PENNINE LANCASHIRE
COMMUNITY SAFETY
PARTNERSHIP

Domestic Homicide Review

In respect of Nicole, who took her own life in July 2022

Report produced for Pennine Lancashire Community Safety Partnership by

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Independent Chair and Author

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1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Nicole (a pseudonym), a resident of Accrington prior to her death which occurred in July 2022.

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

1.3 Nicole died in hospital in late July 2022 several days after hanging herself from a tree near the home of her partner Craig (also a pseudonym) – who had been in her company until shortly before the incident. Nicole's cause of death was given as hypoxic brain injury.[1] For several days before the incident Nicole had been living in a refuge in another town following her discharge from a hospital to which she had been admitted under the Mental Health Act. During her brief stay in the refuge she had been reported to the police as a missing person on several occasions when leaving the refuge to contact Craig. Nicole had been in a relationship with Craig for over four years during which she disclosed numerous incidents of domestic abuse to professionals which indicated a pattern of severe violence and coercive and controlling behaviour from Craig. The police investigation into Nicole's death concluded that there was no third party involvement in the hanging incident which led to her death. Lancashire Constabulary subsequently reviewed the circumstances leading up to the death of Nicole, considered whether the domestic abuse she was subjected to was the primary driver for her suicide and further considered whether there was sufficient evidence to pursue a prosecution of unlawful act manslaughter[2]. The Senior

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[1] Cerebral hypoxia - oxygen is needed for the brain to make use of glucose, its major energy source. If the oxygen supply is interrupted, consciousness will be lost within 15 seconds and damage to the brain begins to occur after about four minutes without oxygen. A complete interruption of the supply of oxygen to the brain is referred to as cerebral anoxia. If there is still a partial supply of oxygen, but at a level which is inadequate to maintain normal brain function, this is known as cerebral hypoxia.

[2] Manslaughter is primarily committed in one of three ways:

1. Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
2. Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and

Investigating Officer (SIO) who completed the review concluded that although the evidence of domestic abuse was strong and the negative impact of this on Nicole was clear, on the day on which the hanging incident took place, domestic abuse as the direct reason for the actions Nicole took to end her own life was not substantiated sufficiently to support a prosecution for unlawful act manslaughter.

1.4 On 9th September 2022 representatives of Pennine Lancashire Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) following the death of Nicole.

1.5 The review decided to consider agency contact with Nicole, her partner Craig and those of Nicole's children with whom she was in contact between June 2019 – when concerns relating to Nicole began to escalate - and her death in late July 2022. Events of relevance to the review which occurred outside this timeframe have also been considered.

1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is murdered or apparently takes their own life as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

DHR Timescales

1.7 This review began on 11th October 2022 and was concluded in December 2023. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The delay in completing this DHR is as a result of the complexity of the case, the volume of material to consider and the impact of the Lancashire Constabulary review – which delayed DHR contact with the perpetrator.

3. Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are to be agreed with Nicole's family if possible and used in the report to protect the identity of the individuals involved. At the time of her death, Nicole was 42 years old and her partner Craig was 47. Nicole was White British as is Craig.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case Nicole leaves her mother and father, a sister and seven children. Pennine Lancashire Community Safety Partnership wishes to express sincere condolences to the family and friends of Nicole.

2.0 TERMS OF REFERENCE

2.1 The terms of reference for the DHR are as follows:

1. To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

2. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.

4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and in the time leading up to the suicide.

5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes as a result of the review process, with the aim of better safeguarding families.

6. All enquiries are to be restricted to a period of no more than 3 years prior to the date of the suicide, and until the review has concluded. However, any historical information or convictions of domestic abuse, outside of this timeframe should be included.

7. To provide details of additional records concerning Domestic Violence and Medical Issues including Mental Health or Physical Injury or Disability that may have a relevant impact on the review.

8. To consider any cultural, environmental or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection, and learning why any interventions did not work for them.

9. To consider the impact that the Covid-19 Pandemic had on the victim accessing support to Domestic Abuse Services, and how the pandemic may have led to increasing episodes of Domestic Abuse, and the deterioration of the victim's mental health.

10. To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

11. To consider the impact of long term domestic abuse on the wider family, particularly the children of the victim in this case.

3.0 METHODOLOGY

3.1 On 5th August 2022 Lancashire Constabulary referred the case to Pennine Lancashire Community Safety Partnership for consideration of completing a DHR. As stated, on 9th September 2022 representatives of Pennine Lancashire Community Safety Partnership decided that the circumstances of the death met the criteria for a DHR.

3.2 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with Nicole, her partner Craig and those of her children she was in contact with.

3.3 The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

Contributors to the DHR

3.4 The following agencies provided Individual Management Reviews to inform the review:

Lancashire County Council – Adult Safeguarding
Crown Prosecution Service
Department for Work and Pensions
Lancashire County Council – Children Social Care
East Lancashire Hospital Trust
HARV Domestic Abuse Services & HARV Housing CIC
HCRG Care Group
Hyndburn Council – Environmental Health
Hyndburn Council – Housing
Lancashire and South Cumbria ICB
Lancashire and South Cumbria NHS Foundation Trust
Lancashire Victim Support
North West Ambulance Service

Lancashire Constabulary
Safenet

The following agencies provided short reports to inform the review:

High School A

3.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

The DHR Panel Members

3.6 The DHR Panel consisted of the following. After considering the risk presented by the perpetrator, it was decided not to include the names of DHR Panel members.

Role	Organisation
Housing Advice & Homelessness Manager	Hyndburn Borough Council
Centre and Business Manager	Hyndburn & Ribble Valley (HARV) Outreach Domestic Abuse Services
Quality Improvement and Safeguarding Manager,	Lancashire County Council (until June 2023)
Specialist Safeguarding Nurse Children,	HCRG Care Group
Head of Policy and OD / CSP Chair,	Hyndburn Borough Council
Specialist Safeguarding Practitioner	NHS Lancashire and South Cumbria Integrated Care Board (July 2023 onwards)

Manager	Safenet (Lancashire Refuge Service)
Policy, Information and Commissioning Manager	Lancashire County Council
Senior Practitioner	Family Care, East Lancashire Hospitals NHS Trust
Head of Environmental Health	Hyndburn Borough Council
Review Officer/Investigator	Lancashire Constabulary
Pennine Community Safety Coordinator	Blackburn with Darwen Council (January 2023 onwards)
Domestic Abuse Development Coordinator	Safenet
Pennine Community Safety Coordinator	Blackburn with Darwen Council (until January 2023)
Specialist Safeguarding Practitioner,	NHS Lancashire and South Cumbria Integrated Care Board (until July 2023)
Safeguarding Strategy and Operations Manager	Lancashire County Council (June 2023 onwards)
Community Safety Manager	Hyndburn Borough Council
David Mellor	Independent DHR Chair and Author
Head of Safeguarding/PiPoT Lead	Lancashire and South Cumbria NHS Foundation Trust
Policy and Partnership Support Officer,	Office of the Police and Crime Commissioner for Lancashire
Senior manager - Safeguarding, Inspection and Audit	Lancashire County Council
Named Professional Safeguarding Adults,	East Lancashire Hospitals NHS Trust

3.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on six occasions; 11th October 2022, 12th January, 3rd February, 30th March, 5th July and 8th September 2023.

3.8 Nicole's parents and her children were advised by letter that a Domestic Homicide Review had been commissioned and the letter was accompanied by the relevant Home Office leaflet. Nicole's parents and adult children were invited to contribute to the DHR if they wished to do so. Nicole's mother shared her account through two telephone conversations with the independent author. Nicole's eldest son shared his account via a meeting with the independent author by video conferencing. Nicole's eldest son benefitted from support provided by AAFDA (Advocacy After Fatal Domestic Abuse). Arrangements were made for Nicole's mother and her eldest son to read and comment on the final draft of the DHR report. Nicole's mother read and commented but Nicole's eldest son decided to defer reading and commenting on the DHR report after receiving unrelated news which caused him considerable stress. It is hoped that it will be possible for Nicole's eldest son to read and comment on the DHR report prior to publication. His AAFDA advocate has approved of this approach. Nicole's mother and her eldest son were offered the opportunity to choose a pseudonym. Nicole's mother said that she was happy with the pseudonym provisionally chosen by the DHR chair. Nicole's eldest son has been asked to consider a pseudonym and may be in a position to suggest an alternative pseudonym at a later stage. Neither Nicole's mother nor her eldest son wished to meet the DHR Panel.

Author of the overview report

3.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has eleven years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

3.10 The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

3.11 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

3.12 He has no connection to services in Pennine Lancashire.

Parallel reviews

3.13 An inquest into Nicole's death was held on 28th September 2023 at which the Coroner reached a conclusion of suicide. Additionally, Lancashire and South Cumbria NHS Foundation Trust (LSCFT) has completed a Serious Incident Review (SIR).

Equality and diversity

3.14 The protected characteristics relevant to Nicole are addressed in Paragraphs 6.108 – 6.112.

Dissemination

3.15 In additional to the DHR Panel members, the report will also be sent to:

Name	Organisation

(List to be completed in due course to include the Police and Crime Commissioner for Lancashire and the Domestic Abuse Commissioner for England and Wales)

4.0 INVOLVEMENT OF THE FAMILY OF NICOLE

4.1 Nicole's mother has had two telephone conversations with the independent author and Nicole's eldest son contributed to the DHR by a video conferencing conversation with the independent author.

Nicole's mother

4.2 As a child she said that Nicole had been 'quite easily led' and had become involved in glue-sniffing. Later in the conversation she said that as an adult Nicole was 'strong-willed'.

4.3 She said that Nicole found out that she was 'bi-polar' about 15 years ago.

4.4 She said that Nicole had been a 'happy go lucky' person before she met Craig. She was a good friend who would help anyone. She was employed as a carer for older people and her mother said that she loved that job.

4.5 Nicole's mother said that she and Nicole's father didn't really know Craig but she felt that 'he wasn't wired right'. She said that he manipulated and controlled Nicole. He took (used) her 'bi-polar' medication. Nicole's mother added that she could tell when Nicole had not been able to take her medication by the way she talked. She added that the medication helped to 'keep her on an even keel'. She said that Craig didn't let Nicole have her own bank account so she had no option but to go back to him. She said that he even drew money out of Nicole's bank account whilst she was in a coma prior to her death. When one of her children helped Nicole out and transferred money to her, it went into Craig's bank account. Her mother said that Nicole had always managed her own money in her earlier relationships.

4.6 She said that Nicole phoned her on the night she was found hanging. Her mother said that she hadn't realised that Nicole had been discharged from the Harbour Hospital following her admission under the Mental Health Act. Nicole's mother was critical of the Harbour for not 'sorting out' her money prior to her discharge – implying that this allowed Craig to continue to exercise financial control over Nicole. (Nicole's mother appeared to place substantial emphasis on Craig's control over Nicole's finances).

4.7 Nicole's mother said that her daughter was a 'strong bubbly person' who could fend for herself and look out for herself until she met Craig. Thereafter he (Craig) just 'chipped away and chipped away' at that independent spirit until he got control of her.

4.8 She said that Nicole had never mentioned her fear of Craig hurting her children but that threats of this nature 'would not surprise her in the slightest'.

4.9 Nicole's mother said that she and her husband 'stepped back' from supporting their daughter after she became involved with the father of child 6 and 7. As a result she said she knew less about her daughter's life during the period in which she was in a relationship with Craig than at other times in her life. (I formed the impression that Nicole's mother's knowledge of her daughter's relationship with Craig was partly or perhaps largely derived from information which

has been shared with her since Nicole's death, including possibly being a consultee on other review/investigation activity.)

4.10 Nicole's mother had no comments about services in contact with her daughter. She asked – 'how do you help someone who won't help themselves?' (Remarks which she directed at her daughter Nicole). Nicole's mother said that she felt that a Mental Health Act admission was the 'only thing'.

4.11 Nicole's mother read the final draft DHR report and said that she felt that it was a thorough report. She said that the contents of the report confirmed her view that Nicole did not get the care she needed during her second admission to the Harbour Hospital, that she should have been safe from Craig there, but she wasn't and that her benefits should have been sorted out before she was discharged. Nicole's mother said that she would like to have been informed about the bravery award for the Police Officers who tried to save her daughter's life.

Nicole's son

4.12 Nicole's eldest son contributed to the DHR by a video conferencing conversation with the independent author.

4.13 He was clear that he held Craig responsible for his mother's death, saying that if it wasn't for Craig 'she would still be here.' Nicole's son said that he felt that his mother 'had no escape' from Craig. The only escape was to take her own life.

4.14 Nicole's son said that his mother's relationship with Craig appeared 'normal' when they first got together. She didn't live with him at that time. They would go to the pub together.

4.15 The son recalled Nicole bringing two of her children to stay with him. The son said that Nicole appeared very agitated at that time and that she began pulling her hair out and banging her head on the steering wheel of her car. He said that Craig was in the car with her at that time.

4.16 Looking back, her son said that Nicole was 'one of the strongest people you could ever meet' so the idea that she could find herself in a relationship in which she couldn't look after herself was totally unexpected.

4.17 After he began looking after two of Nicole's children, Nicole's son said that he had much less frequent contact with his mother. He said that his mother went 'AWOL' and that there 'were never any presents' after this time. He said that Craig would never allow Nicole to spend time with him (her son) and would keep saying to her 'we need to go, we need to go'. This prompted a recollection of hearing Craig saying to his mother 'wait until you get home and you will get a crack'. Nicole's son said that he challenged Craig when he heard him threaten his mother in this way. However, Nicole's son said that his mother often 'put on a front' and told him not to worry about her as she would 'sort him (Craig) out'.

4.18 Nicole's son said that during his mother's relationship with Craig he noticed that she would have cuts and bruises from time to time. Sometimes he said that she said that she had harmed herself and caused the visible injuries and on other occasions his mother said that she had to say that she had injured herself or Craig would 'batter' her.

4.19 Nicole's son said that Craig kept taking his mother's phones off her and either smashing them or selling them. The son said that he helped her set up a new bank account to try and help her to keep her money separate from his. He recalled her having a 'money plan' which related to what her son described as 'emergency money' of around £1400 which she didn't tell Craig about. Nicole's son said that Craig eventually found out about this money and took it off Nicole, claiming that she owed money to him and some of his family members.

4.20 Nicole's son said that during her relationship with Craig he noticed that she was losing weight and said that it was almost as if she was 'decaying'. Nicole's son described Craig as 'the worst kind' who presented himself as loving and caring but in reality he was 'venomous' and 'scared to be alone'. The son said that Craig took his mother's 'bi-polar' medication and gave her the tramadol prescribed to him.

4.21 He recalled being approached by a Police Sergeant who sought his help to 'get his mother out' of her relationship with Craig. He said that he did what he could to support the police at that time which led to his mother being admitted to hospital under the Mental Health Act for a short time. He recalled that efforts were made to persuade his mother to go and stay with his aunt (Nicole's sister) in Greater Manchester but 'she never went'.

4.22 Nicole's son moved on to describe a subsequent occasion when the police approached him for help with his mother. He remembered the police officer saying to him that Craig would 'end up killing' his mother. He recalled that his mother agreed to go to a refuge but then went 'straight back to him (Craig)'. Nicole's son said that he began to feel helpless in that he felt that he couldn't do anything to help his mother end her relationship with Craig.

4.23 Nicole's son said that his mother feared that if she got away from Craig, he (Craig) 'would come to my (the son's) house – inferring a threat to Nicole's son should Nicole manage to leave him. He said that he recalled her saying to him 'you need to move' and going on to say, 'as soon as you move, I can leave'. Nicole's son said that he applied for a 'hundred' houses but only managed to get two viewings as they had a dog.

4.24 Nicole's son said that the police told him that his mother was pregnant and responded by saying that she couldn't be pregnant as she had been sterilised 'straight after' child 7's birth. The son recalled that, after she had been sterilised, she had said that she was pregnant to a previous partner who had pushed her down the stairs when he was drunk. Nicole's son said that his mother told that partner that she had been pregnant and had lost the baby as a result of being pushed down the stairs. Nicole's son said that he didn't know whether his mother claimed to be pregnant in order to try and keep herself safe from violence or whether there were other factors – adding that items for a baby had been found at her flat. Nicole's son suggested that his mother had not talked to him about her false pregnancy because she often tried to present herself to him as 'tough' and she may have felt that the false pregnancy indicated weakness on her part.

4.25 Nicole's son said that after her final admission under the Mental Health Act, his mother rang him from refuge 1 and sounded positive. She said that she had her own room, a shop, friends and one of her children had been to see her. Then he said that he heard Craig's voice in the background asking his mother who she was speaking to.

4.26 Nicole's son went on to describe the events which took place on the evening of the incident which led to his mother's death. He and his partner became aware that his mother planned to take her own life from a message on social media and drove to the area in which they believed she might be and arrived at the scene to see her hanging from a tree, being cut down and falling into the river below.

4.27 He said that whilst his mother was being treated in intensive care following the incident, he said that Craig was a 'nightmare' in that he kept trying to go to the hospital and visit her. The son said that he received 'phone call after phone call' from Craig. Nicole's son said that he found it difficult to deal with the fact that people felt sorry for Craig as though he and his mother had been in a 'normal' relationship. When he rang Craig to inform him that Nicole had passed away, her son said that Craig began 'kicking off' over the phone. Thereafter, he said that Craig rang him 'every single day' to ask why he was not allowed to attend Nicole's funeral. He felt that following the hanging incident, Craig 'played the victim'.

4.28 Looking back, Nicole's son said that he eventually distanced himself from his mother. He described the pattern of abuse leading to his mother being supported to go to a refuge before returning to Craig once more as a 'recurring' situation. He added that he began to feel that he simply couldn't help his mother and 'gave up on her' – which he felt that 'the authorities' did over time. He asked why agencies didn't consider helping Nicole's children to leave the area as a means of giving Nicole more confidence to leave Craig without fearing that he would harm her family. He went on to say that his mother loved her kids that much that she 'lay down her life for them'.

4.29 Arrangements were made for Nicole's son to read and comment on the final draft DHR report, supported by his AAFDA advocate. Unfortunately, shortly after taking possession of the report, but before he had the chance to read it, Nicole's son received unrelated news which caused him considerable stress. He advised his AAFDA advocate that he was not in the right frame of mind to read the report and so it was agreed to offer Nicole's son a further opportunity to read and comment on the report at a later stage and before the DHR is published.

Nicole's partner Craig

4.30 Craig was informed by letter that the DHR had been commissioned and when the Lancashire Constabulary review of their investigation into Nicole's death was completed, he was contacted by telephone to offer him the opportunity to contribute to the DHR should he wish to do so. Craig did not respond.

5.0 CHRONOLOGY/OVERVIEW

Background information (Paragraph 5.1 to 5.4)

5.1 Nicole was born in 1979. She lived with her parents during her early years but after her parents separated she appears to have lived with her father for several years in the Greater Manchester area before becoming looked after by the local authority during her teenage years and being placed in foster care in a neighbouring local authority area. Nicole experienced childhood trauma in the form of physical and sexual abuse and began self-harming from the age of 13. She gave birth to her first child at the age of 18 and went on to have seven children in all. There were periodic interventions from children's social care and partner agencies in relation to the impact of Nicole's mental ill health on her capacity to parent her children and meet their needs. Over time her children began to be cared for by other family members and at the time her relationship with Craig began in 2017 two of her children were in her care. Nicole underwent a sterilisation procedure in 2013.

5.2 Nicole had a long history of poor mental health with episodes of low mood, depression (including post-natal depression) and compulsory admissions under the Mental Health Act. She was diagnosed with personality disorder[3] in 1997. Nicole was registered with a number of different GP practices, primarily in the Pennine Lancashire area. She had a number of brief interventions from mental health services, usually presenting when in crisis, but would regularly disengage when she noted an improvement in her mental health or circumstances. In 2010 she presented at Hospital ED (Emergency Department) following an attempted hanging whilst under the influence of alcohol. Nicole's GP records indicate 'alcohol dependency' in the same year. In their contribution to the DHR both Nicole's mother and her eldest son refer to Nicole having a diagnosis of bipolar disorder[4] but this has not been confirmed from the information relating to Nicole's medical history shared with this DHR. Nicole was noted to frequently not be concordant with her medication and to regularly not attend medical appointments.

5.3 It is unclear to what extent abusive relationships may have been a factor in her history of missed medical appointments. Nicole disclosed domestic abuse in previous intimate relationships. She and her children were documented to have fled domestic abuse from her then partner in 2005 and the police investigated a Section 18 wounding against her in 2007 although she declined to support a prosecution on that occasion.

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[3] Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into 4 main areas which are emotional instability – the psychological term for which is "affective dysregulation"; disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions"; impulsive behaviour; and intense but unstable relationships with others.

[4] Bipolar disorder is a mental health condition that affects a person's moods, which can swing from one extreme to another. It used to be known as manic depression.

5.4 Craig had numerous contacts with his GP practice over the years and was twice referred to mental health services for anxiety and depression but did not engage on either occasion. It is understood that his children were permanently removed from his care in 2011 for reasons which are not known to the DHR. He attempted to take his own life by hanging in 2013. He has a number of previous convictions which primarily relate to offences of dishonesty. He was charged with several offences of violence against former intimate partners but none of these prosecutions succeeded with an important factor being the former partners declining to support a prosecution. There are two documented breaches of restraining orders in respect of a former partner.

PHASE 1 (Paragraphs 5.5 – 5.22) during which Nicole reached out to HARV and made detailed disclosures of domestic abuse - including controlling and coercive behaviour - by Craig, lost the custody of the two children who remained in her care and experienced suicidal ideation and an overdose and had a brief admission to hospital under the Mental Health Act.

5.5 On 4th May 2019 Nicole was conveyed to hospital by ambulance after contacting NWAS (North West Ambulance Service NHS Foundation Trust) via the 999 system to report 'strong thoughts' of suicide, low mood and pain in her left kidney area. She said that she had stopped taking anti-depressant medication two days earlier. She also said that she had been using crack cocaine throughout that day. She added that she lived alone and lacked community support. East Lancashire Hospitals NHS Foundation Trust (ELHT) has been unable to locate hospital ED information relating to this hospital attendance.

5.6 On 13th May 2019 Lancashire children's social care received a referral stating that the two of her children who had been in the care of Nicole (then aged 13 and 12) were residing with Nicole's adult son and his partner due to the impact of Nicole's mental health on her ability to meet the needs of the two children. Children's social care carried out an assessment which found that Nicole was unable to ensure the safety of the two children by preventing them from witnessing domestic abuse or because of Nicole's 'self-destructive' behaviours such as drinking alcohol, mood swings and attempts to take her own life. Nicole was said to be of no fixed abode and currently moving from place to place. The outcome of the assessment was that the two children would be supported by Child in Need (CIN)[5] planning – which continued until July 2020.

[5] A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. The Child in Need Plan must identify the lead professional, any resources or services that will be needed to achieve the planned outcomes within the agreed timescales. Engagement with Child in Need plans is voluntary.

5.7 On 2nd June 2019 Nicole was conveyed to hospital after her partner Craig contacted NWAS via the 999 system to say that she had taken an overdose of Tramadol[6]. He said she was unconscious, sweating profusely and had had a seizure. During the call he went on to say that Nicole was not breathing effectively and CPR instructions were given. Following CPR, Nicole apparently regained consciousness and Craig reported that she was pushing him away. The hospital ED established that Nicole had taken an 'intentional' overdose of 14 x 45mg Mirtazapine[7] and 15-20 Tramadol 'after an argument'. Nicole self-discharged the following day contrary to medical advice and prior to a psychiatric review. She was documented to have disclosed that her 'partner is controlling her'. There is no documented consideration of any action to safeguard her from harm by the hospital. A follow-up appointment with Accrington community mental health team (CMHT) appears to have been arranged but Nicole did not attend. Her GP was notified. At that time Nicole was not prescribed any medication so it is not known how she obtained the Mirtazapine or Tramadol. Her partner Craig was prescribed Tramadol at that time.

5.8 Prior to self-discharging from hospital following day (3rd June 2019) Nicole emailed HARV[8] (Hyndburn and Ribble Valley) domestic abuse team to ask, 'what help she could get' as she was in an abusive relationship where her partner 'attacked her mentally', 'abused her' and had 'stripped her naked saying she had had sex with other men'. She added that she was 'very scared' that if her partner found out that she had contacted HARV, he would 'go mad'. She said that she was in hospital after taking an overdose following a night of his 'mental torture' adding that this was the fourth time in a month she had tried to kill herself. She said that she didn't want police involvement as 'his family was very well known'. She added that she had let her children go to her son 'for now' as 'it had all made her very ill with depression'. She said she stayed with her partner as she had nowhere to live. HARV responded to Nicole to establish a safe means of contact. She agreed to phone them the following morning when she anticipated that Craig would be at work. She added that she was 'so glad' she had taken the first step and contacted HARV before she 'ended up dead', saying she felt 'so broken'.

5.9 On 6th June 2019 Nicole rang HARV. She said that this was her first opportunity to make the phone call as her partner was 'always present' and she said she was 'extremely concerned' that he would return and 'catch her' on the phone. She disclosed that he had 'physically attacked' her twice since her discharge from hospital. (HARV appeared to be under the apparently mistaken

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[6] Tramadol is a strong painkiller from a group of medicines called opiates, or narcotics. It's used to treat moderate to severe pain, for example after an operation or a serious injury. Tramadol is available only on prescription.

[7] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety. Mirtazapine is only available on prescription.

[8] HARV exists primarily to provide women and children who are experiencing or have experienced domestic violence, with a range of services which enable them to make informed decisions about their future.

impression that a Domestic Violence Protection Order (DVPO)[9] had been served on Craig). Nicole confirmed her recent hospital admission and disclosed that Craig had 'stormed' onto the ward screaming 'next time I'll leave you on the floor and not bother saving your life'. Nicole said that she had discharged herself due to the embarrassment and shame she felt about Craig's behaviour towards her whilst in the hospital. Nicole said that she had declined domestic abuse support from hospital staff as she had contacted HARV.

5.10 Nicole went on to make a number of disclosures about her relationship with Craig which she said had begun in October 2017 - although she said that they had separated briefly before resuming their relationship. She said that Craig had only recently 'allowed' her to have a new mobile phone after removing her previous phone from her two months earlier. She went on to say that the phone enabled Craig to 'check up on her' whilst he was at work and that he checked her phone and that he 'went mad' when he found a text message relating to the viewing of a private let property the previous day. He refused to go to work to ensure that she did not leave the 'bedsit' in which they lived in a shared house to attend the viewing. She added that she had saved up £700 to use as a deposit on a private letting but he had taken this off her. She said that she was registered with B-With-Us[10] but as she had accumulated rent arrears on a previous property she was unable to access a property in her own right (she was correct to state that she had accumulated rent arrears but this does not appear to have been a complete barrier to renting a property). Nicole went on to say that Craig had stopped her working as a carer because he suspected her of using her employment as an opportunity to meet men, 'forced' her to smoke crack cocaine – threatening physical violence if she did not do so – and made her transfer her benefits to his bank account. Nicole reiterated that Craig forced her to remove all her clothes to check whether she had had sex with anyone. She added that Craig isolated her from family and friends. When a refuge place for Nicole and child 5 was discussed with her, she declined this on the basis that leaving Craig could place her children at risk from him. The HARV worker strongly advised Nicole to report the domestic abuse to the police but she declined to do so because she feared the repercussions from Craig and his large family living in the area. Nicole

[9] A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agencies. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

[10] Be-With-Us is a partnership between local councils and social landlords in Blackburn with Darwen, Burnley, Hyndburn, Pendle and Rossendale to provide homes to rent to meet a range of needs. (Website states no bond or deposit required).

was also provided with safety advice including registering for the 999 text service[11] – which she said she had already done. An in-person appointment the following day was discussed but Nicole was unsure whether she would be able to attend as she said that Craig wouldn't go to work if he suspected that she was 'up to something', adding that he might have been trying to ring her during the current phone call to HARV. However, an in-person appointment was arranged for 10th June 2019.

5.11 Nicole did not attend the 10th June 2019 appointment and HARV emailed her to check that she was safe. She replied that Craig had stayed off work and said that she would re-contact HARV the following day – which she did not do. She asked HARV not to email her as Craig 'got into them'.

5.12 On 3rd July 2019 Nicole's case was reviewed by the HARV manager as Nicole had not initiated contact since 10th June 2019 and HARV had been reluctant to email her. HARV's escalation process requires contact with partner agencies where they have identified a risk but are unable to complete a risk assessment, as in this case. Later in the day HARV contacted the police to request a welfare check and children's social care to share details of the domestic abuse which Nicole had disclosed to HARV and ask them to check whether any of her children were at risk of harm as a result of the domestic abuse disclosed by their mother. The police visited Nicole who was alone as Craig was at work. She disclosed that she had made two further attempts to take her own life during the three weeks since she had last contacted HARV – once through an overdose of prescribed drugs and once by hanging (neither of these incidents appeared to have been reported at the time). She added that she currently felt clear headed and not suicidal. Nicole declined all safeguarding measures, saying that she was preparing to leave Craig and go to a refuge. She added that she had put her 'good clothes' in the boot of her car which she had parked away from the address she shared with Craig. She also advised that she had set up a new email address which she thought Craig was unaware of. The police put a marker on the address which Nicole shared with Craig to the effect that all calls were to be treated as urgent even if there was no request for the police. All future communication with Nicole was to be by email. The police completed a DASH[12] risk assessment which identified a 'high' risk and she was referred to MARAC[13] via the Multi-Agency Safeguarding Hub (MASH) and

[11] If a person cannot make voice calls, they can contact the 999 emergency services by SMS text from their mobile phone. Emergency SMS is part of the standard 999 service which has been designed specifically for people with hearing loss or difficulty with speech. Emergencies include if someone's life is at risk or a crime is happening now, someone is injured or threatened or the person needs an ambulance urgently.

[12] DASH (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to MARAC and what other support might be required.

[13] Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing

the IDVA service for ongoing support although it was noted that Nicole was already in contact with HARV. The police also submitted a 'high' risk PVP (protecting vulnerable persons) form but it was anticipated that no further action would be taken in respect of this as Nicole had declined all safeguarding measures. The DHR has received no indication that Nicole's case was considered at a MARAC meeting.

5.13 On 4th July 2019 the MASH advised HARV that children's social care would be taking no further action in response to the information shared with them by HARV the previous day as her children resided with other relatives and there were no identified risks to the children arising from Nicole's relationship with Craig. The police also contacted HARV to update on their safe and well visit to Nicole and pass on the 'safe' email address she had shared with the police. HARV emailed Nicole to ask her to get in touch with them if she required further assistance. Nicole replied that she would contact HARV soon but again requested no email contact 'in case Craig sees'.

5.14 On (Friday) 5th July 2019 the police safeguarding team contacted HARV, who documented that the police were working on a strategy which appeared to entail the arrest of Craig together with strong encouragement of Nicole to go into a refuge or other place of safety as the police feared they would be unable to 'hold' Craig. HARV responded by saying that obtaining a refuge place on a Friday afternoon would be difficult and they would require information about any additional needs such as mental health, drugs or alcohol which Nicole may have. HARV advised the police and children's social care of Nicole's fear that Craig could harm her children – specifically her adult son and her two children who lived with him - if she left Craig. Later that day the police spoke to Nicole's adult son who advised that his mother and Craig had previously assaulted each other although he noted that his mother had recently lost 'quite a bit of weight' and had recently had a 'breakdown' after not taking her medication. The adult son did not wish to become involved as he wished to focus on protecting the two younger siblings who were in his care. Whilst speaking to the police, the adult son phoned Nicole who advised the police that she had a plan to leave Craig and implied that this could take place in a week's time. The police put a marker on the eldest son's address and he agreed that his partner, his two younger siblings and himself would download the 'Hollie Guard' app which provides a range of safety features for people at risk.

5.15 During the early evening of 7th July 2019 Nicole's eldest son contacted the police via the 999 system to report that his mother Nicole and her partner Craig had attended his address and were arguing and making threats of violence. The police attended promptly but Nicole and Craig had left. A 'standard' risk DASH was completed but was not shared through the MASH as the

practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

incident was classed as a 'verbal argument only' with 'no violence used'. It is unclear to what extent the incident was initially linked to recent police contact with Nicole.

5.16 On 8th July 2019 the police updated HARV on their 5th July 2019 contact with Nicole's eldest son and Nicole and advised that Nicole was 'completely uncooperative' and 'completely unwilling to help herself' by engaging with officers. The police planned to contact Nicole again to 'see if they could get through to her somehow'. The police later developed a plan to arrange a meeting at one of Nicole's children's school with Nicole and her eldest son the following day as a pretext for assisting her to leave Craig although this plan was abandoned after Nicole was unable to leave her address to make her way to the school as Craig had not gone to work.

5.17 On 10th July 2019 Nicole visited the HARV premises in a distressed state. She was wrestling with the decision of whether to leave Craig or not. She disclosed that he had assaulted her that day. She was unhappy about the extent to which others appeared to her to be taking decisions about her and began expressing regret that she had disclosed domestic abuse to professionals. Refuges were explored in nearby towns. One of the refuges declined to offer her a place as a result of her recent attempt to take her own life and Nicole felt that the other refuge under consideration was too far away. Additionally that second refuge expressed reservations about offering her a place as she had had to be moved from that refuge in the past. Whilst at HARV, Nicole spoke to an IDVA for around two hours and was also supported to phone her sister before running out of the HARV premises and getting into her car. Officers from the police safeguarding team were present and prevented her from driving off by confiscating her car keys and then detained her under Section 136[14] of the Mental Health Act. At that time Nicole was presenting as angry, upset, shouting and saying she wished to take her own life. Nicole was taken to the hospital ED (emergency department) as a place of safety and later transferred to The Harbour Hospital[15] in Blackpool.

5.18 Nicole was admitted to The Harbour Hospital under Section 2[16] of the Mental Health Act due to increasing suicidal ideation, the main trigger for which was cited to be 'abusive

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[14] Section 136 is an emergency power which allows a constable to remove a person to a place of safety (or keep them at a place of safety), if the person appears to a police officer to be suffering from a mental disorder and to be in immediate need of care or control - if the police officer believes removal to a place of safety is necessary in the interests of that person, or for the protection of others. The person should then receive a mental health assessment, and any necessary arrangements should be made for their on-going care.

[15] The Harbour is a 154 bed mental health hospital, which provides care and treatment for adults who cannot be safely treated at home (Provider LSCFT).

[16] Section 2 of the Mental Health Act allows for a person to be admitted to hospital, for up to 28 days, to assess whether they are suffering from a mental disorder, the type of mental disorder and/or how the person responds to treatment.

relationship'. She was noted to 'use a ligature to attempt suicide in the suite'. (no further details known) Nicole reported significant controlling and coercive behaviour to the nursing team including being prevented from leaving her flat, internal examination to check she hadn't been 'cheating', physical abuse, sexual abuse, taking her phone off her when she is alone in the flat and withholding access to prescribed medication. A 'safeguarding concern' was raised. The 'safeguarding concern' was received by Lancashire County Council who took the view that the primary focus of the 'concern' related to a MHA assessment and so a safeguarding referral was not generated.

5.19 Nicole's eldest son expressed concern that Craig could 'turn up' at The Harbour and on 12th July 2019 Nicole was transferred to a different site, due to the risk of Craig attending the Harbour.

5.20 By 16th July 2019 a marked improvement in Nicole's mood and presentation was noted and she was documented to have blocked Craig's phone number and to have ended contact with him. She planned to improve her relationship with her children and requested self-discharge to her sister's address. This was agreed and she was discharged to her sister's address and was to be followed up by the Home Treatment Team (HTT) for that area. The police (presumably Lancashire Constabulary) were notified.

5.21 On 24th July 2019 the HTT for the area in which Nicole's sister lived referred her to Hyndburn, Rossendale and Ribble Valley HTT for follow up as she had moved back to live with Craig. MARAC was said to be 'involved' although there is no indication that Nicole had actually been heard at MARAC at that time.

5.22 By 1st August 2019 both HARV and the police became aware that Nicole had returned to live with Craig and no longer had the mobile phone provided to her by the police and had a new number. It was understood that her elder son had helped his mother obtain a flat but it was unclear whether she intended to use it. Her elder son said that he needed to look after the two younger siblings who were living with him and would be cutting ties with his mother. HARV decided that it was not safe to attempt contact with Nicole now that she was living with Craig again and that she was aware of how to contact HARV if she needed them.

PHASE 2 (Paragraph 5.23 – 5.37) during which domestic abuse resumed following her return to Craig, a 'breathing space' was achieved through a DVPO although it proved challenging to encourage Nicole to access alternative accommodation including refuges.

5.23 During the afternoon of 2nd August 2019 Nicole contacted the police to report that she had been assaulted in the street by a male who had also kicked her car and caused damage (This

appears to have been a 'road rage' as opposed to a domestic abuse related incident). The police attended and established that Nicole was uninjured although she disclosed that she was pregnant. Arrangements were made to obtain a statement from Nicole but she later said that she was 'too busy' to provide the statement and no further action was taken.

5.24 The following day (3rd August 2019) Nicole's eldest son contacted the police to report that his mother had phoned him to say that Craig had 'beaten her up', specifically he had punched her in the stomach and caused her to bleed from her vagina. The son added that Nicole was 13 weeks pregnant and may be having a miscarriage. The police referred Nicole to MARAC. There is no indication that Nicole was offered any support in respect of this reported pregnancy at that time.

5.25 Around 1am on 4th August 2019 Nicole contacted the police to advise that she was trying to leave Craig but he had been preventing her departure by sitting on her car. She said that she had managed to remove Craig from her car and had left and therefore did not need the police 'right now'. The incident was categorised as grade 2 (Priority – Police attendance in 1 hour) and later deferred. Telephone contact was made with Nicole on the morning of the next day (5th August 2019) when she 'sounded upset'. Shortly afterwards officers met her at a pre-arranged location when she said that she was 'halfway there' to leaving Craig, but that police involvement would 'ruin everything'. She appeared very upset and was trembling and had what were documented to be 'old ligature marks' around her neck. The officers 'raised an interest within the MASH' (the MASH reviews the DASH risk assessment and can alter the risk assessment by increasing or decreasing it as a result of the MASH review) which created a High-Risk Domestic Abuse Police Safeguarding Report which was shared with the IDVA service and MARAC.

5.26 Later the same day (5th August 2019) the police arrested Craig who denied assaulting Nicole or coercive control when interviewed. He was detained in police custody overnight. The police noted a bruise on Nicole's forehead which she said had been caused by Craig. Although Nicole declined to make a statement or support a prosecution the police recorded Nicole's disclosure on bodycam which it was hoped could enable Craig to be charged with an offence. The police spoke to a 'friend' of Nicole who stated that she (Nicole) was frequently assaulted by Craig and had sustained facial injuries when Craig smashed a plate of food over her head. The 'friend' was unwilling to provide a statement.

5.27 On 6th August 2019 Craig was released from police custody without charge although the police planned to obtain a DVPO. The police and HARV worked together in an effort to secure a refuge space for Nicole over the following days. Nicole was reluctant to leave the local area and expressed a preference for a refuge in a nearby town – which had a space for a woman with children which was therefore not available to Nicole. She had left Craig's address and initially stayed with a 'friend' in Blackpool who she later disclosed to be Craig's cousin. She appeared reluctant to divulge where she was staying and there were professional doubts about her honesty in this regard. Her eldest son was thought to be continuing to attempt to obtain a flat

for his mother. The police contacted DWP to get Nicole's 'benefits changed over'. (It is not clear what 'changing over' Nicole's benefits referred to. It was not until 27th April 2020 that the DWP changed Nicole's bank details to those of Craig (Paragraph 5.73). DWP documented that Nicole told them that her 'ex beat her up and took her money'. DWP advised her that they were unable to replace the money and that no advances were available to her at that time.) Nicole said that she planned to engage with the HTT but on 20th August 2019 she was discharged back to the care of her GP by the HTT. Following a brief input from the crisis team, Nicole had not attended any HTT appointments including a cold call to her 'home address'.

5.28 The police made a successful application to the Magistrates Court for a DVPO which was intended to afford Nicole protection from Craig for 28 days. This was served on Craig on 8th August 2019. The Order stated that Craig was not to contact, be abusive or intimidating to Nicole and gave the police the power to search his property should Nicole not be at an address where she was expected to be. It is understood that Craig had 'told the court' that he would not comply with the Order.

5.29 HARV continued in their efforts to find Nicole a space in a refuge. After refuge 1 – a complex needs refuge - initially declined a HARV referral in respect of Nicole on 12th August 2019 on the grounds that her needs would be better met elsewhere, they conditionally accepted a referral the following day subject to a telephone conversation with Nicole when they decided that they were unable to offer her a place on the grounds that she had denied that substance use was an 'impacting factor' which she needed support to address. Nicole said that whilst she had been using Crack Cocaine, this had been under duress and had not used it since leaving Craig. Refuge 1 suggested that Nicole could access a 'regular' refuge and an alternative refuge was discussed although they currently had no spaces. Refuge 1 offered to share the referral form with other refuges and later tried unsuccessfully to obtain Nicole's consent to contact children's social care to seek information which could enhance her refuge 1 referral. Around this time Nicole told HARV that she was currently living in her car and felt very vulnerable in terms of her safety and accommodation needs. She went on to say that she had 'nearly crumbled' and returned to Craig, who she said was not bothered about the DVPO, was still trying to get to her and would make her life 'hell' as soon as the Order expired.

5.30 On 20th August 2019 Nicole's case was heard at MARAC. A comprehensive summary of Nicole's recent disclosures of domestic abuse was provided. The expiry date of the DVPO was noted to be 5th September 2019. The MARAC actions included regular contact with the victim by the police and the IDVA service, support for Nicole to register with a GP practice, approach to 'Housing', for Adult Social Care to conduct a review of Nicole in respect of capacity issues and her regular declining of mental health services. There is no indication that Adult Social Care conducted a review of Nicole at that time. The DHR has been advised that it is the relevant agency's responsibility to ensure that their action was completed. MARAC did not monitor the completion of actions at that time.

5.31 The following day (21st August 2019) Nicole attended HARV in a distressed state. In an earlier phone conversation with HARV she said that she had 'nothing and non-one' and that 'everything had been taken from me'. She said that she felt anxious about her current situation and felt like she wanted to return to Craig because, despite the abuse, at least she would have somewhere to stay. She went on to say that she felt like everyone was telling her what she should do and giving her instructions and telling her what changes she needed to make in her life, without actually providing her with the means to achieve those changes.

