide when she needed help (Friend)

She struggled a lot with her mental health and was self-harming from a young age. I just wish she had got support sooner, once the kids were removed, she really went downhill, and her drinking escalated (Family member).

11.5 Routine Screening

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

Health based routine enquiry or "Asking the Question" of a patient whether they have experienced domestic abuse, has been researched in detail for over a decade[59]. There are many benefits to ensuring health professionals are trained to ask patients whether they are experiencing domestic abuse, and this is of particular importance for GP practices because 41% of victims attend general practices for support[60].

We can see from the IMR submitted by UHMBT that midwives routinely asked Ella the question. However, this was not the case in her experience with community mental health or substance misuse services. CMH was patchy in its response to DA and substance misuse services did not ask Ella about DVA at all.

The chronology information provided evidence that Ella was very open and proactive about disclosing the abuse Ryan was subjecting her to. The GP noted that her mental health diagnosis did not interfere with her ability to seek help or speak about the DVA at home.

It is of paramount importance for victims of domestic abuse that they are asked the question within all health settings. The onus is on professionals to be curious and pro-actively ask their patients if they are suffering domestic abuse rather than waiting for them to ask for help themselves. This factor is arguably even more important when a victim has complex needs. Research shows us that the routine opportunities to ask victims whether they are experiencing domestic abuse in health-based settings yields better results. In addition, this should not be a one off as routinely 'asking' gives the message to victims and survivors that disclosing domestic abuse is acceptable and that everyone is asked therefore nobody is particularly targeted[61].

Health services are often a key agency, for victims of domestic abuse. In a three-and half-year period, Ella had two children by Ryan, she was in contact with CMH, had been admitted to the emergency department for an attempted suicide, had regular contact with her GP surgery, and had sought some support with substance misuse agencies. Aside from Social Care, health services had the most contact with Ella and therefore the most opportunities. Health is the catalyst in reaching victims like Ella. The nature of routine enquiry fosters a sense of openness about domestic abuse and if Ella had been asked on numerous occasions, and perhaps at earlier stages interventions could have been made sooner.

> *Ella's pregnancies were always fine, the usual pregnancy cravings and she never had complications that I saw with A. However, the youngest two children I was told of the usual, she got cravings, tiredness and she also mentioned this time she had hair loss… But she couldn't say a lot due to Ryan making her cut contact with me. She later told me the hair loss was from Ryan pulling her hair out (Friend).*

11.6 Impact of Domestic Homicide/Suicide on professionals

Through panel meetings and the IMR data, the review author was able to understand more about the impact of Ella's death on professionals. Sometimes the clinical process of a DHR

[59] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf
[60] http://irisi.org/
[61] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf p.8

does less to illuminate the impact of the loss of a victim on staff than it does to illuminate the changes that can be made. To make changes in organisational culture or practices, professionals need to feel heard and understood. Challenges on professional practice and systems is essential to bring about change, however, where before professionals can reflect on what changes are needed, they need to be supported to move past the impact of the death of someone they worked with.

The immediate aftermath of the death of a patient/service user can sometimes manifest in a trauma response from professionals. Staff within primary care, particularly the GPs surgery, felt the loss of Ella keenly. They were the closest organisation trying to support Ella at the point of her death, having tried to help her through the termination of her fourth pregnancy.

The GP was able to liaise with the chair of the review via the appropriate panel member, this provided an insight to the impact on staff at the surgery. Through correspondence with the chair of the review a doctor at the practice was able to explain:

> *I would like to emphasise…the sense of urgency with which we worked, the role of my staff in trying to desperately help procuring the pregnancy termination and the desperation my staff felt when they had failed. At the time they viewed her suicide as in some way their fault that they were unable to achieve the appointment in a format that was accessible, and some time was spent by myself helping my staff understand the underlying issues.*

The same doctor had read the first draft of the review and commented on how little the surgery knew about the full situation, which lends itself to the commentary on sharing of information at all levels with victims. However, the panel agreed that the important element to note in this section is the impact that a death linked to domestic abuse can have on professionals.