5.32 Nicole was supported to check her status with the B-With-Us home housing association property search and rental service which advised that she was currently 'closed' and would need to re-register. However, she was reluctant to re-register because of her prior rent arrears. Nicole also rang DWP to request an urgent payment which was declined as she had already accessed an emergency payment within a specific timeframe. A HARV worker accompanied Nicole to an appointment at Hyndburn Borough Council to discuss her homelessness needs and request emergency temporary accommodation. They explained that Nicole had been made unintentionally homeless as a result of the DVPO. An assessment was completed following which it was decided that Nicole was eligible to access emergency temporary accommodation at Maundy Relief[17]. Arrangements were to be made with Maundy Relief to arrange a female night worker to be in place to support Nicole and she would be advised when she could attend the Maundy Relief building. Nicole was advised that this accommodation was a temporary solution and that her application for homelessness support would be assessed against the relevant legislative framework. Additionally, she would be expected to take the necessary steps in order to attempt to secure her own housing, including addressing the substantial rent arrears she had accumulated with Hyndburn Homes (now Onward Homes) and also re-activating her B-With-us account. HARV later texted the arrangements to Nicole to enable her to access emergency temporary accommodation that evening. Unfortunately, Nicole did not take up the offer of this accommodation, saying that she 'was scared that it would be full of alkies and smackheads'.

5.33 HARV continued to search for refuge accommodation but advised Nicole that this would continue to prove challenging given her strong preference for somewhere local.

5.34 During the early hours of 31st August 2019 Nicole contacted the police via the 999 system to report that she had been assaulted by her ex-partner Craig and had gone to a friend's house as a place of safety. Officers attended the friend's house but Nicole declined to provide a statement or support a prosecution. A 'high' risk 'domestic abuse interest was raised through MASH'.

[17] Maundy Relief offers a range of services including food, accommodation, mental and physical health services and benefit advice.

5.35 On 5th September 2019 Nicole attended 'minor injuries' where she was treated for a right wrist injury sustained following a 'trip/fall' and a cut ankle which she said had been caused by broken glass.

5.36 On 19th September 2019 Nicole was again discussed at MARAC following the 31st August 2019 referral. The MARAC actions included conducting a safeguarding visit to Nicole and to try and establish whether she was pregnant.

5.37 On 4th October 2019 Nicole phoned HARV after a period of minimal contact and said that she was now ready to go into a refuge. HARV checked refuge availability and only one refuge was available which Nicole appeared to reject on the grounds that she would prefer to go to a refuge in a different town.

PHASE 3 (Paragraph 5.38 – 5.50) during which Craig was arrested for an assault on Nicole and remanded to prison for three months. Whilst the evidence-led prosecution of Craig ultimately did not succeed, it provided agencies supporting Nicole with a further 'breathing space' during which she registered with a GP practice. She was placed in refuge 2 – although this was short lived.

5.38 During the early hours of 7th October 2019 a member of the public contacted the police to report that they had seen a van driven by Craig stop in the street following which Craig subsequently punched and kicked Nicole. Officers attended and arrested Craig for assault. He was also arrested for the 31st August 2019 assault (Paragraph 5.34). This offence had taken place during the period when the DVPO applied but the alleged breach of the Order was not proceeded with as he was charged with a substantive offence of assault. Nicole declined to provide a witness statement or support a prosecution. The police referred the matter to Crown Prosecution Service (CPS) Direct[18] to request a charging decision. The charging lawyer concluded that the Threshold Test[19] criteria were satisfied and authorised two charges, assault occasioning actual bodily harm and driving whilst disqualified. The evidence was largely reliant on the

[18] CPS Direct is a 'virtual' 15th Area (The CPS had 14 regional teams across England and Wales) and provides charging decisions on priority cases 24 hours a day, 365 days a year. Much of CPS Direct's work is out of hours. Our dedicated network of over 160 prosecutors is based throughout England and Wales. To receive a charging decision, police officers and other investigators either call a single national number and are connected to the next available Duty Prosecutor, or they submit and receive charging decisions digitally.

[19] In limited circumstances, where the Full Code Test is not met, the Threshold Test may be applied to charge a suspect. The seriousness or circumstances of the case must justify the making of an immediate charging decision, and there must be substantial grounds to object to bail. There must also be a rigorous examination of the five conditions of the Threshold Test, to ensure that it is only applied when necessary and that cases are not charged prematurely. All five conditions must be met before the Threshold Test can be applied.

account given by the independent witness. Craig was placed before Blackburn Magistrates Court the following day (8th October 2019) where he entered 'not guilty' pleas. He was remanded in custody and transferred to HMP Preston – where he remained until his trial took place on 2nd December 2019.

5.39 Both Nicole and Craig were treated at the hospital for injuries sustained during the incident. Nicole was treated for a head injury, facial bruising and a reduced range of movement to her left wrist. Craig was treated for a laceration to his upper left arm which was documented to have been caused by a knife. His arm was sutured and dressed and his GP informed. The police suspected that Craig and Nicole had been involved in 'drug taxing' (when one drug user steals drugs from another drug user) which resulted in Craig being injured following which he assaulted Nicole. The police were concerned for Nicole's safety given that Craig had a large family in the Accrington area with a reputation for violence who it was feared may seek retribution. Nicole was placed in refuge 2 on 8th October 2019 and a Domestic Violence Disclosure Scheme (DVDS)[20] disclosure made to her.

5.40 Also on 8th October 2019 Nicole completed temporary registration with GP practice 2. She was noted to reside in a refuge (refuge 2). The following day Nicole was seen by her new GP due to having found a lump in her breast. Nicole disclosed that her ex-partner used to beat her up regularly and would not allow her to see her GP in relation to the lump on her breast. She was documented to have lost 3 stones in weight in recent weeks 'due to stress and abuse'. She was also noted to have bruises across her nose, ear, head and both eyes. The GP documented that she had been 'repeatedly beaten up' over the last few days. The GP referred Nicole to the breast clinic under the two-week fast track referral for suspected breast cancer.

5.41 On 10th October 2019 Nicole's new GP practice contacted the GP practice with which she was previously registered (GP Practice 1) to request a 'note summary' and a list of medication. GP practice 2 received the 'note summary' – a brief 3 page clinical summary, which is standard practice when a person temporarily registers with a GP Practice. Full GP records would not be requested until the temporary registration became permanent. On 14th October 2019 GP practice 2 received a discharge summary in respect of her hospital attendance following the assault on 7th October 2019. This wasn't followed up by the GP, although Nicole had disclosed assaults to the GP during the 9th October 2019 consultation.

[20] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

5.42 On 18th October 2019 HARV received a phone call from Hyndburn Council who had been asked to provide homeless accommodation for Nicole after she had been asked to leave the refuge in which she had been placed. Hyndburn Council wished to establish the full circumstances of Nicole's departure from the refuge. HARV established that Nicole had been staying in a refuge for the past 9 days but had been asked to leave that day because she had slept at the refuge for only 2 of the 9 days and had 'gone AWOL' on a number of occasions and was believed to have returned to Craig – which can't be accurate as he was on remand - her 'chaotic' behaviour put others at risk and the police had been called to drunken and disorderly behaviour by Nicole that day. Hyndburn Council was informed and the possibility of sourcing alternative refuge accommodation was discussed and HARV advised of the difficulties they had encountered in obtaining a refuge place for her.

5.43 On the same date (18th October 2019) Nicole was taken to hospital ED by the police. She had sustained a sprained wrist. It is assumed that this hospital attendance was linked to the incident at the refuge. Her GP was notified.

5.44 On 23rd October 2019 the GP practice was advised that Nicole had not attended two breast clinic appointments and would not be offered any further appointments in accordance with the clinic's policy. The GP practice contacted the refuge where Nicole was staying to advise the manager that Nicole had missed two breast clinic appointments. It appears that the refuge was unsure of Nicole's whereabouts at that time and said they would contact the police in an effort to locate her and advise her to contact her GP. When the GP practice re-contacted the refuge in early November 2019 they were advised that Nicole had been advised of the missed appointments but that the refuge would speak to her again.

5.45 On 11th November 2019 Nicole's GP practice completed a MARAC information form in respect of a forthcoming MARAC meeting. They provided minimal details of their contact with Nicole and the missed breast clinic appointments but omitted the disclosures of domestic abuse she made to the GP and the lack of contact with her since she first registered.

5.46 On the same date Craig's GP practice received a letter from HMP Preston's healthcare department seeking information about why Craig had been commenced on Tramadol as this medication was of tradeable value in the prison environment. The GP practice replied that there was no reason why Craig could not be switched to a suitable alternative. The DHR has been advised that Tramadol had been prescribed as long term pain relief medication following an injury to his knee/leg.

5.47 On 13th November 2019 Nicole's GP practice was able to make direct phone contact with her to advise of the importance of attending the breast clinic appointment which resulted in a new referral to the breast clinic under the two week rule.

5.48 On 19th November 2019 Nicole's case was heard at MARAC which was made aware that Craig was remanded in custody and that Nicole was staying in a refuge.

5.49 On 27th November 2019 the breast clinic again discharged Nicole from their service after she did not attend the two appointments offered after her GP made a fresh referral. The initial GP referral to the breast clinic had included information relating to Nicole's disclosures of domestic abuse but there is no indication that this was taken into account when the breast clinic made decisions following Nicole's missed appointments.

5.50 On 2nd December 2019 Craig appeared before Blackburn Magistrates Court. CPS Northwest had conducted several reviews of the case which had confirmed that there was a realistic prospect of conviction based on the account of the independent witness who had positively identified Craig. Unfortunately, the independent witness did not attend Court and efforts to contact him were unsuccessful. Matters were complicated by Nicole's attendance at Court as a defence witness. The defence advised that she had provided a signed statement indicating that she had been attacked twice on the night of the assault and that Craig was not responsible and had only acted to protect her. The prosecution advocate assessed that it was not possible to proceed with only the res gestae[21] evidence given by police officers and made an application to adjourn the case to secure the attendance of the independent witness which was refused by the Court. As a result the CPS offered no evidence leading to the charges being dismissed and Craig being released from custody.

PHASE 4 (Paragraphs 5.51– 5.71) during which there was again a 'breathing space' after Craig was arrested and briefly remanded in prison following an assault on Nicole following which she was encouraged to provide an ABE account but ultimately did not. The influence/intimidation of Craig's wider family may have been a factor. Nicole spent some time in a refuge before returning to Craig following his release from prison. She also secured a rental property in Rishton – although she may not have stayed there often – which led to a change in GP practice. The Covid-19 pandemic began.

[21] Res gestae describes a common law doctrine governing the testimony under hearsay rules. A court would normally refuse to admit evidence statements that a witness says he or she heard another person say. Res gestae is based on the belief that because certain statements are made naturally, spontaneously and without deliberation during the course of an event, they carry a high degree of credibility and leave little room for misunderstanding or misinterpretation. The doctrine held that such statements are more trustworthy than other second-hand statements and therefore should be admissible as evidence.

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5.51 On 25th January 2020 police officers found Nicole in the street distressed and intoxicated. She disclosed that she had been assaulted by Craig who she said had punched her to the head, grabbed her around the throat and struck her on the back with a fishing rod. She went on to say that he had inserted his fingers into her vagina to examine her for semen, accusing her of sleeping with other men. She said that he then strangled her. She added that the attack took place over several hours during which she lost consciousness. She was taken to hospital. In the meantime, Craig contacted the police to report Nicole missing, expressing concern for her welfare.

5.52 A 'strategy discussion' was convened and a 'high' risk Domestic Abuse interest was raised through MASH and a referral made to MARAC and the IDVA Service. Nicole initially remained in hospital whilst arrangements were being made to find her refuge accommodation. The hospital ED sent an adult safeguarding alert to the Trust adult safeguarding team which was forwarded to the hospital independent sexual violence advisor (ISVA) who visited Nicole on the ward. The hospital sent a discharge letter to Nicole's GP which referred only to a 'social problem' and did not clarify who the perpetrator of the assault was.

5.53 The police arrested Craig and contacted CPS Direct on 26th January 2020 to request a charging decision. The charging lawyer concluded that the Threshold Test criteria were satisfied and authorised charges of assault occasioning actual bodily harm and sexual assault by penetration. The evidence was reliant on the account given by Nicole. Craig was placed before the Magistrates Court on 27th January 2020 when his application for bail was refused and he was remanded to HMP Preston.

5.54 Following her discharge from hospital, Nicole initially stayed in hotel accommodation and then moved to stay with Craig's brother and his partner whilst HARV worked with Hyndburn Housing to access accommodation for her. HARV's attempts to source refuge accommodation were complicated by the fact that Nicole was unwilling to stay in a refuge too far away from home, although she said that she was open to a refuge in the area in which her sister lived. Additionally, refuge places tended to be taken very quickly when they became available which meant that Nicole's uncertainty, hesitation and continuing distress could result in her missing out on refuge spaces.

5.55 On 28th January 2020 Nicole registered with GP Practice 3 and completed a new patient questionnaire. Craig was noted as her next of kin. It is assumed that Nicole changed GP practice as a result of a change of address.

5.56 On the following day (29th January 2020) Nicole was seen by her new GP who documented that there were 'no old notes available'. She disclosed the recent assault by her 'abusive partner'

and said she had received a 'few blows' to her head which had caused her pain and noise in her ear. The GP signposted her to urgent care in light of the trauma to her head.

5.57 On 31st January 2020 the police safeguarding team engaged with Nicole in an effort to encourage her to engage with support from the IDVA service and obtain safe accommodation. Nicole was said to be currently unsure about providing an account by the achieving best evidence (ABE)[22] approach. It was noted that Nicole was homeless and staying with the brother of Craig, and there were concerns that she may be discouraged or intimidated from pursuing a complaint against Craig by his family members as they were suspected of doing previously.

5.58 On 3rd February 2020 Nicole attended the minor injuries service at Accrington Victoria to seek treatment for her ear from which fluid was documented to be coming out. It appears that she was referred to the hospital urgent care centre where she was diagnosed with a perforated eardrum. Her GP practice was notified and on 6th February 2020 received letters from the hospital ear nose and throat (ENT) clinic and the health and neck clinic which advised that Nicole had suffered some hearing loss due to the perforated eardrum – which was also infected.

5.59 On 5th February 2020 Nicole's GP practice 2 received a MARAC information request which the practice did not complete.

5.60 On the same date Craig's GP practice was again contacted by HMP Preston who made the same enquiry in relation to his Tramadol prescription as previously (see Paragraph 5.46) but there is no indication that the GP practice replied.

5.61 On 7th February 2020 Craig was released on bail following a hearing at Burnley Crown Court. He was subject to conditions of non-contact, exclusion from any address Nicole was known to be staying at, and a 'residence and a doorstep' curfew – requiring him to reside at a specified address at specified times of the day and present himself at the door on the request of a police officer. Craig's defence advised the Court that Nicole had written a letter in which she stated that she couldn't be sure that she had been digitally penetrated by Craig as she had

[22] Achieving Best Evidence (ABE) is an interview process for child and adult victims and witnesses during a criminal investigation, the pre-trial preparation process and the support available to witnesses in court. The ABE interview guidance includes video-recorded interviews with vulnerable and intimidated witnesses where the recording is intended to be played as evidence-in-chief in court. ABE is intended to promote a strong victim-centred and trauma-informed approach.

consumed alcohol at that time. It appeared that Nicole no longer wished to support the prosecution.

5.62 On 18th February 2020 Nicole's case was heard at MARAC. It was noted that there had been 8 referrals made in respect of Nicole over a twelve month period. The actions arising from the meeting included for the police officer in the case to review the case in the light of MARAC's concerns and referrals to Inspire substance misuse service and mental health services were to be considered. MARAC felt that Nicole was 'very high risk' and that agencies she contacted should encourage her to engage with support. A vulnerable marker was to be put on her new address.

5.63 On the same date HARV closed Nicole's case as she was documented to have disengaged from the service.

5.64 Also on the same date Nicole's GP practice received feedback from the MARAC meeting and a note was placed in her GP records to encourage engagement with services but the expected flags were not placed in her records.

5.65 On 25th February 2020 the police safeguarding team visited Nicole at her new address. She said that she had been unable to respond to calls as she had 'broken' the phone previously provided by the police. She said she had seen 'glimpses' of Craig in Accrington and said that she was feeling lonely and felt unsure about providing an account of the assault as she felt she was in a 'no win situation'. She was asked to reconsider refuge accommodation in Manchester.

5.66 On 25th February 2020 Nicole saw her GP in relation to the lump in her breast. She said that she had seen her previous GP about this issue but that her ex-partner would not let her out of the house to attend appointments – which was misleading as he had been on remand at the time. She disclosed that her ex-partner was in prison after assaulting her – which was also incorrect. The GP also discussed Nicole's mental health and prescribed Mirtazapine[23] and Olanzapine[24]. Nicole said that she was currently unable to eat or sleep. The GP referred her to the breast clinic.

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[23] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety.

[24] Olanzapine helps to manage symptoms of mental health conditions such as seeing, hearing, feeling or believing things that others do not, feeling unusually suspicious or having muddled thoughts (schizophrenia), feeling agitated or hyperactive, very excited, elated, or impulsive (mania symptoms of bipolar disorder) and if the person has bipolar disorder, olanzapine can also stop their mania symptoms coming back.

5.67 On 2nd March 2020 Nicole attended the breast clinic for mammogram and biopsy in an area of 'asymmetry' of her breast. She disclosed that the lump had been present since September 2019 but that her partner beat her and wouldn't allow her out of the house.

5.68 On 10th March 2020 Nicole's GP wrote to her to warn her that she was at risk of being removed from the GP practice if she continued to miss appointments – having missed two. The letter went on to advise that should there be specific problems which were preventing her from attending appointments she should contact the practice. This letter runs contrary to the MARAC request to encourage engagement with services.

5.69 On 17th March 2020 the GP received a letter from the breast clinic to advise that the results of Nicole's biopsy were normal but that a magnetic resonance imaging (MRI) scan was still recommended, which Nicole did not access.

5.70 On 23rd March 2020 the first England lockdown in response to the Covid-19 pandemic began.

5.71 On 24th March 2020 Nicole visited her GP practice to collect a fit note[25] and was seen by a GP who noted her history of domestic abuse and a prior diagnosis of personality disorder. The fit note was issued and Nicole was advised to register with a practice closer to her home as she was documented to have moved out of the Rishton area. Many subsequent fit notes were issued without Nicole being seen although the move away from in-person GP consultations introduced during the pandemic may have been a significant factor.

PHASE 5 (Paragraphs 5.72 – 5.87) during which Nicole appeared to be living with Craig again and her mental health began to deteriorate markedly culminating in an attempt to hang herself. Nicole withdrew her support for the prosecution of Craig for assaults.

5.72 During the evening of 31st March 2020 a male (not Craig) contacted the police to report that Nicole was drunk and violent in the street and 'getting into everyone's faces' and had

[25] Healthcare professionals issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

damaged the male's bicycle. The police arrested Nicole for being drunk and disorderly but after she disclosed that she had taken an overdose of drugs, she was taken to hospital where she was de-arrested and no further police action taken. Nicole was treated for an overdose of opiates and antidepressant drugs and later discharged. There is no indication that her GP practice (GP practice 3) was notified.

5.73 On 27th April 2020 Nicole contacted the Department for Work and Pensions (DWP) and advised them that her bank account had been 'frozen due to fraud' and enquired about how she could arrange to have her benefit (Universal Credit) into her uncle's bank account. A Universal Credit agent helped her to update the new bank account details which was under the name of Craig.

5.74 On 4th May 2020 Nicole contacted the Hyndburn Housing advice team to claim that she had been illegally evicted from the Rishton address. When the matter was investigated, the landlord stated that Nicole had started the tenancy in February 2020 but had never moved into the property. When contacted again by the Housing advice team, Nicole said that she was staying with a friend and didn't need emergency accommodation.

5.75 On 27th May 2020 Nicole visited her GP practice with her partner to request a continuation of her fit note which she asked to be back dated. The GP documented that her partner 'did all the talking' for Nicole.

5.76 On 3rd June 2020 Nicole contacted her GP practice to ask for an urgent review following a decline in her mental health. She was documented to have been self-harming ('minor' lacerations), and to have taken an intentional overdose of Tramadol. She was given advice to contact the crisis team if she felt she was a risk to herself, to which she responded that 'things were not as bad as that, but she needed help'. The GP attempted to call her back later that day but was unable to obtain a reply and left a voicemail message. The GP practice planned to signpost her to Mindsmatter[26] if she called back and sent her a text message to advise that she self-referred to the Lancashire Women's Centre[27].

5.77 On 17th June 2020 Nicole contacted her GP following what was documented to be an act of deliberate self-harm the previous night when she cut her arms due to 'stress and not sleeping'.

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[26] Mindsmatter is a well-being service offering a range of free psychological therapies to people aged 16 and over in Lancashire. They are part of the nationwide Improving Access to Psychological Therapies (IAPT) service delivered by Lancashire and South Cumbria NHS Foundation Trust.

[27] Lancashire Women are a charity which aims to empower women to live safer, happier and more positive lives.

She had apparently already self-referred to Mindsmatter The GP documented no active thoughts of suicide or self-harm.

5.78 On 22nd June 2020 the CPS concluded that there was no longer any realistic prospect of a conviction in respect of either charge of assault or sexual assault by penetration arising from the 25th January 2020 incident (see Paragraph 5.52). In addition to the letter she had earlier written casting doubt on the digital penetration disclosure (Paragraph 5.61), she had subsequently retracted her original account of the assault, stating that she was 'equally to blame' for the situation having been drunk and thrown a bottle at Craig, who she said had acted in 'self-defence'. She also denied that the bruise to her back was as a result of being hit with a fishing rod and said her father had inflicted this injury when she was a child. She further stated that should the case go to trial, she would give evidence in Craig's defence.

5.79 From 4th July 2020 many Covid-19 restrictions were lifted for a time although many services continued to operate exceptional delivery models.

5.80 On 17th July 2020 the CIN plan ended in respect of the two children of Nicole who were living with her eldest son (see Paragraph 5.6) as he had made a private application to the Family Court for a Child Arrangement Order[28] in order to make decisions in respect of the children.

5.81 During July 2020 children's social care received three anonymous emails which stated that Nicole had resumed her relationship with Craig which was putting pressure on her eldest son and placing her two children who lived with her eldest son at risk. Children's social care completed a children and family assessment, the outcome of which was a further CIN plan to support Nicole's eldest son to obtain the Child Arrangement Order referred to above. However, one of the children went to live with their grandparents and the case of the other child was closed by children's social care after Nicole gave consent to her eldest son to 'act with parental responsibility' in respect of this child. At that time there was a six month waiting time for Family Court hearings due to the pandemic.

5.82 On 13th August 2020 Craig appeared at Magistrates Court in respect of charges of assault and sexual assault by penetration arising from the 25th January 2020 incident (see Paragraph 5.52). No evidence was offered by the prosecution and a formal 'not guilty' verdict was recorded.

[28] These orders decide who the child is to live with or spend time with and can be granted to more than one person whether they live together or not. If a child arrangements order states that the child will live with a person, that person will have parental responsibility for that child until the order ceases.

5.83 On 24th August 2020 Nicole's GP received a letter from the mental health crisis team which advised that Maundy Relief staff had contacted them on 19th August 2020 following concerns around Nicole's deteriorating mental health, in particular experiencing suicidal ideation following an increase in the abuse disclosed when she attempted to leave the relationship with Craig. She had been referred to the HTT and advised to contact emergency services if she was unable to maintain her safety.

5.84 On 27th August 2020 Nicole's GP practice received a letter from Mindsmatter which advised that Nicole was not eligible for their support due to her self-harming behaviours, longstanding mental health difficulties and 'relationship difficulties'.

The letter recommended that Nicole discuss 'alternative options' with the HTT.

5.85 On 28th August 2020 Nicole's GP was advised that the HTT had discharged Nicole from their care on 20th August 2020 due to disengagement. The HTT letter noted that she had attempted to hang herself a few days prior to the HTT becoming involved.

5.86 On 28th October 2020 Nicole contacted her GP to request a referral back to the HTT. The GP sent a referral letter to the HTT the following day without contacting Nicole for further consultation. The HTT has no record of receiving the GP referral.

5.87 On 31st October 2020 the second England Covid-19 lockdown commenced.

PHASE 6 (Paragraphs 5.88 – 5.118) during which Nicole disclosed she was pregnant which generated professional concern for the welfare of the unborn child and concern that the birth may be concealed given the likelihood that the child would be lawfully removed at birth. Nicole's 2013 sterilisation, which would make a pregnancy very unlikely but not impossible, was not confirmed for several months. It was subsequently established that Nicole had falsely claimed she was pregnant as a means of keeping her safer from domestic abuse.

5.88 During the early hours of 8th November 2020 Craig and Nicole assaulted a female in a fast-food shop by punching and kicking her and pulling her hair. Both Craig and Nicole were arrested. The CPS subsequently authorised charges against both Craig and Nicole for assault by beating contrary to Section 39 Criminal Justice Act 1988. The evidence in the case was based on the accounts provided by the victim, a witness and CCTV footage. Whilst in police custody Nicole was seen by the LSCFT Liaison and Diversion team to whom she disclosed that she was 5 months pregnant but had not informed any health professionals and was drinking heavily, taking medication in relation to her mental health, was low in mood and had attempted to self-harm. She did not consent to an assessment by the team. The police requested midwifery to carry out

an antenatal check on Nicole. A midwife visited Nicole whilst she was in police custody and noticed that she had a 'large bump' but she was unwilling to engage in any examination at that time. Midwifery planned to visit Nicole again following her release from custody. Midwifery noted Nicole's history of mental ill health and domestic abuse. The police also made a referral to children's social care.

5.89 On 10th November 2020 the Lancashire MASH contacted Nicole's GP practice (GP practice 3) to query whether Nicole had been sterilised previously. The MASH explained that Nicole had stated that she was five months pregnant but 'information from another party' (a previous partner of Nicole) indicated that she had been sterilised previously. The GP practice advised that there was no record of any sterilisation in her 'current notes'. (The DHR has been advised that GP practice 3 did not receive Nicole's complete health records from her previous GP practice (GP practice 2 – with which Nicole had registered as a temporary patient)). Nicole had in fact been sterilised in 2013. The GP practice put a note on the system to contact 'social services' if Nicole presented at the GP practice pregnant.

5.90 On 18th and 26th November 2020 joint home visits to Nicole by a social worker and a midwife received no reply.

5.91 On 3rd December 2020 Nicole's GP issued a fit note without arranging a consultation with her although this was during the second England Covid-19 lockdown.

5.92 Just before 5am on 5th December 2020 Nicole was discovered by a police officer at the rear of Accrington Police Station in a distressed state. She stated that Craig had attacked her by repeatedly punching her to the face and she had then picked up a knife and stabbed him in the arm in order 'to get him off her'. She was arrested on suspicion of Section 18 wounding (grievous bodily harm with intent) and officers went to the address she shared with Craig but did not locate him until later in the day and established that he was 'well'. Nicole was later released and Craig was circulated as wanted for assaulting Nicole.

5.93 On 7th December 2020 Nicole contacted her GP practice to ask why her Olanzapine prescription had been decreased, adding that she still needed the higher dose as her mental health was 'still not good'. Her GP tried to contact her the following day without success and a note was added to her patient records that she should be put through to the GP if she rang again.

5.94 On 15th December 2020 midwifery made a pan-Lancashire midwifery alert after Nicole did not attend the second clinic appointment.

5.95 On 21st December 2020 Nicole attended hospital ED with an infection in the fingers of both hands which she attributed to having burned them whilst cooking. Whilst hospital ED staff would have been aware that Nicole had been heard at MARAC as this information is recorded in the 'special register', there is no indication that they were aware of the pan-Lancashire alert and contacted midwifery.

5.96 On the same date a strategy discussion[29] took place in respect of Nicole and her unborn baby at which it was decided that Section 47 Enquiries[30] would be undertaken.

2021

5.97 On 4th January 2021 Nicole phoned the DWP to advise that when she rang the DWP a few days earlier to update her bank account details, she had given the wrong details. She said that she was ringing to correct her mistake. As a result her bank account details were changed (back) to those of Craig. Maundy Relief had supported Nicole to apply for a Personal Independence Payment (PiP)[31] in September 2020 and Nicole was notified that her application for PIP had been successful later in January 2021.

5.98 On 5th January 2021 Nicole's GP attempted to phone her after she had phoned the GP practice the day before to request a fit note. The GP obtained no reply and placed a note on her file that a GP review should be carried out before another fit note was issued. On 8th January 2021 Nicole contacted the GP Practice again to request a fit note and an in-person consultation with a GP was arranged for 11th January 2021 which she did not attend.

5.99 On 6th January 2021 England entered the third national lockdown in response to the Covid-19 pandemic.

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[29] The purpose of a strategy discussion or meeting is to decide whether the threshold has been met for a single or joint agency (Children Social Care and Police) child protection investigation, and to plan that investigation. Strategy meetings are held when it is suspected a child has suffered, or is likely to suffer, serious harm.

[30] Once the strategy meeting/discussion has made a decision to initiate a Section 47 Enquiry its purpose is to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

[31] Personal Independence Payment (PIP) can help with extra living costs if a person has both a long-term physical or mental health condition or disability and difficulty doing certain everyday tasks or getting around because of their condition.

5.100 On 14th January 2021 Nicole contacted her GP practice to request an appointment the same day and she was booked in for an in-person consultation for 18th January 2021 which was completed by telephone as Nicole reported respiratory symptoms. Nicole confirmed her pregnancy saying that her last period had been in July 2020 and that she had a midwifery appointment on 22nd January 2021. The GP practice liaised with midwifery and established that no such appointment was planned and that her pregnancy was now deemed to be a 'denied/concealed' pregnancy. The GP added a note to Nicole's records that no fit note was to be issued unless Nicole was seen in-person by a GP.

5.101 On 14th January 2021 an initial child protection conference (ICPC)[32] took place at which Nicole's unborn child was made subject to a child protection plan on the ground of neglect. Nicole was estimated to be 8 months pregnant.

5.102 On 19th January 2021 MARAC considered both Nicole and Craig – apparently both as victims and perpetrators following the 5th December 2020 incident (Paragraph 5.92). Limited details of the MARAC discussion have been shared with the DHR. It was noted that Nicole had been referred to the IDVA. Children's social care are mentioned so it appears that Nicole's reported pregnancy may have been discussed.

5.103 On 3rd February 2021 a core group meeting took place at which it was stated that children's social care had commenced 'pre-proceedings'[33] and planned to complete a pre-birth assessment. Nicole had still not attended a booking appointment in respect of her pregnancy. It was said that she had consented to domestic abuse support from Hyndburn Victim Support (IDVA).

5.104 During February 2021 Nicole spoke with a social worker about a pre-proceedings meeting and indicated that she was ready to attend the meeting and leave Craig. The social worker and HARV began to explore refuge accommodation for Nicole before she decided against this course of action.

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[32] A Child Protection Conference is a meeting between parents/carers, the child or young person (where appropriate), supporters or advocates and those practitioners most involved with the child, young person and family. There is an initial conference (ICPC) which is followed by review conferences (RCPC).

[33] Pre-proceedings is both a period of time and formal process. It is where children's social care consider whether they need to apply to the Family Court to start care proceedings.

5.105 Nicole continued not to attend antenatal appointments and the social worker and health visitor attempted to make home visits but obtained no reply. Professionals were mindful of the risks to Nicole from Craig in planning their attempts to contact her.

5.106 Between 8th March and 17th May 2021 a stepped approach to lifting Covid-19 restrictions was adopted in England.

5.107 On 10th March 2021 a further core group meeting took place at which it was stated that the pregnancy remained unconfirmed. Children's social care were continuing to complete the pre-birth assessment.

5.108 On 26th March 2021 a midwife saw Nicole at the address she shared with Craig but she was denied access by Nicole who said that there was someone in the house who she didn't want to know she was pregnant. It was arranged that she would attend a booking appointment the following week, but she did not do so.

5.109 On 15th April 2021 Craig phoned Nicole's GP practice to arrange an in-person appointment for Nicole as he said she had been having 'fits'. He also wanted a back dated fit note for her. When he phoned back the following day he was strongly advised that Nicole should go to urgent care. It was documented that Craig's priority appeared to be the fit note. No fit note was eventually issued. The GP practice did not share the details of this interaction with any other agency.

5.110 On 21st April 2021 the police carried out a welfare check and confirmed that Nicole was well and appeared pregnant.

5.111 On 27th April 2021 Nicole phoned her GP practice to say that her self-harming had increased and that she had attempted to cut her throat. She also asked for a fit note. The GP offered her an in-person consultation the following day which Nicole said that she was unable to attend. The GP practice took no further action at that time.

5.112 On 6th May 2021 the police carried out a further welfare check on Nicole who was noted to be well and appeared heavily pregnant.

5.113 On 12th May 2021 a strategy meeting took place in respect of Nicole's unborn child. Concern was expressed that the parents may attempt to conceal the birth as they would be aware that the local authority would seek to legally remove the child at birth. It was noted that none of her existing 7 children were in Nicole's care, although 3 of them were then adults.

5.114 On 19th May 2021 the health visitor and midwife made a home visit. Nicole was not at home but was seen walking to her home address with shopping. She declined the visit saying that she had a Mindsmatter appointment later that day. The health visitor later established that Nicole was not under the care of Mindsmatter. The health visitor/midwife appointment was rearranged for 20th May 2021 but Nicole was unavailable on that date.

5.115 On 28th May 2021 Nicole notified the DWP of a change of bank details from those of Craig. However, Nicole contacted the DWP again on 6th July 2021 to change her bank account details back to Craig's bank account. This transaction necessitated an in-person interview with Nicole and Craig. The interview took place on 2nd August 2021 and Craig's bank details were verified. It is not known whether Nicole was accompanied by Craig although records confirmed that his bank card was provided.

5.116 On 19th July 2021 midwifery carried out checks which confirmed Nicole's prior sterilisation which meant that the likelihood that she was pregnant was low – but could not be ruled out. The following month the health visitor decided to carry out no further antenatal visits.

5.117 On 5th September 2021 Nicole attended hospital ED with a lacerated and possibly infected ankle, reporting that she had cut herself on glass. There is no indication that there was any enquiry about pregnancy or domestic abuse. Nicole's GP received a discharge summary which described the laceration of her ankle to be the result of an accident involving trauma at home. The GP Practice took no further action as there was no further action indicated for the GP in the discharge notification. This was the second unplanned hospital ED attendance during the 'concealed pregnancy' period. The East Lancashire Hospital Trust (ELHT) has advised the DHR that it is unclear whether the concealed pregnancy concerns were flagged on Nicole's patient record.

5.118 On 6th September 2021 a further strategy meeting took place in respect of Nicole's unborn child and it was agreed that it was unlikely that she was pregnant. The child protection plan was to be closed for the unborn child on the grounds that Nicole was not believed to be pregnant. A review child protection conference (RCPC) subsequently (18th October 2021) took place at which it was formally decided to close the child protection plan in respect of the unborn child as Nicole was highly unlikely to be pregnant.

PHASE 7 (Paragraph 5.119 –5.131) During this phase the reported violence recommenced following the period during which Nicole had claimed to be pregnant. Agencies appeared to be reluctant to take formal action to protect Nicole in case it increased the risk of domestic abuse she faced.

5.119 On 24th September 2021 Nicole phoned the police from a telephone outside Accrington Police Station to report that she had been assaulted by Craig and was frightened to return to their 'shared' flat – where she said that the assault had taken place. The police attended and spoke to Nicole who had returned to the flat – which Craig had left. She disclosed that Craig had punched her in the face after he had accused her of having another male in the flat and having sex with other men. She said that she did not wish to make a formal complaint as she did not want to go through the formal court process. She said that she planned to leave Craig and go to an address he did not know. She was given safety advice and a crime of assault was recorded, a referral made to MARAC and IDVA notified.

5.120 On 12th October 2021 Nicole's case was heard at MARAC at which it was agreed that a flag would be placed on the 'hospital system' should Nicole attend and that her GP should offer her an appointment should she engage and that IDVA would attempt a joint visit with 'LSCFT'. MARAC was concerned that agencies were unable to speak to Nicole.

5.121 On 21st October 2021 Nicole's GP practice received the action from MARAC requesting that they offer her an appointment should any opportunity to engage arise. The GP practice took no action in response to the MARAC action. No note was placed on their system to highlight the MARAC request nor were any active attempts made to contact Nicole.

5.122 Also on 21st October 2021 the case in which Craig and Nicole were charged with assault (Paragraph 5.87) came before the Magistrates Court but was adjourned. Nicole attended and the defence stated that she was not well enough to participate in proceedings as she stated that she had suffered a seizure, was eight months pregnant and had lost blood.

5.123 On 22nd November 2021 Nicole visited her GP practice and asked if the GP would refer her to mental health services 'due to self-harm'. Nicole was not seen by a GP nor was she encouraged to wait to be seen. No further action was taken at that time.

5.124 On 3rd December 2021 Nicole's GP issued her with a fit note following a telephone consultation. During this consultation the GP advised Nicole that she was able to self-refer to Mindsmatter. There appear to have been no flags or alerts put on Nicole's records to highlight the importance of offering her a face to face appointment.

5.125 On 10th December 2021 a community midwife contacted the police to request a welfare check on Nicole as she had phoned the hospital to report she was 8 months pregnant but had not subsequently attended the appointment arranged. The police visited Craig's flat and saw Nicole. Craig was also present. The officer documented that Nicole confirmed that she was pregnant and that midwifery could contact her via Craig's phone. Midwifery referred Nicole to children's social care on the basis that she may be in the late stages of a pregnancy.

5.126 Between 28th October and 15th December 2021 the IDVA service attempted to contact Nicole's GP practice to request them to contact Nicole in a safe way if possible and also to offer her IDVA support. In response the GP practice phoned Nicole on 21st December 2021 to offer her a face to face appointment to 'discuss medication' but Craig answered the phone. An appointment was arranged for 30th December 2021 which Nicole does not appear to have attended.

5.127 At 2.05am on 26th December 2021 Nicole contacted the police via the 999 system to report that she had been assaulted in a telephone kiosk by Craig who had caused cuts to her neck by 'holding knives to her' and that he found it 'funny' to pick up knives. She also told the call taker that she 'wanted to end it all' and 'throw herself under something'. Officers attended and noted small scratch marks and a small cut to her throat and head. They drove her to stay at a friend's address overnight. Nicole declined to support a prosecution as she stated that she 'could not face' going through the Court Process. Nicole was assessed as a high risk victim of domestic abuse and the crime of assault was recorded. The police safeguarding team were to apply for a DVPN. They also documented that no further attempts to be made to contact Nicole as police involvement 'causes her more trouble'.

2022

5.128 Nicole's further claims that she was pregnant were considered at a strategy discussion held on 9th February 2022 at which it was agreed that Nicole was highly unlikely to be pregnant and all agencies expressed concern that Nicole was stating that she was pregnant to protect herself from violence from Craig. The case was again closed by children's social care and information was to be shared with Nicole's GP and the police were to complete a 'domestic abuse notification'. (In December 2021 Nicole disclosed to a Social Worker that she had lied about being pregnant in order to protect herself from her partner).

5.129 On 18th January 2022 Nicole's case was heard at MARAC. The meeting was advised that safe contact with Nicole remained challenging and that when professionals visited her, this aggravated Craig who would injure Nicole following such visits. The police advised that Nicole's family had 'cut ties' with her which prevented contact with Nicole via family members. Contact had been made with the hairdressers situated below Craig's flat and safety planning completed with them. Children's social care advised that Nicole had falsely claimed to be pregnant as if Craig believed she was pregnant, he 'will go easy on her.' A DVPN remained under consideration 'but only if it could be managed'. There is no indication that a DVPN was obtained.

5.130 On 16th February 2022 the case in which Craig and Nicole were charged with an assault (Paragraph 5.87) came before the Magistrates Court. Neither Craig nor Nicole were present as they were stated to be Covid positive. Based primarily on CCTV evidence Nicole was convicted of

assault and no evidence was offered against Craig. Nicole was later sentenced and a fine, costs and victim surcharge imposed.

5.131 On 21st February 2022 Nicole's GP practice was advised that her case had been closed by children's social care as she was considered unlikely to be pregnant. This was documented on her GP record as 'MARAC – case closed'.

PHASE 8 (Paragraph 5.132 – 5.141) During this phase Nicole was assaulted by Craig with an ashtray and found a place in refuge 3 but did not stay there very long and after being reported as a missing person to the police, she was found at Craig's address.

5.132 On Friday 18th March 2022 Nicole attended HARV. She was very distressed and disclosed that Craig had hit her over the head with a glass ash tray that morning and she had run away whilst he was putting the bins out. She said that she had nowhere to go, adding that although she had her own flat, she could not go there as 'people just let her partner in'. She said that she had no clothes, money or a phone. The HARV worker noted a visible mark on Nicole's forehead. HARV contacted the police on Nicole's behalf after she said that she was willing to make a statement to the police but would not support a prosecution. HARV asked Nicole about her pregnancy and she initially said that she had 'lost' the baby but later disclosed that she had lied about the pregnancy to her partner to 'prevent arguments'. HARV also provided her with a mobile phone and she agreed that her new number could be shared with her eldest son.

5.133 HARV supported Nicole to obtain a place in a refuge 3. Safenet – the provider of the refuge – documented the assault with the ash tray and also financial abuse as Nicole disclosed that her benefits were paid into Craig's bank account. She stated that she was currently taking Mirtazapine (30mg) and Olanzapine (10mg) daily. Arrangements were made for Nicole to travel to refuge 3 by taxi and she arrived during the early evening of the same day.

5.134 On Saturday 19th March 2022 Safenet asked Nicole to complete the 'moving in' paperwork but she asked to do this later as she was feeling overwhelmed. She was given emotional support. Later in the day a DASH risk assessment was completed which identified a high risk and Nicole was referred to MARAC. The DHR has been advised by Lancashire Constabulary that there is no record of this MARAC referral being received.

5.135 After spending two nights in the refuge, on Sunday 20th March 2022 Nicole said that she would be 'going to see her Dad' and may not return to the refuge that evening. The overnight stay policy – no overnight stays permitted during the first 7 days following admission - was explained to Nicole.

5.136 The police had been unable to speak to Nicole prior to her departure to the refuge and on Monday 21st March 2022 they contacted HARV. The police said that they planned to arrest Craig and were considering a DVPN but if Nicole was out of the area and safeguarded, the DVPN would not be necessary. HARV contacted the refuge who advised that Nicole had stayed at her father's address the previous night and that they anticipated her return to the refuge later that day. However, Nicole requested, and was granted, permission to stay at her father's address for a second night.

5.137 Nicole did not return to the refuge on 22nd March 2022. When phoned by the refuge she said that she was safe and well and that her mother would be bringing her back to the refuge on 23rd March 2022. When contacted by Safenet on 23rd March 2022, Nicole said that she felt safe at her father's address and did not feel ready for the refuge and so she would call at the refuge to collect her belongings the following day.

5.138 Nicole did not return to the refuge on 24th March and after establishing that the address of her father provided by Nicole did not exist, on 25th March 2022 Safenet reported Nicole as a missing person to the police. They expressed concern that Nicole may have returned to Craig, adding that they had received a text message from Nicole that day in which she had written 'You know he has started again'. The police completed a missing person report and contacted Nicole by phone and she said that she was staying with her sister. Nicole was advised by the police that they would need to see her in person and she agreed to attend a police station in the town in which her sister lived for this purpose, but did not do so.

5.139 On 28th March 2022 Nicole was found at Craig's flat. She was documented to be 'safe and well' and said that she had been with Craig since leaving the refuge.

5.140 On 31st March 2022 Nicole contacted her GP practice to request an in-person appointment regarding 'mental health and self-harm'. The GP practice did not respond to this request until 4th April 2022 and an in-person appointment was arranged for 11th April 2022, which Nicole attended but left shortly after arriving and therefore was not seen.

5.141 After making further unsuccessful attempts to contact Nicole, HARV closed her case on 19th April 2022, documenting that Nicole had 'disengaged' and it was 'unsafe' to contact her.

PHASE 9 (Paragraph 5.142 –5.197) During this phase one of Nicole's children reported that Nicole had been assaulted by Craig who was arrested for Section 47 assault and coercion and control and bailed by the police. On 11th June 2022 Nicole was admitted to The Harbour Hospital under Section 2 of the Mental Health Act

following drug induced psychosis. The hospital decided to permit Craig to visit and phone Nicole during her admission and his evident controlling behaviour continued. She was reported as a missing person from the Harbour on 25th June 2022 and located by the police at Craig's address. Nicole was discharged to refuge 1 on 12th July 2022 but did not settle there and was reported missing by refuge 1 on several occasions when it is suspected that she returned to Craig. The hanging incident which subsequently led to her death took place on 21st July 2022 after she had again left the refuge and spent time with Craig.

5.142 On 4th May 2022 the High School attended by one of Nicole's children (then 16) contacted the police to report that the child had attended school in a distressed state and told staff that Nicole had been assaulted by Craig and had injuries to her face for which the child believed Nicole needed to seek medical attention. At that time the child was placed with foster carers and although there was supposed to be no contact between Nicole and her child, Nicole would often attempt to obtain money from the child.

5.143 The police were unable to locate Nicole until the following day (5th May 2022) as she had left Craig's flat and stayed elsewhere overnight. When spoken to by the police Nicole disclosed that she had tried to separate from Craig around a month ago. She went on to say that he stopped her seeing friends, leaving his flat or attending appointments. She added that she and Craig had a joint Post Office account into which her benefits were paid. She disclosed that Craig had previously attempted to strangle her and she said that she was also afraid of a member of Craig's family who had previously threatened her. She disclosed that Craig had previously threatened to hurt her eldest son. A high risk DASH was completed and a MARAC referral made. Following the incident in which she disclosed she had been assaulted by Craig, Nicole had attempted to cut her own throat and caused a 'nick' in her skin which had bled for a time.

5.144 After liaising with HARV, the police contacted Safenet and supported Nicole to obtain a place in refuge 4.

5.145 During the evening of the same day (5th May 2022) the police arrested Craig for assault occasioning actual bodily harm and coercive and controlling behaviour. Following interview he was released on police bail to enable the police to continue their investigation and prepare a prosecution file for the CPS to consider. Craig was bailed to return to the police station on 26th May 2022. His police bail conditions were not to contact or interfere with Nicole either directly or indirectly Nicole and not to approach within 50 metres any location where he knew or suspected the victim to be. When Craig answered his bail on 26th May 2022 he was released under investigation and so the prior bail conditions no longer applied. The investigation of Nicole's 5th May 2022 disclosures did not progress expeditiously and key tasks such as interviewing witnesses remained outstanding at the time of the 21st July 2022 incident in which Nicole sustained injuries which led to her death.

5.146 Shortly before midnight on 11th June 2022 Nicole contacted the police from the public telephone outside Accrington Police Station to report that her 'ex-partner' Craig had given her drugs she believed to be Crack Cocaine which had induced psychosis. She sounded distressed and went on to disclose that Craig was bullying her, following her around whilst 'feeding her' with Valium and Crack Cocaine. She added that the drugs had caused her to slur her speech and struggle to stand up which Craig had filmed and found amusing.

5.147 Officers attended shortly after 1am on 12th June 2021 - after the patrol initially deployed to this call was redeployed to a higher priority call - and they summoned an ambulance as Nicole was having difficulty breathing and had tried to cut her neck with a razor and said that Craig had laughed at her whilst she self-harmed. The ambulance crew noted Nicole to be upset and agitated and she disclosed to them that during her abusive relationship with her 'current partner' she has lost her job, home, children and car. She went on to say that she had previously 'dropped charges' against him after his family threatened her. She also disclosed that he made her take recreational drugs and that he had forced himself on her and would not allow her to wear underwear. She added that for the past 3 days she had been feeling increasingly suicidal and had made attempts to end her life in her partners presence and that he had filmed her distress and 'encouraged her', stating he was going to post it on social media.

5.148 The ambulance crew conveyed Nicole to the hospital where she was seen by the Mental Health Liaison Team (MHLT). Nicole spoke at length about her experience of domestic abuse and disclosed self-harming as a means of managing her distress by scratching her arm with a plastic bottle. A Mental Health Act assessment was completed following which it was recommended that Nicole should be admitted to hospital under Section 2 of the Mental Health Act.

5.149 During her initial admission to the hospital Nicole was also interviewed by the police who completed a high risk DASH assessment. Nicole further disclosed that Craig 'mentally tortured' her by 'calling me all the names under the sun'. She said that she continually feared violence and that she could not even go to the toilet because she was so frightened. She said that Craig – who she described as 'evil' and 'nasty' – saw all of this as a game and was driving her to want to take her own life. She said that following his recent arrest for assaulting her, she resumed their relationship after he begged her to do so. She went on to disclose that Craig had threatened to kill her kids if she did not 'get him out of jail'. She said that he had threatened to kill her and had strangled her on previous occasions.

5.150 The Police officer arranged to have the locks changed at her flat so that Craig could not gain access and the new keys were handed to Nicole at the hospital. There is also a reference to a High-Risk Trigger Plan which had been created by the Lancashire Constabulary Safeguarding team in February 2022. The Trigger Plan provided a summary of the domestic abuse history and set out requested action should Nicole seek help from the police in relation to domestic abuse from Craig.

5.151 Safeguarding referrals were completed by the ELHT and NWAS. Adult Social Care received the safeguarding referral from NWAS on 13th June 2021, noting that they had received no previous adult safeguarding referrals in respect of Nicole. At that point the identity of Nicole's abusive partner was not known. This remained the case until this information was shared with Adult Social Care by ward staff at the Harbour on 30th June 2022. The NWAS safeguarding referral re-iterated the information contained in Paragraph 5.147, but also stated that Nicole said that she normally took Crack Cocaine but what her partner had given her on 11th June 2022 had caused quite different side effects. She also disclosed tying a ligature around her neck during the two days prior to contacting the police. She went on to say that Craig had taken her mobile phone and sold it, locked her in his flat and took her prescribed medication off her. The safeguarding referral was forwarded to the Mental Health Safeguarding Adults Team.

5.152 Also on 13th June 2022 a pre-MARAC information sharing from was received by Craig's GP which placed a flag on his records to show that he was an alleged perpetrator of domestic abuse.

5.153 On 14th June 2022 Nicole was admitted to The Harbour Hospital under Section 2 of the Mental Health Act. She asked to speak to her 'ex-partner' to request him to 'bring her items' onto the ward. Nicole's request was escalated to the deputy ward manager due to the safeguarding concerns. Nicole was nursed on Level 2 – intermittent observations[34] due to risk to self.

5.154 On 15th June 2022 Nicole again disclosed that she thought that Craig had drugged her by spiking her drink and telling her that it was Crack Cocaine, which she did not believe the substance to be. She also disclosed that her suicidal thoughts were of longstanding. She said

[34] This level is appropriate when patients are potentially, but not immediately, at risk of disturbed/aggressive behaviour or risk to self. This level of observation is not appropriate where a patient is assessed as an immediate risk of suicide. This level of observation is not generally appropriate for patients who have achieved any level of unescorted leave unless specific risks exist within the ward that do not affect the general population.

Intermittent observation means that the patient's location and wellbeing should be visually checked at a specified interval. Observations frequency and timing of intermittent observations should be decided as part of the individual risk assessment.

Frequency of intermittent checks should be determined by the risk assessment and included within the care plan; level 2 observations are more frequently than hourly but do not require the person to be in continual eyesight. Consideration needs to be given to whether Level 2 observations are to be completed at regular or irregular intervals. (Taken from LSCFT Mental Health Therapeutic Observation Policy and Procedure CL071)

that she held her partner responsible for the loss of 'everything' including her children, her car and her home.

5.155 On the same date ward staff had a discussion with the hospital safeguarding team which advised staff to make 'routine enquiry' about domestic abuse when safe to do so, report any further disclosures and consider safeguarding concerns on discharge. During the day Craig contacted the ward and asked to speak to Nicole, a request which was initially denied. The ward team spoke to Nicole at Craig's request to enable her to access money and belongings although Craig advised that he was unable to drop off her belongings as his van had broken down in Manchester and he had used Nicole's money to repair it. Nicole later self-harmed with a ligature which was not attached to a fixed point.

5.156 On 16th June 2022 Nicole expressed frustration that the ward team were not enabling her to have visits with Craig, who she said was helping her. Ward staff sought advice from the hospital safeguarding team which advised that the hospital could not interfere with Nicole's human rights in respect of contact with loved ones. However, ward staff were advised to note the frequency of calls and share this information with Nicole's allocated Social Worker/IDVA and to undertake an assessment of her mental state following contact and offer support as appropriate. Ward staff were also to re-visit IDVA support as part of safety planning. A Care Programme Approach (CPA) review was to be arranged.

5.157 On 17th June 2022 Nicole tied a ligature around her neck but did not attach it to a fixed point. The ligature was removed by staff and Nicole declined one to one time with staff. Staff noted that Nicole had spoken to Craig throughout the shift via telephone.

5.158 On 18th June 2022 Nicole was visited on the ward by Craig. She was observed to be tearful during the visit but reported that it went well. Following the visit she reported increased thoughts of self-harm.

5.159 On 19th June 2022 Nicole appeared distressed following a telephone call with Craig and staff increased monitoring of her. She self-harmed by banging her head and punched a wall sustaining bruises to her hand. She declined one to one support but became settled after the incident. Later the same date Nicole was found with a ligature around her neck in her bed space following a discussion with her partner. The level of observation of Nicole was reviewed and it was decided that it would remain unchanged at level 2. PRN medication (as and when needed) was utilised and one to one time offered. Later the same day Nicole barricaded herself in her bedroom. She had a ligature around her neck and was resistive. Staff were required to put her in arm holds to remove the ligature. Staff noted that the incident was precipitated by telephone contact with Craig.

5.160 On 21st June 2022 Nicole's case was heard at MARAC when both the 4th May and 11th June 2022 incidents were considered. It was noted that Nicole was currently admitted to the Harbour Hospital under the Mental Health Act, and it was decided that the IDVA service and the Harbour Hospital should coordinate appropriate support for the victim. MARAC appeared to be unaware of the central role Adult Social Care were playing at that time.

5.161 On 21st June 2022 Nicole denied her initial disclosures that she had been 'forced' to take drugs prior to her admission and said that this disclosure reflected her paranoia at that time. It was noted that Craig continued to phone the ward and speak to Nicole. Ward staff had attended a 'safeguarding' meeting on 17th June 2022 at which it was agreed that Nicole's discharge needed to be planned carefully given the level of risk but that unescorted ground leave would be granted the following week.

5.162 On 22nd June 2022 Nicole became distressed and agitated following a visit from Craig and self-harmed by tying a ligature in her bedroom.

5.163 On 23rd June 2022 Harbour Hospital was advised of the MARAC outcome and ward staff planned to contact the IDVA service as a result. The ward team were advised by the Nurse Associate to formally assess Nicole's capacity to accept visits from Craig, taking into consideration his coercive and controlling behaviour and to fully supervise all visits by Craig. There is no indication that the capacity assessment was undertaken.

5.164 On 24th June 2022 the police investigating officer visited Nicole who declined to provide a witness statement or provide an ABE interview. She stated that she intended to leave Accrington, was 'well away' from Craig and had re-connected with her family. Nicole signed the officer's notebook to indicate that she did not wish to discuss the matter further with police. The crime was subsequently reviewed by a Sergeant who noted that Craig had not been arrested in respect of the 11th June 2022 incident and concluded that there was no realistic prospect of CPS authorising any charges as Nicole had not provided a statement and did not support a prosecution. There was no CCTV evidence or independent witnesses who had provided supporting evidence. The officer recorded on the rationale that there was no previous history of domestic abuse between Craig and Nicole which was incorrect as there was a very substantial history of domestic abuse and a domestic abuse trigger plan in place (the DHR has been advised that the Sergeant is subject to a Lancashire Constabulary Professional Standards Department investigation).

5.165 On 25th June 2022 Craig phoned the ward to inform that he would not be able to attend for his scheduled visit to Nicole due to 'issues with his car'. Nicole requested PRN and to go on unescorted leave for 30 minutes which was agreed. A member of ward staff then observed Nicole with a male in the hospital reception and she was later seen to get into a car with Craig. Nicole did not return from leave and so the hospital reported Nicole to the police as a missing

person. Craig later phoned the ward to inform them that Nicole had travelled to Preston to meet him and that he would be driving her back to the ward. Nicole also phoned the ward and stated that she was in nearby Blackpool 'town'. Ward staff later re-contacted Craig by phone and he said that Nicole did not want to return to the ward. Nicole took the phone. She was very distressed - crying and raising her voice - and became agitated when informed that she must return to hospital as she was detained under the Mental Health Act, and that failure to do so would result in the police returning her to the hospital. Around 5pm that day Craig phoned the ward to say that he had dropped Nicole off at a nearby bus stop but when staff went to the bus stop, Nicole was not there.

5.166 During the early afternoon of the following day (26th June 2022) the police attended the Harbour Hospital to obtain further details. Whilst the police were present Nicole returned to the ward, stating that she had been dropped off by Craig. Nicole said that she had seen friends whilst absent from the ward and had taken Cocaine – although a drug screen was negative. Superficial cuts to her arms and marks to her neck were noted which Nicole said that she had done herself. No routine enquiry questions were asked and Nicole's hospital risk assessment was not updated. The police submitted a Vulnerable Adult marker assessed as High Risk on the investigation for the attention of the MASH. The MASH took no further action as Nicole had returned to the Harbour Hospital and the domestic abuse trigger plan was in place.

5.167 On 28th June 2022 'volatile communication' was noted between Nicole and Craig over the phone. Nicole then refused to speak with Craig any further, following which he then became hostile and threatening to ward staff.

5.168 On 29th June 2022 a Psychology Formulation was completed by the inpatient psychologist which made the following recommendations:

- That Nicole would benefit from developing positive healthy relationships with staff and dropping in to psychology skills groups;
- That the outcome of the MARAC may identify additional safeguarding support to help reduce the risks she faced from her partner;
- Nicole would benefit from a referral to the CMHT and allocation of a Care Coordinator for a period of assessment;
- Nicole would benefit from receiving trauma-focussed psychological therapy, to help her with the consequences of her many traumatic experiences including the loss of her children;
- Nicole would benefit from accessing Inspire to help her with substance misuse.

5.169 Nicole was then discharged from inpatient psychology. No referrals to the CMHT or Inspire were made.

5.170 Also on 29th June 2022 Craig visited Nicole on the ward. The visit was supervised by ward staff who had agreed that Nicole would give them a pre-arranged signal when she wished to terminate the visit. Craig was noted to be under the influence of alcohol and ward staff noted his controlling and manipulative behaviour in withholding money from Nicole. Nicole was noted to be very upset at the conclusion of the visit and was provided with a great deal of reassurance by ward staff who planned to discuss Craig visiting Nicole whilst under the influence of alcohol at their next MDT. This issue was not discussed at the next MDT.

5.171 On 30th June 2022 Nicole was seen by the hospital social worker when Nicole raised concerns about 'outstanding payments' relating to her flat which should have been made 'automatically' but had not. The social worker contacted 'safeguarding' to ask them to contact Nicole or himself. On the same date Nicole was supported to contact Personal Independent Payments (PIP) and Universal Credit to change the payment address her vouchers were sent to and prevent any further money from 'going missing'. Craig continuously rang Nicole throughout the day (24 calls between 9.30am and 10pm) which she mostly declined due to the distress 'he was causing her'. The ward team began logging calls from Craig due to their concern that he was harassing Nicole.

5.172 On 1st July 2022 Nicole appeared distressed after receiving regular phone calls from Craig and asked staff to tell Craig that she was unavailable.

5.173 On 3rd July 2022 Nicole required support at times due to distress arising from phone calls from Craig. Nicole was advised to not answer the call if she felt it affected her mental state. She continued to talk to Craig on the phone.

5.174 On 4th July 2022 Nicole's ASC social worker was emailed by the manager of refuge 1 to advise that they had availability coming up in refuge 1. It was planned to support Nicole to complete a referral to refuge 1 so that she could be admitted direct from the Harbour. Craig rang Nicole 'countless times' which annoyed her and so she asked ward staff to tell Craig that she had gone to bed.

5.175 On the same date (4th July 2022) Nicole was supported to contact Universal Credit to cancel all DWP payment exception service[35] vouchers to her home address (address 1) so that

[35] The Payment Exception Service is a way for people who do not have a bank account to collect benefit or pension payments. They're only available in very limited circumstances.

no one was able to access her money while she was in hospital (Nicole had arranged for her benefits to be paid to her via the payment exception scheme from 5th May 2022). Universal Credit advised that they were unable to change her address until she had a phone number to contact. At that time Nicole did not have a mobile phone, having 'broken' her previous one. Arrangements were being made to access a mobile phone for Nicole, change her benefits address to the hospital for now and arrange to pay off her current debt to her landlord. The DWP have no record of this being accomplished prior to Nicole's death.

5.176 On 5th July 2022 a multi-disciplinary team meeting took place at the Harbour Hospital which was attended by the hospital ward Consultant, staff nurse, the ASC social worker (virtually), refuge 1 and the police. The IDVA service was not involved in the meeting. The ward had referred Nicole to the IDVA service on 29th June 2022 but on the day after this disciplinary multi-meeting she declined IDVA support. Nicole joined the meeting part way through. It was stated that Nicole had gradually become more settled on the ward although she had been distressed by Craig's visits. The staff nurse stated that assessments indicated that 'a lot' of Nicole's mental health issues had been as a consequence of the abusive relationship with Craig and staff had observed that Nicole's mood would 'dip immensely' when she had had phone contact with him. She presented as agitated and panicked and had shared increased urges to self-harm. During periods in which Nicole had no contact with Craig she was settled and mixed well with other patients. Nicole was said to be 'unsure' about the prospective refuge 1 placement. A referral was said to have been made to the CMHT although this didn't actually happen and HTT would provide 48 hour follow up following discharge. The police advised that there was a trigger plan should Nicole contact the police in an emergency. The ASC social worker was to develop a robust safeguarding plan for the community.

5.177 Also on 5th July 2022 Craig phoned numerous times during the shift to the point where Nicole became distressed by this. She also reported difficulty sleeping. Nicole was also tearful about the prospect of going to a refuge on discharge.

5.178 On 6th July 2022 Nicole declined to engage with the IDVA service who would not be offering further support as a result. Ward staff attempted to complete a DASH risk assessment on this date but Nicole declined. The DASH was to be followed up the next day, but this was overlooked and no DASH was attempted until 11th July 2022 when Nicole again declined.

5.179 On 7th July 2022 Nicole's GP received a MARAC information request in relation to a forthcoming MARAC meeting scheduled for 19th July 2022. There is no indication that the form was completed or returned.

5.180 On 8th July 2022 the ASC social worker phoned Nicole on the ward. She said that she had 'mixed feelings' about being discharged to a refuge and went on to say that she didn't feel that

she had come to harm from Craig and that the disclosures she previously made were as a result of paranoia brought on by using illicit drugs.

5.181 On the same date (8th July 2022) Nicole completed the refuge 1 referral by phone. She disclosed that Craig had been abusing her for 4 years and that when she attempted to leave him he would start to harass her children – which she said was her biggest fear and was why she had returned to him previously.

5.182 Also on the same date Craig visited Nicole on the ward and he was observed to ask her about her iPad use and whether she had access to social media, whether any men were contacting her and asking whether she had been speaking on the ward phone to anyone else. He was heard making comments such as 'come on, me and you in the toilet now'.

5.183 Also on 8th July 2022 the police safeguarding team visited Nicole and provided her with reassurance in relation to her placement in the refuge.

5.184 On 11th July 2022 the pre-discharge meeting took place at the Harbour. It was stated that Nicole had agreed to be discharged to refuge 1 and was deemed to have capacity to make this decision. Her Section 2 Hospital Order was due to expire at which time she would become an informal patient. Two weeks discharge medication was to be provided. Once registered with a new GP practice they would continue the prescription. The ASC social worker advised that he would review the safeguarding plan in a few weeks before considering closing the safeguarding alert. Arrangements were made for the HTT to complete a 48 hour follow up on 13th July 2022 at refuge 1. Nicole was noted to have no mobile phone but the police were to allocate one to her.

5.185 Also on 11th July 2022 the Harbour updated Nicole's enhanced risk assessment in preparation for discharge. The current risks were stated to be substance misuse, vulnerable to exploitation, 'stigmatised condition or state' and physical health.

5.186 On 12th July 2022 Nicole was discharged to refuge 1. She was provided with a new mobile phone by the police. She reported feeling overwhelmed now that she had left Craig and feeling slightly low in mood. She was provided with emotional support. She was also visited by the police safeguarding team. Craig phoned the Harbour and was advised only that Nicole had been discharged and had arranged her own transport. During the day the ASC social worker and the manager of refuge 1 discussed the possibility of obtaining an injunction against Craig given his continued attempts to contact Nicole. There is no indication that this was progressed further. Nicole's GP was notified of her discharge from the Harbour although Nicole was in the process of registering with a new GP practice.

5.187 On 13th July 2022 Nicole was visited in the refuge by the HTT who noted that she had made a good recovery on the ward and that her mental health had improved. The HTT provided contact numbers for the LSCFT immediate response service. At a subsequent MDT, the HTT concluded that there was no ongoing role for the HTT and Nicole would be under the care of her GP.

5.188 Shortly before midnight on 14th July 2022 refuge 1 reported Nicole missing to the police. She had last been seen at 10.30am that day and said that she was going to a friend's BBQ. Refuge 1 had later contacted Nicole by phone and she asked to stay out as she said that she was drunk at a party and could not get home. Her request was refused unless she divulged the address at which she was staying. Nicole hung up. The police phoned Craig who said that he was in Blackpool and that Nicole was not with him.

5.189 On 15th July 2022 the police spoke to Nicole by phone and she said that she planned to return to refuge 1 that evening where officer's spoke to her and the missing person report was closed.

5.190 Nicole again did not return to the refuge on 16th July 2022 and so refuge 1 made a second missing person report. The police traced Nicole to Accrington bus station. She said that she had been visiting friends although she had noticed Craig at the bus station. She said that her mobile phone was broken and so arrangements were made to provide her with an alternative phone.

5.191 On 18th July 2022 refuge 1 again reported Nicole missing to the police. She returned to the refuge the following day.

5.192 On 19th July 2022 Nicole's case was discussed at MARAC which noted that she had been missing from refuge 1. It was noted that Nicole would be signposted to Inspire and the Women's Centre and that her GP would provide ongoing care in relation to her mental health.

5.193 On 20th July 2022 the police brought Nicole back to the refuge during the morning after Nicole had been away from refuge 1 all night. She reported a 'self-injury' to her neck. She stated that she had been at Craig's flat, having gone there to retrieve some of her belongings. She disclosed that Craig had taken her money from her. She also disclosed that Craig had been ringing her children and as she didn't want him harassing her children, this was the reason she

went to his address. An emergency appointment was made for Nicole to renew her prescription of Fluoxetine[36] as she said she had run out.

5.194 Later the same day a support worker from refuge 1 saw Nicole involved in a verbal altercation with a male she suspected to be Craig. The police were called and returned Nicole to the refuge in the late evening. Refuge 1 staff noticed broken skin on Nicole's hairline and Nicole disclosed that she had tried to cut her neck. She said that she and another resident of refuge 1 had spent the evening with Craig smoking crack which had been purchased with her money. She said that Craig had become verbally abusive and had tried to burn her eye (no further details). She also disclosed that her previous phone had been smashed by Craig rather than broken when falling from a trampoline as she had previously claimed.

5.195 Shortly before midnight Nicole left the refuge to smoke a cigarette but did not return. Nicole was traced by the police during the early hours of the morning and told officers she was walking around to clear her head and said that she intended to return to the refuge.

5.196 Nicole did not return to the refuge and so on the morning of 21st July 2022 refuge 1 reported Nicole missing. Refuge 1 contacted Nicole by phone during the afternoon when she told them that she was meeting one of her children in Oswaldtwistle at 7pm and would return to the refuge later in the evening. At 8.33pm refuge 1 received a text from Nicole to say that she was on her way to the refuge and would arrive by 10.30pm

5.197 At 9.04pm the police received several reports to state that a woman (Nicole) had hanged herself from a bridge over a stream. On the arrival of the police Nicole was hanging with a ligature around her neck over a wall leading down to a small river. Craig had scaled the wall and used a knife provided by a householder to cut the ligature. In the process of being cut down both Nicole and Craig fell into the river, where Nicole was found to be unresponsive. The police commenced CPR until the arrival of paramedics who transported her to hospital where she never regained consciousness and died several days later after her life support was switched off.

5.198 Craig provided the police with an account of Nicole's final hours which she had spent at Craig's address. He stressed that he had tried to persuade her to return to the refuge but he said that Nicole was adamant that the refuge wished to 'section' her under the Mental Health Act. On the basis of the information shared with this DHR, caution should be exercised about any account provided by Craig.

[36] Fluoxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and sometimes obsessive compulsive disorder and bulimia. It works by increasing the levels of serotonin in the brain.

6.0 ANALYSIS

6.1 In this section of the report each of the terms of reference questions will be considered in turn.

To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

6.2 Nicole had been well known to mental health services for many years prior to her relationship with Craig beginning in October 2017. She had a number of brief interventions from mental health services - usually presenting when in crisis. Thereafter agencies would struggle to further engage

with her after she had received initial care and treatment. However, during the period under review agencies could have improved their engagement with Nicole following her initial presentation whilst in crisis. This issue will be expanded upon later in the report.

6.3 Following the birth of her fifth child in 2007 Nicole experienced postnatal depression and described intense suicidal ideation. She was detained for six months under Section 3 of the Mental Health Act (MHA) in Greater Manchester and made significant attempts to end her life whilst in hospital, requiring resuscitation and care in an acute hospital. Following this admission, Nicole had a short period of care coordination under a community mental health team.

6.4 In 2010 she presented at hospital ED in Lancashire following an attempted hanging whilst under the influence of alcohol. She was supported by the Home Treatment Team (HTT) for a month and then discharged to the Complex Care and Treatment Team. She was care coordinated by a social worker for a further eight months and then discharged back to her GP. During this time she maintained stability in her mental health and was able to maintain custody of her children.

6.5 As stated Nicole's relationship with Craig began in October 2017. By May 2019 Nicole's life circumstances appeared to have deteriorated markedly. At this time the two of her children who had remained in her care moved to live with her eldest son and his partner and did not return to Nicole's care. She was experiencing domestic abuse from Craig, drinking alcohol to excess, experiencing accommodation instability and making attempts to take her own life (Paragraph 5.6). In May 2019 she was conveyed to hospital after reporting 'strong thoughts' of suicide (Paragraph 5.5). She said that she had stopped taking her anti-depressant medication two days earlier although the lack of Nicole's concordance with medication noted by this DHR may be attributable in part to Craig preventing her from taking her medication or using it for himself (Paragraph 4.5).

6.6 The following month (June 2019) Nicole was hospitalised following an intentional overdose of Tramadol – which she wasn't prescribed at that time, although her partner Craig had been prescribed Tramadol for many years – and Mirtazapine 'after an argument' (Paragraph 5.6). Whilst in hospital Nicole made a number of disclosures to HARV including that she had taken the overdose following a night of Craig's 'mental torture' adding that this was the fourth time in a month she had tried to kill herself (Paragraph 5.7). When she saw the police the following month, Nicole disclosed that she had made two further attempts to take her own life during the three weeks since she had last contacted HARV – once through an overdose of prescribed drugs and once by hanging (Paragraph 5.12). There is no indication that Nicole sought – or was able to seek - medical help at the time of these further attempts on her own life.

6.7 When she was first admitted to the Harbour Hospital in July 2019 under Section 2 of the Mental Health Act due to increasing suicidal ideation, the main trigger for this was documented to be her 'abusive relationship'. During her admission she used a ligature 'to attempt suicide' (Paragraph 5.18).

6.8 Following her brief Mental Health Act admission, Nicole returned to Craig and the following month (August 2019) the police noted what were documented to be 'old ligature marks' around her neck (Paragraph 5.25).

6.9 In March 2020 Nicole disclosed that she had taken an overdose of drugs and was taken to hospital by the police and treated for an overdose of opiates and antidepressant drugs and later discharged. There is no indication that her GP practice (GP practice 2) was notified (Paragraphs 5.72 and 5.74).

6.10 Nicole twice contacted her GP practice in June 2020 to ask for an urgent review following a decline in her mental health. She was documented to have been self-harming ('minor' lacerations) and had taken an intentional overdose of Tramadol. The GP practice signposted her to Mindsmatter which later advised that Nicole was not eligible for their support due to her self-harming behaviours, longstanding mental health difficulties and 'relationship difficulties'. They recommended that Nicole discuss 'alternative options' with the HTT (Paragraph 5.85).

6.11 During August 2020 Nicole attempted to hang herself and was referred to the HTT which was unable to engage her (Paragraphs 5.83, 5.85 and 5.86). She also made contact with Maundy Relief which expressed concern around her deteriorating mental health, in particular experiencing suicidal ideation following an increase in the abuse disclosed when she attempted to leave the relationship with Craig. When Nicole contacted her GP to request a referral back to the HTT in October 2020, the GP referral was not received by the HTT (Paragraph 5.86)

6.12 During April 2021 Nicole phoned her GP practice to say that her self-harming had increased and that she had attempted to cut her throat (Paragraph 5.111). The GP offered her an in-person consultation the following day which Nicole said that she was unable to attend. This took place during the period when Nicole was falsely claiming to be pregnant and she may have been reluctant to see her GP in-person in case it was discovered that he was not actually pregnant.

6.13 During November 2021 Nicole visited her GP practice and asked if the GP would refer her to mental health services 'due to self-harm' but she was not seen by a GP nor was she encouraged to wait to be seen. No further action was taken (Paragraph 5.123).

6.14 When reporting an assault by Craig to the police in December 2021 Nicole told the call taker that she 'wanted to end it all' and 'throw herself under something' (Paragraph 5.127).

6.15 On 31st March 2022 Nicole contacted her GP practice to request an in-person appointment regarding 'mental health and self-harm'. The GP practice responded to this request on 4th April 2022 and an in-person appointment was arranged for 11th April 2022 which Nicole attended but left shortly after arriving and therefore was not seen (Paragraph 5.140).

6.16 When the incidents occurred which led to Nicole's second Mental Health Act admission to the Harbour Hospital in June 2022 she disclosed to the police that she had tried to cut her neck with a razor and said that Craig had laughed at her whilst she self-harmed. Shortly afterwards she disclosed to the ambulance crew that for the past three days she had been feeling increasingly suicidal and had made attempts to end her life in her partners presence and that he had filmed her distress and 'encouraged her', stating he was going to post it on social media (Paragraph 5.147). Prior to her Mental Health Act admission Nicole was seen by the hospital MHLT to whom she spoke at length about her experience of domestic abuse and disclosed self-harming as a means of managing her distress by scratching her arm with a plastic bottle (Paragraph 5.147). She further disclosed that Craig 'mentally tortured' her by 'calling me all the names under the sun'. She said that she continually feared violence and that she could not go to the toilet because she was so frightened. She said that Craig – who she described as 'evil' and 'nasty' – saw all of this as a game and was driving her to want to take her own life (Paragraph 5.149). She also disclosed that Craig took her medication off her (Paragraph 5.151).

6.17 Following her Mental Health Act admission to the Harbour Hospital, Nicole disclosed that her suicidal thoughts were of longstanding. She said that she held her partner responsible for the loss of 'everything' including her children, her car and her home (Paragraph 5.154).

6.18 Nicole had substantial contact by phone and in-person with Craig during her admission to the Harbour. The staff nurse stated that assessments indicated that 'a lot' of Nicole's mental health issues had been as a consequence of the abusive relationship with Craig and staff had observed that Nicole's mood would 'dip immensely' when she had phone contact with him. She presented as agitated and panicked and had shared increased urges to self-harm. She attempted to harm herself with ligatures on three occasions (Paragraphs 157, 159 and 162). During periods in which Nicole had no contact with Craig she was settled and mixed well with other patients (Paragraph 5.175).

6.19 Nicole frequently explicitly linked the abuse she disclosed in her relationship with Craig to her mental health and self-harming behaviours and this accorded with the view of the professionals who managed to engage with Nicole for any length of time. She also disclosed that Craig appeared to take pleasure from her distress and also filmed her when she was in distress and spoke of posting the material on social media. Nicole also spoke of Craig encouraging her to harm herself.

6.20 In his contribution to this DHR, Nicole eldest son felt that his mother 'had no escape' from Craig. The only escape was to take her own life (Paragraph 4.12). His observation may be borne out to an extent by research.

6.21 Refuge (the national domestic violence charity) and the University of Warwick published research which explored the link between domestic abuse and suicide (1) in 2018. They found that suicidality (suicidal thoughts, plans and attempts) is more prevalent amongst domestically abused women than their non-abused counterparts. They also found that depression, post-traumatic stress, anxiety and their behavioural consequences, such as social isolation, substance misuse and self-harm are common outcomes of domestic abuse, noting that these negative consequences are recognised risks for suicide.

6.22 Additionally, the study draws attention to the theory that suicidal acts (completed or not) are understood as a 'cry of pain', rather than a 'cry for help', with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible (2). This theory goes on to suggest that regarding suicidality as a 'cry for help' rather than a 'cry of pain' risks obscuring the needs of those who may be in the greatest psychological pain and more likely to take their own lives in the future.

6.23 The recently revised Strategy for Preventing Suicide in England (3) notes that more evidence on a link between domestic abuse and suicide has emerged in recent years. The Suicide Prevention Strategy notes that the Home Office continues to collate data on domestic abuse victim suicides at a national level, and although it is recognised that this data is likely to underestimate the number of victim suicides following domestic abuse, it is hoped that this data will improve the ability to start to understand and compare trends over time (4).

6.24 The England Suicide Prevention Strategy has identified seven priority groups for tailored and targeted support, two of which would have included Nicole, namely 'people who have self-harmed' and 'people in contact with mental health services'.

- People who have self-harmed – the strategy states that self-harm does not necessarily mean someone is experiencing suicidal thoughts or feelings but observes that self-harm is associated with a significant risk of subsequent suicide (5). Nicole twice self-harmed by tying a ligature around her neck during the month prior to her death (Paragraphs 5.159 and 5.162).

- 'People in contact with mental health services' – people known to be in contact with mental health services (including anyone who has been in contact with such services within 12 months) represent around 27% of all deaths by suicide in England. Nicole was

discharged from the Harbour Hospital 9 days prior to the hanging incident which caused her subsequent death.

- Nicole also falls into a third priority group - 'people in contact with the criminal justice system'. Whilst her contact with the criminal justice system was invariably as a victim, she had been convicted of an assault five months prior to her death (Paragraph 5.130).

6.25 Additionally there were common suicide risk factors present in Nicole's life, specifically:

- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse
- Financial difficulty and economic adversity (6).

6.26 It is unclear whether Nicole's risk of suicide was fully recognised and acted upon once the discharge plan to refuge 1 began to break down and whether she could have been re-referred back to the HTT, or indeed whether the HTT could have remained involved beyond the single contact they had with Nicole shortly after she moved to refuge 1. The LSCFT Serious Investigation Review (SIR) report has been shared with this DHR. The SIR found that at the time Nicole was discharged from the Harbour Hospital she was not exhibiting any signs of current risk to self and after visiting Nicole at refuge 1, the HTT concluded that the level of support available at refuge 1 was sufficient to meet Nicole's needs. Information was provided to refuge 1 to enable them to refer Nicole back to LSCFT mental health services should this be required. LSCFT were not advised that the discharge plan had begun to break down. However, at the time the HTT saw Nicole at refuge 1 there was no documentation of 'routine enquiry', the opportunity to enquire whether she had resumed contact with Craig was overlooked and Nicole's risk assessment was not updated.

ENGAGEMENT WITH PRIMARY CARE, ACUTE CARE AND SECONDARY MENTAL HEALTH SERVICES

6.27 As previously stated in Paragraph 6.2, there appears to be a pattern of Nicole presenting to services when in crisis following which agencies would struggle to further engage with her. This appeared to be the case on occasions during the period on which this DHR focusses. For example Nicole self-discharged against medical advice from hospital following her 2nd June 2019 admission after an intentional overdose. However, Nicole later disclosed to HARV that she had discharged herself due to the embarrassment and shame arising from Craig 'storming' onto the ward and screaming 'next time I'll leave you on the floor and not bother saving your life' (Paragraph 5.9). As a result of her self-discharge the planned hospital psychiatric review did not take place and Nicole did not attend a follow up appointment with the community mental health team (Paragraph 5.7).

6.28 However, there were other occasions when it is unclear whether GP's hospital attendances were followed up by services in the community (Paragraph 5.5) or her GP practice informed of her hospital attendance (Paragraph 5.72). Additionally, the system did not always work for Nicole such as when a GP referral to the HTT does not appear to have been received by the latter service (Paragraph 5.86). The possibility that Craig may have been preventing Nicole from seeking further help from health services in the community was considered by the MARAC (Paragraph 5.62) which requested agencies she contacted to encourage her to engage with support.

MENTAL CAPACITY

6.29 The question of whether or not Nicole was making decisions of her own free was only rarely considered as a discrete question by professionals who appear to have generally taken the view that there was no reason to doubt Nicole's mental capacity. The exceptions to this assumption of mental capacity were in August 2019 when a MARAC action was for Adult Social Care 'to conduct a review of Nicole in respect of capacity issues and her regular declining of mental health services' (Paragraph 5.30), although there is no indication that this was actioned; in June 2022 when the ward team at the Harbour Hospital were requested to formally assess Nicole's capacity to accept visits from Craig, taking into consideration his coercive and controlling behaviour (5.163) although there is no indication that this was actioned either; and in July 2022 when Nicole was deemed to have capacity to decide to be discharged from the Harbour Hospital to refuge 1 (Paragraph 5.184). There should have been a formal assessment of Nicole's mental capacity, taking into consideration Craig's coercive and controlling behaviour and the impact this may have had on her judgement and decision making.

6.30 This is a particularly complex issue for practitioners to consider and has been the subject of case law. For example, a 2010 Court of Protection judgement found that the elderly parents of a 50 year old man were constrained from exercising their decision making capacity due to their son's coercive and controlling behaviour towards them (7). The Local Government Association (LGA) guide to support practitioners and managers - *Domestic Abuse and Adult Safeguarding* - draws attention to the fact that being at risk of harm can limit an individual's capacity to safeguard themselves due to the psychological process that focusses an individual on acting within the immediate context of the threats that they face, in order to limit the abuse and their impact. This can lead victims to identify with the perpetrator and can prevent them from acknowledging the level of risk they face (8). It commonly prevents people leaving or ending a relationship.

6.31 The Mental Capacity Act 2005 (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise

decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices'. The Code of Practice suggests issues worthy of further investigation might include whether the person is 'easily influenced by undue pressure' (9).

6.32 The LSCFT SIR report observes that routine enquiry should not be regarded as a one-off activity and should be considered regularly at reviews and in one-to-one sessions. The SIR report also observes that capacity to engage in unwise decisions, such as contact with an abusive partner, cannot be assumed based on a person's capacity to make other decisions around their care. The SIR recommends that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour should be at the foundation of clinical decision making for people experiencing domestic abuse.

To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and in the time leading up to the suicide.

NICOLE'S MHA ADMISSION TO THE HARBOUR HOSPITAL.

6.33 During her admission to the Harbour Hospital under Section 2 of the Mental Health Act from 14th June until her discharge on 12th July 2022 Nicole was exposed to frequent domestic abuse from Craig despite the best efforts of the ward staff to safeguard her. The Harbour Hospital was not a safe place for Nicole as a result.

6.34 When Nicole initially asked to speak to Craig her request was escalated to the deputy ward manager which was an appropriate response although the outcome of the escalation was unclear (Paragraph 5.153).

6.35 When Craig contacted the ward and asked to speak to Nicole his request was initially denied (Paragraph 5.155). However, after Nicole expressed frustration that the ward team were not facilitating visits from Craig the hospital safeguarding team advised that the hospital could not interfere with Nicole's human rights in respect of contact with loved ones (Paragraph 5.156). Adopting a human rights approach to this decision was not inappropriate but human rights apply to a range of issues including the right to life, liberty and security of the person. It would have been appropriate for the hospital safeguarding team to have consulted with partner agencies such as the police who could have provided valuable contextual information to inform the decision. However, the hospital safeguarding team advised ward staff to note the frequency of calls and share this information with Nicole's allocated Social Worker/IDVA and to complete mental state assessments following contact and offer support as appropriate. There is no

indication that mental state assessments were completed. There was also no suggestion from the hospital safeguarding team that the decision to allow contact between Craig and Nicole should be reviewed in the light of the monitoring of frequency and impact on Nicole of contact from Craig.

6.36 There were many occasions on which a review of the decision to allow contact with Craig should have been reviewed and arguably suspended such as on 19th June 2022, when, following telephone contact with Craig, Nicole self-harmed by banging her head and punched a wall sustaining bruises to her hand, was twice found with a ligature around her neck and staff were required to put her in arm holds to remove the ligature on the second occasion (Paragraph 5.159).

6.37 As previously stated Craig's coercive and controlling behaviour led ward staff management to advise ward staff to formally assess Nicole's capacity to accept visits from Craig, but there is no indication that this occurred (Paragraph 5.163). The LSCFT SIR report notes that advice provided to ward staff by the safeguarding duty worker was not documented in clinical records but in a separate log system accessed only by the safeguarding team. The SIR concluded that this was a likely contributor to the actions advised by the safeguarding team not being followed by the ward team.

6.38 As well as adversely affecting her mood, Craig may also have been in a position to influence Nicole not to support a prosecution for outstanding assaults (Paragraph 5.161).

6.39 Craig's role in supporting, encouraging or coercing Nicole to abscond from the ward should surely have led to a review of his contact with her (Paragraph 5.163) although there was an absence of routine enquiry of Nicole when she later returned to the ward nor was the hospital risk assessment updated. Additionally, the Police could have considered investigating Craig for an offence of assisting a patient detained under the MHA to absent themselves without leave (Section 128 MHA).

6.40 Craig's observed abuse of Nicole on the ward escalated. On 29th June 2022 Craig visited Nicole whilst under the influence of alcohol and ward staff noted his controlling and manipulative behaviour in withholding money from Nicole (Paragraph 5.170). On 8th July 2022 ward staff observed Craig to ask her about her iPad use and whether she had access to social media, whether any men were contacting her and asking whether she had been speaking on the ward phone to anyone else. He was heard making comments such as 'come on, me and you in the toilet now' (Paragraph 5.182). Craig perpetrated economic abuse and controlling behaviour in relation to Nicole's contact with men and appeared to be trying to persuade or coerce her to have sex with him in the ward toilets. There is no indication that this was escalated and DASH risk assessments were not completed on the grounds that Nicole declined to participate. There is an expectation that professionals will complete DASH risk assessments even when victims

decline to answer questions on the basis of what is known or observed about the domestic abuse.