Given that Cumbria is undertaking a number of DHRs, we know that other professionals will have been affected by other suicides/homicides in the area, the review panel members all agreed that the impact on staff is rarely recognised. There are positive changes happening in Cumbria and the author of the review noted the real drive for change. However, it is important that trauma informed support is available for professionals alongside victims. These can be in the format of effective internal policies[62] which can shape the culture of the organisational response for professionals doing difficult jobs; however, the panel will recommend a coordinated multi-agency review of internal support mechanisms for staff who have been affected by the homicide or suicide of a victim of domestic abuse. This lends itself well to ensuring the workforce in Cumbria is able to tackle recommendations that have been set by panels in Cumbria on DHRs.

11.7 <u>Children and Domestic Abuse</u>

The Home Office Quality Assurance (QA) panel noted that the experience of domestic abuse that Ella and Ryan's children were subjected to were 'unseen' and 'unheard'. We know that

[62] https://iebh.eku.edu/sites/iebh.eku.edu/files/files/ATC-Staff-Wellness-121316_FINAL.pdf

experiencing domestic abuse as a child often leads to lifelong trauma and health implications for victims and these can exist well into adulthood[63]. It is therefore vital that services respond rapidly to the needs of children living with abusive parents.

Given that all three children were subject to child protection plans and ultimately removed from the care of their parents, the voice of the children, however young, is incredibly important. Section 3[64] of the Domestic Abuse Act 2021 specifically states that any child under the age of 18 years who *'sees, hears, or experiences'* the effects of domestic abuse and is related to the victim or perpetrator, is the be regarded as a victim themselves.

It is clear that CSC were alert to the abuse the children were experiencing and made steps to protect them, however the comment from the Quality Assurance panel offers the chair and the panel the opportunity to ensure the voice of children is more roundly recognised in future reviews.

12. Good practice

The panel noted the high calibre of the IMRs from all agencies. The many issues highlighted in the analysis section have already been noted by professionals and work is underway or is already completed, this will undoubtedly make a difference to victims of domestic abuse in Cumbria, particularly those with multiple and complex needs.

The model of support midwifery has in place with a specialist professional who has deeper understanding across multiple and complex needs is to be commended. More resources for roles like these in other statutory organisations should be considered.

The proactive ways in which VS and social workers tried to engage Ella and Ryan in support should be commended.

As a region Cumbria have implemented many changes in the area to respond better to victim/survivors of domestic abuse and these are reflected in full in section 14.1.

13. Key findings

13.1 Multi-Agency Training

The panel felt that multi-agency training, i.e., different organisations being trained together, would be much more beneficial than siloed training programmes. This approach builds relationships amongst professionals, creates a shared ownership, and therefore provides a more cohesive knowledge of what is available when supporting both victims and perpetrators of domestic abuse.

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[63] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3869039/

[64] https://www.cps.gov.uk/cps/news/children-classed-domestic-abuse-victims-under-new-guidance#:~:text=Section%203%20of%20the%20Domestic,be%20regarded%20as%20a%20victim.

There is a clear need to review the current training offer for all professionals on the issues highlighted in this report. Some of the issues raised require specialised and focused training including but not limited to:

- Personality Disorder Training
- Coercive and Controlling Behaviour
- Trauma informed responses
- Substance misuse and complex needs training for victims of domestic abuse
- Suicide Awareness and interventions

Some of the training above is already being implemented and this is reflected in section 15 – Action Plan.