6.41 The Staff Nurse who attended the multi-disciplinary team meeting at the Harbour on 5th July 2022 summed up the situation which ward staff had observed as follows:

'Assessments indicated that 'a lot' of Nicole's mental health issues had been as a consequence of the abusive relationship with Craig and staff had observed that Nicole's mood would 'dip immensely' when she had phone contact with him. She presented as agitated and panicked and had shared increased urges to self-harm. During periods in which Nicole had no contact with Craig she was settled and mixed well with other patients' (Paragraph 5.176)

DISCHARGE FROM THE HARBOUR HOSPITAL TO REFUGE 1

6.42 Discharge planning was multi-disciplinary and took place in sufficient time to consider all relevant issues. However, there were a number of planned actions which do not appear to have taken place particularly the referral to the CMHT to enable Nicole to be supported using a Care Programme Approach or the referral to Inspire – although it appears that the Harbour Hospital anticipated that this would be done by refuge 1.

6.43 The discharge plan was founded on the assumption that Nicole would go to refuge 1 and accept the support provided there. This was a 'load bearing' assumption in that if this assumption failed then discharge planning arrangements as a whole would fail. There is no indication that Nicole's previous involvement with refuges was taken into account. If it had, professionals would have realised that Nicole had invariably struggled to settle in refuges in the past and had often not stayed there beyond the first couple of nights. This understanding of Nicole's history could have prompted the development of a contingency plan to address the probability that Nicole would not stay in refuge 1 for long.

6.44 One contingency which could have been further considered was the possibility of obtaining an order to prevent Craig contacting Nicole. The ASC social worker and the manager of refuge 1 had discussed the possibility of obtaining an 'injunction' against Craig but there is no indication that this was progressed further (Paragraph 5.185). By this time the previously impose Police bail conditions were no longer in force and the opportunity to investigate the offence of assisting a patient detained under the MHA to absent themselves without leave had been missed. The DHR has been advised that a DVPO was not an option which could have been considered at that point as it is a protective measure intended to be applied in the 'immediate aftermath of a domestic violence incident' although some of Craig's interactions with Nicole whilst admitted to the Harbour Hospital could have been considered to be domestic abuse incidents.

6.45 Following her discharge, the HTT made a single visit to her before closing the case (Paragraph 5.186). If the HTT had been aware that Nicole struggled to settle in refuges then it could have been beneficial to make a further visit. Nicole was in the process of registering with GP practice 4 at that time which was linked to refuge 1 and was very familiar with providing care to patients who were residents of the refuge.

6.46 MARAC was aware that Nicole's discharge from the Harbour to refuge 1 had not progressed smoothly and that she had been reported missing but do not appear to have made any enquiries about any contingency plan.

To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

RESPONSE TO EVIDENCE OF CONTROLLING AND COERCIVE BEHAVIOUR

6.47 Reviewing the period on which this DHR focusses as a whole, it is clear that determined efforts were made to safeguard Nicole by agencies working individually and in partnership.

6.48 Nicole disclosed controlling and coercive behaviour by Craig on many occasions. The Domestic Abuse Act 2021 Statutory Guidance provides examples of the range of behaviours which might be considered controlling or coercive (10) including the following behaviours apparent from this DHR:

- Physical violence, violent or threatening behaviour, sexual abuse, emotional or psychological abuse, economic abuse and verbal abuse

- Controlling or monitoring the victim's daily activities and behaviour, including making them account for their time, dictating what they can wear, what and when they can eat, when and where they may sleep;

- Controlling a victim's access to finances, including monitoring their accounts or coercing them into sharing their passwords to bank accounts in order to facilitate economic abuse;

- Isolating the victim from family, friends and professionals who may be trying to support them, intercepting messages or phone calls;

- Preventing the victim from taking medication, or accessing medical equipment and assistive aids, over-medicating them, or preventing the victim from accessing health or social care (especially relevant for disabled victims or those with long-term health conditions);

- Using substances to control a victim through dependency, or controlling their access to substances;

- Using children to control the victim, e.g. threatening to take the children away.

6.49 Nicole's mother said that her daughter had been a 'strong bubbly person' who could fend for herself and look out for herself until she met Craig. Thereafter he (Craig) just 'chipped away and chipped away' at her independent spirit until he got control of her (Paragraph 4.7). Nicole's son described how Craig would never allow Nicole to spend time with him (her son) and would keep saying to her 'we need to go, we need to go' (Paragraph 4.16) and that Craig kept taking his mother's phones off her and either smashing them or selling them (Paragraph 4.18). Nicole's son noticed his mother's significant weight loss whilst in the relationship with Craig (Paragraph 4.19) as did her GP on one occasion documenting her to have lost 3 stone in weight in recent weeks 'due to stress and abuse' (Paragraph 5.40).

6.50 The combination of the range of Craig's controlling and coercive behaviours proved very resistant to professional efforts to support Nicole to leave Craig other than for short periods when she briefly accessed refuges, when Craig was on remand in prison custody and when a DVPO was obtained on one occasion. However, with the benefit of hindsight two types of controlling and coercive behaviour appeared to be very significant in preventing Nicole from escaping her abusive relationship with Craig.

ECONOMIC ABUSE

6.51 The first of these particularly significant controlling and coercive behaviours was economic abuse which the Domestic Abuse Act 2021 Statutory Guidance defines as behaviour that has a substantial adverse effect on an individual's ability to acquire, use or maintain money or other property, or to obtain goods or services. This can include an individual's ability to acquire food or clothes, or access transportation or utilities. These behaviours can include an attempt to control through restriction, exploitation and/or sabotage (11).

6.52 In her contribution to the DHR, Nicole's mother said that Craig 'didn't let Nicole have her own bank account' and so her daughter 'had no option but to go back to him' (Paragraph 4.5).

Nicole's mother said that Craig continued to withdraw money from Nicole's bank account during her final hospital admission following the hanging incident. She said that Nicole had always managed her own money in her earlier relationships. Nicole's mother was critical of the arrangements for discharging her daughter from the Harbour Hospital in July 2022 because she felt that greater priority should have been given to 'sorting out' her money prior to her discharge – implying that Craig's continuing control over her benefits increased the chances of Nicole returning to him (Paragraph 4.6). In his contribution to the DHR Nicole's eldest son said that he helped his mother set up a new bank account to try and help her keep her money separate from Craig's (Paragraph 4.18). Her son also disclosed that Nicole had managed to secrete 'emergency money' of £1400 which she didn't tell Craig about but that he eventually found out about this money and took it off her (Paragraph 4.18). Nicole also disclosed to HARV that she had saved £700 to use as a deposit on a private letting but Craig had also taken this off her (Paragraph 5.10).

6.53 Professionals may have suspected that Nicole's benefits were paid into Craig's bank account in August 2019 and the Police appeared to have attempted to support her to get her 'benefits changed over' (Paragraph 5.27), although the DWP appeared to treat this contact as a request to replace money taken from her by Craig – which they declined. The DWP documented that Nicole's 'ex beat her up and took her money' at that time.

6.54 The first record the DWP have of changing Nicole's bank details to those of Craig was in April 2020 (Paragraph 5.73). Nicole subsequently (January 2021) changed the details of the bank into which her benefits were paid back to her own account only to reverse this decision a few days later (Paragraph 5.97). Nicole again tried to change her bank details from Craig's to her own in May 2021 only to change them back to Craig's bank details the following month (Paragraph 5.115). This transaction necessitated an in-person DWP interview with Nicole and Craig. The interview took place on 2nd August 2021 and Craig's bank details were verified. It is not known whether Nicole was accompanied by Craig although records confirmed that his bank card was provided.

6.55 During March 2022 Safenet documented financial abuse after Nicole disclosed that her benefits were paid into Craig's bank account (Paragraph 5.133). During Nicole's Mental Health Act admission to the Harbour Hospital during June and July 2022 ward staff noted his controlling and manipulative behaviour in withholding money from Nicole (Paragraph 5.170) although efforts to change the address to which her DWP payment exception service vouchers were sent were unsuccessful as the DWP advised that they were unable to change her address until Nicole had a phone number to contact (Paragraph 5.175). At that time Nicole did not have a mobile phone and although she was supplied with a new mobile phone prior to her discharge the change of address to which her DWP vouchers should be sent had not been accomplished prior to her discharge or her subsequent death. Following her discharge to refuge 1, Nicole disclosed that whilst absent from the refuge Craig had 'taken her money from her' (Paragraph 5.193).

6.56 The DHR Panel discussed the challenges involved in helping a victim of domestic abuse regain control of their finances whilst they remained in a relationship with the perpetrator. Changing the victim's bank details to their own bank risked an escalation in abuse from the perpetrator and pressure to reverse the change – which is what appeared to have happened twice to Nicole. It was appropriate for the DWP to insist on an in-person interview to effect the second change back to Craig's bank account details although it would have been helpful for the DWP to have documented the meeting more fully. The change of address to which Nicole's DWP vouchers were sent should have been a key element of the discharge plan but after initial efforts to achieve this were frustrated by Nicole's lack of a mobile phone, this task appeared to be overlooked when Nicole was later provided with a phone.

6.57 The DHR has been advised of the work of Surviving Economic Abuse, which is a UK charity dedicated to raising awareness of economic abuse and transforming responses to it. Their strategic priorities are:

- Public understanding and behaviour change
- Professional response and systems change
- Legal, regulatory and public policy change and
- Survivor partnerships, evidence and equality.

6.58 The DHR Author is also completing a second DHR (DHR 'Rose') for Pennine Lancashire CSP in which economic abuse is the dominant form of coercion and control used by the perpetrator. Members of the DHR Panels for 'Nicole' and 'Rose' are involved in other current Pennine Lancashire CSP DHRs in which economic abuse is prominent. There may therefore be value in developing a bespoke action plan to address economic abuse as a form of coercion and control which draws upon the learning from this DHR and the other Pennine Lancashire CSP DHRs in which economic abuse is a prominent factor. In this DHR key areas of learning relate to devising strategies to support victims regain or achieve some degree of financial independent whilst they are in, or attempting to leave, abusive relationships and ensuring that hospital discharge planning arrangements for victims of domestic abuse ensure that all necessary steps have been taken to enable the victim to regain control of their finances.

USING CHILDREN TO CONTROL THE VICTIM.

6.59 The second of the particularly significant controlling and coercive behaviours related to Nicole's fear that if she left Craig, he would harm her children. Nicole had seven children, of whom five -including her eldest son who was an adult - lived locally. The first indication that this was a concern for Nicole was during her contact with HARV from June 2019 when she declined a refuge place on the basis that leaving Craig could place her children at risk from him (Paragraph 5.10). HARV subsequently shared this information with the Police and Children's Social Care (Paragraph 5.14).

6.60 Nicole made further disclosures of her fear of the risk that Craig presented to her children. In May 2022 she advised the Police that Craig had previously threatened to hurt her eldest son (Paragraph 5.143). The following month she disclosed that Craig had threatened to 'kill her kids' if she did not 'get him out of jail' (Paragraph 5.149). On 8th July 2022 Nicole disclosed to refuge 1 that when she attempted to leave Craig he would start to harass her children – which she said was her biggest fear and was why she had returned to him previously (Paragraph 5.181). When the Police returned her to refuge 1 on 20th July 2022 she disclosed that Craig had been ringing her children and the reason she had gone to his address was that she didn't want him harassing her children (Paragraph 5.193).

6.61 In his contribution to this DHR, Nicole's son said that his mother feared that if she got away from Craig, he 'would come to the son's house' – inferring a threat to Nicole's son should Nicole manage to leave him. Nicole's son also said that he recalled his mother saying to him 'you need to move' and going on to say 'as soon as you move, I can leave'. Nicole's son said that he applied for a 'hundred' houses but only managed to get two viewings as he and his partner had a dog (Paragraph 4.22). He asked why agencies didn't consider helping Nicole's children to leave the area as a means of giving Nicole more confidence to leave Craig without fearing that he would harm her family (Paragraph 4.27).

6.62 The impact of Nicole's fear that Craig could harm her children if she left him has become more apparent with hindsight. There is no indication that any specific action was taken in response to Nicole's disclosures in this regard. Had professionals better understood Nicole's fears, they could have considered a plan to try and alleviate those fears which could have involved supporting her eldest son and Nicole's two children who were placed with him to move out of the area if this was feasible and they wished to do so.

6.63 It is noticeable that in this case professionals eventually became a little 'stuck' in terms of how best to safeguard Nicole given the range of actions which had previously been implemented in an effort to support Nicole to leave Craig. Reflecting back on the case one further option professionals could have considered could have been to analyse the behaviours Craig engaged in to control and coerce Nicole. If this had been done it seems possible that the importance of addressing Nicole's fears that Craig may harm her children may have become more apparent.

INTIMIDATING BEHAVIOUR TO DISCOURAGE OR CUT SHORT CONTACT WITH PROFESSIONALS.

6.64 Before moving on from Craig's coercive and controlling behaviours, there is merit in highlighting his behaviour when he 'stormed' onto the ward of the hospital to which she had been admitted following an intentional overdose and screaming 'next time I'll leave you on the floor and not bother saving your life' (Paragraph 5.9). Craig's behaviour led to Nicole discharging herself from hospital against medical advice due to the embarrassment and shame cause by

Craig's behaviour. Researchers at Dewis Choice have recently adapted the Duluth Power and Control Wheel – which was developed by Pence, McDonnel and Paymar (1982) as a tool to explain the variety of ways perpetrators use power and control to manipulate and abuse victims. The adapted version was informed by a six year longitudinal study undertaken by Dewis Choice which captured the lived experience of 131 older victim-survivors of domestic abuse from intimate/ex-intimate partners and/or family members. The adapted Duluth Power and Control wheel describes controlling behaviours under the domains 'Using emotional abuse', 'Using coercion and threats', 'Using economic abuse, 'Misuse of privilege', 'Minimising, denying and blaming', 'Limiting environmental mastery', 'Using isolation' and 'Using intimidation' (12). 'Using intimidation' includes 'being rude and intimidating to your guest to discourage future contact' which captures the impact of Craig's behaviour on Nicole's decision to discharge herself from hospital.

To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

6.65 Nicole had a history of substance misuse which had a direct deteriorating effect upon her mental health. Using substances would have been likely to have affected Nicole's ability to determine how much danger she was in, to protect herself from abuse and her ability to obtain help. It is well documented that the effects of addiction and domestic abuse are far reaching. Those who are victims of domestic abuse are more likely to struggle with mental health disorders and require inpatient treatment to overcome trauma and abuse. The DHR has been advised of

guidance for health and social care agencies in delivering care to individuals who have a dual diagnosis of mental illness and substance misuse. This was identified as a likely feature within this case and the guidance stresses the importance of robust multi agency working and information sharing.

USING SUBSTANCES TO CONTROL A VICTIM THROUGH DEPENDENCY OR CONTROLLING THEIR ACCESS TO SUBSTANCES.

6.66 Shortly before her Mental Health Act admission to the Harbour Hospital in June 2022 Nicole began disclosing that Craig had been giving her drugs, specifically Valium and Crack Cocaine and that the latter controlled drug had induced psychosis (Paragraph 5.146). She said that the drugs had cause her to slur her speech and struggle to stand up – which she said Craig had filmed and found amusing. The effect of being encouraged or coerced into taking drugs appears to have been to humiliate her and increase Craig's control over her. Nicole was diagnosed with Mental and Behavioural Disorder secondary to multiple substance use on admission to the Harbour and her symptoms subsided shortly after admission. During her subsequent admission to the Harbour Hospital Nicole withdrew her disclosure that she had been forced to take drugs and said that this

disclosure had reflected her paranoia at the time (Paragraph 5.161 and 5.180). It is unclear whether these subsequent views were a true account or whether she was beginning to minimise the extent to which Craig had abused her. There is one (earlier) reference to Nicole being referred to substance misuse services (Paragraph 5.62) although there is no indication that she accessed such services during the period on which the DHR focusses.

SEXUAL ABUSE

6.65 Another form of controlling and coercive behaviour Nicole disclosed was sexual abuse. She said that Craig forced her to remove all her clothes to check whether she had had sex with anyone (Paragraph 5.10), examined and digitally penetrated her vagina to check for signs of sexual intercourse and would not allow her to wear underwear. Additionally ward staff observed Craig to attempt to coerce her into having sexual intercourse with him whilst she was a patient in the Harbour Hospital.

STRANGULATION

6.66 Nicole disclosed non-fatal strangulation on several occasions. In January 2020 she said that Craig had strangled her in an attack which took place over several hours during which she lost consciousness (Paragraph 5.51). Nicole made further disclosures of non-fatal strangulation by Craig in May 2022 (Paragraph 5.143) and June 2022 (Paragraph 5.149). Since June 2022 this has been an offence under Section 70 of the Domestic Abuse Act 2021.

6.67 The final point to make in respect of controlling and coercive behaviour is that Craig's family appear to have been instrumental in the control he exercised over Nicole at times (Paragraphs 5.10 and 5.146), particularly when Craig was in custody on remand. It is therefore imperative for professionals to recognise that coercion and control may not just be experienced from the identified perpetrator, and that risk assessment and safety planning should take this into account.

FABRICATED PREGNANCY

6.68 An unusual aspect of this case was that Nicole falsely claimed to be pregnant on a number of occasions apparently in order to protect herself from abuse from Craig. The first occasion on which Nicole claimed to be pregnant was in August 2019 when she - and later her eldest son - advised the Police that she was pregnant (Paragraphs 5.23 and 5.24). There is no indication that Nicole was offered any support in respect of this reported pregnancy at that time although when her case was discussed at MARAC the following month the actions included conducting a safeguarding visit to Nicole to try and establish whether she was pregnant (Paragraph 5.36)

6.69 Whilst in police custody in November 2020 Nicole was seen by the Liaison and Diversion team to whom she disclosed that she was 5 months pregnant but said she had not informed any health professionals. The police requested midwifery to carry out an antenatal check on Nicole and a midwife visited Nicole whilst she was in police custody and noticed that she had a 'large bump' but was unwilling to engage in any examination at that time. Midwifery planned to visit Nicole again following her release from custody. The Police made a referral to children's social care (Paragraph 5.88).

6.70 The Lancashire MASH contacted Nicole's GP practice to confirm information from a previous partner of Nicole that she had been sterilised previously. The GP practice advised that there was no record of any sterilisation in her 'current notes'. However, not all of Nicole's health records were available to the GP at that time due to the transfer of records from GP practice 1 not having been completed for the reasons set out in Paragraph 5.41. Nicole had in fact been sterilised in 2013 (Paragraph 5.89). After Nicole did not attend two antenatal clinic appointments, midwifery made a pan-Lancashire midwifery alert (Paragraph 5.94). However, the hospital did not appear to be aware of the pan-Lancashire alert when Nicole attended hospital in December 2020 (Paragraph 5.95) and September 2021 (Paragraph 5.117). The ELHT has advised the DHR that it is unclear whether the concealed pregnancy concerns were flagged on Nicole's patient record.

6.71 The multi-agency response to Nicole's reported pregnancy was otherwise exemplary. Section 47 Enquiries were initiated (Paragraph 5.96), an initial child protection conference took place at which Nicole's unborn child was made subject to a child protection plan on the ground of neglect (Paragraph 5.101), pre-proceeding procedures were commenced and a pre-birth assessment was completed (Paragraph 5.103). Neither midwifery nor the health visitor were able to contact Nicole although the Police twice made welfare visits which appeared to visually confirm the pregnancy. However, by July 2021 midwifery had carried out checks which confirmed Nicole's prior sterilisation which meant that the likelihood that she was pregnant was low – but could not be ruled out (Paragraph 5.116). In October 2021 the child protection plan in respect of the unborn child was closed as Nicole was considered highly unlikely to be pregnant (Paragraph 5.118).

6.72 In December 2021 Nicole phoned the hospital to report that she was eight months pregnant but did not attend the midwifery appointment arranged. Midwifery referred her to children's social care (Paragraph 5.125). Later the same month Nicole disclosed to a social worker that she had lied about being pregnant in order to protect herself from her partner. At a strategy meeting held in February 2022 it was again agreed that Nicole was highly unlikely to be pregnant and all agencies expressed concern that Nicole had fabricated her pregnancy to protect herself from violence from Craig (Paragraph 5.128). At a MARAC meeting held in January 2022 children's social care advised that Nicole had falsely claimed to be pregnant as if Craig believed she was pregnant, she believed that he would 'go easy on her' (Paragraph 5.129). When Nicole sought support from HARV in March 2022 she was asked about her pregnancy and initially

replied that she had 'lost' the baby but later disclosed that she had lied about the pregnancy to Craig to 'prevent arguments' (Paragraph 5.132).

6.73 In his contribution to the DHR, Nicole's son said that his mother had undergone a sterilisation procedure shortly after the birth of her seventh child. Her son recalled that she had subsequently claimed to be pregnant and to have 'lost' the baby to a previous partner who had pushed her down the stairs when he was drunk. He added that he was unsure whether Nicole had fabricated the pregnancy during her relationship with Craig in order to keep herself safe and wondered whether her claims were related to her mental health issues. He added that items for a baby had been found at his mother's flat following her death (Paragraph 4.23).

6.74 Notwithstanding her son's doubts about his mother's intentions in fabricating a pregnancy she disclosed to both children's social care and HARV that she had done so in order to protect herself from abuse from Craig. Assuming this was her intention, this was quite an extreme step to take to try and protect herself from domestic abuse. It involved maintaining the impression that she was pregnant for over a year (November 2020 until December 2021). She reported only one incident of domestic abuse during this period and so -on the basis of the lack of reported incidents – her plan may have been successful. Reported physical violence began almost immediately after the fabricated pregnancy period came to an end (Paragraph 5.92) and appeared to intensify until her admission to the Harbour Hospital in June 2022. However, during the fabricated pregnancy period Nicole avoided contact with health professionals which may have reduced the opportunity to disclose domestic abuse to professionals and adversely affected the continuity of her care. The likelihood that Nicole's pregnancy was fabricated could have been established much earlier had there been effective transfer of patient records when she registered with GP practices 1 and 2. However, one important consequence of the difficulty in clarifying that she had undergone a sterilisation procedure many years earlier was that a range of professionals became involved with Nicole and midwifery, the health visitor and police officers made, or attempted to make contact with her on a regular basis. Additionally, through the processes invoked to safeguard her unborn child there was quite intensive scrutiny of her case for around a year. However, once it had been established that Nicole was highly unlikely to be pregnant this professional oversight/involvement ceased. Although her fabricated pregnancy was discussed at MARAC in January 2022, there was an opportunity to review Nicole's likely needs following the discovery that her pregnancy was fabricated and potentially consider an adult safeguarding referral on the grounds that she had care and support needs, was exposed to a potentially enhanced risk of domestic abuse and because of her care and support needs was unable to protect herself from abuse.

6.75 Nicole's son's view was that there may have been an alternative or additional factors in her fabricated pregnancy. It is noted that Nicole had given birth to seven children, none of whom were in her care and she had become increasingly isolated from her family. It seems possible that presenting herself as pregnant may have helped her to feel more optimistic about the future for a time.

ACCESSING A PATIENT'S MEDICAL HISTORY WHEN REGISTERING WITH A NEW GP

6.76 As stated above, it may have been possible to establish the likelihood that Nicole's pregnancy was fabricated much earlier had Nicole's patient records held by GP Practice 3 been sufficiently comprehensive. When Nicole registered with GP Practice 3 in January 2020, the practice documented that there were no old notes available' (Paragraph 5.56) and the DHR has been advised that it appears that GP Practice 3 was not provided with Nicole's full GP records.

CONSIDERATION OF LEGAL OPTIONS – DOMESTIC VIOLENCE PREVENTION ORDERS

6.77 A DVPO was obtained on one occasion. This was served on Craig on 8th August 2019 following Nicole's disclosures of assault and controlling and coercive behaviour by Craig (Paragraph 5.28). The Order stated that Craig was not to contact, be abusive or intimidating to Nicole and gave the police the power to search his property should Nicole not be at an address where she was expected to be. It appeared helpful that Nicole's case was considered at MARAC during the period for which the DVPO applied as the MARAC actions - regular contact with the victim by the police and the IDVA service, support Nicole to register with a GP practice, approach 'Housing', for Adult Social Care to conduct a review of Nicole in respect of capacity issues and her regular declining of mental health services (Paragraph 5.30) – set the agenda for multi-agency working to make effective use of the 'breathing space' that a DVPO provides. Agencies worked hard to support Nicole during this period although there is no indication that Adult Social Care became involved as anticipated by MARAC.

6.78 Craig did not comply with the terms of the DVPO as Nicole disclosed an assault by him on 31st August 2019 (Paragraph 5.34) – 6 days prior to the expiry of the Order – and it is understood that he had earlier told the Court that he would not comply with it and Nicole had disclosed that he was 'still trying to get to her' and would 'make her life hell' as soon as the Order expired (Paragraph 5.29). Nicole was later arrested for the 31st August 2019 assault but the breach of the Order was not proceeded with as Craig was charged with the substantive offence of assault.

6.79 DVPOs were subsequently considered but not applied for again. When a DVPN was under consideration in December 2021 and January 2022 there appeared to be reservations about adopting this approach as police involvement was perceived to cause Nicole 'more trouble' (Paragraphs 5.127 and 5.129). A DVPO was again considered in March 2022 but deemed not necessary as Nicole 'was out of the area and safeguarded' (Paragraph 5.136) which was correct as she was in a refuge in a different town but knowledge of Nicole's history would have suggested that this arrangement could be quite short-lived and Nicole was located at Craig's address just over a week after entering the Lancaster refuge.

CONSIDERATION OF LEGAL OPTIONS - EVIDENCE-LED PROSECUTION

6.80 An evidence-led prosecution was initiated by the CPS following an assault on Nicole by Craig in October 2019 in respect of which Nicole declined to provide a witness statement or support a prosecution (Paragraph 5.38). The authorisation of charges against Craig led to his remand in custody for almost three months. However, the evidence was largely reliant on the account given by the independent witness, who did not attend Court and efforts to contact him were unsuccessful. Matters were complicated by Nicole's attendance at Court as a defence witness and the charges were dismissed by the Magistrates Court (Paragraph 5.50).

6.81 The question of whether more could have been done to support the independent witness in this case was raised by the DHR Panel. The CPS advised that they work in conjunction with police to ensure appropriate support is in place for witnesses giving evidence in criminal proceedings. Special measures are a series of provisions that help vulnerable and intimidated witnesses give their best evidence in court and help to relieve some of the stress associated with giving evidence. Special measures include the granting of 'screens' to shield a witness from the defendant when giving evidence or a live link enabling a witness to give evidence from outside a courtroom. Special measures discussions with the police should take place at an early stage and witnesses consulted on their preferences. This information should be communicated to CPS along with any information which would support an application for special measures.

6.82 The DHR has also been advised that witnesses are also supported by the local Witness Care Unit (WCU), which is managed by the police. The WCU manages the care of victims and witnesses from the point of charge through to the conclusion of a case. The allocated witness care officer will contact a witness if a defendant decides to plead not guilty to discuss any support and assistance that may be required to attend court which would include the need for special measures. In addition to keeping a witness updated, the WCU will help a witness attend the trial and give evidence e.g., by assisting with transport to court. The WCU will also facilitate a pre-court visit if required by a witness. In this case special measures were not requested by the independent witness, although he was supported by a dedicated witness care officer.

6.83 A further prosecution was initiated by the CPS after Nicole disclosed a physical and sexual assault by Craig in January 2020 (Paragraph 5.51). The evidence was reliant on the account given by Nicole who eventually declined to make a statement and went on to write a letter casting doubt on her disclosure of digital penetration and retracted her original account of the assault. She further stated that should the case go to trial she would give evidence in Craig's defence (Paragraph 5.78).

6.84 The CPS has advised the DHR that restraining orders could have been considered in respect of the 2019 and 2020 matters as such orders may be made on conviction or acquittal for any criminal offence. These orders are intended to be preventative and protective. For a restraining order on acquittal, section 5A Protection from Harassment Act 1997 provides that a court may make a restraining order if it considers it is necessary to protect a person from harassment by the defendant. In respect of the 2019 allegations, an application for a restraining order on acquittal was not made and was not requested by Nicole. As she had never supported the prosecution of Craig in this case, had continued her relationship with him and attended Court in his defence, it is likely any such application would have been refused as by the Court in the absence of any evidence to demonstrate she was subject to undue influence. With regard to the 2020 allegations, an application for a restraining order on acquittal was not made. The CPS could have directed police to obtain Nicole's updated views on whether such an order was required given the case was not formally finalised for several months and some time had passed since the decision to stop the case was communicated to her. Consideration could also have been given to making an application in the absence of her support on the basis she was subject to undue influence given information provided by Nicole to the Police in which it was suggested she was under significant pressure from Craig's family and associates. However, this would have necessitated evidence being called pertaining to these disclosures and it was very likely that the application would have been contested by the defence.

NICOLE'S ENGAGEMENT WITH REFUGES

6.85 Nicole often appeared uncertain as to whether she should accept the offer of a place in a refuge and when she did, she appeared to really struggle to adapt to life in the refuges in which she was found a place during the period on which this DHR focusses.

6.86 She was frequently reluctant to leave the local area, expressing a preference for a refuge in a nearby town but this refuge had a space only for a woman with children at that time (Paragraph 5.27). As refuge places tend to be taken very quickly when they became available, this meant that Nicole's uncertainty and hesitation resulted in her missing out on refuge spaces on occasion. It seems possible that her fears for the safety of her children should she succeed in leaving Craig may have been a factor in wishing to stay in the local area. During August 2019 Nicole was referred to refuge 1 – a complex needs refuge - but at that time the level of her needs or her willingness to accept support for identified needs such as her use of substances were barriers to the acceptance of her referral (Paragraph 5.29). In October 2019 Nicole reluctantly accepted a place in a refuge 2 but was asked to leave after staying there for only 2 nights out of 9 and her 'chaotic' behaviour was said to put others at risk (Paragraph 5.42).

6.87 Additionally, the influence of Craig appeared to be a factor in Nicole remaining in refuges for brief periods only. In March 2022 HARV supported Nicole to obtain a place in a refuge 3 (Paragraph 5.133). Arrangements were made for Nicole to travel to refuge 3 by taxi and she arrived during the early evening of the same day. After spending two nights in the refuge, Nicole said that she would be 'going to see her Dad' and may not return to the refuge that evening.

The overnight stay policy – no overnight stays permitted during the first 7 days following admission - was explained to her (Paragraph 5.135). She requested, and was granted, permission to stay at her father's address for a second night (Paragraph 5.136). After she had spent a further night away from the refuge, Safenet – the provider of the refuge - reported her missing to the Police after establishing that the address that Nicole had provided as her father's address did not exist (Paragraph 5.138). The Police later found her at Craig's address where she was documented to be 'safe and well' and said that she had been with Craig since leaving the refuge (Paragraph 5.139).

6.88 Craig also appeared to be instrumental in her gradual disengagement from refuge 1 in the days before the hanging incident which led to her death. She was discharged to refuge 1 on 12th July 2022 and in the intervening nine days before the hanging incident, Nicole was reported missing to the Police by refuge 1 five or six times. On at least four of these occasions she spent time with Craig.

6.89 The DHR Panel discussed whether refuges could have done more to help Nicole settle in the refuge environment. However, it is acknowledged that survivors are admitted to a refuge after choosing to be referred to the refuge, they then reside in the refuge as independent adults with capacity who make their own decisions and are supported by refuge staff with advice and safety measures. The DHR has been advised by Safenet that not all survivors who are admitted to a refuge are planning to leave the perpetrator permanently – some residents go to a refuge for respite and/or to find out what their options are. Safenet also advise that on average a woman leaves an abusive relationship seven times before she leaves for good so it follows that sometimes a resident of a refuge will continue to have contact with a perpetrator whilst staying in a refuge. Safenet advised that in 2022 the average length of being in an abusive relationship for refuge 1 residents was 34 months, leaving numerous times and then returning to the perpetrator (13). Safenet also advised the DHR that they recognise that mobile phones play a huge role in post separation coercive control and they work with survivors around safety concerns if they maintain contact with perpetrators – assuming this contact is known by staff. Safenet also advise that it is not always achievable to ask survivors to cut off mobile phone contact with the perpetrator for safety reasons including being better informed about the risks from the perpetrators from their mobile phone contact and advise 'mute don't block.

MARAC

6.90 MARAC adopted a strategic approach to the large number of referrals they considered in respect of Nicole. MARAC played an important role in assuring itself that there was a comprehensive multi-agency approach to exploiting the 'breathing space' provided by the DVPO (Paragraph 5.30). When MARAC considered Nicole's case on 18th February 2020 they viewed her as 'very high risk' and requested agencies she contacted to encourage her to engage with support (Paragraph 5.62). MARAC developed this approach further when they considered a referral in respect of Nicole on 12th October 2021 when it was agreed that a 'flag' should be placed on the 'hospital system' should Nicole – who was falsely claiming to be pregnant at this

time – attend and that her GP should offer her an appointment should she engage and that the IDVA should attempt a joint visit with mental health services (Paragraph 5.120).

6.91 MARAC thus very clearly expressed the approach to be adopted by partner agencies, particularly health services. Every effort was to be made to engage with her in-person. Translating this strategic direction into action proved challenging, however. Nicole's GP practice received feedback from the February 2020 MARAC and a note was placed in her GP records to encourage engagement with services but the expected flags were not placed in her records (Paragraph 5.64). Nicole's GP practice later wrote to her to warn her that she was at risk of being removed from the GP practice if she continued to miss appointments – having missed two (Paragraph 5.68). This letter – which may have been a fairly automatic response to a specific number of missed appointments - was contrary to the MARAC request to encourage engagement with services. Although her GP practice saw Nicole on 24th March 2020 when she attended to collect a fit note, many subsequent fit notes were issued without Nicole being seen (Paragraph 5.71). When Nicole's GP practice received feedback from the October 2021 MARAC requesting that they offer her an appointment should any opportunity to engage arise. The GP practice took no action in response to the MARAC action. No note was placed on their system to highlight the MARAC request nor were any active attempts made to contact Nicole (Paragraph 5.121).

6.92 MARAC did not always receive relevant information from Nicole's GP practice when requested. For example on 7th July 2022 Nicole's GP received a MARAC information request in relation to a forthcoming MARAC meeting scheduled for 19th July 2022. There is no indication that the form was completed or returned (Paragraph 5.179).

6.93 There were a large number of MARAC referrals made in respect of Nicole during the period under review. Locating each and every MARAC record has not been a straightforward task. At the time of writing there are two MARAC referrals which do not appear to have resulted in Nicole's case being heard at MARAC:

- On or around 3rd July 2019 the police completed a DASH risk assessment which disclosed a 'high' risk and she was referred to MARAC via the Multi-Agency Safeguarding Hub (MASH) and the IDVA service for ongoing support although it was noted that Nicole was already in contact with HARV (Paragraph 5.12).
- On Saturday 19th March 2022 Safenet completed a DASH risk assessment which disclosed a high risk and Nicole was referred to MARAC. The refuge was in Lancaster so it may have gone to a different MARAC, although Lancashire Constabulary have advised the DHR that there is no record of the referral being received (Paragraph 5.134).

6.94 It is suspected this is an issue which has been commented upon before but the DHR has been advised that MARAC does not monitor the completion of actions -which appears to have

allowed the apparent absence of the Adult Social Care review of Nicole to go unchallenged (Paragraph 5.30).

ACCESS TO HEALTHCARE FOR VICTIMS OF DOMESTIC ABUSE

6.95 The ELHT breast clinic twice discharged Nicole from their care after she did not attend two appointments following GP referrals (Paragraphs 5.44 and 5.49). Nicole was discharged on the second occasion despite the GP referral including information relating to Nicole's disclosures of domestic abuse. When Nicole attended the breast clinic after a third GP referral she disclosed that her partner had not allowed her out of the house to attend appointments (Paragraph 5.66).

THE WHOLE SYSTEM FOR SAFEGUARDING VICTIMS OF DOMESTIC ABUSE WAS UNABLE TO IMPROVE THE SITUATION FOR NICOLE.

6.96 Partner agencies deployed most of the tools in the Domestic Abuse 'tool box' – positive action to arrest, charge and remand of the perpetrator, a determined attempt to progress an evidence-led prosecution, refuge support on numerous occasions, DVPO, Domestic Abuse trigger plans etc. However, Nicole's situation had not improved and arguably it had deteriorated as she appeared to have come to realise that if she reported abuse and attempted to engage with agencies, she could face retribution from Craig.

6.97 Under safeguarding children arrangements, many safeguarding children partnerships have a policy which requires a professional to escalate matters if they form the view that the 'system' is not working for a child and their family and their lived experience is not improving. Arguably there should be a similar requirement of professionals in circumstances where the system is not working for a victim of domestic abuse despite the efforts of professionals from partner agencies.

'VICTIM FATIGUE'

6.98 Generally professionals adopted a sympathetic and compassionate approach to Nicole and made commendable efforts to work individually and collectively to safeguard her from domestic abuse. However, after initially saying that she was 'so glad' she had taken the first step and contacted HARV before she 'ended up dead' (Paragraph 5.8), Nicole appeared to become unhappy about the extent to which others appeared to be taking decisions about her and began expressing regret that she had disclosed domestic abuse to professionals (Paragraph 5.16). She later went on to say that she felt like everyone was telling her what she should do and giving her instructions and telling her what changes she needed to make in her life, without actually providing her with the means to achieve those changes (Paragraph 5.31). She described her

situation as 'no win' (Paragraph 5.65). After two unsuccessful prosecutions in which Nicole eventually decided, or was perhaps pressurised, into making statements in support of the defence, she said that she did not wish to make a formal complaint as she did not want to go through the formal court process (Paragraph 5.119) and later stated that she 'could not face' going through the Court Process (Paragraph 5.127).

6.99 Nicole's son said that he began to feel helpless in that he felt that he couldn't do anything to help his mother end her relationship with Craig (Paragraph 4.21) and 'gave up on her' – which he felt that 'the authorities' did over time (Paragraph 4.27).

6.100 In another DHR completed by this independent author, members of that DHR Panel felt that it is not uncommon for victims who have suffered long term abuse to begin to feel that reporting incidents will not really change things for them – and as in Nicole's case - may actually worsen their situation.

'VICTIM BLAMING' LANGUAGE.

6.101 Although professionals largely adopted a compassionate approach to Nicole, occasionally there were examples of language which could be perceived to be 'victim blaming'. For example, Nicole's behaviour was described as 'self-destructive' (Paragraph 5.6) and she was described as 'completely uncooperative' and 'completely unwilling to help herself' (Paragraph 5.16).

MANAGING THE RISK PRESENTED BY THE PERPETRATOR TO FUTURE PARTNERS.

6.102 It has only been possible to conduct DHRs when a victim of domestic abuse apparently takes their own life for a relatively short period of time (the Home Office DHR guidance was amended to allow DHRs in such circumstances in December 2016). The number of 'suicide DHRs' completed has steadily grown and so there is now quite a sizeable known cohort of perpetrators of domestic abuse whose partners or ex-partners have taken their own life.

6.103 Craig is one such perpetrator. His previous convictions primarily relate to offences of dishonesty. He has been charged with several offences of violence against former intimate partners but none of these prosecutions succeeded with an important factor being that the former partners declined to support a prosecution. There are two documented breaches of restraining orders in respect of a former partner. However, as a result of this DHR, a great deal is now known about Craig as a perpetrator of domestic abuse based not only on the disclosures made by Nicole but also the detailed documentation by ward staff of his conduct towards Nicole whilst she was a patient in the Harbour Hospital.

6.104 The question arises of what action should be taken to manage the risks that this cohort of domestic abusers present. In DHR's in which there is a homicide the perpetrators invariably receive a sentence of life imprisonment. In the case of a 'suicide DHR' , perpetrators are free to move on to another victim.

FLAGGING PERPETRATORS BY GPS

6.105 A related issue is the extent to which GP practices flag domestic abuse

perpetrators. Craig's GP practice did not flag him as an alleged perpetrator until quite late in this sequence of events (Paragraph 5.152) despite his domestic abuse history with Nicole and what appears to be a substantial domestic abuse perpetrator history prior to his relationship with Nicole commencing. The DHR Panel has been advised that Primary Care receives guidance from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) relating to the Recording of Domestic Abuse and MARAC information on Electronic Medical Records (EMR) (14). The guidance sets out relevant principles which include ensuring that any decision to record the information in the perpetrator's EMR is made with due regard to the associated risks. This includes ensuring that any reference to domestic abuse in a perpetrator's record is redacted if records are provided to the perpetrator unless the GP Practice is certain it is information that the perpetrator already knows and the need to be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children's EMRs - including via online access to their own information and their children's information, as well as the risk of a perpetrator having coercive access to the victim's EMR. GP practices are advised not to record a disclosure of domestic abuse in the alleged perpetrator record unless their professional judgement deems it necessary. The types of issues to be considered when exercising professional judgement in this regard are not elaborated upon. Turning to MARAC feedback in relation to the perpetrator, the guidance reiterates the Royal College of General Practitioners (RCGP) recommendation that no information from MARAC should be stored in the perpetrator's record due to the potential risk of being seen by the perpetrator.

6.106 SafeLives has also provided a MARAC guide for GPs (15) which advised that

where a GP is <u>certain</u> that the perpetrator is aware that domestic abuse has been disclosed to the police or other agency, relevant information regarding domestic abuse or MARAC information should be recorded in the perpetrator's record. Where the GP is <u>not certain</u> that the perpetrator is aware of any allegation (or disclosure), the GP should not record information on the perpetrator's record. The Safelives guidance concludes that as it is unlikely that the GP will be certain of the extent of the perpetrators knowledge of domestic abuse disclosures or allegations to other agencies, in most circumstances, the GP will not record information within the perpetrator's notes.

To consider any cultural, environmental or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection, and learning why any interventions did not work for them.

6.107 The 'protected characteristics' of 'sex', 'disability' and 'pregnancy and maternity' apply to Nicole.

SEX

6.108 Domestic abuse research has found the difference between experiences and involvement in domestic abuse between men and women to be stark, with men significantly more likely to be repeat perpetrators and men significantly more likely than women to use physical violence, threats and harassment (16). There are also significant differences in the extent to which economic abuse affects male and female victims of domestic abuse. Women are more likely to report experiencing financial abuse than men (17) and women are likely to suffer this type of abuse for much longer than men (18).

DISABILITY

6.109 Nicole had a long history of poor mental health with episodes of low mood, depression (including post-natal depression) and compulsory admissions under the Mental Health Act. She was diagnosed with personality disorder[37] in 1997. The key barrier faced by Nicole in accessing care, treatment and support for her mental health issues was the coercive and controlling behaviour by Craig which limited Nicole in the exercise of her free will in accessing services at times.