13.2 Routine screening

The use of routine enquiry for domestic abuse in health settings is sporadic across health services. The findings in this report point to a need to revisit routine enquiry for health professionals[65], including Mental Health and Substance Misuse services. Whilst also being mindful of the intersecting needs and compounding factors of patients with complex needs.

a. Perpetrators of Domestic abuse

The benefit of hindsight means we can often see where professionals have unwittingly colluded with a perpetrator's behaviour, sometimes this comes in the form of placing all the expectations onto the victim to make changes, particularly when children are under a child protection plan. There can be a refocus of professional's minds in light of what we have learnt from Ella's life and Ryan's actions. It is easy for us as professionals to focus all our support on the victim, but when working with the whole family, or both victim and perpetrator, we must equally challenge perpetrators behaviour and hold them to account at every turn. All too often they continue to hide in plain sight, and their absence in processes or our lack of challenge just feeds into the narrative that they are either not the problem or they will not be made to take responsibility for their actions. The message this sends to victims is the same one the perpetrator sends, and it is our job to respond to that better.

Recommendations will be made by panel to re-focus minds on the tactics of perpetrators, especially where CCB is such a known feature.

b. Accessible Frameworks of support

There is a possible over reliance on the DASH across the country. Whole commissioning frameworks base service provision on the premise of grading systems and specialist domestic abuse services have focused very heavily on the importance of the DASH over the last fifteen years.

That is not to say it is not a useful tool, although we do not know it's effectiveness in predicting serious harm or homicide, or indeed reducing it, it is an excellent conversation starter – can lead onto a robust needs assessment - and its implementation cannot be underestimated in terms of the increase in shared partnership language and working together to support victims.

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[65]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

The IMR from Victim Support highlights a trend that is not unique to Cumbria or to VS themselves, they have since made changes to their system, which will be reflected in section 14.1. Professionals nationally should spend time reflecting on where our over reliance on tools or process gets in the way of victims getting support, we must also reflect on whether we are prioritising some victims over others based on a tool that doesn't have the adequate evidence to legitimately confirm whether it is accurate.

Similarly strict processes of discharging patients and service users from community mental health or substance misuse provision do not adequately reflect the understanding of what life may be like for a victim of domestic abuse. The work that has been done by CMH and substance-misuse agencies in Cumbria is encouraging as it allows for flexibility where service users have multiple needs.

Ultimately as organisations our job is to reflect and ask ourselves the purpose of the systems and tools we use, as some can act as a blocker to victims accessing support. We must ask ourselves the purpose of these tools, what we expect their outcome to be, whether we are being excessively rigid in our approach to our own systems and centring victims in our work when our overall goal is to engage them in support. The work done by VS in Cumbria can be used as a template for sharing knowledge with national partners.

13.5 Ella's loved one's (Victim Voice)

The last words of this report are reserved for Ella's loved one's:

> *There was a letter in her drawer she did not make us aware of…the letter mentioned she wasn't getting her children back. We believe that was the final tipping point with the new pregnancy and having to go through that trauma again (Friend)*
>
> *Ella was looking for someone to love her from a really young age. In every photo you will always see her smiling and laughing, but she was incredibly lonely from a young age and suffered with mental health issues and alcohol issues. Alcohol abuse was a concurrent theme from the age of 13 really.*
>
> *I was always suspicious of Ryan right from the start, there were a lot of red flags right from the start, he was constantly drinking, and he appeared emasculated by his own shortcomings. We tried to be there for her and give her advice from the start, but we couldn't tell her what to do, we just tried to be there for her.*
>
> *Ryan was incredibly lazy, and he never helped her. We knew he was abusive, and she was struggling but she shut herself off, she was so vulnerable, and he took full advantage of that.*
>
> *Ella loved her kids with all her heart. When she had A, she seemed really settled, all the pictures of her with the kids are so beautiful. Her kids gave her something to live for and a reason to survive.*
>
> *I know agencies don't often have enough funding to really get to grasp with what people need when they are in mental health crisis, but I also know how hard it is to get support for mental health issues. It was even harder for Ella because her life was often chaotic. When agencies give up on you, it makes you feel like there is no point. I think losing her children was inevitable, she was in such crisis for a long time,*

and she just couldn't cope, once that happened, she just spiralled out of control. From my perspective she was hoping and trying to get the children back, but once she got the letter from the police with the charge of child neglect, that was really the end for her, she knew she wasn't going to get them back and that broke her. You know at that point she was in the house on her own, it was COVID, and the national lockdown had just been announced, it was the house she was abused in and had previously raised and then lost her children; it is not really surprising she lost her hope then. I agree that the police could have done that differently, maybe if they had done it in person, with support she might have got the right intervention.

Something that hurts a lot of us that knew Ella was that Ryan just got away with his behaviour. For some reason he was able to pray on an already vulnerable person, he caused further damage to her mental health – he created havoc - and was never really held to account. Ryan was abusive to Ella and the children, and he walked away, taking no responsibility for his actions.

If opportunities had been different for Ella, she would have been a great Mum and could have had a happy life, it wasn't her as a person that was bad, it was circumstances and the abuse she experienced that led to her not being able to cope. I miss her a lot. (Family member)

14. Recommendations

14.1 Positive Developments in Cumbria

Police have undertaken DA Matters Training in 2022/23 and thus far they have trained around 650 officers and 65 Champions. Early findings from evaluations evidence an increased learning from officers.

Cumbria local authority is paying for the non-police version of DA Matters for their staff. Local authority staff and police officers are going on the Train the Trainers course to ensure there is a lasting legacy within the local area.

The Cumbria Adult Safeguarding Board Spring Conference 2023 had an input from Ladslikeus a CIC organisation from Manchester who do Trauma informed training - Cumbria Constabulary are looking to replicate this training for officers.

DVA incidents reported to the police involving children are now triaged within 24hrs of the incident. This allows for earlier intervention and referrals. MARACs are now held in Cumbria weekly in three separate areas and professionals are able to refer cases based on their judgement rather than on the number of positive ticks on the risk assessment form.

Multi Agency training on the DASH has been promoted and provided in April 2023

Social Care have implemented learning from Ella's case including:

- Professional Curiosity: Professional Curiosity Briefing to Execs across the Cumbria Partnership pledged/committed to deliver/train/upskill the workforce on Professional Curiosity. Undertaken training/briefings and held a conference whereby Professional Curiosity was a key theme throughout the day.

- Trauma Informed Practice: Cumbria Safeguarding Adults Board held their Spring Safeguarding Adults Conference on the 8th March where Trauma Informed Practice was the key theme throughout the day. Sessions were facilitated and presented by individuals with lived experience, focussing on the importance of being trauma informed and professionally curious when working with vulnerable adults.
- Cumbria are in the process of developing a Trauma Informed Cumbria Network across partner organisations under the Safer Cumbria Board. This will provide an opportunity for a Trauma Informed Operational Group with partners across the system to strengthen policies/procedures and to upskill our workforce in support and work alongside vulnerable children/adults and families in a trauma informed way.

Victim Support Developments on Accessible Frameworks

The following input was provided to the chair of the review from Victim Support Cumbria. The work undertaken by VS to respond to the needs of victims and the requirements of safeguarding is to be commended and their model will be highlighted by the panel as a national recommendation:

As our understanding of the dynamics of domestic abuse increases, we feel that some of tools to assess risk, particularly in relation to coercive control, are not as effective as we would like. There is also a concern that over reliance on a series of questions and ticks is not nuanced or sensitive enough to gauge a more thorough understanding, particularly around identifying patterns of behaviours and where there is little or no physical violence. We also know that use of physical violence (as opposed to the threat) may not be present in some of the most dangerous and high risk of harm situations. Given this over the last 4 years we have worked both internally and with partner agencies to ensure that we are utilising all the tools and resources to improve our response and help keep victims safe and disrupt and challenge perpetrators.