PREGNANCY AND MATERNITY

6.110 Nicole gave birth to her first child at the age of 18 and went on to have seven children in all. She underwent a sterilisation procedure in her early thirties. Over time her children began to be cared for by other family members and at the time her relationship with Craig began in 2017 only two of her children were in her care and they were subsequently supported by children's social care to move to the care of Nicole's eldest son in 2019 and never returned to their mother's care. Although the fabricated pregnancy which Nicole sustained for almost a year from

[37] Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into 4 main areas which are emotional instability – the psychological term for which is "affective dysregulation"; disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions"; impulsive behaviour; and intense but unstable relationships with others.

late 2020 onwards appears to have been primarily motivated by Nicole's desire to feel safer from physical abuse from Craig, she may also have experienced a yearning to become pregnant, or present herself as pregnant, given her loss of the custody of her younger children.

6.111 The independent author has recently completed a thematic review of the apparent suicides of five parents from whom their children had been lawfully removed or their access to their children had been lawfully restricted. Whilst in each case there were a number of known antecedents of suicide apparent, it was also clear that the loss or restriction of contact with their children was a factor which appeared to adversely affect their hopes for the future.

INTERSECTIONALITY

6.112 Intersectionality has been defined as a 'metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking' (19). Nicole may have experienced Adverse Childhood Experiences (ACEs) - which are defined as 'stressful events occurring in childhood including domestic abuse, parental abandonment through separation or divorce, a parent with a mental health condition, being the victim of abuse or neglect, a member of the household being in prison and/or growing up in a household in which there are adults experiencing alcohol and drug use problems' (20). Nicole experienced childhood trauma in the form of physical and sexual abuse and began self-harming from the age of 13. She was a care experienced young person. It is not known whether this had a positive impact on her young life or not. Nicole's childhood experiences may have had a 'long reach' (21) into her adulthood. Nicole appears to have become alcohol dependent for a time and used Crack Cocaine, although some of her drug use may have taken place as a result of duress. Clearly Nicole's adult life was blighted by the impact of domestic abuse which took an increasingly extreme and all-encompassing form during her relationship with Craig.

To consider the impact that the Covid-19 Pandemic had on the victim accessing support to Domestic Abuse Services, and how the pandemic may have led to increasing episodes of Domestic Abuse, and the deterioration of the victim's mental health.

6.113 The first Covid-19 lockdown began a little over a month after MARAC formed the view that because Nicole was 'very high risk' agencies with which she was in contact should encourage her to engage with support. The exceptional delivery models adopted by partner agencies in response to the pandemic inadvertently frustrated MARAC's aim, as their opportunities to interact with her on an in-person basis diminished.

6.114 Just after the second lockdown began Nicole began presenting as pregnant, and was able to maintain this fabricated pregnancy for approaching a year. The restrictions introduced as a

result of the second and third Covid lockdowns do not appear to have helped or hindered her efforts to maintain the fiction of her pregnancy because professionals made determined efforts to engage with her because of concerns about the risks to her unborn baby. However it is not known whether the prospect of spending further periods isolated with Craig may have been a factor which motivated Nicole to claim she was pregnant in order to reduce the risk of abuse from him.

To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.

GOOD PRACTICE

6.115 Overall, this was a very challenging case and there was much diligent, purposeful, person centred and compassionate work by professionals from a range of agencies.

- HARV and the police worked very effectively together (in Phase 1) in an effort to safeguard Nicole.

- The efforts of the CPS to mount an evidence-led prosecution of Craig were impressive.

- Partner agencies worked very effectively together to assess and manage the risks to the 'unborn child' when Nicole fabricated a pregnancy in order to protect herself from domestic abuse from Craig.

- The Lancashire Constabulary High Risk Trigger Plan was a valuable addition to the methods used by professionals in an effort to safeguard Nicole.

- Five Lancashire Constabulary officers won a National Police Bravery Award in 2023 for their efforts to save Nicole's life on 21st July 2022. The officers had to jump over a 10 foot wall into the river below in order to rescue Nicole and perform CPR. They were then assisted by the Fire and Rescue Service who lowered an aerial platform into the river onto which Nicole was placed in order to raise her over the wall and allow her transfer to a waiting ambulance.

7.0 CONCLUSION

7.1 Nicole's relationship with Craig began in 2017. Nicole made disclosures of significant domestic abuse including coercive and controlling behaviour to the police and HARV in 2019 who attempted to support Nicole to leave her relationship with Craig. The domestic abuse she was experiencing appeared to be adversely affecting Nicole's mental health and she was hospitalised following an overdose of Craig's prescribed medication and later briefly admitted to hospital under the Mental Health Act. The two of her seven children who remained with Nicole permanently left her care.

7.2 Her relationship with Craig continued and after Nicole disclosed a physical assault by Craig a DVPO provided a breathing space for a time although it proved challenging to support and encourage Nicole to access a refuge. Nicole's reluctance to access, or remain very long, in refuges is a recurring theme although it is suspected that Craig frequently influenced her decisions to leave refuges through economic abuse and making threats to harm her children. With hindsight Nicole's fear that Craig could harm her children appears to have been a much more significant factor in Craig's control over Nicole than professionals became aware of at the time.

7.3 Strenuous efforts were made to initiate evidence-led prosecutions when Nicole disclosed assaults by Craig and positive action taken to arrest him, following which he spent periods on remand which again provided partner agencies with further breathing space to support Nicole to leave Craig. However, Nicole was reluctant to support prosecutions and when she did so initially, she subsequently withdrew support. She appears to have come under so much pressure from Craig and/or his family members at these times that she eventually became very reluctant to support prosecutions. Agencies also became concerned that interventions they made in attempt to safeguard Nicole could inadvertently put her at increased risk of abuse from Craig.

7.4 From late 2020 throughout much of 2021 Nicole falsely claimed to be pregnant having undergone a sterilisation procedure several years earlier – which agencies were unable to confirm initially. Effective multi-agency work was undertaken to safeguard the apparent unborn child until Nicole subsequently disclosed that she had fabricated the pregnancy in the hope that it would reduce physical abuse from Craig. The abuse experienced in her relationship with Craig appeared to take a heavy toll on her mental health and Nicole was again admitted to hospital under the Mental Health Act in June 2022. Craig continued to exert coercive and controlling behaviour when visiting or telephoning her during this admission. Nicole was discharged to a refuge but experienced similar difficulties in settling in the refuge as had been the case when she had accessed refuge provision previously. Craig appeared to undermine Nicole's resolve to remain in the refuge and she was reported missing from the refuge on several occasions. During one of these missing episodes Nicole hung herself in a public place after spending time in Craig's company. She subsequently died in hospital.

8.0 LESSONS TO BE LEARNT AND RECOMMENDATIONS

All recommendations are addressed to Pennine Lancashire Community Safety Partnership but will also need to be considered by Hyndburn Borough Council.

8.1 In this case partner agencies generally worked very diligently individually and collectively to try and safeguard Nicole from domestic abuse from Craig but were unable to prevent her from taking her own life. The challenge this case presents is to explore how the 'whole system' for safeguarding victims of domestic abuse can be further strengthened to support victims of the very intensive and unrelenting domestic abuse suffered by Nicole which severely diminished the quality of her life and appears to have extinguished any hope she had for a more positive future to the extent that she took her own life.

Response to evidence of controlling and coercive behaviour

8.2 It is noticeable that in this case professionals eventually became a little 'stuck' in terms of how best to safeguard Nicole given the range of actions which had previously been implemented in an effort to support Nicole to leave Craig. Reflecting on the case, one further option professionals could have considered could have been to analyse the behaviours Craig engaged in to control and coerce Nicole. If this had been done it seems possible that the importance of addressing Nicole's fears that Craig may harm her children may have become more apparent.

8.3 Controlling and coercive behaviour can take many forms. This case suggests that carefully analysing the 'methods' of coercive control employed by the perpetrator and speaking to the victim about the impact of controlling and coercive behaviour on her life, in particular her freedom to make decisions about whether to remain in or leave the relationship could be of value. Such analysis could have drawn greater attention to Nicole's fears that if she did not return to Craig, he could harm her children – none of whom were in her care – but many of whom lived locally. From time to time Nicole's shared these fears with professionals but it is largely as a result of this DHR that the impact of Nicole's fears that Craig could harm her children have become more prominent. Analysis could also have focussed greater attention on the need to seize opportunities to support Nicole to regain control over her finances at key points such as her discharge from the Harbour Hospital. It is therefore recommended that there should be greater professional attention paid to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. There may be merit in devising a tool to help professionals analyse controlling and coercive behaviour based on the 'types' of controlling and coercive behaviour set out in the Domestic Abuse Act 2021 Statutory Guidance.

RECOMMENDATION 1

That Pennine Lancashire Community Safety Partnership promotes greater professional attention to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. The Partnership may also wish to consider requesting relevant partners to devise a tool to help professionals analyse controlling and coercive behaviour based on the 'types' of controlling and coercive behaviour set out in the Domestic Abuse Act 2021 Statutory Guidance.

Tackling economic abuse

8.4 Craig exercised control over Nicole by apparently insisting that her benefits were paid into his bank account and there is evidence that when Nicole managed to switch the payment of benefits back to her own bank account she quickly reversed those arrangements and requested the DWP to restore the payment of benefits into Craig's bank account. The DHR Panel discussed the challenges involved in helping a victim of domestic abuse regain control of her finances whilst she remained in an abusive relationship with the perpetrator. Changing the victim's bank details to their own bank risked an escalation in abuse from the perpetrator and pressure to reverse the change – which is what appeared to happen to Nicole.

8.5 However, there was an opportunity to intervene more decisively to change the address to which Nicole's DWP vouchers were sent as a key element of her discharge plan following her second Mental Health Act admission but after initial efforts to achieve this were frustrated by Nicole's lack of a mobile phone, this task appeared to be overlooked when Nicole was later provided with a new phone. Whilst recognising the challenges involved in supporting victims to regain control of their finances whilst they remain in a relationship with their abuser, professionals are in a stronger position to help a victim of domestic abuse regain control of their finances when they have left or are leaving the abusive relationship and so it is recommended that the Community Safety Partnership highlight the importance of such action and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.

RECOMMENDATION 2

That when they disseminate the learning from this DHR, Pennine Lancashire Community Safety Partnership highlight the importance of action to support victims of domestic abuse to regain control of their finances when leaving an abusive relationship and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.

8.6 As previously stated, the DHR Author is also completing a second DHR (DHR 'Rose') for Pennine Lancashire CSP in which economic abuse is the dominant form of coercion and control used by the perpetrator. Additionally, members of the DHR Panels for 'Nicole' and 'Rose' are involved in other current Pennine Lancashire CSP DHRs in which economic abuse is prominent. There may therefore be value in developing a bespoke action plan to address economic abuse as a form of coercion and control which draws upon the learning from this DHR and the other Pennine Lancashire CSP DHRs in which economic abuse is a prominent factor. There may be benefit in partnering with the UK charity Surviving Economic Abuse.

Mental Capacity

8.7 Nicole's capacity to make decisions was only rarely formally considered. Nicole's capacity to make decisions in respect of her personal safety were affected by 'undue pressure' arising from the evidence of Craig's controlling and coercive behaviour could have received greater professional attention than it did. The LSCFT Serious Incident Review (SIR) observes that capacity to engage in unwise decisions, such as contact with an abusive partner, cannot be assumed based on a person's capacity to make other decisions around their care. The SIR goes onto recommend that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour should be at the foundation of clinical decision making for people experiencing domestic abuse.

RECOMMENDATION 3

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to advise on the steps it plans to take, or has already taken, to ensure that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour are at the foundation of clinical decision making for people experiencing domestic abuse.

Fabricated pregnancy

8.8 Nicole disclosed to professionals that she fabricated a pregnancy in order to protect herself from abuse from Craig. This was quite an extreme step to take to try and protect herself from domestic abuse, involving maintaining the impression that she was pregnant for over a year (November 2020 until December 2021). She reported only one incidents of domestic abuse during this period and so - on the basis of the lack of reported incidents – her plan may have been successful. Reported physical violence began almost immediately after the fabricated pregnancy period came to an end and appeared to intensify until her admission to the Harbour Hospital in June 2022.

8.9 However, during the fabricated pregnancy period Nicole avoided contact with health professionals which may have reduced her opportunity to disclose domestic abuse to professionals and adversely affected the continuity of her health care. The likelihood that Nicole's pregnancy was fabricated could have been established much earlier had GP Practice 3 held information about her 2013 sterilisation. However, one important consequence of the difficulty in clarifying that she had undergone a sterilisation procedure many years earlier was that a range of professionals became involved with Nicole and made, or attempted to make, contact with her on a regular basis. Additionally, through the processes invoked to safeguard her unborn child there was quite intensive scrutiny of her case for around a year. However, once it had been established that Nicole was highly unlikely to be pregnant this professional oversight/involvement ceased. There was a missed opportunity to review Nicole's needs following the discovery that her

pregnancy was fabricated, including the risk of resumption or intensification of domestic abuse and to have potentially considered an adult safeguarding referral on the grounds that she had care and support needs, was exposed to a potentially enhanced risk of domestic abuse and because of her care and support needs was unable to protect herself from abuse.

8.10 The DHR Panel was minded to recommend that the Lancashire Concealed and Denied Pregnancy guidance should be amended to reflect the learning from this case to reflect the possibility that the pregnancy may have been fabricated for other reasons such as to protect the woman from domestic abuse. However, the DHR Panel has been advised that it would not be appropriate to amend the guidance as the focus of that guidance is on safeguarding the unborn child. However, there is important learning from this case in relation to the importance of considering the needs of the victim of domestic abuse who has fabricated a pregnancy to reduce domestic abuse when the partner agencies involved in safeguarding her unborn child step away. It is therefore recommended that the learning from this case is shared with the local Safeguarding Children Partnership and the local Safeguarding Adults Board and that when the Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted.

RECOMMENDATION 4

That Pennine Lancashire Community Safety Partnership shares the learning in respect of fabricated pregnancy with both the local Safeguarding Children Partnership and Safeguarding Adults Board and that when the Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted to professionals.

Nicole's MHA admission to the Harbour Hospital

8.11 Lancashire and South Cumbria NHS Foundation Trust shared the Serious Incident Review (SIR) report with the DHR. Overall, the SIR found that there was evidence of good safeguarding and multi-agency working from the ward staff and domestic violence services in terms of seeking advice and at discharge planning.

However, domestic abuse continued during Nicole's MHA admission to the Harbour Hospital (Paragraphs 6.33 to 6.42). The ward team supporting Nicole clearly had concern about the visits to the ward from Craig. A full MDT review involving the police and LSCFT safeguarding practitioners would have supported the team to fully understand and assess Nicole's capacity to enable robust decision making. On review of the ward's ability to prevent a person from visiting the ward, no guidance for clinical teams could be found. Therefore LSCFT intend to amend the current Inpatient Standard Operating Procedure to include clear guidance around visitors to inpatient wards who may pose risk to patients or staff (LSCFT Single Agency Recommendation 7 – see Appendix A for all Single Agency Recommendations).

8.12 The LSCFT Safeguarding Team exists to provide expert advice and guidance for clinical teams directly caring for those at risk of harm from others. Unfortunately, some of the key advice sought from the LSCFT Safeguarding Team was not acted upon by the ward team. For example the advice that a robust capacity assessment should be completed and documented within the notes around Nicole's understanding of the coercion and control aspect of the domestic abuse in order to inform the decision of whether to allow Craig to visit the ward, was overlooked. Therefore the LSCFT has recommended that the ward identify processes to ensure that actions that are agreed as required by the wider multi-disciplinary team are effectively handed over and completed in a timely manner (LSCFT Single Agency Recommendation 2) and LSCFT has recommended that their safeguarding team consider a process to ensure that safeguarding advice is recorded in the clinical record to ensure continuity of care and improved communication (LSCFT Single Agency Recommendation 5).

8.13 The SIR identified a number of key points where routine enquiry or DASH assessment would have been beneficial to enable ward staff to gain further insight into Nicole's relationship with Craig and escalate concerns to the LSCFT safeguarding team and Lancashire Constabulary. The SIR found that there was a gap in the knowledge of clinical teams in relation to the purpose, and recording of routine enquiry and who is the right person to complete a DASH, when is the right time to complete a DASH, as well as the overall purpose of a DASH risk assessment. The LSCFT has recommended that the ward improve their knowledge and understanding of current procedure and policy to support those experiencing domestic abuse, including the requirement for routine enquiry and understanding of the DASH assessment (LSCFT Single Agency Recommendation 1). The HTT did not document routine enquiry during their follow up visit to Nicole after she had been discharged to refuge 1 and so it is recommended that LSCFT Single Recommendation 1 is expanded to encompass the HTT.

8.14 The SIR found that supporting Nicole was challenging for the ward staff and went on to note that much of the support was provided by health care assistants who do not routinely document clinical records which led to a mismatch between the clinical records and the level of therapeutic intervention expressed by staff to the SIR process. LSCFT have therefore recommended that all patients admitted to the ward have regular one-to-one time with either their primary nurse or named nurse for the shift (LSCFT Single Agency Recommendation 3). The SIR also noted that working with domestic abuse is a psychologically challenging area of nursing and so teams require substantial support to enable safe and robust decision making as well as to discuss the impact this has on their own wellbeing. Reflective group sessions or formulation sessions give staff the opportunity to reflect on the care delivered and enhance the confidence and capacity to care, improving outcomes for services users. The LSCFT therefore recommended that there should be adequate support and safeguarding supervision in place for clinical teams dealing with complex cases of domestic abuse (LSCFT Single Agency recommendation 4).

8.15 Nicole was clinically optimised for discharge much earlier than her actual discharge date and her admission was prolonged in an effort to facilitate Nicole's safe and effective transition to the community. However, there were a number of planned actions which did not take place

particularly the referral to the CMHT to enable Nicole to be supported using a Care Programme Approach or the referral to Inspire, although it appears that the Harbour Hospital anticipated that this would be done by refuge 1. Additionally, efforts to change the address to which her DWP payment exception service vouchers were sent had not been completed. Furthermore, the discharge plan was founded on the assumption that Nicole would go to refuge 1 and accept the support provided there. There is no indication that Nicole's previous involvement with refuges was taken into account. If it had, professionals would have realised that Nicole had invariably struggled to settle in refuges in the past and had often not stayed there beyond the first couple of nights. This understanding of Nicole's history could have prompted the development of a contingency plan to address the probability that Nicole would not stay in refuge 1 for long. One contingency which could have been further considered was the possibility of obtaining an order to prevent Craig contacting Nicole. The ASC social worker and the manager of refuge 1 had discussed the possibility of obtaining an 'injunction' against Craig but there is no indication that this was progressed further. By this time the previously imposed Police bail conditions were no longer in force and the opportunity to investigate the offence of assisting a patient detained under the MHA to absent themselves without leave had been missed. The learning arising from multi-disciplinary discharge planning merits a separate multi-agency recommendation.

RECOMMENDATION 5

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to work with relevant partner agencies to develop a robust approach to multi-disciplinary discharge from hospital of patients at risk from domestic abuse which ensures that discharge planning is informed by the patient's history that the discharge plan is comprehensive and addresses reasonable contingencies.

8.16 Following her discharge, the HTT made a visit to Nicole in refuge 1 before closing the case. The SIR noted that there is no indication of routine enquiry or professional curiosity in relation to contact from Craig. In addition, the SIR noted the absence of an expected enhanced risk assessment which should have been completed at the point of follow up as Nicole was not accepted into home treatment. The LSCFT therefore reinforces the requirement for the completion of an updated enhanced risk assessment when patients are discharged back to the care of a GP by an LSCFT team (LSCFT Single Agency Recommendation 6).

Suicide of victims of domestic abuse.

8.17 The impact of domestic abuse, in particular physical and sexual violence, coercion and controlling behaviour, economic abuse and threats to harm Nicole's family appears to have been a very prominent factor in Nicole's suicide. In this case there seems to very strong evidence of a link between the abuse Nicole disclosed in her relationship with Craig and her mental health problems, her self-harming behaviour and attempts to take her own life.

8.18 The DHR has been advised that the Lancashire and South Cumbria Suicide Prevention Strategy is currently awaiting sign off. A late draft of the Suicide Prevention Strategy has been shared with the DHR. The Strategy highlights the areas of 'leadership', 'prevention', 'intervention', 'postvention' and 'intelligence'.

'Intervention' includes providing effective support to high risk groups and minimising risks through effective protocols and safeguarding practices. The learning derived from this DHR may assist in understanding how to enhance efforts to safeguard victims of entrenched domestic abuse particularly the need to analyse coercion and control methods in order to better tailor support to victims. 'Intelligence' includes sharing lessons learnt, best practice and recommendations from 'Serious Case Reviews/Child Death Overview Reviews'. Serious Case Reviews have been replaced by Child Safeguarding Practice Reviews. It could be of value to the Strategy to also consider learning from 'suicide' DHRs and Safeguarding Adults Reviews where the person subject of the review appears to have taken their own life. The learning from this DHR may also be of relevance to the Hyndburn Borough Council approach to suicide prevention.

RECOMMENDATION 6

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Council Public Health so that the learning from this review, in particular the corrosive impact of prolonged controlling and coercive behaviour on a victim's mental health and the increasing evidence of a link between domestic abuse and suicide, can inform future suicide prevention plans.

The need for escalation when the 'whole system' for safeguarding victims of domestic abuse is unable to improve the situation for a victim.

8.19 Partner agencies working with Nicole deployed most of the tools in the Domestic Abuse 'tool box' – positive action to arrest, charge and remand of the perpetrator, a determined attempt to obtain an evidence-led prosecution, refuge support on numerous occasions, DVPO, Domestic Abuse trigger plans etc. However, Nicole's situation had not improved and arguably it had deteriorated as she appeared to have come to believe, based on her experiences, that if she reported abuse and attempted to engage with agencies, she could face retribution from Craig.

8.20 Under safeguarding children arrangements, many safeguarding children partnerships have a policy which requires a professional to escalate matters if they form the view that the 'system' is not working for a child and their family and their lived experience is not improving. Arguably there could be a similar requirement of professionals in circumstances where the system is not working for a victim of domestic abuse despite the efforts of professionals from partner agencies. The DHR Panel considered making a recommendation but concluded that if such a policy was introduced the logical forum to escalate system concerns would be MARAC – which considered Nicole as a high risk victim on several occasions. However, it may be useful to advise MARAC chairs that repeat referrals could be an indication that the system may not be working

for an individual victim and may therefore present an opportunity to challenge partner agencies to review the action they had taken and consider alternatives.

Victim fatigue

8.21 Over time Nicole appeared to conclude that engaging with professionals, particularly professionals from the criminal justice system, was unlikely to improve her situation and may actually worsen her circumstances. Although Nicole continued to report some incidents, particularly when in crisis, she appeared particularly reluctant to support a prosecution. As a victim of long term, significant, domestic abuse including many facets of controlling and coercive behaviour, Nicole appeared to have largely given up hope that her life could be improved.

8.22 It is recommended that Pennine Lancashire Community Safety Partnership reflects on this finding and considers what action to take. It may be that consulting with services which support victims and with victim's themselves may shed further light on how agencies could relate more effectively to victims who have experienced long term domestic abuse.

RECOMMENDATION 7

That Pennine Lancashire Community Safety Partnership reflects on this finding and considers what action to take. It may be that consulting with services which support victims and with victim's themselves may shed further light on how agencies could relate more effectively to victims who have experienced long term domestic abuse.

The interface between MARAC and Primary Care

8.23 MARAC clearly expressed the approach to be adopted by partner agencies, particularly health services given the risks to which Nicole was exposed. Every effort was to be made to engage with her in-person. Translating this desired approach into action proved challenging, however. After Nicole's GP practice received feedback from the February 2020 MARAC, a note was placed in her GP records to encourage engagement with services but the expected flags were not placed on her records. Nicole's GP practice later wrote to her to warn her that she was at risk of being removed from the GP practice if she continued to miss appointments which was not consistent with the approach advocated by MARAC. When Nicole's GP practice received feedback from the October 2021 MARAC requesting that they offer her an appointment should any opportunity to engage arise, the GP practice took no action in response to the MARAC action. No note was placed on their system to highlight the MARAC request nor were any active attempts made to contact Nicole. It is not known whether this was a particular issue relating to Nicole's GP practice or whether this is an indication of a wider concern.

8.24 Additionally, MARAC did not always receive relevant information from Nicole's GP practice when requested. For example in July 2022 Nicole's GP received a MARAC information request in relation to a forthcoming MARAC meeting but there is no indication that the form was completed or returned. It is therefore recommended that the Community Safety Partnership request the Lancashire and South Cumbria Integrated Care Board to provide or refresh guidance to GP practices on how to manage MARAC actions and requests for information.

RECOMMENDATION 8

That Pennine Lancashire Community Safety Partnership requests the Lancashire and South Cumbria Integrated Care Board to provide or refresh guidance to GP practices on how to manage MARAC actions and requests for information.

Managing the risk presented by the perpetrator to future partners.

8.25 It has only been possible to conduct DHRs when a victim of domestic abuse apparently takes their own life for a relatively short period of time (the Home Office DHR guidance was amended to allow DHRs in such circumstances in December 2016). However, the number of 'suicide DHRs' completed has steadily grown and so there is now quite a sizeable known cohort of perpetrators of domestic abuse whose partners or ex-partners have taken their own life.

8.26 Craig is one such perpetrator. His previous convictions primarily relate to offences of dishonesty. He has been charged with several offences of violence against former intimate partners but none of these prosecutions succeeded partly because his former partners declined to support a prosecution. There are also two documented breaches of restraining orders in respect of a former partner. However, as a result of this DHR a great deal is now known about Craig as a perpetrator of domestic abuse based not only on the substantial disclosures made by Nicole but also the detailed documentation by ward staff of his conduct towards Nicole whilst she was a patient in the Harbour Hospital.

8.27 The question arises of what action should be taken to manage the risks that this cohort of domestic abusers present. In DHR's in which there is a homicide the perpetrators invariably receive a sentence of life imprisonment. In the case of the 'suicide DHR' perpetrators they are free to move on to other relationships which may expose their future partners to risks similar to those experienced by Nicole. The DHR has been advised that it would be possible to refer Craig to MAPPA although a minimum of two agencies would need to support such a referral. Discussions have been initiated with the Lancashire MAPPA co-ordinator in order to think through the merits of a MAPPA referral and the level of public protection such a referral could achieve. The issue of what should be done to manage the risks which the cohort of 'DHR suicide' perpetrators may present to future intimate partners may need to be further considered by the Pennine Lancashire Community Safety Partnership. In another local DHR the perpetrator has

been encouraged to access a perpetrator support programme. This option could not be discussed with Craig as he did not contribute to the DHR. Another option is to consider referring Craig to the MATAC (Multi-Agency Tasking and Co-ordination) protocol – which assesses and plans a bespoke set of interventions to target and disrupt serial perpetrators and/or support them to address their behaviour. The MATAC protocol has been, or is in the process of being, implemented in several Police Force areas. It is not known if Lancashire Constabulary plan to implement MATAC. Pennine Lancashire Community Safety Partnership may wish to reflect on how best to consider addressing the risks to future partners of 'suicide' DHR perpetrators such as Craig.

Disruption of perpetrators

8.28 Efforts were made to disrupt Craig as a perpetrator of domestic abuse by positive action to arrest him, remand him in prison custody, the use of a DVPO and the development of domestic abuse trigger plans. These disruption efforts were successful only in the short to medium term and never changed the overall dynamic. The DHR has been made aware of the piloting of the DRIVE model - in which case workers, liaising closely with local Police and support agencies, deploy a two-pronged disruption approach through the criminal justice system and/or support for unresolved personal issues to stop the domestic abuse - in the Bay and Fylde/Wyre areas of Lancashire during 2023. Pennine Community Safety Partnership may wish to consider introducing a wider range of perpetrator interventions including disruptions.

Flagging perpetrators by GPs

8.29 The related issue of flagging of domestic abuse perpetrators has been discussed by the DHR Panel. As previously stated, Craig's GP practice did not flag him as an alleged perpetrator until quite late in this sequence of events despite his domestic abuse history with Nicole and other former partners. The guidance for GP practices in respect of flagging partners is set out in Paragraphs 6.107 and 6.108. It is suggested the Pennine Lancashire Community Safety Partnership simply notes the issue at the current time.

Investigation of apparent suicides following domestic abuse

8.30 Lancashire Constabulary have shared their revised guidance on this issue but the learning from this DHR suggests there may be a need to further review the guidance to ensure they consider the evidence which may need to be preserved where the victim survives the initial incident but dies a relatively short time later – in this case the blood samples obtained from Nicole following her hospital admission. It is suggested that Lancashire Constabulary considers a single agency recommendation in respect of this issue. Lancashire Constabulary are considering this issue.

Non-Fatal Strangulation

8.31 Nicole disclosed non-fatal strangulation on several occasions. Since June 2022 this has been an offence under Section 70 of the Domestic Abuse Act 2021. The DHR Panel has been advised of the Non- Fatal Strangulation and Suffocation Training offered by the Joint Partnership Business Unit which is aimed at front line practitioners and managers from both adults and children's services across Blackburn with Darwen, Blackpool and Lancashire.

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APPENDIX A

Single Agency Recommendations:

Crown Prosecution Service Northwest

- No recommendations

Department for Work and Pensions

- No recommendations – under review.

East Lancashire Hospitals NHS Foundation Trust

- Continued promotion of 'routine enquiry' regarding DVA in all ELHT services – this is well embedded in midwifery services.

- Continued development of stronger links and implementation of DVA referral pathway with breast care service.

- Continued promotion of DVA pathway created with ED.

- Mandatory DVA and SV training commenced in January 2022 – training to highlight cases such as this where there were potential 'missed opportunities' to enquire about DVA and escalate concerns.

- Safeguarding Team, Hospital IDVA & ISVA to have a greater presence in ED and UCC's – weekly drop-ins/supervision sessions to commence January 2023.

- DNA appointments – to be looked at for policy review.

- Audit of SR to be completed within the next 12 months – special concern is who has access to the SR and how visible is it

HARV Domestic Abuse and HARV Housing (and providers of support to victims of domestic abuse generally)

- Providers of support to victims of domestic abuse should not close clients' cases if they are unsafe to contact. In such circumstances, providers of support to victims of domestic abuse should explore alternative methods of contacting the victim. Consulting with partner agencies may assist in finding a safe method of contacting the victim.

HCRG Care Group (0-19 services)

- No recommendations

Hyndburn Borough Council Environmental Health

- No recommendations

Hyndburn Borough Council Housing

- No recommendations

Lancashire Children's Social Care

- Children's Social Care and enhanced midwifery teams to have better communication about potential pregnancies where the unborn child will require safeguarding (Multi-agency recommendation)

Lancashire and South Cumbria NHS Integrated Care Board

- To ensure complete transfer of patient records upon registration.

- To ensure that primary care providers have the correct knowledge, skills and are implementing best practice policies to effectively share information to improve safeguarding practice.

- To ensure staff are aware of the importance of consistent professional curiosity including the use of routine enquiry for domestic abuse.

- To ensure records are appropriately alerted when there are safeguarding concerns.

- Ensure referrals to mental health services are completed in a robust and effective way which takes into account the individuals' history, current presentation and diagnosis.

- To ensure the domestic abuse policy and safeguarding adult and child policies are implemented.

Lancashire and South Cumbria NHS Foundation Trust

1. Stevenson Ward team to improve their knowledge and understanding of current procedure and policy to support those experiencing domestic abuse. This includes the requirement for routine enquiry and understanding of the DASH assessment.

2. As the ward team did not complete a number of tasks identified via expert advice or CPA meetings (capacity assessment, HSNAs, children's safeguarding, referral to CMHT, initial care plan), Stevenson Ward is recommended to identify processes to ensure that actions that are agreed as required by the wider MDT are effectively handed over and completed in a timely manner.

3. All patients admitted to the Stevenson Ward to have regular one-to-one time with either their primary nurse or named nurse for the shift.

4. The Trust should ensure there is adequate support and safeguarding supervision in place for clinical teams dealing with complex cases of domestic abuse.

5. LSCFT Safeguarding Team to explore alternative IT options for the recording of advice that is provided to practitioners contacting the team via duty that can be linked to the clinical records of service users.

6. Enhanced risk assessments are updated when patients are not deemed appropriate for home treatment at the 48hr follow up.

7. The trust to amend the current inpatient Standard operating procedure to include clear guidance around visitors to inpatient wards who may pose risk to patients or staff.

8. This report and the learning are to be shared with the ward staff who should review the lessons learned. The learning on a page should be distributed Trust-wide within the Patient Safety Bulletin.

Lancashire Constabulary

- Silo Consideration – Lancashire Constabulary dealt with numerous cases of domestic abuse and reported coercive and controlling behaviour by Craig. One of the aspects in most of Nicole's reported incidents is the fact that Nicole often was unsupportive of any criminal proceedings. Consideration could / should have been given to linking cases to provide evidence to support the potential for an evidence led prosecution of Craig could linking incidents have strengthened evidence-led prosecution. Would a specialist DA investigator have helped.

- Evidence Led Prosecution – Information contained in one of the investigations suggest consideration was given to an evidence led prosecution approach, however, there are other investigations where this consideration should also have been made.

- Victim Lack of Support – In numerous cases Nicole declined to support any criminal proceedings or provide any evidence at Court. How robust are police protocols at dealing with such events?

- (A discussion with the Lancashire Constabulary Development Manager with responsibility for Domestic Abuse will be held in order to review the three potential learning areas as

identified above) (The outcome of this discussion and finalisation of single agency recommendations is awaited)

Lancashire Safeguarding Adult Service

- A new online Safeguarding Portal has been introduced to support professionals to refer Safeguarding Concern Information to the Safeguarding Adult Service.

- For the Safeguarding Adult Service to continue to work with partnership agencies to provide advice in relation to when to raise a Safeguarding Adult Referral. The Safeguarding Champions Network is a key forum where joined up safeguarding approaches can be promoted. For this network to be used to promote positive changes in Safeguarding Practice.

- To promote face to face visits in safeguarding enquiries that relate to domestic abuse. (To be discussed in Supervision with individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).

- To share information about the National Centre for Domestic Violence across the Safeguarding Adult Service to increase awareness of the support available for service users to seek a Civil Order that prevents contact from people alleged to have caused harm. (To be discussed in Supervision with Individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).

- For a detailed risk assessment to be completed on the safeguarding module that includes information about a person's ability to keep safe alongside further exploration if appropriate about any mixed feelings about possible options available and the safeguarding plan. (To be discussed in Supervision with Individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).

- Domestic abuse training is recorded on individual safeguarding workers training logs as training that is required. For team managers to reinforce the need for safeguarding workers to attend Domestic Abuse Training and update their training logs.

- The Model of Enquiry is continuously under review at this time. Consideration will be given as to whether reference to gathering information from family members / significant people in their lives and involving them in discussing concerns and the safeguarding

plan. (in line with service users' capacity and consent) is appropriate to update on the Model of Enquiry.

- In what was a complex and difficult case that included domestic abuse, mental Ill health and substance misuse professionals were able to see Nicole's holistic needs and in relation to the cycle of abuse accepted that Nicole was likely to be minimising the level of risk in relation to domestic abuse. This could have enabled MDT further discussion and resulted in actions to explore with Nicole sensitively and further, risks of an ongoing cycle of domestic abuse, her options and support. For this learning to be shared across the Safeguarding Adult Service.

- The Learning from this case will be discussed with staff at Learning Circles to develop rich learning across the service.

Lancashire Victims Service

- No recommendations

North West Ambulance Service NHS Foundation Trust

- No recommendations

SafeNet Domestic Abuse Services

- Completion of DASH & MARAC forms – staff to receive more training on process & how to complete forms.

- Actions from DASH to inform Safety Planning – additional training needed so that Safety Plan reflects severity, frequency & factors indicated on DASH. (Training on completing a Safety Plan to include how Safety Plan reflects information on DASH. Safety Plan submitted on OASIS is not substantial enough for the level of risk.

  (SafeNet case management system OASIS shows that the DASH was not to standard (date, staff, signature, actions not fully completed)

  DASH states that there is no risk to the children (Lancaster Refuge)

  No evidence of a MARAC form despite it being cited that there were grounds to refer

- Medical support – to be discussed in teams' importance of professional curiosity. To develop as a short training session with examples from practice (20th July Nicole returned to Jane's Place Refuge & staff recorded self-injury to Nicole neck. Nicole disclosed this to staff. No medical support offered.

- CHILDREN – Nicole perceived at risk by Craig. (To assess the effectiveness of processes in place regarding actioning information relating to risk of children not in mother's care. It is documented a number of times that Nicole was returning to Craig due to the fear that her children were at risk. Not documented what course of action SafeNet took regarding this risk.)

- CIVIL REMEDIES – What was the offer of Civil legal support to Nicole and did it reflect level of risk? No record of Nicole being offered Civil Legal Remedies. However, this was difficult as high number of Missing Person Reports.

APPENDIX B – EXECUTIVE SUMMARY

Pennine Lancashire Community Safety Partnership

Domestic Homicide Review Executive Summary

In respect of Nicole - who took her own life in July 2022

Independent Author – David Mellor BA QPM

Report completed on 4th March 2024

1.0 **INTRODUCTION**

1.1 This is an Executive Summary of a Domestic Homicide Review (DHR) undertaken by Pennine Lancashire Community Safety Partnership following the death of Nicole (a pseudonym).

1.2 Nicole died in hospital in late July 2022 several days after hanging herself from a tree near the home of her partner Craig (also a pseudonym) – who had been in her company until shortly before the incident. Nicole's cause of death was given as hypoxic brain injury.[38] For several days before the incident Nicole had been living in a refuge in another town following her discharge from a hospital to which she had been admitted under the Mental Health Act. During her brief stay in the refuge she had been reported to the police as a missing person on several occasions when leaving the refuge to contact Craig. Nicole had been in a relationship with Craig for over four years during which she disclosed numerous incidents of domestic abuse to professionals which indicated a pattern of severe violence and coercive and controlling behaviour from Craig. The police investigation into Nicole's death concluded that there was no third party involvement in the hanging incident which led to her death. Lancashire Constabulary subsequently reviewed the circumstances leading up to the death of Nicole, considered whether the domestic abuse she was subjected to was the primary driver for her suicide and further considered whether there

[38] Cerebral hypoxia - oxygen is needed for the brain to make use of glucose, its major energy source. If the oxygen supply is interrupted, consciousness will be lost within 15 seconds and damage to the brain begins to occur after about four minutes without oxygen. A complete interruption of the supply of oxygen to the brain is referred to as cerebral anoxia. If there is still a partial supply of oxygen, but at a level which is inadequate to maintain normal brain function, this is known as cerebral hypoxia.

was sufficient evidence to pursue a prosecution of unlawful act manslaughter[39]. The Senior Investigating Officer (SIO) who completed the review concluded that although the evidence of domestic abuse was strong and the negative impact of this on Nicole was clear, on the day on which the hanging incident took place, domestic abuse as the direct reason for the actions Nicole took to end her own life was not substantiated sufficiently to support a prosecution for unlawful act manslaughter.

1.3 The DHR process began with an initial meeting of representatives of Pennine Lancashire Community Safety Partnership on 9th September 2022 when the decision to hold a DHR was unanimously agreed. All agencies that potentially had contact with Nicole and her partner Craig prior to Nicole's death were contacted and asked to confirm whether they had involvement with them. The agencies which confirmed contact were asked to secure their files.

1.4 The following agencies provided Individual Management Reviews to inform the review:

Lancashire County Council – Adult Safeguarding
Crown Prosecution Service
Department for Work and Pensions
Lancashire County Council – Children Social Care
East Lancashire Hospital Trust
HARV Domestic Abuse Services & HARV Housing CIC

[39] Manslaughter is primarily committed in one of three ways:

4. Killing with the intent for murder but where a partial defence applies, namely loss of control, diminished responsibility or killing pursuant to a suicide pact.
5. Conduct that was grossly negligent given the risk of death, and did kill ("gross negligence manslaughter"); and
6. Conduct taking the form of an unlawful act involving a danger of some harm that resulted in death ("unlawful and dangerous act manslaughter").

HCRG Care Group
Hyndburn Council – Environmental Health
Hyndburn Council – Housing
Lancashire and South Cumbria Integrated Care Board (ICB)
Lancashire and South Cumbria NHS Foundation Trust
Lancashire Victim Support
North West Ambulance Service
Lancashire Constabulary
Safenet

The following agencies provided short reports to inform the review:

High School A

1.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

1.6 Nicole's mother and Nicole's eldest son contributed to the DHR. Nicole's eldest son was supported by AAFDA (Advocacy After Fatal Domestic Abuse).

The DHR Panel Members

1.7 The DHR Panel consisted of:

Role	Organisation
Housing Advice & Homelessness Manager	Hyndburn Borough Council
Centre and Business Manager	Hyndburn & Ribble Valley (HARV) Outreach Domestic Abuse Services
Quality Improvement and Safeguarding Manager,	Lancashire County Council (until June 2023)
Specialist Safeguarding Nurse Children,	HCRG Care Group
Head of Policy and OD / CSP Chair,	Hyndburn Borough Council
Specialist Safeguarding Practitioner	NHS Lancashire and South Cumbria Integrated Care Board (July 2023 onwards)
Manager	Safenet (Lancashire Refuge Service)
Policy, Information and Commissioning Manager	Lancashire County Council
Senior Practitioner	Family Care, East Lancashire Hospitals NHS Trust
Head of Environmental Health	Hyndburn Borough Council
Review Officer/Investigator	Lancashire Constabulary
Pennine Community Safety Coordinator	Blackburn with Darwen Council (January 2023 onwards)
Domestic Abuse Development Coordinator	Safenet
Pennine Community Safety Coordinator	Blackburn with Darwen Council (until January 2023)
Specialist Safeguarding Practitioner,	NHS Lancashire and South Cumbria Integrated Care Board (until July 2023)
Safeguarding Strategy and Operations Manager	Lancashire County Council (June 2023 onwards)
Community Safety Manager	Hyndburn Borough Council
David Mellor	Independent DHR Chair and Author
Head of Safeguarding/PiPoT Lead	Lancashire and South Cumbria NHS Foundation Trust

Policy and Partnership Support Officer,	Office of the Police and Crime Commissioner for Lancashire
Senior manager - Safeguarding, Inspection and Audit	Lancashire County Council
Named Professional Safeguarding Adults,	East Lancashire Hospitals NHS Trust

1.8 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on six occasions; 11th October 2022, 12th January, 3rd February, 30th March, 5th July and 8th September 2023.

Author of the overview report

1.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has eleven years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

1.10 The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

1.11 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.12 He has no connection to services in Pennine Lancashire.

2.0 Terms of Reference

2.1 The terms of reference for the DHR are as follows:

1. To establish the circumstances surrounding the suicide and how experiences of domestic abuse contributed to this.

2. To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations worked together and carried out their duties and responsibilities.

3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. Agencies will also identify good practice and how that enabled partners to work together in this case.

4. To establish whether the concerns and responses by professionals and their organisations were appropriate both historically and in the time leading up to the suicide.