Towards the end of 2019 VS Cumbria became aware of Professor Jane Monckton Smith's Intimate partner homicide timeline research and we began to explore ways of implementing the research into our risk assessment process. Around this time Cumbria Constabulary began a MARAC Operating procedures (MoP) review process and in March 2020 released updated criteria. A result was a re-wording of MARAC eligibility criteria to ***very*** *high risk. As an IDVA service we were concerned that the re-wording of the MoP, in addition to a new team of safeguarding hub officers taking on responsibility for reviewing & assessing partner agency MARAC referrals, could result in high-risk cases being rejected by MARAC.*

Cumbria VS workers were confident to challenge any rejected MARAC referrals & provide clear rationale & professional concerns regarding the significant high-risk indicators present but were concerned that partner agencies may not have the knowledge and confidence to challenge and/or ability to evidence significant risk clusters using their professional judgement regardless of the DASH risk assessment score. During 2020 we worked to locally merge the Homicide timeline stages guidance into our risk assessment process which assisted us to build an improved picture of risk and help partner agencies with their

assessments. However, administration of completing 2 assessments was time consuming for case workers.

VS Cumbria requested permission from Professor Smith to blend her homicide timeline guidance & 8 Stages model into our DASH risk assessment tool and started to pilot the merged tool mid-2021. Once we had embedded this process in Cumbria VS and, we offered training and the merged risk tools to partner agencies across the county to increase their awareness of domestic abuse & help them to identify significant risk clusters regardless of the DASH score; with the goal of helping them to improve their understanding of risk & assisting them to be professionally curious.

This work led to VS Cumbria working with our National DA lead to create a shorter risk assessment tool based around Professor Jane Monckton Smith's 5 critical Questions & the 8 stages research. Both the merged risk assessment tools are designed to capture all known risks, using the Homicide timeline stages as guidance to evidence risk escalation rather than relying on a score/checklist.

The merged tools also assist us to move away from any victim blaming narrative, identify clear movement through the 8 stages (sometimes with limited information) & focus on the perpetrator's characteristics & behaviours. Focus on those causing the harm is critical and recognised in Governments Perpetrator strategy & implementation of the MATAC process in Cumbria. The merged tools can also help assess a perpetrators eligibility to access behaviour changing programmes.

This method also helps us to predict potential further escalation through the 8 Stages, evidence coercive & controlling behaviours and increased risk of serious harm in the absence of physical abuse. It allows VS (and other agencies) to offer support and/or intervention at an earlier opportunity in the victim's journey through the 8 stages. (Victim Support, Lee Evans Area Manager)

<u>LSCFT – Improvements as a result of Ella's case</u>

- Telephone appointments are now well established in the Community Mental Health Assessment recovery teams when Service Users are self-isolating. All patients are RAG rated (RAG rating Red/Amber/Green to ensure the most urgent cases are prioritised) on referral to the service and are reviewed following any changes in presentation. The team review the ratings weekly and increase/decrease appointments pending needs/risk.

- Clinical and Professional practice groups for Band 7 practitioners have now commenced within The Bay led by the Director of Nursing and Quality to discuss serious incident reviews and findings. Both forums have been developed to support clinicians to voice professional concerns, develop as clinical leads and provide meaningful discussion around serious incidents and assurances around implementation of actions plans.

- LSCFT recognise the complexities around clients with an Emotional Unstable Personality Disorder diagnosis and have introduced within each Community Mental Health team structured clinical management supervision through the personality disorder network.

- LSCFT Safeguarding team have developed ‘Think Family’ level 3 safeguarding training to highlight the complexities and interface of child and vulnerable adults safeguarding. To promote consideration of the service users family whatever that may look like to aid assessment of risk and clinical interventions. This incorporates the importance of developing networks and establishing relationships between practitioners working across children and adult services. It also emphasises the need for practitioners to think about the impact of adult mental health on the wellbeing of children and reiterates the use of genograms.

- Safeguarding Champions have been introduced across LSCFT networks, which supports with dissemination of any Safeguarding themes including 7 minute briefing reports on topics such as “Myth of the Invisible Men” and Routine Enquiry, along with supporting Safeguarding supervision within each team.

- LSCFT have a Domestic Abuse Operational group led by the Safeguarding team and supported by a Consultant Nurse from the network. To ensure interface with the networks in relation to this agenda, to educate and disseminate key information and to respond to strategic and legislative developments. Additionally, this group has coordinated key audit activity in relation to Domestic Abuse in order to evaluate practice standards in this area and to support the quality improvement journey.