5. To establish whether organisations have appropriate policy and procedures to respond to the circumstances identified in this case and to recommend any changes as a result of the review process, with the aim of better safeguarding families.

6. All enquiries are to be restricted to a period of no more than 3 years prior to the date of the suicide, and until the review has concluded. However, any historical information or convictions of domestic abuse, outside of this timeframe should be included.

7. To provide details of additional records concerning Domestic Violence and Medical Issues including Mental Health or Physical Injury or Disability that may have a relevant impact on the review.

8. To consider any cultural, environmental or mental capacity issues which may have contributed to any barriers the victim faced in accessing protection and learning why any interventions did not work for them.

9. To consider the impact that the Covid-19 Pandemic had on the victim accessing support to Domestic Abuse Services, and how the pandemic may have led to increasing episodes of Domestic Abuse, and the deterioration of the victim's mental health.

10. To consider the impact the victim's substance misuse had on their deterioration of mental health, and the impact the substance misuse had on the increasing episodes of domestic abuse.

11. To consider the impact of long term domestic abuse on the wider family, particularly the children of the victim in this case.

3.0 Summary Chronology

Background information (Paragraph 3.1 to 3.4)

3.1 Nicole was born in 1979. She lived with her parents during her early years but after her parents separated she appears to have lived with her father for several years in the Greater Manchester area before becoming looked after by the local authority during her teenage years and being placed in foster care in a neighbouring local authority area. Nicole experienced childhood trauma in the form of physical and sexual abuse and began self-harming from the age of 13. She gave birth to her first child at the age of 18 and went on to have seven children in all. There were periodic interventions from children's social care and partner agencies in relation to the impact of Nicole's mental ill health on her capacity to parent her children and meet their needs. Over time her children began to be cared for by other family members and at the time her relationship with Craig began in 2017 only child 4 and child 5 were in her care. Nicole underwent a sterilisation procedure in 2013.

3.2 Nicole had a long history of poor mental health with episodes of low mood, depression (including post-natal depression) and compulsory admissions under the Mental Health Act. She was diagnosed with personality disorder[40] in 1997. Nicole was registered with a number of

[40] Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into 4 main areas which are emotional instability – the psychological term for which is "affective dysregulation"; disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions"; impulsive behaviour; and intense but unstable relationships with others.

different GP practices, primarily in the Pennine Lancashire area. She had a number of brief interventions from mental health services, usually presenting when in crisis, but would regularly disengage when she noted an improvement in her mental health or circumstances. In 2010 she presented at Hospital ED (Emergency Department) following an attempted hanging whilst under the influence of alcohol. Nicole's GP records indicate 'alcohol dependency' in the same year. In their contribution to the DHR both Nicole's mother and her eldest son refer to Nicole having a diagnosis of bipolar disorder[41] but this has not been confirmed from the information relating to Nicole's medical history shared with this DHR. Nicole was noted to frequently not be concordant with her medication and to regularly not attend medical appointments.

3.3 It is unclear to what extent abusive relationships may have been a factor in her history of missed medical appointments. Nicole disclosed domestic abuse in previous intimate relationships. She and her children were documented to have fled domestic abuse from her then partner in 2005 and the police investigated a Section 18 wounding against her in 2007 although she declined to support a prosecution on that occasion.

3.4 Craig had numerous contacts with his GP practice over the years and was twice referred to mental health services for anxiety and depression but did not engage on either occasion. It is understood that his children were permanently removed from his care in 2011 for reasons which are not known to the DHR. He attempted to take his own life by hanging in 2013. He has a number of previous convictions which primarily relate to offences of dishonesty. He was charged with several offences of violence against former intimate partners but none of these prosecutions succeeded with an important factor being the former partners declining to support a prosecution. There are two documented breaches of restraining orders in respect of a former partner.

3.5 On 13th May 2019 Lancashire children's social care received a referral stating that the two of her children who had been in the care of Nicole (child 4 – then 13 and child 5 – then 12) were residing with Nicole's adult son - then 21 and his partner due to the impact of Nicole's mental health on her ability to meet the needs of the younger children. Children's social care carried out an assessment which found that Nicole was unable to ensure the safety of the two children by preventing them from witnessing domestic abuse or because of Nicole's 'self-destructive' behaviours such as drinking alcohol, mood swings and attempts to take her own life. Nicole was said to be of no fixed abode and currently moving from place to place. The outcome of the

[41] Bipolar disorder is a mental health condition that affects a person's moods, which can swing from one extreme to another. It used to be known as manic depression.

assessment was that the two children would be supported by Child in Need (CIN)[42] planning – which continued until July 2020.

3.6 On 2nd June 2019 Nicole was conveyed to hospital after her partner Craig contacted NWAS via the 999 system to say that she had taken an overdose of Tramadol[43]. The hospital ED established that Nicole had taken an 'intentional' overdose of 14 x 45mg Mirtazapine[44] and 15-20 Tramadol 'after an argument'. Nicole self-discharged the following day contrary to medical advice and prior to a psychiatric review. She was documented to have disclosed that her 'partner is controlling her'. There is no documented consideration of any action to safeguard her from harm by the hospital. A follow-up appointment with Accrington community mental health team (CMHT) appears to have been arranged but Nicole did not attend. Her GP was notified. At that time Nicole was not prescribed any medication so it is not known how she obtained the Mirtazapine or Tramadol. Her partner Craig was prescribed Tramadol at that time.

3.7 Prior to self-discharging from hospital following day (3rd June 2019) Nicole emailed HARV[45] (Hyndburn and Ribble Valley) domestic abuse team to ask 'what help she could get' as she was in an abusive relationship where her partner 'attacked her mentally', 'abused her' and had 'stripped her naked saying she had had sex with other men'. She added that she was 'very scared' that if her partner found out that she had contacted HARV, he would 'go mad'. She said that she was in hospital after taking an overdose following a night of his 'mental torture' adding that this was the fourth time in a month she had tried to kill herself. She said that she didn't want police involvement as 'his family was very well known'. She added that she had let her children go to her son 'for now' as 'it had all made her very ill with depression'. She said she stayed with her partner as she had nowhere to live. HARV responded to Nicole to establish a

[42] A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. The Child in Need Plan must identify the lead professional, any resources or services that will be needed to achieve the planned outcomes within the agreed timescales. Engagement with Child in Need plans is voluntary.

[43] Tramadol is a strong painkiller from a group of medicines called opiates, or narcotics. It's used to treat moderate to severe pain, for example after an operation or a serious injury. Tramadol is available only on prescription.

[44] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety. Mirtazapine is only available on prescription.

[45] HARV exists primarily to provide women and children who are experiencing or have experienced domestic violence, with a range of services which enable them to make informed decisions about their future.

safe means of contact.. She added that she was 'so glad' she had taken the first step and contacted HARV before she 'ended up dead', saying she felt 'so broken'.

3.8 On 6th June 2019 Nicole rang HARV. She said that this was her first opportunity to make the phone call as her partner was 'always present' and she said she was 'extremely concerned' that he would return and 'catch her' on the phone. She disclosed that he had 'physically attacked' her twice since her discharge from hospital. Nicole confirmed her recent hospital admission and disclosed that Craig had 'stormed' onto the ward screaming 'next time I'll leave you on the floor and not bother saving your life'. Nicole said that she had discharged herself due to the embarrassment and shame she felt about Craig's behaviour towards her whilst in the hospital.

3.9 Nicole went on to make a number of disclosures of domestic abuse. She said that Craig had only recently 'allowed' her to have a new mobile phone after removing her previous phone from her two months earlier. She added that the phone enabled Craig to 'check up on her' whilst he was at work and that he checked her phone and that he 'went mad' when he found a text message relating to the viewing of a private let property the previous day. He refused to go to work to ensure that she did not leave the 'bedsit' in which they lived in a shared house to attend the viewing. She added that she had saved up £700 to use as a deposit on a private letting but he had taken this off her. She said that she was registered with B-With-Us[46] but as she had accumulated rent arrears on a previous property she was unable to access a property in her own right (she was correct to state that she had accumulated rent arrears but this does not appear to have been a complete barrier to renting a property). Nicole went on to say that Craig had stopped her working as a carer because he suspected her of using her employment as an opportunity to meet men, 'forced' her to smoke crack cocaine – threatening physical violence if she did not do so – and made her transfer her benefits to his bank account. Nicole reiterated that Craig forced her to remove all her clothes to check whether she had had sex with anyone. She added that Craig isolated her from family and friends. When a refuge place for Nicole was discussed with her, she declined this on the basis that leaving Craig could place her children at risk from him. HARV arranged an in-person appointment with Nicole on 10th June 2019. Nicole did not attend the 10th June 2019 appointment and HARV emailed her to check that she was safe. She replied that Craig had stayed off work and said that she would re-contact HARV the following day – which she did not do. She asked HARV not to email her as Craig 'got into them'.

[46] Be-With-Us is a partnership between local councils and social landlords in Blackburn with Darwen, Burnley, Hyndburn, Pendle and Rossendale to provide homes to rent to meet a range of needs. (Website states no bond or deposit required).

3.10 On 3rd July 2019 Nicole's case was reviewed by the HARV manager as Nicole had not initiated contact since 10th June 2019 and HARV had been reluctant to email her. HARV's escalation process requires contact with partner agencies where they have identified a risk but are unable to complete a risk assessment, as in this case. Later in the day HARV contacted the police to request a welfare check and children's social care to share details of the domestic abuse which Nicole had disclosed to HARV and ask them to check whether any of her children were at risk of harm. The police visited Nicole who was alone as Craig was at work. She disclosed that she had made two further attempts to take her own life during the three weeks since she had last contacted HARV – once through an overdose of prescribed drugs and once by hanging (neither of these incidents appeared to have been reported at the time). She added that she currently felt clear headed and not suicidal. Nicole declined all safeguarding measures, saying that she was preparing to leave Craig and go to a refuge. She added that she had put her 'good clothes' in the boot of her car which she had parked away from the address she shared with Craig. She also advised that she had set up a new email address which she thought Craig was unaware of. The police put a marker on the address which Nicole shared with Craig to the effect that all calls were to be treated as urgent even if there was no request for the police. All future communication with Nicole was to be by email. The police completed a DASH[47] risk assessment which identified a 'high' risk and she was referred to MARAC[48] although the DHR has received no indication that Nicole's case was considered at a MARAC meeting.

3.11 On 10th July 2019 Nicole visited the HARV premises in a distressed state. She was wrestling with the decision of whether to leave Craig or not. She disclosed that he had assaulted her that day. She was unhappy about the extent to which others appeared to her to be taking decisions about her and began expressing regret that she had disclosed domestic abuse to professionals. Refuges were explored in nearby towns. One of the refuges declined to offer her a place as a result of her recent attempt to take her own life and Nicole felt that the other refuge under consideration was too far away. Additionally that second refuge expressed reservations about offering her a place as she had had to be moved from that refuge in the past. Whilst at HARV, Nicole spoke to an IDVA for around two hours and was also supported to phone her sister before

[47] DASH (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to MARAC and what other support might be required.

[48] Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

running out of the HARV premises and getting into her car. Officers from the police safeguarding team were present and prevented her from driving off by confiscating her car keys and then detained her under Section 136[49] of the Mental Health Act. At that time Nicole was presenting as angry, upset, shouting and saying she wished to take her own life. Nicole was taken to the hospital ED (emergency department) as a place of safety and later transferred to The Harbour Hospital[50] in Blackpool.

3.12 Nicole was admitted to The Harbour Hospital under Section 2[51] of the Mental Health Act due to increasing suicidal ideation, the main trigger for which was cited to be 'abusive relationship'. She was noted to 'use a ligature to attempt suicide in the suite'. (no further details known) Nicole reported significant controlling and coercive behaviour to the nursing team including being prevented from leaving her flat, internal examination to check she hadn't been 'cheating', physical abuse, sexual abuse, taking her phone off her when she is alone in the flat and withholding access to prescribed medication. A 'safeguarding concern' was raised. The 'safeguarding concern' was received by Lancashire County Council who took the view that the primary focus of the 'concern' related to a MHA assessment and so a safeguarding referral was not generated.

3.13 Nicole's eldest son expressed concern that Craig could 'turn up' at The Harbour and on 12th July 2019 Nicole was transferred to a different site, due to the risk of Craig attending the Harbour. By 16th July 2019 a marked improvement in Nicole's mood and presentation was noted and she was documented to have blocked Craig's phone number and to have ended contact with him. She planned to improve her relationship with her children and requested self-discharge to her sister's address. This was agreed and she was discharged to her sister's address and was to be followed up by the Home Treatment Team (HTT) for that area. The police were notified.

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[49] Section 136 is an emergency power which allows a constable to remove a person to a place of safety (or keep them at a place of safety), if the person appears to a police officer to be suffering from a mental disorder and to be in immediate need of care or control - if the police officer believes removal to a place of safety is necessary in the interests of that person, or for the protection of others. The person should then receive a mental health assessment, and any necessary arrangements should be made for their on-going care.

[50] The Harbour is a 154 bed mental health hospital, which provides care and treatment for adults who cannot be safely treated at home (Provider LSCFT).

[51] Section 2 of the Mental Health Act allows for a person to be admitted to hospital, for up to 28 days, to assess whether they are suffering from a mental disorder, the type of mental disorder and/or how the person responds to treatment.

3.14 On 24th July 2019 the HTT for the area in which Nicole's sister lived referred her to Hyndburn, Rossendale and Ribble Valley HTT for follow up as she had moved back to live with Craig. HARV decided that it was not safe to attempt contact with Nicole now that she was living with Craig again and that she was aware of how to contact HARV if she needed them.

3.15 On 3rd August 2019 Nicole's eldest son contacted the police to report that his mother had phoned him to say that Craig had 'beaten her up'. During the early hours of the following morning Nicole contacted the police to advise that she was trying to leave Craig, but he had been preventing her departure by sitting on her car. She said that she had managed to remove Craig from her car and had left and therefore did not need the police 'right now'. Officers later met her at a pre-arranged location when she said that she was 'halfway there' to leaving Craig, but that police involvement would 'ruin everything'. She appeared very upset and was trembling and had what were documented to be 'old ligature marks' around her neck. The police referred Nicole to MARAC.

3.16 On 5th August 2019 the police arrested Craig who denied assaulting Nicole or coercive control when interviewed. He was detained in police custody overnight. Although Nicole declined to make a statement or support a prosecution the police recorded Nicole's disclosure on bodycam which it was hoped could enable Craig to be charged with an offence.

3.17 On 6th August 2019 Craig was released from police custody without charge.

The police made a successful application to the Magistrates Court for a (DVPO)[52]

which stated that Craig was not to contact, be abusive or intimidating to Nicole and gave the police the power to search his property should Nicole not be at an address where she was expected to be. It is understood that Craig had 'told the court' that he would not comply with the Order.

[52] A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agencies. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

3.18 HARV continued in their efforts to find Nicole a space in a refuge. Around this time Nicole told HARV that she was currently living in her car and felt very vulnerable in terms of her safety and accommodation needs. She went on to say that she had 'nearly crumbled' and returned to Craig, who she said was not bothered about the DVPO, was still trying to get to her and would make her life 'hell' as soon as the Order expired.

3.19 On 20th August 2019 Nicole's case was heard at MARAC. MARAC actions included regular contact with the victim by the police and the IDVA service, support for Nicole to register with a GP practice, approach to 'Housing', for Adult Social Care to conduct a review of Nicole in respect of capacity issues and her regular declining of mental health services. There is no indication that Adult Social Care conducted a review of Nicole at that time. The DHR has been advised that it is the relevant agency's responsibility to ensure that their action was completed. MARAC did not monitor the completion of actions at that time.

3.20 The following day Nicole attended HARV in a distressed state. She said that she had 'nothing and non-one' and that 'everything had been taken from me'. She said that she felt anxious about her current situation and felt like she wanted to return to Craig because, despite the abuse, at least she would have somewhere to stay. She went on to say that she felt like everyone was telling her what she should do and giving her instructions and telling her what changes she needed to make in her life, without actually providing her with the means to achieve those changes. A HARV worker accompanied Nicole to an appointment at Hyndburn Borough Council to discuss her homelessness needs and request emergency temporary accommodation. They explained that Nicole had been made unintentionally homeless as a result of the DVPO. An assessment was completed following which it was decided that Nicole was eligible to access emergency temporary accommodation at Maundy Relief[53]. Arrangements were to be made with Maundy Relief to arrange a female night worker to be in place to support Nicole and she would be advised when she could attend the Maundy Relief building. Nicole was advised that this accommodation was a temporary solution and that her application for homelessness support would be assessed against the relevant legislative framework. HARV later texted the arrangements to Nicole to enable her to access emergency temporary accommodation that evening. Unfortunately, Nicole did not take up the offer of this accommodation, saying that she 'was scared that it would be full of alkies and smackheads'. HARV continued to search for refuge accommodation but advised Nicole that this would continue to prove challenging given her strong preference for somewhere local.

[53] Maundy Relief offers a range of services including food, accommodation, mental and physical health services and benefit advice.

3.21 During the early hours of 31st August 2019 Nicole contacted the police via the 999 system to report that she had been assaulted by her ex-partner Craig and had gone to a friend's house as a place of safety. Officers attended the friend's house but Nicole declined to provide a statement or support a prosecution. A further MARAC referral was made. MARAC discussed Nicole's case on 19th September 2019 and requested a safeguarding visit was made to Nicole. On 4th October 2019 Nicole phoned HARV and said that she was now ready to go into a refuge. HARV checked refuge availability and only one refuge was available which Nicole appeared to reject on the grounds that she would prefer to go to a refuge in a different town.

3.22 On 7th October 2019 a member of the public contacted the police to report that they had seen a van driven by Craig stop in the street following which Craig subsequently punched and kicked Nicole. Officers attended and arrested Craig for assault. He was also arrested for the 31st August 2019 assault (Paragraph 3.21). This offence had taken place during the period when the DVPO applied but the alleged breach of the Order was not proceeded with as he was charged with a substantive offence of assault. Nicole declined to provide a witness statement or support a prosecution. The police referred the matter to Crown Prosecution Service (CPS) Direct[54] to request a charging decision. The charging lawyer concluded that the Threshold Test[55] criteria were satisfied and authorised two charges, assault occasioning actual bodily harm and driving whilst disqualified. The evidence was largely reliant on the account given by the independent witness. Craig was placed before Blackburn Magistrates Court the following day where he entered 'not guilty' pleas. He was remanded in custody and transferred to HMP Preston – where he remained until his trial took place on 2nd December 2019.

[54] CPS Direct is a 'virtual' 15th Area (The CPS had 14 regional teams across England and Wales) and provides charging decisions on priority cases 24 hours a day, 365 days a year. Much of CPS Direct's work is out of hours. Our dedicated network of over 160 prosecutors is based throughout England and Wales. To receive a charging decision, police officers and other investigators either call a single national number and are connected to the next available Duty Prosecutor, or they submit and receive charging decisions digitally.

[55] In limited circumstances, where the Full Code Test is not met, the Threshold Test may be applied to charge a suspect. The seriousness or circumstances of the case must justify the making of an immediate charging decision, and there must be substantial grounds to object to bail. There must also be a rigorous examination of the five conditions of the Threshold Test, to ensure that it is only applied when necessary and that cases are not charged prematurely. All five conditions must be met before the Threshold Test can be applied.

3.23 Nicole was placed in refuge 2 on 8th October 2019 and a Domestic Violence Disclosure Scheme (DVDS)[56] disclosure made to her. Nicole completed temporary registration with GP practice 2 following her move into the refuge. Nicole was seen by her new GP due to having found a lump in her breast. Nicole disclosed that her ex-partner used to beat her up regularly and would not allow her to see her previous GP in relation to the lump on her breast. She was documented to have lost 3 stones in weight in recent weeks 'due to stress and abuse'. She was also noted to have bruises across her nose, ear, head and both eyes. The GP documented that she had been 'repeatedly beaten up' over the last few days. The GP referred Nicole to the breast clinic under the two-week fast track referral for suspected breast cancer.

3.24 On 10th October 2019 Nicole's new GP practice contacted the GP practice with which she was previously registered (GP Practice 1) to request a 'note summary' and a list of medication. GP practice 2 received the 'note summary' – a brief 3 page clinical summary, which is standard practice when a person temporarily registers with a GP Practice. Full GP records would not be requested until the temporary registration became permanent.

3.25 On 23rd October 2019 the GP practice was advised that Nicole had not attended two breast clinic appointments and would not be offered any further appointments in accordance with the clinic's policy. The GP referral to the breast clinic had included information relating to Nicole's disclosures of domestic abuse but there is no indication that this was taken into account when the breast clinic made decisions following Nicole's missed appointments.

3.26 On 13th November 2019 Nicole's GP practice was able to make direct phone contact with her to advise of the importance of attending the breast clinic appointment which resulted in a new referral to the breast clinic under the two week rule. On 27th November 2019 the breast clinic again discharged Nicole from their service after she did not attend the two appointments offered after her GP made a fresh referral.

3.27 On 19th November 2019 Nicole's case had been heard at MARAC which was made aware that Craig was remanded in custody and that Nicole was staying in a refuge.

[56] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

3.28 On 2nd December 2019 Craig appeared before Blackburn Magistrates Court. CPS Northwest had conducted several reviews of the case which had confirmed that there was a realistic prospect of conviction based on the account of the independent witness who had positively identified Craig. Unfortunately, the independent witness did not attend Court and efforts to contact him were unsuccessful. Matters were complicated by Nicole's attendance at Court as a defence witness. The prosecution advocate assessed that it was not possible to proceed with only the res gestae[57] evidence given by police officers and made an application to adjourn the case to secure the attendance of the independent witness which was refused by the Court. As a result the CPS offered no evidence leading to the charges being dismissed and Craig being released from custody.

2020

3.29 On 25th January 2020 police officers found Nicole in the street distressed and intoxicated. She disclosed that she had been assaulted by Craig who she said had punched her to the head, grabbed her around the throat and struck her on the back with a fishing rod. She went on to say that he had inserted his fingers into her vagina to examine her for semen, accusing her of sleeping with other men. She said that he then strangled her. She added that the attack took place over several hours during which she lost consciousness. She was taken to hospital where she was found to have a perforated eardrum. In the meantime, Craig contacted the police to report Nicole missing, expressing concern for her welfare.

3.30 A 'strategy discussion' was convened and a referral made to MARAC and the IDVA Service. Nicole initially remained in hospital whilst arrangements were being made to find her refuge accommodation. The hospital ED sent an adult safeguarding alert to the Trust adult safeguarding

[57] Res gestae describes a common law doctrine governing the testimony under hearsay rules. A court would normally refuse to admit evidence statements that a witness says he or she heard another person say. Res gestae is based on the belief that because certain statements are made naturally, spontaneously and without deliberation during the course of an event, they carry a high degree of credibility and leave little room for misunderstanding or misinterpretation. The doctrine held that such statements are more trustworthy than other second-hand statements and therefore should be admissible as evidence.

team which was forwarded to the hospital independent sexual violence advisor (ISVA) who visited Nicole on the ward.

3.31 The police arrested Craig and contacted CPS Direct on 26th January 2020 to request a charging decision. The charging lawyer concluded that the Threshold Test criteria were satisfied and authorised charges of assault occasioning actual bodily harm and sexual assault by penetration. The evidence was reliant on the account given by Nicole. Craig was placed before the Magistrates Court on 27th January 2020 when his application for bail was refused and he was remanded to HMP Preston.

3.32 Following her discharge from hospital, Nicole initially stayed in hotel accommodation and then moved to stay with Craig's brother and his partner whilst HARV worked with Hyndburn Housing to access accommodation for her. HARV's attempts to source refuge accommodation were complicated by the fact that Nicole was unwilling to stay in a refuge too far away from home, although she said that she was open to a refuge in the area in which her sister lived. Additionally, refuge places tended to be taken very quickly when they became available which meant that Nicole's uncertainty, hesitation and continuing distress could result in her missing out on refuge spaces.

3.33 On 28th January 2020 Nicole registered with GP Practice 3. It is assumed that Nicole changed GP practice as a result of a change of address.

3.34 On 31st January 2020 the police safeguarding team engaged with Nicole in an effort to encourage her to engage with support from the IDVA service and obtain safe accommodation. Nicole was said to be currently unsure about providing an account by the achieving best evidence (ABE)[58] approach. It was noted that Nicole was homeless and staying with the brother of Craig, and there were concerns that she may be discouraged or intimidated from pursuing a complaint against Craig by his family members as they were suspected of doing previously.

[58] Achieving Best Evidence (ABE) is an interview process for child and adult victims and witnesses during a criminal investigation, the pre-trial preparation process and the support available to witnesses in court. The ABE interview guidance includes video-recorded interviews with vulnerable and intimidated witnesses where the recording is intended to be played as evidence-in-chief in court. ABE is intended to promote a strong victim-centred and trauma-informed approach.

3.35 On 7th February 2020 Craig was released on bail following a hearing at Burnley Crown Court. He was subject to conditions of non-contact, exclusion from any address Nicole was known to be staying at, and a 'residence and a doorstep' curfew – requiring him to reside at a specified address at specified times of the day and present himself at the door on the request of a police officer. However, it appeared that Nicole no longer wished to support the prosecution.

3.36 On 18th February 2020 Nicole's case was heard at MARAC. It was noted that there had been 8 referrals made in respect of Nicole over a twelve month period. The actions arising from the meeting included for the police officer in the case to review the case in the light of MARAC's concerns and referrals to Inspire substance misuse service and mental health services were to be considered. MARAC felt that Nicole was 'very high risk' and that agencies she contacted should encourage her to engage with support. A vulnerable marker was to be put on her new address.

3.37 On 25th February 2020 the police safeguarding team visited Nicole at her new address. She said that she had been unable to respond to calls as she had 'broken' the phone previously provided by the police. She said she had seen 'glimpses' of Craig in Accrington and said that she was feeling lonely and felt unsure about providing an account of the assault as she felt she was in a 'no win situation'.

3.38 On the same date Nicole saw GP 3 who referred her to the breast clinic. The GP also discussed Nicole's mental health and prescribed Mirtazapine[59] and Olanzapine[60]. On 2nd March 2020 Nicole attended the breast clinic for mammogram and biopsy in an area of 'asymmetry' of her breast. She disclosed that the lump had been present since September 2019 but that her partner beat her and wouldn't allow her out of the house. The results of Nicole's biopsy were normal but that a magnetic resonance imaging (MRI) scan was still recommended, which Nicole did not access.

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[59] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety.

[60] Olanzapine helps to manage symptoms of mental health conditions such as seeing, hearing, feeling or believing things that others do not, feeling unusually suspicious or having muddled thoughts (schizophrenia),

feeling agitated or hyperactive, very excited, elated, or impulsive (mania symptoms of bipolar disorder) and if the person has bipolar disorder, olanzapine can also stop their mania symptoms coming back.

3.39 On 10th March 2020 Nicole's GP wrote to her to warn her that she was at risk of being removed from the GP practice if she continued to miss appointments – having missed two. The letter went on to advise that should there be specific problems which were preventing her from attending appointments she should contact the practice. This letter ran contrary to the MARAC request to encourage engagement with services.

3.40 On 27th April 2020 Nicole contacted the Department for Work and Pensions (DWP) and advised them that her bank account had been 'frozen due to fraud' and enquired about how she could arrange to have her benefit (Universal Credit) into her uncle's bank account. A Universal Credit agent helped her to update the new bank account details which was under the name of Craig.

3.41 On 27th May 2020 Nicole visited her GP practice with her partner (assumed to be Craig) to request a continuation of her fit note which she asked to be back dated. The GP documented that her partner 'did all the talking' for Nicole.

3.42 On 3rd June 2020 Nicole contacted her GP practice to ask for an urgent review following a decline in her mental health. She was documented to have been self-harming ('minor' lacerations), and to have taken an intentional overdose of Tramadol. She was given advice to contact the crisis team if she felt she was a risk to herself, to which she responded that 'things were not as bad as that, but she needed help'. The GP practice planned to signpost her to Mindsmatter[61] if she called back and sent her a text message to advise that she self-referred to the Lancashire Women's Centre[62].

3.43 On 17th June 2020 Nicole contacted her GP following what was documented to be an act of deliberate self-harm the previous night when she cut her arms due to 'stress and not sleeping'. She had apparently already self-referred to Mindsmatter The GP documented no active thoughts of suicide or self-harm.

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[61] Mindsmatter is a well-being service offering a range of free psychological therapies to people aged 16 and over in Lancashire. They are part of the nationwide Improving Access to Psychological Therapies (IAPT) service delivered by Lancashire and South Cumbria NHS Foundation Trust.

[62] Lancashire Women are a charity which aims to empower women to live safer, happier and more positive lives.

3.44 On 22nd June 2020 the CPS concluded that there was no longer any realistic prospect of a conviction in respect of either charge of assault or sexual assault by penetration arising from the 25th January 2020 incident (see Paragraph 3.29). Nicole had retracted her original account of the assaults and had stated that should the case go to trial, she would give evidence in Craig's defence. When Craig appeared at Magistrates Court on 13th August 2020 no evidence was offered by the prosecution and a formal 'not guilty' verdict was recorded.

3.45 On 27th August 2020 Nicole's GP practice received a letter from Mindsmatter which advised that Nicole was not eligible for their support due to her self-harming behaviours, longstanding mental health difficulties and 'relationship difficulties'.

The letter recommended that Nicole discuss 'alternative options' with the HTT. On 28th August 2020 Nicole's GP was advised that the HTT had discharged Nicole from their care on 20th August 2020 due to disengagement. The HTT letter noted that she had attempted to hang herself a few days prior to the HTT becoming involved. On 28th October 2020 Nicole contacted her GP to request a referral back to the HTT. The GP sent a referral letter to the HTT the following day without contacting Nicole for further consultation. The HTT has no record of receiving the GP referral.

3.46 During the early hours of 8th November 2020 Craig and Nicole were alleged to have assaulted a female in a fast-food shop by punching and kicking her and pulling her hair. Both Craig and Nicole were arrested. The CPS subsequently authorised charges against both Craig and Nicole. Whilst in police custody Nicole was seen by the LSCFT Liaison and Diversion team to whom she disclosed that she was 5 months pregnant but had not informed any health professionals and was drinking heavily, taking medication in relation to her mental health, was low in mood and had attempted to self-harm. She did not consent to an assessment by the team. The police requested midwifery to carry out an antenatal check on Nicole. A midwife visited Nicole whilst she was in police custody and noticed that she had a 'large bump' but she was unwilling to engage in any examination at that time. Midwifery planned to visit Nicole again following her release from custody. The police also made a referral to children's social care.

3.47 On 10th November 2020 the Lancashire MASH contacted Nicole's GP practice (GP practice 3) to query whether Nicole had been sterilised previously. The MASH explained that Nicole had stated that she was five months pregnant but 'information from another party' (a previous partner of Nicole) indicated that she had been sterilised previously. The GP practice advised that there was no record of any sterilisation in her 'current notes'. (The DHR has been advised that GP practice 3 did not receive Nicole's complete health records from her previous GP practice (GP

practice 2 – with which Nicole had registered as a temporary patient)). Nicole had in fact been sterilised in 2013. The GP practice put a note on the system to contact 'social services' if Nicole presented at the GP practice pregnant.

3.48 Just before 5am on 5th December 2020 Nicole was discovered by a police officer at the rear of Accrington Police Station in a distressed state. She stated that Craig had attacked her by repeatedly punching her to the face and she had then picked up a knife and stabbed him in the arm in order 'to get him off her'. She was arrested on suspicion of Section 18 wounding (grievous bodily harm with intent) and officers went to the address she shared with Craig but did not locate him until later in the day and established that he was 'well'. Nicole was later released and Craig was circulated as wanted for assaulting Nicole.

3.49 On 15th December 2020 midwifery made a pan-Lancashire midwifery alert after Nicole did not attend two clinic appointments.

3.50 On 21st December 2020 a strategy discussion[63] took place in respect of Nicole and her unborn baby at which it was decided that Section 47 Enquiries[64] would be undertaken.

2021

3.51 On 4th January 2021 Nicole phoned the DWP to advise that when she rang the DWP a few days earlier to update her bank account details, she had given the wrong details. She said that she was ringing to correct her mistake. As a result her bank account details were changed (back) to those of Craig.

[63] The purpose of a strategy discussion or meeting is to decide whether the threshold has been met for a single or joint agency (Children Social Care and Police) child protection investigation, and to plan that investigation. Strategy meetings are held when it is suspected a child has suffered, or is likely to suffer, serious harm.

[64] Once the strategy meeting/discussion has made a decision to initiate a Section 47 Enquiry its purpose is to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

3.52 On 14th January 2021 Nicole contacted her GP practice to request an appointment the same day and she was booked in for an in-person consultation for 18th January 2021 which was completed by telephone as Nicole reported respiratory symptoms. Nicole confirmed her pregnancy saying that her last period had been in July 2020 and that she had a midwifery appointment on 22nd January 2021. The GP practice liaised with midwifery and established that no such appointment was planned and that her pregnancy was now deemed to be a 'denied/concealed' pregnancy.

3.53 On 14th January 2021 an initial child protection conference (ICPC)[65] took place at which Nicole's unborn child was made subject to a child protection plan on the ground of neglect. Nicole was estimated to be 8 months pregnant.

3.54 On 3rd February 2021 a core group meeting took place at which it was stated that children's social care had commenced 'pre-proceedings'[66] and planned to complete a pre-birth assessment. Nicole had still not attended a booking appointment in respect of her pregnancy.

3.55 Nicole continued not to attend antenatal appointments and the social worker and health visitor attempted to make home visits but obtained no reply. Professionals were mindful of the risks to Nicole from Craig in planning their attempts to contact her.

3.56 On 15th April 2021 Craig phoned Nicole's GP practice to arrange an in-person appointment for Nicole as he said she had been having 'fits'. He also wanted a back dated fit note for her. When he phoned back the following day he was strongly advised that Nicole should go to urgent care. It was documented that Craig's priority appeared to be the fit note. No fit note was eventually issued. The GP practice did not share the details of this interaction with any other agency.

[65] A Child Protection Conference is a meeting between parents/carers, the child or young person (where appropriate), supporters or advocates and those practitioners most involved with the child, young person and family. There is an initial conference (ICPC) which is followed by review conferences (RCPC).

[66] Pre-proceedings is both a period of time and formal process. It is where children's social care consider whether they need to apply to the Family Court to start care proceedings.

3.57 On 21st April and 6th May 2021 the police carried out welfare checks and confirmed that Nicole was well and appeared pregnant.

3.58 On 27th April 2021 Nicole phoned her GP practice to say that her self-harming had increased and that she had attempted to cut her throat. She also asked for a fit note. The GP offered her an in-person consultation the following day which Nicole said that she was unable to attend. The GP practice took no further action at that time.

3.59 On 12th May 2021 a strategy meeting took place in respect of Nicole's unborn child. Concern was expressed that the parents may attempt to conceal the birth as they would be aware that the local authority would seek to legally remove the child at birth. It was noted that none of her existing 7 children were in Nicole's care, although 3 of them were then adults.

3.60 On 28th May 2021 Nicole notified the DWP of a change of bank details from those of Craig. However, Nicole contacted the DWP again on 6th July 2021 to change her bank account details back to Craig's bank account. This transaction necessitated an in-person interview with Nicole and Craig. The interview took place on 2nd August 2021 and Craig's bank details were verified. It is not known whether Nicole was accompanied by Craig although records confirmed that his bank card was provided.

3.61 On 19th July 2021 midwifery carried out checks which confirmed Nicole's prior sterilisation which meant that the likelihood that she was pregnant was low – but could not be ruled out. The following month the health visitor decided to carry out no further antenatal visits.

3.62 On 6th September 2021 a further strategy meeting took place in respect of Nicole's unborn child and it was agreed that it was unlikely that she was pregnant. The child protection plan was to be closed for the unborn child on the grounds that Nicole was not believed to be pregnant. A review child protection conference (RCPC) subsequently (18th October 2021) took place at which it was formally decided to close the child protection plan in respect of the unborn child as Nicole was highly unlikely to be pregnant.

3.63 On 24th September 2021 Nicole phoned the police from a telephone outside Accrington Police Station to report that she had been assaulted by Craig and was frightened to return to their 'shared' flat – where she said that the assault had taken place. The police attended and spoke to Nicole who had returned to the flat – which Craig had left. She disclosed that Craig had

punched her in the face after he had accused her of having another male in the flat and having sex with other men. She said that she did not wish to make a formal complaint as she did not want to go through the formal court process. She said that she planned to leave Craig and go to an address he did not know. She was given safety advice and a crime of assault was recorded, a referral made to MARAC and IDVA notified.

3.64 On 12th October 2021 Nicole's case was heard at MARAC at which it was agreed that a flag would be placed on the 'hospital system' should Nicole attend and that her GP should offer her an appointment should she engage and that IDVA would attempt a joint visit with mental health services. MARAC was concerned that agencies were unable to speak to Nicole.

3.65 On 22nd November 2021 Nicole visited her GP practice and asked if the GP would refer her to mental health services 'due to self-harm'. Nicole was not seen by a GP nor was she encouraged to wait to be seen. No further action was taken at that time.

3.66 On 10th December 2021 a community midwife contacted the police to request a welfare check on Nicole as she had phoned the hospital to report she was 8 months pregnant but had not subsequently attended the appointment arranged. The police visited Craig's flat and saw Nicole. Craig was also present. The officer documented that Nicole confirmed that she was pregnant and that midwifery could contact her via Craig's phone. Midwifery referred Nicole to children's social care on the basis that she may be in the late stages of a pregnancy.

3.67 Between 28th October and 15th December 2021 the IDVA service attempted to contact Nicole's GP practice to request them to contact Nicole in a safe way if possible and also to offer her IDVA support. In response the GP practice phoned Nicole on 21st December 2021 to offer her a face to face appointment to 'discuss medication' but Craig answered the phone. An appointment was arranged for 30th December 2021 which Nicole does not appear to have attended.

3.68 At 2.05am on 26th December 2021 Nicole contacted the police via the 999 system to report that she had been assaulted in a telephone kiosk by Craig who had caused cuts to her neck by 'holding knives to her' and that he found it 'funny' to pick up knives. She also told the call taker that she 'wanted to end it all' and 'throw herself under something'. Officers attended and noted small scratch marks and a small cut to her throat and head. They drove her to stay at a friend's address overnight. Nicole declined to support a prosecution as she stated that she 'could not face' going through the Court Process. Nicole was assessed as a high risk victim of domestic abuse and the crime of assault was recorded. The police safeguarding team were to apply for a

DVPN. They also documented that no further attempts to be made to contact Nicole as police involvement 'causes her more trouble'.

2022

3.69 Nicole's further claims that she was pregnant were considered at a strategy discussion held on 9th February 2022 at which it was agreed that Nicole was highly unlikely to be pregnant and all agencies expressed concern that Nicole was stating that she was pregnant to protect herself from violence from Craig. The case was again closed by children's social care and information was to be shared with Nicole's GP and the police were to complete a 'domestic abuse notification'. (In December 2021 Nicole disclosed to a Social Worker that she had lied about being pregnant in order to protect herself from her partner).

3.70 On 18th January 2022 Nicole's case was heard at MARAC. The meeting was advised that safe contact with Nicole remained challenging and that when professionals visited her, this aggravated Craig who would injure Nicole following such visits. Children's social care advised that Nicole had falsely claimed to be pregnant as if Craig believed she was pregnant, he 'will go easy on her.' A DVPN remained under consideration 'but only if it could be managed'. There is no indication that a DVPN was obtained.

3.71 On Friday 18th March 2022 Nicole attended HARV. She was very distressed and disclosed that Craig had hit her over the head with a glass ash tray that morning and she had run away whilst he was putting the bins out. She said that she had nowhere to go, adding that although she had her own flat, she could not go there as 'people just let her partner in'. She said that she had no clothes, money or a phone. The HARV worker noted a visible mark on Nicole's forehead. HARV contacted the police on Nicole's behalf after she said that she was willing to make a statement to the police but would not support a prosecution. HARV asked Nicole about her pregnancy and she initially said that she had 'lost' the baby but later disclosed that she had lied about the pregnancy to her partner to 'prevent arguments'. HARV also provided her with a mobile phone and she agreed that her new number could be shared with her eldest son. HARV supported Nicole to obtain a place in a refuge 3.

3.72 On Saturday 19th March 2022 Safenet – the provider of the refuge - asked Nicole to complete the 'moving in' paperwork but she asked to do this later as she was feeling overwhelmed. She was given emotional support. Later in the day a DASH risk assessment was completed which identified a high risk and Nicole was referred to MARAC. The DHR has been

advised by Lancashire Constabulary that there is no record of this MARAC referral being received.

3.73 After spending two nights in the refuge, on Sunday 20th March 2022 Nicole said that she would be 'going to see her Dad' and may not return to the refuge that evening. The overnight stay policy – no overnight stays permitted during the first 7 days following admission - was explained to Nicole. Nicole did not return to the refuge and after establishing that the address of her father provided by Nicole did not exist, on 25th March 2022 Safenet reported Nicole as a missing person to the police. They expressed concern that Nicole may have returned to Craig. On 28th March 2022 Nicole was found at Craig's flat. She was documented to be 'safe and well' and said that she had been with Craig since leaving the refuge.

3.74 After making further unsuccessful attempts to contact Nicole, HARV closed her case on 19th April 2022, documenting that Nicole had 'disengaged' and it was 'unsafe' to contact her.

3.75 On 4th May 2022 the High School attended by Child 4 (then 16) contacted the police to report that the child had attended school in a distressed state and told staff that Nicole had been assaulted by Craig and had injuries to her face for which the child believed Nicole needed to seek medical attention. At that time the child was placed with foster carers and although there was supposed to be no contact between Nicole and her child, Nicole would often attempt to obtain money from the child.

3.76 The police were unable to locate Nicole until the following day (5th May 2022) as she had left Craig's flat and stayed elsewhere overnight. When spoken to by the police Nicole disclosed domestic abuse from Craig including stopping her seeing friends, leaving his flat or attending appointments. She added that Craig had previously attempted to strangle her and she said that she was also afraid of a member of Craig's family who had previously threatened her. She also disclosed that Craig had previously threatened to hurt her eldest son. A high risk DASH was completed and a MARAC referral made. Following the incident in which she disclosed she had been assaulted by Craig, Nicole had attempted to cut her own throat and caused a 'nick' in her skin which had bled for a time. After liaising with HARV, the police contacted Safenet and supported Nicole to obtain a place in refuge 4.

3.77 Later the same day (5th May 2022) the police arrested Craig for assault occasioning actual bodily harm and coercive and controlling behaviour. Following interview he was released on police bail to enable the police to continue their investigation and prepare a prosecution file for

the CPS to consider. Craig was bailed to return to the police station on 26th May 2022. His police bail conditions were not to contact or interfere with Nicole either directly or indirectly Nicole and not to approach within 50 metres any location where he knew or suspected the victim to be. When Craig answered his bail on 26th May 2022 he was released under investigation and so the prior bail conditions no longer applied. The investigation of Nicole's 5th May 2022 disclosures did not progress expeditiously and key tasks such as interviewing witnesses remained outstanding at the time of the 21st July 2022 incident in which Nicole sustained injuries which led to her death.

3.78 Shortly before midnight on 11th June 2022 Nicole contacted the police from the public telephone outside Accrington Police Station to report that her 'ex-partner' Craig had given her drugs she believed to be Crack Cocaine which had induced psychosis. She sounded distressed and went on to disclose that Craig was bullying her, following her around whilst 'feeding her' with Valium and Crack Cocaine. She added that the drugs had caused her to slur her speech and struggle to stand up which Craig had filmed and found amusing. Officers attended shortly after 1am on 12th June 2021 - after the patrol initially deployed to this call was redeployed to a higher priority call - and they summoned an ambulance as Nicole was having difficulty breathing and had tried to cut her neck with a razor and said that Craig had laughed at her whilst she self-harmed. The ambulance crew noted Nicole to be upset and agitated and she disclosed that for the past 3 days she had been feeling increasingly suicidal and had made attempts to end her life in her partners presence and that he had filmed her distress and 'encouraged her', stating he was going to post it on social media.

3.79 The ambulance crew conveyed Nicole to the hospital where she was seen by the Mental Health Liaison Team (MHLT). Nicole spoke at length about her experience of domestic abuse and disclosed self-harming as a means of managing her distress by scratching her arm with a plastic bottle. A Mental Health Act assessment was completed following which it was recommended that Nicole should be admitted to hospital under Section 2 of the Mental Health Act. During her initial admission to the hospital Nicole was also interviewed by the police who completed a high risk DASH assessment. Nicole further disclosed that Craig 'mentally tortured' her by 'calling me all the names under the sun'. She said that she continually feared violence and that she could not even go to the toilet because she was so frightened. She said that Craig – who she described as 'evil' and 'nasty' – saw all of this as a game and was driving her to want to take her own life. She said that following his recent arrest for assaulting her, she resumed their relationship after he begged her to do so. She went on to disclose that Craig had threatened to kill her kids if she did not 'get him out of jail'. She said that he had threatened to kill her and had strangled her on previous occasions.

3.80 Safeguarding referrals were completed by the ELHT and NWAS. Adult Social Care received the safeguarding referral from NWAS on 13th June 2021, noting that they had received no previous adult safeguarding referrals in respect of Nicole. The safeguarding referral was forwarded to the Mental Health Safeguarding Adults Team.

3.81 On 14th June 2022 Nicole was admitted to The Harbour Hospital under Section 2 of the Mental Health Act. She asked to speak to her 'ex-partner' to request him to 'bring her items' onto the ward. Nicole's request was escalated to the deputy ward manager due to the safeguarding concerns. Nicole was nursed on Level 2 – intermittent observations[67] due to risk to self.

3.82 On 15th June 2022 Nicole again disclosed that she thought that Craig had drugged her by spiking her drink and telling her that it was Crack Cocaine, which she did not believe the substance to be. She also disclosed that her suicidal thoughts were of longstanding. She said that she held her partner responsible for the loss of 'everything' including her children, her car and her home.

3.83 On the same date ward staff had a discussion with the hospital safeguarding team which advised staff to make 'routine enquiry' about domestic abuse when safe to do so, report any further disclosures and consider safeguarding concerns on discharge. During the day Craig contacted the ward and asked to speak to Nicole, a request which was initially denied. The ward team spoke to Nicole at Craig's request to enable her to access money and belongings although Craig advised that he was unable to drop off her belongings as his van had broken down in

[67] This level is appropriate when patients are potentially, but not immediately, at risk of disturbed/aggressive behaviour or risk to self. This level of observation is not appropriate where a patient is assessed as an immediate risk of suicide. This level of observation is not generally appropriate for patients who have achieved any level of unescorted leave unless specific risks exist within the ward that do not affect the general population.

Intermittent observation means that the patient's location and wellbeing should be visually checked at a specified interval. Observations frequency and timing of intermittent observations should be decided as part of the individual risk assessment.

Frequency of intermittent checks should be determined by the risk assessment and included within the care plan; level 2 observations are more frequently than hourly but do not require the person to be in continual eyesight. Consideration needs to be given to whether Level 2 observations are to be completed at regular or irregular intervals. (Taken from LSCFT Mental Health Therapeutic Observation Policy and Procedure CL071)

Manchester and he had used Nicole's money to repair it. Nicole later self-harmed with a ligature which was not attached to a fixed point.

3.83 On 16th June 2022 Nicole expressed frustration that the ward team were not enabling her to have visits with Craig, who she said was helping her. Ward staff sought advice from the hospital safeguarding team which advised that the hospital could not interfere with Nicole's human rights in respect of contact with loved ones. However, ward staff were advised to note the frequency of calls and share this information with Nicole's allocated Social Worker/IDVA and to undertake an assessment of her mental state following contact and offer support as appropriate. Ward staff were also to re-visit IDVA support as part of safety planning. A Care Programme Approach (CPA) review was to be arranged.

3.84 On 19th June 2022 Nicole appeared distressed following a telephone call with Craig and staff increased monitoring of her. She self-harmed by banging her head and punched a wall sustaining bruises to her hand. She declined one to one support but became settled after the incident. Later the same date Nicole was found with a ligature around her neck in her bed space following a discussion with her partner. PRN medication (as and when needed) was utilised and one to one time offered. Later the same day Nicole barricaded herself in her bedroom. She had a ligature around her neck and was resistive. Staff were required to put her in arm holds to remove the ligature. Staff noted that the incident was precipitated by telephone contact with Craig.

3.85 On 21st June 2022 Nicole's case was heard at MARAC when both the 4th May and 11th June 2022 incidents were considered. It was noted that Nicole was currently admitted to the Harbour Hospital under the Mental Health Act, and it was decided that the IDVA service and the Harbour Hospital should coordinate appropriate support for the victim.

3.86 On 21st June 2022 Nicole denied her initial disclosures that she had been 'forced' to take drugs prior to her admission and said that this disclosure reflected her paranoia at that time. It was noted that Craig continued to phone the ward and speak to Nicole. On 23rd June 2022 the ward team were advised by the Nurse Associate to formally assess Nicole's capacity to accept visits from Craig, taking into consideration his coercive and controlling behaviour and to fully supervise all visits by Craig. There is no indication that the capacity assessment was undertaken.

3.87 On 24th June 2022 the police investigating officer visited Nicole who declined to provide a witness statement or provide an ABE interview. She stated that she intended to leave

Accrington, was 'well away' from Craig and had re-connected with her family. Nicole signed the officer's notebook to indicate that she did not wish to discuss the matter further with police. The crime was subsequently reviewed by a Sergeant who noted that Craig had not been arrested in respect of the 11th June 2022 incident and concluded that there was no realistic prospect of CPS authorising any charges as Nicole had not provided a statement and did not support a prosecution. There was no CCTV evidence or independent witnesses who had provided supporting evidence. The officer recorded on the rationale that there was no previous history of domestic abuse between Craig and Nicole which was incorrect as there was a very substantial history of domestic abuse and a domestic abuse trigger plan in place (the DHR has been advised that the Sergeant is subject to a Lancashire Constabulary Professional Standards Department investigation).

3.88 On 25th June 2022 Nicole requested to go on unescorted leave for 30 minutes which was agreed. A member of ward staff then observed Nicole with a male in the hospital reception and she was later seen to get into a car with Craig. Nicole did not return from leave and so the hospital reported Nicole to the police as a missing person. During the early afternoon of the following day (26th June 2022) the police attended the Harbour Hospital to obtain further details. Whilst the police were present Nicole returned to the ward, stating that she had been dropped off by Craig. Nicole said that she had seen friends whilst absent from the ward and had taken Cocaine – although a drug screen was negative. Superficial cuts to her arms and marks to her neck were noted which Nicole said that she had done herself. No routine enquiry questions were asked and Nicole's hospital risk assessment was not updated. The police submitted a Vulnerable Adult marker assessed as High Risk on the investigation for the attention of the MASH. The MASH took no further action as Nicole had returned to the Harbour Hospital and the domestic abuse trigger plan was in place.

3.89 On 29th June 2022 a Psychology Formulation was completed by the inpatient psychologist which made the following recommendations:

That Nicole would benefit from developing positive healthy relationships with staff and dropping in to psychology skills groups;

That the outcome of the MARAC may identify additional safeguarding support to help reduce the risks she faced from her partner;

Nicole would benefit from a referral to the CMHT and allocation of a Care Coordinator for a period of assessment;

Nicole would benefit from receiving trauma-focussed psychological therapy, to help her with the consequences of her many traumatic experiences including the loss of her children;

Nicole would benefit from accessing Inspire to help her with substance misuse.

Nicole was then discharged from inpatient psychology. No referrals to the CMHT or Inspire were made.

3.90 Also on 29th June 2022 Craig visited Nicole on the ward. The visit was supervised by ward staff who had agreed that Nicole would give them a pre-arranged signal when she wished to terminate the visit. Craig was noted to be under the influence of alcohol and ward staff noted his controlling and manipulative behaviour in withholding money from Nicole. Nicole was noted to be very upset at the conclusion of the visit and was provided with a great deal of reassurance by ward staff who planned to discuss Craig visiting Nicole whilst under the influence of alcohol at their next MDT. This issue was not discussed at the next MDT.

3.91 On 4th July 2022 Nicole's ASC social worker was emailed by the manager of refuge 1 to advise that they had availability coming up in refuge 1. It was planned to support Nicole to complete a referral to refuge 1 so that she could be admitted direct from the Harbour. On the same date Nicole was supported to contact Universal Credit to cancel all DWP payment exception service[68] vouchers to her home address so that no one was able to access her money while she was in hospital (Nicole had arranged for her benefits to be paid to her via the payment exception scheme from 5th May 2022). Universal Credit advised that they were unable to change her address until she had a phone number to contact. At that time Nicole did not have a mobile phone, having 'broken' her previous one. Arrangements were being made to access a mobile phone for Nicole, change her benefits address to the hospital for now and arrange to pay off her current debt to her landlord. The DWP have no record of this being accomplished prior to Nicole's death.

3.92 On 5th July 2022 a multi-disciplinary team meeting took place at the Harbour Hospital which was attended by the hospital ward Consultant, staff nurse, the ASC social worker (virtually), refuge 1 and the police. The IDVA service was not involved as Nicole had declined their support. Nicole joined the meeting part way through. It was stated that Nicole had gradually become more settled on the ward although she had been distressed by Craig's visits. The staff nurse stated that assessments indicated that 'a lot' of Nicole's mental health issues had been as a consequence of the abusive relationship with Craig and staff had observed that Nicole's mood would 'dip immensely' when she had had phone contact with him. She presented as agitated and panicked and had shared increased urges to self-harm. During periods in which Nicole had no

[68] The Payment Exception Service is a way for people who do not have a bank account to collect benefit or pension payments. They're only available in very limited circumstances.

contact with Craig she was settled and mixed well with other patients. Nicole was said to be 'unsure' about the prospective refuge 1 placement. A referral was said to have been made to the CMHT although this didn't actually happen and that HTT would provide 48 hour follow up following discharge. The police advised that there was a trigger plan should Nicole contact the police in an emergency. The ASC social worker was to develop a robust safeguarding plan for the community.

3.93 On 6th July 2022 ward staff attempted to complete a DASH risk assessment but Nicole declined. The DASH was to be followed up the next day, but this was overlooked and no DASH was attempted until 11th July 2022 when Nicole again declined.

3.94 On 8th July 2022 Nicole completed the refuge 1 referral by phone. She disclosed that Craig had been abusing her for 4 years and that when she attempted to leave him he would start to harass her children – which she said was her biggest fear and was why she had returned to him previously. Later that day Craig visited Nicole on the ward and he was observed to ask her about her iPad use and whether she had access to social media, whether any men were contacting her and asking whether she had been speaking on the ward phone to anyone else. He was heard making comments such as 'come on, me and you in the toilet now'.

3.95 On 11th July 2022 the pre-discharge meeting took place at the Harbour. It was stated that Nicole had agreed to be discharged to refuge 1 and was deemed to have capacity to make this decision. Her Section 2 Hospital Order was due to expire at which time she would become an informal patient. Two weeks discharge medication was to be provided. Once registered with a new GP practice they would continue the prescription. The ASC social worker advised that he would review the safeguarding plan in a few weeks before considering closing the safeguarding alert. Arrangements were made for the HTT to complete a 48 hour follow up on 13th July 2022 at refuge 1. Nicole was noted to have no mobile phone but the police were to allocate one to her.

3.96 On 12th July 2022 Nicole was discharged to refuge 1. She was provided with a new mobile phone by the police. She reported feeling overwhelmed now that she had left Craig and feeling slightly low in mood. She was provided with emotional support. She was also visited by the police safeguarding team. Craig phoned the Harbour and was advised only that Nicole had been discharged and had arranged her own transport. During the day the ASC social worker and the manager of refuge 1 discussed the possibility of obtaining an injunction against Craig given his continued attempts to contact Nicole. There is no indication that this was progressed further. Nicole's GP was notified of her discharge from the Harbour although Nicole was in the process of registering with a new GP practice.

3.97 On 13th July 2022 Nicole was visited in the refuge by the HTT who noted that she had made a good recovery on the ward and that her mental health had improved. The HTT provided contact numbers for the LSCFT immediate response service. At a subsequent MDT, the HTT concluded that there was no ongoing role for the HTT and Nicole would be under the care of her GP.

3.98 Between 14th July and 21st July 2022 refuge 1 reported Nicole to the police as a missing person on four separate occasions. On the first occasion she said that she had attended a friend's BBQ and was unable to get back to the refuge. On the second occasion the Police traced her to Accrington bus station. On the third occasion Nicole said that she had been to Craig's flat to retrieve some of her belongings. She disclosed that Craig had taken her money from her. She also disclosed that Craig had been ringing her children and as she didn't want him harassing her children, this was the reason she went to his address. The police also returned Nicole to refuge 1 after she had spent the evening with Craig smoking crack which she said had been purchased with her money. On two of the occasions when the police returned Nicole to the refuge she disclosed that she had tried to self-harm by cutting her neck.

3.99 On 19th July 2022 Nicole's case had been discussed at MARAC which noted that she had been missing from refuge 1. It was noted that Nicole would be signposted to Inspire and the Women's Centre and that her GP would provide ongoing care in relation to her mental health.

3.100 On 21st July 2022 refuge 1 reported Nicole missing for the fourth time. The refuge had telephone contact with her during the day. At 9.04pm the police received several reports to state that a woman (Nicole) had hanged herself from a bridge over a stream. On the arrival of the police Nicole was hanging with a ligature around her neck over a wall leading down to a small river. Craig had scaled the wall and used a knife provided by a householder to cut the ligature. In the process of being cut down both Nicole and Craig fell into the river, where Nicole was found to be unresponsive. The police commenced CPR until the arrival of paramedics who transported her to hospital where she never regained consciousness and died several days later after her life support was switched off.

3.101 Craig provided the police with an account of Nicole's final hours which she had spent at Craig's address. He stressed that he had tried to persuade her to return to the refuge but he said that Nicole was adamant that the refuge wished to 'section' her under the Mental Health Act. On the basis of the information shared with this DHR, caution should be exercised about any account provided by Craig.

4.0 Key issues arising from the review.

4.1 In this case partner agencies generally worked very diligently individually and collectively to try and safeguard Nicole from domestic abuse from Craig but were unable to prevent her from taking her own life. The challenge this case presents is to explore how the 'whole system' for safeguarding victims of domestic abuse can be further strengthened to support victims of the very intensive and unrelenting domestic abuse suffered by Nicole which severely diminished the quality of her life and appears to have extinguished any hope she had for a more positive future to the extent that she took her own life.

Response to evidence of controlling and coercive behaviour

4.2 It is noticeable that in this case professionals eventually became a little 'stuck' in terms of how best to safeguard Nicole given the range of actions which had previously been implemented in an effort to support Nicole to leave Craig. Reflecting on the case, one further option professionals could have considered could have been to analyse the behaviours Craig engaged in to control and coerce Nicole. If this had been done it seems possible that the importance of addressing Nicole's fears that Craig may harm her children may have become more apparent.

4.3 Controlling and coercive behaviour can take many forms. This case suggests that carefully analysing the 'methods' of coercive control employed by the perpetrator and speaking to the victim about the impact of controlling and coercive behaviour on her life, in particular her freedom to make decisions about whether to remain in or leave the relationship could be of value. Such analysis could have drawn greater attention to Nicole's fears that if she did not return to Craig, he could harm her children – none of whom were in her care – but many of whom lived locally. From time to time Nicole's shared these fears with professionals but it is largely as a result of this DHR that the impact of Nicole's fears that Craig could harm her children have become more prominent. Analysis could also have focussed greater attention on the need to seize opportunities to support Nicole to regain control over her finances at key points such as her discharge from the Harbour Hospital. It is therefore recommended that there should be greater professional attention paid to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. There may be merit in devising a tool to help professionals analyse controlling and coercive behaviour based on the 'types' of controlling and coercive behaviour set out in the Domestic Abuse Act 2021 Statutory Guidance.

Recommendation 1

That Pennine Lancashire Community Safety Partnership promotes greater professional attention to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. The Partnership may also wish to consider requesting relevant partners to devise a tool to help professionals analyse controlling and coercive behaviour based on the 'types' of controlling and coercive behaviour set out in the Domestic Abuse Act 2021 Statutory Guidance.

Tackling economic abuse

4.4 Craig exercised control over Nicole by apparently insisting that her benefits were paid into his bank account and there is evidence that when Nicole managed to switch the payment of benefits back to her own bank account she quickly reversed those arrangements and requested the DWP to restore the payment of benefits into Craig's bank account. The DHR Panel discussed the challenges involved in helping a victim of domestic abuse regain control of her finances whilst she remained in an abusive relationship with the perpetrator. Changing the victim's bank details to their own bank risked an escalation in abuse from the perpetrator and pressure to reverse the change – which is what appeared to happen to Nicole.

4.5 However, there was an opportunity to intervene more decisively to change the address to which Nicole's DWP vouchers were sent as a key element of her discharge plan following her second Mental Health Act admission but after initial efforts to achieve this were frustrated by Nicole's lack of a mobile phone, this task appeared to be overlooked when Nicole was later provided with a new phone. Whilst recognising the challenges involved in supporting victims to regain control of their finances whilst they remain in a relationship with their abuser, professionals are in a stronger position to help a victim of domestic abuse regain control of their finances when they have left or are leaving the abusive relationship and so it is recommended that the Community Safety Partnership highlight the importance of such action and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.

Recommendation 2

That when they disseminate the learning from this DHR, Pennine Lancashire Community Safety Partnership highlight the importance of action to support victims of domestic abuse to regain control of their finances when leaving an abusive relationship and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.

4.6 As previously stated, the DHR Author is also completing a second DHR (DHR 'Rose') for Pennine Lancashire CSP in which economic abuse is the dominant form of coercion and control used by the perpetrator. Additionally, members of the DHR Panels for 'Nicole' and 'Rose' are involved in other current Pennine Lancashire CSP DHRs in which economic abuse is prominent. There may therefore be value in developing a bespoke action plan to address economic abuse as a form of coercion and control which draws upon the learning from this DHR and the other Pennine Lancashire CSP DHRs in which economic abuse is a prominent factor. There may be benefit in partnering with the UK charity Surviving Economic Abuse.

Mental Capacity

4.7 Nicole's capacity to make decisions was only rarely formally considered. Nicole's capacity to make decisions in respect of her personal safety were affected by 'undue pressure' arising from the evidence of Craig's controlling and coercive behaviour could have received greater professional attention than it did. The LSCFT Serious Incident Review (SIR) observes that capacity to engage in unwise decisions, such as contact with an abusive partner, cannot be assumed based on a person's capacity to make other decisions around their care. The SIR goes onto recommend that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour should be at the foundation of clinical decision making for people experiencing domestic abuse.

Recommendation 3

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to advise on the steps it plans to take, or has already taken, to ensure that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour are at the foundation of clinical decision making for people experiencing domestic abuse.

Fabricated pregnancy

4.8 Nicole disclosed to professionals that she fabricated a pregnancy in order to protect herself from abuse from Craig. This was quite an extreme step to take to try and protect herself from domestic abuse, involving maintaining the impression that she was pregnant for over a year (November 2020 until December 2021). She reported only one incidents of domestic abuse during this period and so - on the basis of the lack of reported incidents – her plan may have been successful. Reported physical violence began almost immediately after the fabricated pregnancy period came to an end and appeared to intensify until her admission to the Harbour Hospital in June 2022.

4.9 However, during the fabricated pregnancy period Nicole avoided contact with health professionals which may have reduced her opportunity to disclose domestic abuse to professionals and adversely affected the continuity of her health care. The likelihood that Nicole's pregnancy was fabricated could have been established much earlier had GP Practice 3 held information about her 2013 sterilisation. However, one important consequence of the difficulty in clarifying that she had undergone a sterilisation procedure many years earlier was that a range of professionals became involved with Nicole and made, or attempted to make, contact with her on a regular basis. Additionally, through the processes invoked to safeguard her unborn child there was quite intensive scrutiny of her case for around a year. However, once it had been established that Nicole was highly unlikely to be pregnant this professional oversight/involvement ceased. There was a missed opportunity to review Nicole's needs following the discovery that her pregnancy was fabricated, including the risk of resumption or intensification of domestic abuse and to have potentially considered an adult safeguarding referral on the grounds that she had care and support needs, was exposed to a potentially enhanced risk of domestic abuse and because of her care and support needs was unable to protect herself from abuse.

4.10 The DHR Panel was minded to recommend that the Lancashire Concealed and Denied Pregnancy guidance should be amended to reflect the learning from this case to reflect the possibility that the pregnancy may have been fabricated for other reasons such as to protect the woman from domestic abuse. However, the DHR Panel has been advised that it would not be appropriate to amend the guidance as the focus of that guidance is on safeguarding the unborn child. However, there is important learning from this case in relation to the importance of considering the needs of the victim of domestic abuse who has fabricated a pregnancy to reduce domestic abuse when the partner agencies involved in safeguarding her unborn child step away. It is therefore recommended that the learning from this case is shared with the local Safeguarding Children Partnership and the local Safeguarding Adults Board and that when the

Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted.

Recommendation 4

That Pennine Lancashire Community Safety Partnership shares the learning in respect of fabricated pregnancy with both the local Safeguarding Children Partnership and Safeguarding Adults Board and that when the Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted to professionals.

Nicole's MHA admission to the Harbour Hospital

4.11 Lancashire and South Cumbria NHS Foundation Trust shared the Serious Incident Review (SIR) report with the DHR. Overall, the SIR found that there was evidence of good safeguarding and multi-agency working from the ward staff and domestic violence services in terms of seeking advice and at discharge planning.

However, domestic abuse continued during Nicole's MHA admission to the Harbour Hospital (Paragraphs 6.33 to 6.42). The ward team supporting Nicole clearly had concern about the visits to the ward from Craig. A full MDT review involving the police and LSCFT safeguarding practitioners would have supported the team to fully understand and assess Nicole's capacity to enable robust decision making. On review of the ward's ability to prevent a person from visiting the ward, no guidance for clinical teams could be found. Therefore LSCFT intend to amend the current Inpatient Standard Operating Procedure to include clear guidance around visitors to inpatient wards who may pose risk to patients or staff (LSCFT Single Agency Recommendation 7 – see Appendix A for all Single Agency Recommendations).

4.12 The LSCFT Safeguarding Team exists to provide expert advice and guidance for clinical teams directly caring for those at risk of harm from others. Unfortunately, some of the key advice sought from the LSCFT Safeguarding Team was not acted upon by the ward team. For example the advice that a robust capacity assessment should be completed and documented within the notes around Nicole's understanding of the coercion and control aspect of the domestic abuse in order to inform the decision of whether to allow Craig to visit the ward, was overlooked. Therefore the LSCFT has recommended that the ward identify processes to ensure that actions that are agreed as required by the wider multi-disciplinary team are effectively handed over and completed in a timely manner (LSCFT Single Agency Recommendation 2) and LSCFT has recommended that their safeguarding team consider a process to ensure that

safeguarding advice is recorded in the clinical record to ensure continuity of care and improved communication (LSCFT Single Agency Recommendation 5).

4.13 The SIR identified a number of key points where routine enquiry or DASH assessment would have been beneficial to enable ward staff to gain further insight into Nicole's relationship with Craig and escalate concerns to the LSCFT safeguarding team and Lancashire Constabulary. The SIR found that there was a gap in the knowledge of clinical teams in relation to the purpose, and recording of routine enquiry and who is the right person to complete a DASH, when is the right time to complete a DASH, as well as the overall purpose of a DASH risk assessment. The LSCFT has recommended that the ward improve their knowledge and understanding of current procedure and policy to support those experiencing domestic abuse, including the requirement for routine enquiry and understanding of the DASH assessment (LSCFT Single Agency Recommendation 1). The HTT did not document routine enquiry during their follow up visit to Nicole after she had been discharged to refuge 1 and so it is recommended that LSCFT Single Recommendation 1 is expanded to encompass the HTT.

4.14 The SIR found that supporting Nicole was challenging for the ward staff and went on to note that much of the support was provided by health care assistants who do not routinely document clinical records which led to a mismatch between the clinical records and the level of therapeutic intervention expressed by staff to the SIR process. LSCFT have therefore recommended that all patients admitted to the ward have regular one-to-one time with either their primary nurse or named nurse for the shift (LSCFT Single Agency Recommendation 3). The SIR also noted that working with domestic abuse is a psychologically challenging area of nursing and so teams require substantial support to enable safe and robust decision making as well as to discuss the impact this has on their own wellbeing. Reflective group sessions or formulation sessions give staff the opportunity to reflect on the care delivered and enhance the confidence and capacity to care, improving outcomes for services users. The LSCFT therefore recommended that there should be adequate support and safeguarding supervision in place for clinical teams dealing with complex cases of domestic abuse (LSCFT Single Agency recommendation 4).

4.15 Nicole was clinically optimised for discharge much earlier than her actual discharge date and her admission was prolonged in an effort to facilitate Nicole's safe and effective transition to the community. However, there were a number of planned actions which did not take place particularly the referral to the CMHT to enable Nicole to be supported using a Care Programme Approach or the referral to Inspire, although it appears that the Harbour Hospital anticipated that this would be done by refuge 1. Additionally, efforts to change the address to which her DWP payment exception service vouchers were sent had not been completed. Furthermore, the discharge plan was founded on the assumption that Nicole would go to refuge 1 and accept the

support provided there. There is no indication that Nicole's previous involvement with refuges was taken into account. If it had, professionals would have realised that Nicole had invariably struggled to settle in refuges in the past and had often not stayed there beyond the first couple of nights. This understanding of Nicole's history could have prompted the development of a contingency plan to address the probability that Nicole would not stay in refuge 1 for long. One contingency which could have been further considered was the possibility of obtaining an order to prevent Craig contacting Nicole. The ASC social worker and the manager of refuge 1 had discussed the possibility of obtaining an 'injunction' against Craig but there is no indication that this was progressed further. By this time the previously imposed Police bail conditions were no longer in force and the opportunity to investigate the offence of assisting a patient detained under the MHA to absent themselves without leave had been missed. The learning arising from multi-disciplinary discharge planning merits a separate multi-agency recommendation.

Recommendation 5

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to work with relevant partner agencies to develop a robust approach to multi-disciplinary discharge from hospital of patients at risk from domestic abuse which ensures that discharge planning is informed by the patient's history that the discharge plan is comprehensive and addresses reasonable contingencies.

4.16 Following her discharge, the HTT made a visit to Nicole in refuge 1 before closing the case. The SIR noted that there is no indication of routine enquiry or professional curiosity in relation to contact from Craig. In addition, the SIR noted the absence of an expected enhanced risk assessment which should have been completed at the point of follow up as Nicole was not accepted into home treatment. The LSCFT therefore reinforces the requirement for the completion of an updated enhanced risk assessment when patients are discharged back to the care of a GP by an LSCFT team (LSCFT Single Agency Recommendation 6).

Suicide of victims of domestic abuse

4.17 The impact of domestic abuse, in particular physical and sexual violence, coercion and controlling behaviour, economic abuse and threats to harm Nicole's family appears to have been a very prominent factor in Nicole's suicide. In this case there seems to very strong evidence of a link between the abuse Nicole disclosed in her relationship with Craig and her mental health problems, her self-harming behaviour and attempts to take her own life.

4.18 The DHR has been advised that the Lancashire and South Cumbria Suicide Prevention Strategy is currently awaiting sign off. A late draft of the Suicide Prevention Strategy has been shared with the DHR. The Strategy highlights the areas of 'leadership', 'prevention', 'intervention', 'postvention' and 'intelligence'. 'Intervention' includes providing effective support to high risk groups and minimising risks through effective protocols and safeguarding practices. The learning derived from this DHR may assist in understanding how to enhance efforts to safeguard victims of entrenched domestic abuse particularly the need to analyse coercion and control methods in order to better tailor support to victims. 'Intelligence' includes sharing lessons learnt, best practice and recommendations from 'Serious Case Reviews/Child Death Overview Reviews'. Serious Case Reviews have been replaced by Child Safeguarding Practice Reviews. It could be of value to the Strategy to also consider learning from 'suicide' DHRs and Safeguarding Adults Reviews where the person subject of the review appears to have taken their own life. The learning from this DHR may also be of relevance to the Hyndburn Borough Council approach to suicide prevention.

Recommendation 6

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Council Public Health so that the learning from this review, in particular the corrosive impact of prolonged controlling and coercive behaviour on a victim's mental health and the increasing evidence of a link between domestic abuse and suicide, can inform future suicide prevention plans.

The need for escalation when the 'whole system' for safeguarding victims of domestic abuse is unable to improve the situation for a victim.

4.19 Partner agencies working with Nicole deployed most of the tools in the Domestic Abuse 'tool box' – positive action to arrest, charge and remand of the perpetrator, a determined attempt to obtain an evidence-led prosecution, refuge support on numerous occasions, DVPO, Domestic Abuse trigger plans etc. However, Nicole's situation had not improved and arguably it had deteriorated as she appeared to have come to believe, based on her experiences, that if she reported abuse and attempted to engage with agencies, she could face retribution from Craig.

4.20 Under safeguarding children arrangements, many safeguarding children partnerships have a policy which requires a professional to escalate matters if they form the view that the 'system'

is not working for a child and their family and their lived experience is not improving. Arguably there could be a similar requirement of professionals in circumstances where the system is not working for a victim of domestic abuse despite the efforts of professionals from partner agencies. The DHR Panel considered making a recommendation but concluded that if such a policy was introduced the logical forum to escalate system concerns would be MARAC – which considered Nicole as a high risk victim on several occasions. However, it may be useful to advise MARAC chairs that repeat referrals could be an indication that the system may not be working for an individual victim and may therefore present an opportunity to challenge partner agencies to review the action they had taken and consider alternatives.

Victim fatigue

4.21 Over time Nicole appeared to conclude that engaging with professionals, particularly professionals from the criminal justice system, was unlikely to improve her situation and may actually worsen her circumstances. Although Nicole continued to report some incidents, particularly when in crisis, she appeared particularly reluctant to support a prosecution. As a victim of long term, significant, domestic abuse including many facets of controlling and coercive behaviour, Nicole appeared to have largely given up hope that her life could be improved.

4.22 It is recommended that Pennine Lancashire Community Safety Partnership reflects on this finding and considers what action to take. It may be that consulting with services which support victims and with victim's themselves may shed further light on how agencies could relate more effectively to victims who have experienced long term domestic abuse.

Recommendation 7

That Pennine Lancashire Community Safety Partnership reflects on this finding and considers what action to take. It may be that consulting with services which support victims and with victim's themselves may shed further light on how agencies could relate more effectively to victims who have experienced long term domestic abuse.

The interface between MARAC and Primary Care

4.23 MARAC clearly expressed the approach to be adopted by partner agencies, particularly health services given the risks to which Nicole was exposed. Every effort was to be made to

engage with her in-person. Translating this desired approach into action proved challenging, however. After Nicole's GP practice received feedback from the February 2020 MARAC, a note was placed in her GP records to encourage engagement with services but the expected flags were not placed on her records. Nicole's GP practice later wrote to her to warn her that she was at risk of being removed from the GP practice if she continued to miss appointments which was not consistent with the approach advocated by MARAC. When Nicole's GP practice received feedback from the October 2021 MARAC requesting that they offer her an appointment should any opportunity to engage arise, the GP practice took no action in response to the MARAC action. No note was placed on their system to highlight the MARAC request nor were any active attempts made to contact Nicole. It is not known whether this was a particular issue relating to Nicole's GP practice or whether this is an indication of a wider concern.

4.24 Additionally, MARAC did not always receive relevant information from Nicole's GP practice when requested. For example in July 2022 Nicole's GP received a MARAC information request in relation to a forthcoming MARAC meeting but there is no indication that the form was completed or returned. It is therefore recommended that the Community Safety Partnership request the Lancashire and South Cumbria Integrated Care Board to provide or refresh guidance to GP practices on how to manage MARAC actions and requests for information.

Recommendation 8

That Pennine Lancashire Community Safety Partnership requests the Lancashire and South Cumbria Integrated Care Board to provide or refresh guidance to GP practices on how to manage MARAC actions and requests for information.

Managing the risk presented by the perpetrator to future partners.

4.25 It has only been possible to conduct DHRs when a victim of domestic abuse apparently takes their own life for a relatively short period of time (the Home Office DHR guidance was amended to allow DHRs in such circumstances in December 2016). However, the number of 'suicide DHRs' completed has steadily grown and so there is now quite a sizeable known cohort of perpetrators of domestic abuse whose partners or ex-partners have taken their own life.

4.26 Craig is one such perpetrator. His previous convictions primarily relate to offences of dishonesty. He has been charged with several offences of violence against former intimate

partners but none of these prosecutions succeeded partly because his former partners declined to support a prosecution. There are also two documented breaches of restraining orders in respect of a former partner. However, as a result of this DHR a great deal is now known about Craig as a perpetrator of domestic abuse based not only on the substantial disclosures made by Nicole but also the detailed documentation by ward staff of his conduct towards Nicole whilst she was a patient in the Harbour Hospital.

4.27 The question arises of what action should be taken to manage the risks that this cohort of domestic abusers present. In DHR's in which there is a homicide the perpetrators invariably receive a sentence of life imprisonment. In the case of the 'suicide DHR' perpetrators they are free to move on to other relationships which may expose their future partners to risks similar to those experienced by Nicole. The DHR has been advised that it would be possible to refer Craig to MAPPA although a minimum of two agencies would need to support such a referral. Discussions have been initiated with the Lancashire MAPPA co-ordinator in order to think through the merits of a MAPPA referral and the level of public protection such a referral could achieve. The issue of what should be done to manage the risks which the cohort of 'DHR suicide' perpetrators may present to future intimate partners may need to be further considered by the Pennine Lancashire Community Safety Partnership. In another local DHR the perpetrator has been encouraged to access a perpetrator support programme. This option could not be discussed with Craig as he did not contribute to the DHR. Another option is to consider referring Craig to the MATAC (Multi-Agency Tasking and Co-ordination) protocol – which assesses and plans a bespoke set of interventions to target and disrupt serial perpetrators and/or support them to address their behaviour. The MATAC protocol has been, or is in the process of being, implemented in several Police Force areas. It is not known if Lancashire Constabulary plan to implement MATAC. Pennine Lancashire Community Safety Partnership may wish to reflect on how best to consider addressing the risks to future partners of 'suicide' DHR perpetrators such as Craig.

Disruption of perpetrators

4.28 Efforts were made to disrupt Craig as a perpetrator of domestic abuse by positive action to arrest him, remand him in prison custody, the use of a DVPO and the development of domestic abuse trigger plans. These disruption efforts were successful only in the short to medium term and never changed the overall dynamic. The DHR has been made aware of the piloting of the DRIVE model - in which case workers, liaising closely with local Police and support agencies, deploy a two-pronged disruption approach through the criminal justice system and/or support for unresolved personal issues to stop the domestic abuse - in the Bay and Fylde/Wyre areas of

Lancashire during 2023. Pennine Community Safety Partnership may wish to consider introducing a wider range of perpetrator interventions including disruptions.

Flagging perpetrators by GPs

4.29 The related issue of flagging of domestic abuse perpetrators has been discussed by the DHR Panel. As previously stated, Craig's GP practice did not flag him as an alleged perpetrator until quite late in this sequence of events despite his domestic abuse history with Nicole and other former partners. The guidance for GP practices in respect of flagging partners is set out in Paragraphs 6.107 and 6.108. It is suggested the Pennine Lancashire Community Safety Partnership simply notes the issue at the current time.

Investigation of apparent suicides following domestic abuse

4.30 Lancashire Constabulary have shared their revised guidance on this issue but the learning from this DHR suggests there may be a need to further review the guidance to ensure they consider the evidence which may need to be preserved where the victim survives the initial incident but dies a relatively short time later – in this case the blood samples obtained from Nicole following her hospital admission. It is suggested that Lancashire Constabulary considers a single agency recommendation in respect of this issue. Lancashire Constabulary are considering this issue.

Non-Fatal Strangulation

4.31 Nicole disclosed non-fatal strangulation on several occasions. Since June 2022 this has been an offence under Section 70 of the Domestic Abuse Act 2021. The DHR Panel has been advised of the Non- Fatal Strangulation and Suffocation Training offered by the Joint Partnership Business Unit which is aimed at front line practitioners and managers from both adults and children's services across Blackburn with Darwen, Blackpool and Lancashire.

Good practice

4.32 Overall, this was a very challenging case and there was much diligent, purposeful, person centred and compassionate work by professionals from a range of agencies.

HARV and the police worked very effectively together (in Phase 1) in an effort to safeguard Nicole.

The efforts of the CPS to mount an evidence-led prosecution of Craig were impressive.

Partner agencies worked very effectively together to assess and manage the risks to the 'unborn child' when Nicole fabricated a pregnancy in order to protect herself from domestic abuse from Craig.

The Lancashire Constabulary High Risk Trigger Plan was a valuable addition to the methods used by professionals in an effort to safeguard Nicole.

Five Lancashire Constabulary officers won a National Police Bravery Award in 2023 for their efforts to save Nicole's life on 21st July 2022. The officers had to jump over a 10 foot wall into the river below in order to rescue Nicole and perform CPR. They were then assisted by the Fire and Rescue Service who lowered an aerial platform into the river onto which Nicole was placed in order to raise her over the wall and allow her transfer to a waiting ambulance.

5.0 Conclusion

5.1 Nicole's relationship with Craig began in 2017. Nicole made disclosures of significant domestic abuse including coercive and controlling behaviour to the police and HARV in 2019 who attempted to support Nicole to leave her relationship with Craig. The domestic abuse she was experiencing appeared to be adversely affecting Nicole's mental health and she was hospitalised following an overdose of Craig's prescribed medication and later briefly admitted to hospital under the Mental Health Act. The two of her seven children who remained with Nicole permanently left her care.

5.2 Her relationship with Craig continued and after Nicole disclosed a physical assault by Craig a DVPO provided a breathing space for a time although it proved challenging to support and encourage Nicole to access a refuge. Nicole's reluctance to access, or remain very long, in refuges is a recurring theme although it is suspected that Craig frequently influenced her decisions to leave refuges through economic abuse and making threats to harm her children. With hindsight Nicole's fear that Craig could harm her children appears to have been a much

more significant factor in Craig's control over Nicole than professionals became aware of at the time.

5.3 Strenuous efforts were made to initiate evidence-led prosecutions when Nicole disclosed assaults by Craig and positive action taken to arrest him, following which he spent periods on remand which again provided partner agencies with further breathing space to support Nicole to leave Craig. However, Nicole was reluctant to support prosecutions and when she did so initially, she subsequently withdrew support. She appears to have come under so much pressure from Craig and/or his family members at these times that she eventually became very reluctant to support prosecutions. Agencies also became concerned that interventions they made in attempt to safeguard Nicole could inadvertently put her at increased risk of abuse from Craig.

5.4 From late 2020 throughout much of 2021 Nicole falsely claimed to be pregnant having undergone a sterilisation procedure several years earlier – which agencies were unable to confirm initially. Effective multi-agency work was undertaken to safeguard the apparent unborn child until Nicole subsequently disclosed that she had fabricated the pregnancy in the hope that it would reduce physical abuse from Craig. The abuse experienced in her relationship with Craig appeared to take a heavy toll on her mental health and Nicole was again admitted to hospital under the Mental Health Act in June 2022. Craig continued to exert coercive and controlling behaviour when visiting or telephoning her during this admission. Nicole was discharged to a refuge but experienced similar difficulties in settling in the refuge as had been the case when she had accessed refuge provision previously. Craig appeared to undermine Nicole's resolve to remain in the refuge and she was reported missing from the refuge on several occasions. During one of these missing episodes Nicole hung herself in a public place after spending time in Craig's company. She subsequently died in hospital.

6.0 Lessons to be learnt and recommendations.

Response to evidence of controlling and coercive behaviour

Recommendation 1

That Pennine Lancashire Community Safety Partnership promotes greater professional attention to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. The Partnership may also wish to consider requesting relevant partners to devise a tool to help professionals analyse controlling and

coercive behaviour based on the 'types' of controlling and coercive behaviour set out in the Domestic Abuse Act 2021 Statutory Guidance.

Tackling economic abuse

Recommendation 2

That when they disseminate the learning from this DHR, Pennine Lancashire Community Safety Partnership highlight the importance of action to support victims of domestic abuse to regain control of their finances when leaving an abusive relationship and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.

Mental Capacity

Recommendation 3

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to advise on the steps it plans to take, or has already taken, to ensure that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour are at the foundation of clinical decision making for people experiencing domestic abuse.

Fabricated pregnancy

Recommendation 4

That Pennine Lancashire Community Safety Partnership shares the learning in respect of fabricated pregnancy with both the local Safeguarding Children Partnership and Safeguarding Adults Board and that when the Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted to professionals.

Nicole's MHA admission to the Harbour Hospital

Recommendation 5

That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to work with relevant partner agencies to develop a robust approach to multi-disciplinary discharge from hospital of patients at risk from domestic abuse which ensures that discharge planning is informed by the patient's history that the discharge plan is comprehensive and addresses reasonable contingencies.

Suicide of victims of domestic abuse.

Recommendation 6

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Council Public Health so that the learning from this review, in particular the corrosive impact of prolonged controlling and coercive behaviour on a victim's mental health and the increasing evidence of a link between domestic abuse and suicide, can inform future suicide prevention plans.

The need for escalation when the 'whole system' for safeguarding victims of domestic abuse is unable to improve the situation for a victim.

It may be useful to advise MARAC chairs that repeat referrals could be an indication that the system may not be working for an individual victim and may therefore present an opportunity to challenge partner agencies to review the action they had taken and consider alternatives.

Victim fatigue

Recommendation 7

That Pennine Lancashire Community Safety Partnership reflects on this finding and considers what action to take. It may be that consulting with services which support victims and with

victim's themselves may shed further light on how agencies could relate more effectively to victims who have experienced long term domestic abuse.

The interface between MARAC and Primary Care

Recommendation 8

That Pennine Lancashire Community Safety Partnership requests the Lancashire and South Cumbria Integrated Care Board to provide or refresh guidance to GP practices on how to manage MARAC actions and requests for information.