- A training package has been produced by the safeguarding Domestic Abuse operational group, exploring the definition of domestic abuse, routine enquiry and support of victims. This is included within the preceptorship training for all newly registered practitioners across the organisation and is currently being disseminated across the whole of LSCFT through lunch and learn sessions.

- The Bay Network has supported 4 practitioners to undertake the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment train the trainer multi agency training to support the care groups.

- Domestic Abuse Policy and procedures have been updated in line with the Domestic Abuse Act 2021 these are available to all practitioners.

- To support the early identification and support of domestic abuse improvements in Rio (Mental health Case Records) have been made to support practitioners in the recording of routine enquiry. This feature is on the home page of a service users clinical records and acts as a prompt to practitioners, this will also aid organisational audit go forward.

- LSCFT has produced a safeguarding pathway and guidance for documenting onto electronic records post MARAC. This provides practitioners with clear information on who is the perpetrator, victim, significant others, which agencies are currently involved, and safety plan agreed. This enables practitioners to utilise this information and reach out to other agencies involved to coordinate effective support.

14.2 Single Agency Recommendations

All single agency recommendations were accepted by the panel and are reflected in the action plan (section 15). Where the panel felt there were further recommendations for agencies, they have added these to the action plan.

14.3 Multi-Agency Recommendations:

Training and Promotion

- Highlight to health professionals the need to report to police where a crime has/may have occurred – police have the 24/7 capacity to respond to emergency situations where intervention is required, whereas other statutory agencies do not have that capacity/ability.
- Multi-agency training for professionals on the links between suicide and domestic abuse
- Multi-agency training for professionals on how to challenge perpetrators of domestic abuse (including CCB) in positive and safe ways.
- Incorporate Trauma informed strategy and training for multi-agency professionals, thereby adopting more holistic TI practice across Cumbria.
- Health to provide an update on success of re-promotion of routine screening in health settings. In addition, re-promote and support professionals in Sub misuse and MH to adopt routine screening.
- Specialist GP to be supported via ICB to share information and raise awareness on working with patients with personality disorders.

Support for staff

- Coordinated multi-agency review of internal support mechanisms for staff who have been affected by the homicide or suicide of a victim of domestic abuse.

Information Sharing and Frameworks of support

- Ensure that all agencies are included and involved in strategy and initial child protection conferences and any follow-on core groups.
- Multi-agency partners to update on all positive developments in Cumbria (s.14.1) and feedback to CSP.
- MARAC review with SafeLives
- Amend discharging policy at for Mental Health and Substance Misuse agencies, to ensure victims of domestic abuse are not penalised for being unable to attend or engage with services.
- Adopt the use of multi-agency chronologies and or DA passport for staff across Cumbria.

14.4 National recommendations:

- The Domestic Abuse Commissioner to adopt Agenda Alliance research into the links between Domestic Abuse and suicidal thoughts – recommendations to be adopted and supported nationally, as per Agenda Alliance report[66]

[66] New Figures Reveal Link Between Suicidal Thoughts and Domestic Abuse - Agenda Alliance

- The Femicide Census[67] recommendations be promoted by the DA Commissioner for England and Wales
- A copy of the findings of Victim Support Cumbria's merged risk assessment process to be shared with VAWG networks nationally.
- DA Commissioner to respond to findings in HMIC report on review of risk assessments.

67

16. Appendix A

Terms of Reference

DHR TERMS OF REFERENCE – Cumbria 2020/South/3

1. Introduction

This Domestic Homicide Review is commissioned by in response to the death of a 28-year-old woman, who died by suicide in March 2020.

The Domestic Homicide Review (DHR) was commissioned because under the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews[68] into an incident involved 'a person to whom she was related or with whom she was or had been in an intimate personal relationship'. The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

The Cumbria Community Safety Partnership has appointed Dr Shonagh Dillon as Chair of the review panel. Dr Dillon is not employed by any of the statutory agencies involved in the review, as identified in section 9 of the Act.

2. Purpose of the review

The purpose of the review is to:

• Establish the facts, with the best information possible, that led to the death of the victim in March 2020 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the victim/family.

• Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

• Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the death.

• Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

• Consider the period of December 2017 until March 2020, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

[68] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

• Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

• Seek the involvement of any appropriate family, neighbours & friends to provide a robust analysis of the events.

• Take account of the coroners' inquest and police guidance in terms of timing and contact with the family.

• Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

• Aim to produce the report by the end of December 2022 subject to responding sensitively to the inquest process and police investigation, the individual management reviews being completed and the potential for identifying matters which may require further review.

Independent Management Reviews

The response of the relevant agencies to any referrals relating to the victim from December 2020 onwards until the point of the death March 2020 It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

What knowledge or information did your agency have that indicated she was a victim of abuse, coercive control or domestic violence and how did your agency protect her? How did your agency assess the risk that her ex/partner posed? What referrals did your agency make?

If your agency had information that indicated that the victim might be at risk of abuse, coercive control or domestic violence was this information shared? If so, with which agencies or professionals?

What knowledge or information did your agency have that indicated her ex/partner might be violent, abusive or controlling and how did your agency respond to this information?

Did Covid-19 have an impact on the support that was offered or provided to the victim? This might include early measures, restrictions, planning or sickness.

How did your agency triangulate the information that was provided by the perpetrator? Was the information he gave simply taken at face value? How did your agency explore this information with the victim? How were her views sought?

And the following specific issues identified in this particular case:

What contact, knowledge and information did your service have with the victim that could have indicated a risk of self-harm and what response was there?

Was consideration given to the victims' history of suicidality and suicide attempts when assessing her risk or how your agency responded to her needs?

Did your agency consider whether the victim's drug/alcohol use may have acted as a barrier to her disclosing that she was a victim of domestic abuse? Did your agency consider this when assessing the risk that she faced both from the perpetrator and to herself?

Did your agency consider whether the victim's mental ill health may have acted as a barrier to her disclosing that she was a victim of domestic abuse? Did your agency consider this when assessing the risk that she faced both from the perpetrator and to herself?

Did your agency have any engagement with the victim's wider family? What did you learn from them and what did your agency do with this information?

When considering your agency's response to the victim, did your agency consider the intersection of domestic abuse, substance use and mental ill health?

Is this the only suicide where domestic abuse is an antecedent?

4. Agency Involvement

Cumbria Constabulary

Children's Social Care

Lancashire & South Cumbria NHS Foundation Trust

Lancashire & South Cumbria Integrated Care Board (LSC ICB) formally known as Morecambe Bay Clinical Commissioning Group

Recovery Steps: Substance Misuse Service (formally known as Unity)

Victim Support

University Hospitals of Morecambe Bay NHS Foundation Trust

5. Individual Needs

Home Office Guidance requires consideration of individual needs and specifically requests that:

"…procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the Carer and their families? Was consideration for vulnerability and disability necessary?"

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.

- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

6. Family involvement

Home Office Guidance requires that:

“members’ of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim’s experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and Carer’s networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances”, and:

“Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.”

The review will seek to involve the family and or friends of the deceased in the review process, taking account of who in the deceased’s family wish to have involved as lead members and to identify other people they think relevant to the review process. We will seek to agree a communication strategy that keeps the family informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this. We will identify the timescale and process of the Coroner’s inquest and police investigation and ensure that the family and or friends are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

7. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

There may be a requirement to access independent legal advice on the part of the review team, and the team will seek funding of this advice from the Partnership and agree from which source this advice will be sought. At this stage it is not anticipated that the review will require additional resources or funding for their time to undertake this review. Should the scope of the review extend beyond the anticipated internal review, the review team will raise this through the Partnership for further guidance.

8. Media

All media interest at any time during this review process will be directed to and dealt with by Cumbria Community Safety Partnership.