Managing the risk presented by the perpetrator to future partners.

Pennine Lancashire Community Safety Partnership may wish to reflect on how best to consider addressing the risks to future partners of 'suicide' DHR perpetrators such as Craig.

APPENDIX C - SINGLE AGENCY ACTION PLANS:

Organisation	**Safenet**							
Actions	**Lead Agency**	**Responsible Lead**	**Key Actions / Intended Outcomes**	**Evidence**	**Key Outcomes Achieved**	**RAG**	**Target Date/ Completion Date**	**Progress/ Completed**
Completion of DASH & MARAC forms *– staff to receive more training on process & how to complete forms* ***Actions from DASH to inform Safety Planning*** *– additional training needed so that Safety Plan reflects severity, frequency & factors indicated on DASH*	Head of Services at Safenet SafeNet Training & Development Officer	Alex Atkinson, Head Of services Karen Bailey, SafeNet Training & Development Officer	• Training on completion & purpose of DASH & risk • Training on MARAC process • Training on completing a Safety Plan to include how Safety Plan reflects information on DASH. Safety Plan submitted on OASIS is not substantial enough for the level of risk.	• SafeNet case management system OASIS shows that the DASH was not to standard (date, staff , signature, actions not fully completed) • DASH states that there is no risk to the children (Lancaster Refuge) • No evidence of a MARAC form despite it being cited that there was grounds to refer	• Staff better equipped to carry out these tasks and as a result with survivors receive safer outcomes & better support • More joined up support with partners via MARAC also enhances safety of the victim-survivor		Periodic case audits to look at quality of safety planning tools Ongoing for 6 months period by Service Manger	Completed Mandatory Training for new employee and refresher training for existing staff.
Medical support *– to be discussed in teams' importance of professional curiosity. To develop as a short training session with examples from practice*	SafeNet Area Service Lead team SafeNet Training & Development Officer	SafeNet Area Service Lead team Karen Bailey, SafeNet Training & Development Officer	Staff to offer support when identify that there is an injury.	20th July Nicole returned to Jane's Place Refuge & staff recorded self-injury to her neck. This was disclosed this to staff. No medical support offered	Survivors to receive key services at an appropriate time.		Monitored via safeguarding incident reports These are reviewed by managers Add medical intervention section in Safeguarding Practitioner training By Next roll out of training October 2023	Completed Examples added to training programme

CHILDREN *– Nicole perceived at risk her partner*	Head of Services at Safenet	Alex Atkinson, Head Of services	To assess the effectiveness of processes in place regarding actioning information relating to risk of children not in mother's care	It is documented a number of times that Nicole was returning to her partner due to the fear that her children were at risk. Not documented what course of action SafeNet took regarding this risk.	• Action to reflect survivor's fear & perceived risk • Better record keeping		Team specific – will explore directly with team supported by manager With immediate effect	Completed – Ongoing discussions, professional curiosity
CIVIL REMEDIES *– What was the offer of Civil legal support to Nicole and did it reflect level of risk*	SafeNet Training & Development Officer SafeNet Area Service Lead team	Karen Bailey, SafeNet Training & Development Officer SafeNet Area Service Lead team	Staff training on civil remedies for DA survivors	No record of Nicole being offered Civil Legal Remedies at JPRR. However, this was difficult as high number of Missing Persons	Civil remedies can assist safety of survivors and form part of a safety plan.		Audit when looking at safety planning resource tools Ongoing for 6 months period by Service Manger	Completed – Included in more depth in Safety Planning Training Manager regular reviews and supports best practice

Organisation	Lancashire Children's Social Care							
Actions	Lead Agency	Responsible Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	RAG	Target Date/ Completion Date	Progress/ Completed
Children's Social Care and enhanced midwifery teams to have better communication about potential pregnancies where the unborn child will require safeguarding (Multi-agency recommendation)	CSC / ICB	Team managers CSC / Catherine Walton	Local teams to have regular communication with midwifery services	6 weekly safeguarding collaboration meetings are now held between CSC, MASH, EDT, Named nurse for midwifery ELHT, 0-19, HCRG and EMT. This meeting has a term of reference, action plan and minutes.	Vulnerable pregnancies now discussed in all services. Themes and trends shared to develop action plans and coordinated working.		July 2024	Completed
	ELHT	Catherine Walton	The ELHT have now appointed a named midwife for safeguarding – full time, This means that there is lead responsible for engaging and coordinating midwifery and safeguarding matters. The role ensures that if safeguarding concerns raised in pregnancy there can be 'deep dives' on files, alerts placed on records, coordinated work across safeguarding services.	As of April 2024 – Catherine Walton now in post. The role has been developed to work in partnership with safeguarding.	ELHT have now appointed a named nurse for midwifery			

Organisation	Lancashire and South Cumbria NHS Foundation Trust							
Actions	Lead Agency	Responsible Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	RAG	Target Date/ Completion Date	Progress/ Completed
Stevenson Ward team to improve their knowledge and understanding of current procedure and policy to support those experiencing domestic abuse. This includes the requirement for routine enquiry and understanding of the DASH assessment.	LSCFT	Jo Morrison/ Laura Holt	All RN to undertake Safeguarding Level 3 training. Routine Enquiry incorporating DASH training to be completed by RNs. Routine enquiry advice and how to record on RiO (available on Trust intranet) to be shared with nursing team and displayed in clinical area. Safeguarding supervisions to be established. Safeguarding Champions to be established. Safeguarding Practitioners to support Fact Find processes. Circulation of current Safeguarding Children and Adults Policy and Procedure.	Safeguarding level 3 training for Stevenson standing at 66.67% (4 staff have become non-compliance during August/September, which would have been 100% compliance. For the Harbour wide, this compliance stands at 79.12%. Routine enquiry incorporating DASH training compliance completed with the RN's in position at the time. Safeguarding supervisions are held monthly via MS Team. Two staff Safeguarding champions have been embedded on Stevenson. The Champions attend monthly safeguarding supervisions, accessing resources and training opportunities. Safeguarding attendance at Fact Find's is now routine practice. Safeguarding Children and Adults Policy and Procedure SG007, live and accessible via intranet and paper documentation. Update on 23/01/25: that Stevenson Ward are compliant with Safeguarding Level 3 training. The compliance is now 81.25%. Safeguarding supervision is in place and The Harbour had a safeguarding week of action in August 2024 to raise awareness of routine enquiry and understanding of the DASH assessment. Fact find processes now have safeguarding practitioners embedded in to them and this is regularly monitored.	Raised staff awareness and understanding of policy and procedures to support abuse. Improved awareness and understanding of routine enquiry into domestic abuse and DASH assessment. This will reduce risk of missed opportunities discuss impact of domestic abuse and therefore improve access to support for individuals.		Completed on 23/01/25.	Ongoing

As the ward team did not complete a number of tasks identified via expert advice or CPA meetings (capacity assessment, HSNAs, children's safeguarding, referral to CMHT, initial care plan), Stevenson Ward is recommended to identify processes to ensure that actions that are agreed as required by the wider MDT are effectively handed over and completed in a timely manner.	LSCFT	Jo Morrison/Laura Holt	Daily Safety Huddles to be embedded with consistent MDT attendance and MDT decision making. Use of a ward based diary for communication from MDT and planned work to be followed from.	Daily MDT Safety Huddles have been embedded in practice, held Monday to Friday. Daily safety huddles have been audited by the Network Medical Director in Q3 24/25. A Trust wide template for the safety huddle has been agreed and embedded in to practice. Ward diary in use. MDT actions are written into the diary for the ward teams awareness and actioning.			Completed on 23/01/2025	Ongoing

All patients admitted to the Stevenson Ward to have regular one-to-one time with either their primary nurse or named nurse for the shift.	LSCFT	Jo Morrison/Laura Holt	Regular named nurse 1:1s to be implemented. Consistent completion of the Inpatient Safety Matrix (ISM).	Primary Nurse 1:1 audits are completed weekly by the Ward Manager. ISM completed monthly by peer reviewers. Record keeping forms one element of this audit, with 1:1 frequency and quality being reviewed. Update on 23/01/25: The Inpatient Safety Matrix is embedded and in December 2024 there was consistent improvement. Stevenson Ward have a pilot programme that is run in collaboration between psychology and nursing staff. The programme includes group sessions and 6 1-1 sessions for individuals engaged in it.	Patients will feel better supported, listened to and involved in their care and treatment.		Completed on 23/01/2025	Ongoing
The Trust should ensure there is adequate support and safeguarding supervision in place for clinical teams dealing with complex cases of domestic abuse.	LSCFT	Jo Morrison / Laura Holt	Each Network within LSCFT is now assigned a designated safeguarding lead who facilitates and supports 1:1 and team level supervision in respect of complex cases and domestic abuse.	Monthly review of incidents, feedback and be-spoke supervisions reviewed by DON and DDON and reported into the trust wide safeguarding group via exception report. Update on 23/01/25: The Network has embedded a weekly Safety Incident Review Panel and has strengthened governance processes from ward to Network triumvirate. These strengthened processes have enabled the Network leadership team to provide increased support and supervision with specific teams.	Staff are adequate support and supervision in respect of complex cases and emerging safeguarding issues especially those involving domestic abuse.		Completed on 23/01/25.	Ongoing
LSCFT Safeguarding Team to explore alternative IT options for the recording of advice that is provided to practitioners contacting the team via duty that can be linked to the	LSCFT	Jo Morrison/Laura Holt	Review of IT systems currently in use across LSCFT. All staff regardless of whether using the system will have read only access to Rio. All safeguarding contacts are now recorded into Rio for all staff to access. Safeguarding practitioner will records live information	The Safeguarding management team meet weekly to discuss and review incident data and duty data, This allows for opportunity to identify themes trends and any areas of learning that need to be embedded. This data id also taken to the Networks Serious Incident Review Panels each week, to ensure the Networks are updated.	Quality if information/advice and consultancy offered to staff Timely response Consistency in record keeping that is available to all staff to access			Ongoing

clinical records of service users.			and recommended actions into patient records. The Duty system has also been reviewed with callers connecting straight to a practitioner rather than admin to allow for real time problem solving and timely response		Data collection and learning identified to support future best practice.			
Enhanced risk assessments are updated when patients are not deemed appropriate for home treatment at the 48hr follow up.	LSCFT	Jo Morrison/Laura Holt	Standard operating procedure for Home based treatment team updated and includes process for completion of discharge form service including risk assessment. Policy dated 16/5/2024.	HBTT currently working towards National Accreditation. Urgent care safety matrix was developed and is now embedded. This is a monthly audit that looks at all aspects of quality in relation to care delivery, including risk assessments. Update on 23/01/25: Current compliance with Enhanced Risk Assessments for HBTT is above 86%. The Fylde HBTT is currently under a weekly improvement group chaired by the Director of Nursing in the Network. HBTT continue to work towards the National Accreditation Standards. The Urgent Care Safety Matrix is embedded and overseen by the Senior Nurse Manager for Community. This is a new role to support improvement and quality.	To embed improvements in HBTT care delivery and maintain consistency with National standards. Monitoring and oversight of the quality of clinical documentation within HBTT.			Ongoing

The trust to amend the current inpatient Standard operating procedure to include clear guidance around visitors to inpatient wards who may pose risk to patients or staff.	LSCFT	Jo Morrison/Laura Holt	Standard operating procedure including guidance around visitors last updated on the 11/7/2024 and includes details around safety and security and procedure for dealing with visitors who may pose risk.	The Trust has strengthened the Standard Operating procedure for Inpatient Services to include information on visitors and how to manage risk relating to visitors. The Trust is embedding Triangle of Care which is a framework for services to follow specifically relating to involvement of families and carers. Stevenson Ward has completed the 1st stage of Triangle of Care.	Families and carers to feel involved in the care of their loved ones. Staff to feel confident in risk assessing visitors for service users who are inpatients. Staff have a process to follow on occasions that they feel visits are not therapeutic and present risk.		Completed on 23/01/2025	Ongoing
This report and the learning is to be shared with the ward staff who should review the lessons learned. The learning on a page should be distributed Trust-wide within the Patient Safety Bulletin.	LSCFT	Jo Morrison/Laura Holt	Ward staff attended a meeting on the 8/3/2023. The meeting was attended in person by the MDT and a number of staff were also present on MS teams.	Stevenson Ward staff have engage in a meeting in which the lessons learned from this case were shared. The Trust has featured themes relating to domestic abuse in two Trust Wide Lessons Learned forums. In December 2021 over 150 staff attended and in June 2022 over 180 staff attended. Partners from the third sector were in attendance at both Learning Lessons forums and worked in partnership to understand themes. The learning on a page was distributed across the Trust within a patient safety bulletin.	For learning to be shared with the team on Stevenson and wider across the Trust. This will hopefully reduce the risk of the same learning being identified in future serious incident reviews.		Completed on 23/01/2025	Ongoing

Organisation	East Lancashire Hospitals NHS Foundation Trust							
Recommendations	Lead Agency	Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	RAG	Target Date/ Completion Date	Progress/ Completed
Continued promotion of 'routine enquiry' regarding DVA in all ELHT services – this is well embedded in midwifery services.	ELHT	Hospital IDVA	Community and Intermediate care staff have now had training on routine enquiry. Pathways now in place for management and escalation of DVA disclosures. Routine enquiry is embedded in ED and continuous promotion through mandatory safeguarding training. All Band 5 (and above) registered staff have enhanced DVA training via Level 3 Adult Safeguarding training every 3 years. All Trust staff access DVA training via Level 1 or Level 2 eLearning depending on role. Training highlights the importance of routine enquiry in all service areas. Posters in key areas	Audit activity has demonstrated strong compliance with routine enquiry. Staff are reporting via feedback that they feel more empowered to ask questions and are feeling they have been upskilled to know the pathways if there is a disclosure of domestic abuse. There has been an increase in domestic abuse being reported for staff and patients, we have seen an increase in referrals into IDVA service for timely support for victims/survivors.	Routine enquiry well embedded in many areas of the Trust and working towards Trust wide. Adult level 3 training now mandatory for all B5 and above registered staff. Level 1&2 training mandated for all staff. Intermediate care staff trained and pathways embedded. Upskilled and empowered workforce.		*March 2024*	Complete

Continued development of stronger links and implementation of DVA referral pathway with breast care service.	ELHT	Hospital IDVA/ ISVA	Macmillan Toolkit at ELHT rollout is in the calendar for September with cancer care staff to look how we implement and embed the toolkit – Link in with service leads within the breast care service and how we further embed referral pathways Referral pathway to be included in DVA policy which is currently under review.	Meeting with cancer care staff and Faye Bennett from NHS LANCASHIRE and South Cumbria Care Board In the process of arranging the meeting with breast care leads to look at pathways and how this can be strengthened IDVA based at Burnley Hospital (base for breast care) to ensure that disclosures of DVA are addressed in a timely way	Pathway in place.		Jan 2025	Ongoing
Continued promotion of DVA pathway created with ED.	ELHT	Safeguarding Team	Safeguarding practitioners attend the daily morning meeting in ED where high-risk patients including those experiencing DVA are discussed. This has strengthened links with the nursing staff, matrons and managers Timely referrals from ED to IDVA & safeguarding services.	Referrals are actioned in a timely manner. Better communication and effective working relationships have been forged.	Yes ED pathways working effectively Timely interventions and improved outcomes for patients experiencing DVA		March 2024	Yes
Mandatory DVA and SV training commenced in January 2022 – training to highlight cases such as this where there were potential 'missed opportunities' to enquire about DVA and escalate concerns.	ELHT	Safeguarding Team	All staff complete training on induction via our learning hub, staff band 5 and above completed adult level 3 training, this is now embedded, and we have further rolled out some extra sessions for staff.	Compliance for staff band 5 and above compliance is now at 80% with the aim to reach 90% (trust target by dec 24) this will ensure ELHT is compliant with mandatory training	Yes – training mandated. Compliance levels increasing and will be compliant by December 2024 Jan 2025 – update – training compliance now at 84% and static – plan in place to achieve 90% by July 2025		July 2025	Ongoing

Safeguarding Team, Hospital IDVA & ISVA to have a greater presence in ED and UCC's – weekly drop-ins/supervision sessions to commence January 2023.	Hospital IDVA /ISVA	HIDVA – ISVA	We are now attending Mon-Fri in ED for the 9am safety meeting and have cases handed over which we can then action. Concerns raised by staff discussed with other key services such as mental health and alcohol services Supervision sessions with ED held on a regular basis facilitated by safeguarding practitioners Better links with nurse in charge and ED Managers	ED referrals have increased Greater communication pathways Effective working relationships	Stronger working relationships Staff being upskilled Timely referrals and concerns being addressed			Complete
DNA appointments – to be looked at for policy review.	Named professional for safeguarding		High risk MARRAC cases are flagged on our electronic patients' records. This alerts member of staff to DVA – key concerns, risks, and actions are all documented Domestic abuse policy is under review, and this will be included into that policy.	DVA policy under review and will include guidance around DVA victims not attending appointments This will be reflected in the domestic abuse policy High risk victims and children flagged on electronic patient records	Appropriate escalation and identification when a known DVA victim haven't attended appointment – what to do if there are immediate concerns Training package under review to include more case scenarios		Mar 25	Ongoing
Audit of SR to be completed within the next 12 months – special concern is who has access to the SR and how visible is it	ELHT		We now have electronic patient records – there is an alert system on that record which is visible to all staff who access that record, Marrac/Marac patients are flagged for 12 months along with their children. Concerns are shared via documentation and staff can see who is involved in case and key concerns and actions Level 3 safeguarding training specifically mentions the flag system	Cerner has been in place since June 23 and staff are now aware of flags and can clearly see concerns Notes added to badgernet for midwifery patients	Flags are visible to all staff on the patient record. Key concerns, risk assessment and support plans are documented in patient notes – accessible and visible.			Complete

Organisation	Lancashire & South Cumbria ICB (Primary Care)							
Actions	Lead Agency	Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	R A G	Target Date/ Completion Date	Progress/ Completed
To ensure complete transfer of patient records upon registration	Lancashire & South Cumbria ICB (Primary Care)	Nikki Carter	To explore with primary care providers and NHS England, the transfer of records process at safeguarding assurance visit. Further actions to be identified if appropriate following assurance visit or potential recommendation to the national team. Bespoke debrief with primary care providers in relation to the findings of this IMR/DHR.	Transfer of records process. Safeguarding assurance visit	Assurance that complete records are transferred between primary care providers upon transfer of patients.		April 24	Completed
To ensure that primary care providers have the correct knowledge, skills and are implementing best practice policies to effectively share information to improve safeguarding practice.	Lancashire & South Cumbria ICB (Primary Care)	Nikki Carter	Ensure safeguarding training compliance. Safeguarding assurance visit. Exploration of safeguarding policies in use. Bespoke debrief with primary care providers in relation to the findings of this IMR/DHR. Pan Lancs GP DA Sample Policy.pdf	Safeguarding assurance framework completion by primary care providers. Safeguarding assurance visit. (Practice B and C) Safeguarding assurance visits completed with all 3 practices involved in the DHR including a presentation to share the findings of the IMR and DHR – To be cascaded to wider practice staff. Reflective discussion with practices regarding - Safeguarding Policies are available on the practice shared drive and GP Teamnet. Staff are alerted to any new or updated policies on GP Teamnet.	Information will be shared appropriately to inform safeguarding. Best practice shared and discussed during assurance visit which led to greater understanding of processes re sharing information and transfer of patient records		April 24	Completed

				Policies include. Safeguarding adults, Domestic Abuse and Sharing of Information guidance including 7 Key points of Information sharing. Practice Manager (B) and admin staff report that SG information is reviewed and scanned within 1 hour of receipt. Guidance is followed for protection of sensitive information on patients' records. Supporting documents shared with practices including: - 7-minute briefing on Coercive control 7-minute briefing on Professional Curiosity DA Guidance for SAB DA flyer for GPs DA guidance for GPs from safe lives. Emis Web - Recording of Domestic Abuse and MARAC information on Electronic Medical Records (EMR) Practices were provided with Guidance on Information Sharing – Advice for practitioners providing safeguarding services to children, young people, parents, and carers. All practices shared their safeguarding training matrix DA and appraisal documentation that includes discussion around safeguarding duties and responsibilities. Practice (B) shared their safeguarding handbook including Domestic Abuse				

To ensure staff are aware of the importance of consistent professional curiosity including the use of routine enquiry for domestic abuse.	Lancashire & South Cumbria ICB (Primary Care)	Nikki Carter	Ensure domestic abuse policy is robustly implemented by undertaking safeguarding assurance visit. Bespoke debrief with primary care providers in relation to the findings of this IMR/DHR. 7MB_Covid-19ProfessionalCuriosity_2020. Domestic Abuse Ask Flyer.docx 7MB_CoerciveControl_2023.pdf	Safeguarding assurance framework completion by primary care providers. Safeguarding assurance visit. (Practice B and C) Safeguarding assurance visits completed with all 3 practices involved in the DHR including a presentation to share the findings of the IMR and DHR – To be cascaded to wider practice staff. Practice Manager (W) re affirmed that the DA policy provided by the ICB was in use and all staff aware of the policy and how to access it for support their safeguarding training matrix DA and appraisal documentation that includes discussion around safeguarding duties and responsibilities. The practice SG Lead has recently attended further training on DA and will be cascading the training to all practice staff. Reflective discussion with practices regarding - Good Practice – (W) practice reported that they have good communication and relationship with the local refuge. A member of the practice liaises with the refuge monthly and the refuge will email with detail of any new ladies staying there that need temporary registration. Good Practice – (W) Practice offers an enhanced service for ladies who are staying at the refuge. Prompt appts etc. The practice (W) is updating their registration questionnaire for ladies at the refuge. The questionnaire asks relevant questions for ladies who are victims of DA that may need specific support with health needs. All practices discuss any safeguarding concerns during fortnightly clinical meetings. Supporting documents shared with practices including: -	Appropriate implementation of domestic abuse policy and the use of routine enquiry		April 24	Completed

				7-minute briefing on Coercive control 7-minute briefing on Professional Curiosity DA Guidance for SAB DA flyer for GPs DA guidance for GPs from safe lives Emis Web - Recording of Domestic Abuse and MARAC information on Electronic Medical Records (EMR) Practice (B) shared and guidance. All practices shared their safeguarding handbook including Domestic Abuse				

Organisation	**Lancashire Constabulary**							
Actions	**Lead Agency**	**Responsible Lead**	**Key Actions / Intended Outcomes**	**Evidence**	**Key Outcomes Achieved**	**RAG**	**Target Date/ Completion Date**	**Progress/ Completed**
Silo Consideration – Lancashire Constabulary dealt with numerous cases of domestic abuse and reported coercive and controlling behaviour by Craig. One of the aspects in most of Nicole's reported incidents is the fact that Nicole often was unsupportive of any criminal proceedings. Consideration could / should have been given to linking cases to provide evidence to support the potential for evidence led prosecution of Craig could linking incidents have strengthened evidence-led prosecution. Would a specialist DA investigator have helped.	Lancashire Constabulary	Detective Chief Superintendent (Head of HQ Vulnerability Governance Unit)	To ensure that officers attending incidents of domestic abuse and coercive and controlling behaviour consider previous and historic incidents of DA between the victim and perpetrator and link the incidents to support evidence in cases of DA and coercive controlling behaviour.	This action is delivered as part of the DA Matters Training delivered to all front-line officers and staff within Lancashire Constabulary. Linked cases could provide evidence to support evidence led prosecutions This case was subject to a review by a Detective Chief Inspector, and it was concluded that there was insufficient evidence to support a prosecution by linking historic cases together prior to the suicide of the victim.	Officers in attendance at domestic incidents consider historic incidents of domestic abuse against the victim. This can lead to successful evidence led prosecutions.		Completed 16/09/2024	Completed

Evidence Led Prosecution – Information contained in one of the investigations suggest consideration was given to evidence led prosecution approach, however, there are other investigations where this consideration should also have been made.	Lancashire Constabulary	Detective Chief Superintendent (Head of HQ Vulnerability Governance Unit)	To consider evidence led prosecution following an incident of domestic abuse whereby a victim is unsupportive of an investigation.	In the event a victim of domestic abuse does not provide a witness statement in support of a prosecution an investigating officer in all cases of domestic abuse will complete an Evidence Led Prosecution Checklist to consider if a series of yes replies should prompt the investigating officer and reviewing supervisor to consider if there is a realistic prospect of conviction based on all available evidence and whether to refer the case to the Crown Prosecution Service (CPS) to consider charge(es).	Lancashire Constabulary Police Officers and Staff consider all evidence in respect of the perpetrator when attending incidents of domestic abuse, discuss the evidence with reviewing officers to ascertain if evidence to support a submission of the case to the CPS for consideration of charges.		Completed 16/09/2024	Completed
Victim Lack of Support – In numerous cases Nicole declined to support any criminal proceedings or provide any evidence at Court. How robust are police protocols at dealing with such events?	Lancashire Constabulary	Detective Chief Superintendent (Head of HQ Vulnerability Governance Unit)	To ensure that policies and protocols provide robust support to victims of domestic abuse and coercive and controlling behaviour to encourage victims to support investigations / prosecutions against perpetrators. To ensure that victims of domestic abuse are supported through Victim Support Services and other Non- Statutory bodies.	This is provided through on-going training within DA Matters.	The support of victims of DA through DA matters training will lead to successful prosecutions and better safeguarding of victims.		Completed 16/09/2024	Completed

(A discussion with the Lancashire Constabulary Development Manager with responsibility for Domestic Abuse will be held to review the three potential learning areas as identified above) (The outcome of this discussion and finalisation of single agency recommendations is awaited)	Lancashire Constabulary	Detective Chief Superintendent (Head of HQ Vulnerability Governance Unit)	The learning areas outlined above have been discussed within the Vulnerability Governance Unit of Lancashire Constabulary.	All the above learning points have been addressed through inclusion within the DA Matters Training delivered to all front-line staff across Lancashire Constabulary. The training is on-going and delivered to all new officers.	The training leads to better outcomes for victims of domestic abuse and coercive controlling behaviour.		Completed 16/09/2024	Completed

Organisation	**Lancashire Safeguarding Adult Service**							
Actions	Lead Agency	Responsible Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	RAG	Target Date/ Completion Date	Progress/ Completed
A new online Safeguarding Portal has been introduced to support professionals to refer Safeguarding Concern Information to the Safeguarding Adult Service.	Safeguarding adults service	Lisa Lloyd	This is a very simple method of professionals and providers referring into safeguarding. The portal guides the referrer and informs decision making around criteria and risk. It has been very effective since its launch.	Professionals are using the portal. Targeted development sessions have been delivered across health, police, providers, and many other professional bodies to raise awareness.	Simplified referral method easily accessible, streamline referral process. Referrers do not need to call the department alerts that meet the section 42 threshold are received and screened very quickly by a triage manager.		*January 2023*	Completed

For the Safeguarding Adult Service to continue to work with partnership agencies to provide advice in relation to when to raise a Safeguarding Adult Referral. The Safeguarding Champions Network is a key forum where joined up safeguarding approaches can be promoted. For this network to be used to promote positive changes in Safeguarding Practice.	Safeguarding adults service	Lisa Lloyd		Feedback is excellent and the sessions are well attended. Colleagues are increasingly knowledgeable and well informed. Referral numbers have significantly increased. We have undertaken joint safeguarding	Greater awareness of how to recognise safeguarding, the different types of abuse and when to refer.		December 2021	Completed
To promote face to face visits in safeguarding enquiries that relate to domestic abuse. (To be discussed in Supervision with individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).	*SGA service*	Lisa Lloyd	The safeguarding adults' procedures state that all Domestic abuse cases must have a face-to-face visit. Visiting is encouraged with all cases not just DA and reported weekly to senior managers and then gaps can be identified.	Each manager submits a weekly report to senior managers. Supervision Case audits	Reduction in risk from DA. Better understanding of risk.		December 2023	completed
To share information about the National Centre for Domestic Violence across the Safeguarding Adult Service to increase awareness of the support available for service users to seek a Civil Order that prevents contact from	SGA service	Lisa Lloyd	NCDV: Trained Safeguarding adults' staff in December 2021 This was delivered in peer groups as to encourage discussion in a	3 sessions delivered across three areas. After the sessions a learning brief was issues to all staff who were encouraged to upload as professional evidence for social work registration.	Increased understanding of NCDV		October 2021	completed

people alleged to have caused harm. (To be discussed in Supervision with Individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).			Learning Circle learning style.					
For a detailed risk assessment to be completed on the safeguarding module that includes information about a person's ability to keep safe alongside further exploration if appropriate about any mixed feelings about possible options available and the safeguarding plan. (To be discussed in Supervision with Individual safeguarding social worker and shared across the safeguarding adult service via Learning Circles).	SGA service	Lisa Lloyd	The risk assessment on the LAS module has been reviewed and revised. It is strength based and captures the ability, wishes and feelings of the individual which are reflected in the safeguarding plan.	Risk assessments and DA has been discussed in learning circles. The new form was discussed in weekly staff washups. DA cases and risk are discussion in all supervisions. C	Risk fully explored and mitigated where possible. Documents very clear.		Revised August 2023	completed
Domestic abuse training is recorded on individual safeguarding workers training logs as training that is required. For team managers to reinforce the need for safeguarding workers to attend Domestic Abuse Training and update their training logs.	SGA Service	Lisa Lloyd	All safeguarding staff complete. Safeguarding adults eLearning and formal 2-day training. DASH RIC training. DA, Stalking, and honour based formal training.	A training log is kept and regularly reviewed by staff and managers. DA is mandatory training amongst staff.	Staff have developed expertise in DA and safeguarding.		Training available and reviewed and updated December 2021 Reviewed January 2024	Completed

			DA including coercion and control.					
The Model of Enquiry is continuously under review at this time. Consideration will be given as to whether reference to gathering information from family members / significant people in their lives and involving them in discussing concerns and the safeguarding plan. (in line with service users' capacity and consent) is appropriate to update on the Model of Enquiry.	SGA	Lisa Lloyd	The model of enquiry clearly states in the procedure that information is gathered during the section 42. If we require information from wider family members where the su has capacity consent is needed. Where capacity is lacked, we always liaise with representative, family or advocate.	All staff understand the process and have management support and learning circles to discuss these complex cases	Staff have as much information as possible to undertake their role.		December 2023	Completed

In what was a complex and difficult case that included domestic abuse, mental lll health and substance misuse professionals were able to see Nicole's holistic needs and in relation to the cycle of abuse accepted that Nicole was likely to be minimising the level of risk in relation to domestic abuse. This could have enabled MDT further discussion and resulted in actions to explore with Nicole sensitively and further, risks of an ongoing cycle of domestic abuse, her options and support. For this learning to be shared across the Safeguarding Adult Service.	SGA	Lisa Lloyd	The safeguarding adults' procedures and guidance has been updated to reflect the need to consider a RAP (Risk assessment and planning meeting with the MDT in all cases of DA.) Managers discuss this in supervision and through daily discussions. RAPs have increased from single figures to 40+ per month across the service.	The minute taking service provide data on the number of RAPs per month. Managers monitor in supervisions.	Joint working has massively improved, and risk shared and mitigated between agencies		Reviewed and updated December 2023	Completed

Organisation	**Lancashire and South Cumbria NHS Foundation Trust**							
Actions	**Lead Agency**	**Responsible Lead**	**Key Actions / Intended Outcomes**	**Evidence**	**Key Outcomes Achieved**	**RAG**	**Target Date/ Completion Date**	**Progress/ Completed**
Stevenson Ward team to improve their knowledge and understanding of current procedure and policy to support those experiencing domestic abuse. This includes the requirement for	LSCFT	Jo Morrison /Laura Holt	All RN to undertake Safeguarding Level 3 training. Routine Enquiry incorporating DASH training to be completed by RNs.	Safeguarding level 3 training for Stevenson standing at 66.67% (4 staff have become non-compliance during August/September, which would have been 100% compliance. For the Harbour wide, this compliance stands at 79.12%.	Raised staff awareness and understanding of policy and procedures to support abuse. Improved awareness and understanding of routine enquiry into domestic abuse and DASH assessment.		Completed on 23/01/25.	Ongoing

routine enquiry and understanding of the DASH assessment.			Routine enquiry advice and how to record on RiO (available on Trust intranet) to be shared with nursing team and displayed in clinical area. Safeguarding supervisions to be established. Safeguarding Champions to be established. Safeguarding Practitioners to support Fact Find processes. Circulation of current Safeguarding Children and Adults Policy and Procedure.	Routine enquiry incorporating DASH training compliance completed with the RN's in position at the time. Safeguarding supervisions are held monthly via MS Team. Two staff Safeguarding champions have been embedded on Stevenson. The Champions attend monthly safeguarding supervisions, accessing resources and training opportunities. Safeguarding attendance at Fact Find's is now routine practice. Safeguarding Children and Adults Policy and Procedure SG007, live and accessible via intranet and paper documentation. Update on 23/01/25: that Stevenson Ward are compliant with Safeguarding Level 3 training. The compliance is now 81.25%. Safeguarding supervision is in place and The Harbour had a safeguarding week of action in August 2024 to raise awareness of routine enquiry and understanding of the DASH assessment. Fact find processes now have safeguarding practitioners embedded in to them and this is regularly monitored.	This will reduce risk of missed opportunities discuss impact of domestic abuse and therefore improve access to support for individuals.			

As the ward team did not complete a number of tasks identified via expert advice or CPA meetings (capacity assessment, HSNAs, children's safeguarding, referral to CMHT, initial care plan), Stevenson Ward is recommended to identify processes to ensure that actions that are agreed as required by the wider MDT are effectively handed over and completed in a timely manner.	LSCFT	Jo Morrison /Laura Holt	Daily Safety Huddles to be embedded with consistent MDT attendance and MDT decision making. Use of a ward based diary for communication from MDT and planned work to be followed from.	Daily MDT Safety Huddles have been embedded in practice, held Monday to Friday. Daily safety huddles have been audited by the Network Medical Director in Q3 24/25. A Trust wide template for the safety huddle has been agreed and embedded in to practice. Ward diary in use. MDT actions are written into the diary for the ward teams awareness and actioning.			Completed on 23/01/2025	Ongoing
All patients admitted to the Stevenson Ward to have regular one-to-one time with either their primary nurse or named nurse for the shift.	LSCFT	Jo Morrison /Laura Holt	Regular named nurse 1:1s to be implemented. Consistent completion of the Inpatient Safety Matrix (ISM).	Primary Nurse 1:1 audits are completed weekly by the Ward Manager. ISM completed monthly by peer reviewers. Record keeping forms one element of this audit, with 1:1 frequency and quality being reviewed. Update on 23/01/25: The Inpatient Safety Matrix is embedded and in December 2024 there was consistent improvement. Stevenson Ward have a pilot programme that is run in collaboration between psychology and nursing staff. The programme includes group sessions and 6 1-1 sessions for individuals engaged in it.	Patients will feel better supported, listened to and involved in their care and treatment.		Completed on 23/01/2025	Ongoing

The Trust should ensure there is adequate support and safeguarding supervision in place for clinical teams dealing with complex cases of domestic abuse.	LSCFT	Jo Morrison /Laura Holt	Each Network within LSCFT is now assigned a designated safeguarding lead who facilitates and supports 1:1 and team level supervision in respect of complex cases and domestic abuse.	Monthly review of incidents, feedback and be-spoke supervisions reviewed by DON and DDON and reported into the trust wide safeguarding group via exception report. Update on 23/01/25: The Network has embedded a weekly Safety Incident Review Panel and has strengthened governance processes from ward to Network triumvirate. These strengthened processes have enabled the Network leadership team to provide increased support and supervision with specific teams.	Staff are adequate support and supervision in respect of complex cases and emerging safeguarding issues especially those involving domestic abuse.		Completed on 23/01/25.	Ongoing
LSCFT Safeguarding Team to explore alternative IT options for the recording of advice that is provided to practitioners contacting the team via duty that can be linked to the clinical records of service users.	LSCFT	Jo Morrison /Laura Holt	Review of IT systems currently in use across LSCFT. All staff regardless of whether using the system will have read only access to Rio. All safeguarding contacts are now recorded into Rio for all staff to access. Safeguarding practitioner will records live information and recommended actions into patient records. The Duty system has also been reviewed with callers connecting straight to a practitioner rather than admin to allow for real time problem solving and timely response	The Safeguarding management team meet weekly to discuss and review incident data and duty data, This allows for opportunity to identify themes trends and any areas of learning that need to be embedded. This data id also taken to the Networks Serious Incident Review Panels each week, to ensure the Networks are updated.	Quality if information/advice and consultancy offered to staff Timely response Consistency in record keeping that is available to all staff to access Data collection and learning identified to support future best practice.			Ongoing

Enhanced risk assessments are updated when patients are not deemed appropriate for home treatment at the 48hr follow up.	LSCFT	Jo Morrison/Laura Holt	Standard operating procedure for Home based treatment team updated and includes process for completion of discharge form service including risk assessment. Policy dated 16/5/2024.	HBTT currently working towards National Accreditation. Urgent care safety matrix was developed and is now embedded. This is a monthly audit that looks at all aspects of quality in relation to care delivery, including risk assessments. Update on 23/01/25: Current compliance with Enhanced Risk Assessments for HBTT is above 86%. The Fylde HBTT is currently under a weekly improvement group chaired by the Director of Nursing in the Network. HBTT continue to work towards the National Accreditation Standards. The Urgent Care Safety Matrix is embedded and overseen by the Senior Nurse Manager for Community. This is a new role to support improvement and quality.	To embed improvements in HBTT care delivery and maintain consistency with National standards. Monitoring and oversight of the quality of clinical documentation within HBTT.			Ongoing

The trust to amend the current inpatient Standard operating procedure to include clear guidance around visitors to inpatient wards who may pose risk to patients or staff.	LSCFT	Jo Morrison/Laura Holt	Standard operating procedure including guidance around visitors last updated on the 11/7/2024 and includes details around safety and security and procedure for dealing with visitors who may pose risk.	The Trust has strengthened the Standard Operating procedure for Inpatient Services to include information on visitors and how to manage risk relating to visitors. The Trust is embedding Triangle of Care which is a framework for services to follow specifically relating to involvement of families and carers. Stevenson Ward has completed the 1st stage of Triangle of Care.	Families and carers to feel involved in the care of their loved ones. Staff to feel confident in risk assessing visitors for service users who are inpatients. Staff have a process to follow on occasions that they feel visits are not therapeutic and present risk.		Completed on 23/01/2025	Ongoing
This report and the learning is to be shared with the ward staff who should review the lessons learned. The learning on a page should be distributed Trust-wide within the Patient Safety Bulletin.	LSCFT	Jo Morrison/Laura Holt	Ward staff attended a meeting on the 8/3/2023. The meeting was attended in person by the MDT and a number of staff were also present on MS teams.	Stevenson Ward staff have engage in a meeting in which the lessons learned from this case were shared. The Trust has featured themes relating to domestic abuse in two Trust Wide Lessons Learned forums. In December 2021 over 150 staff attended and in June 2022 over 180 staff attended. Partners from the third sector were in attendance at both Learning Lessons forums and worked in partnership to understand themes. The learning on a page was distributed across the Trust within a patient safety bulletin.	For learning to be shared with the team on Stevenson and wider across the Trust. This will hopefully reduce the risk of the same learning being identified in future serious incident reviews.		Completed on 23/01/2025	Ongoing

Organisation	HARV Domestic Abuse and HARV Housing							
Actions	Lead Agency	Responsible Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	R A G	Target Date/ Completion Date	Progress/ Completed
Longer periods of joint working with refuges around the time when clients are found emergency accommodation	HH and HARV	Ashleigh	a 2 week handover	Ashleigh housing service manager has changed HARV and HH process to keep joint working for 2 weeks			Dec 2024	Completed

Organisation	MARRAC							
Actions	Lead Agency	Responsible Lead	Key Actions / Intended Outcomes	Evidence	Key Outcomes Achieved	R A G	Target Date/ Completion Date	Progress/ Completed
MARRAC chair to ensure IDVA service are involved with high risk clients (multi-agency recommendation)	Police	DI 3635 Sarah Tucker	Ensure IDVA services are notified of high risk DA victims and involved in the MARRAC process	Lancashire police have an established information sharing agreement with their commissioned service for DA (Lancashire victim Services). This process ensures that all DA crimes are automatically shared with the service. The DA crimes graded as high risk are referred to their IDVA services who assess and make contact. In addition, Lancashire Police have an establish MARRAC assessment panel which includes a representative from the IDVA service. This ensures early intervention and support being offered to victims. IDVA services are also commissioned to attend all LCC MARRACs (and to chair 50% of the meetings).	The established sharing pathway and the extensive involvement of our DA commissioned service ensures that IDVA services are involved in all high risk cases.		Dec 2024	Completed

APPENDIX D – MULTI-AGENCY RECOMMENDATIONS:

Title of DHR	DHR HB1	To be actioned	
Plan	Multi-agency Recommendations	Ongoing	
Independent author	David Mellor	Complete	
Governance arrangements	The Pennine Community Safety Partnership provides the governance arrangements for Domestic Homicide Reviews across the Pennine area. The board will oversee the recommendations to ensure effective implementation and within an appropriate timeframe.		

Recommendations	Lead Agency	Responsible Lead	Key Action/s	Evidence	Key outcomes	Overall RAG	Progress/Outcome achieved	Target date/ completion date
1) That Pennine Lancashire Community Safety Partnership promotes greater professional attention to the 'methods' used by perpetrators to exercise control and to coerce the victim in order to better inform the offer of support to the victim. The Partnership may also wish to consider requesting relevant partners to devise a tool to help professionals analyse controlling and coercive behaviour based on the 'types' of controlling and coercive behaviour set out in	Hyndburn Borough Council/ Pennine CSP	Linda McCarthy/ Lindsay Frew	The Pennine Lancashire CSP is working collaboratively with Domestic Abuse services and Safeguarding Boards across Lancashire. The learning is being incorporated into training, 7-minute briefings and disseminated through the partnership. Providing training and awareness sessions to professionals, including schools, extending reach of healthy relationships worker at HARV to include teachers and parents. Methodology via teams and face-to-face, composition of training including what is domestic abuse, coercive control and DASH risk assessment.	Coercive Control.pdf Lancashire Safeguarding Partnership - 7 Minute Briefings Devise Training package for professionals and young people Evaluation of effectiveness, case studies.	Increase awareness for professionals to recognise and support victims of coercive and controlling behaviours		Completed – further development of a DHR learning report for partners	April 2024 2025- 26

the Domestic Abuse Act 2021 Statutory Guidance.			To conduct Lunch and learn for student social workers, around risk assessment, what is a MARAC?					
2) That when they disseminate the learning from this DHR, Pennine Lancashire Community Safety Partnership highlight the importance of action to support victims of domestic abuse to regain control of their finances when leaving an abusive relationship and consider working with relevant partner agencies such as the DWP to develop practical guidance to advise professionals.	Hyndburn Borough Council/ Pennine CSP DWP	Linda McCarthy/Lindsay Frew Bharati Dwarampudi	Working with CAB in devising and developing 'manage your finances' (budget), composition consisting of debt management as part of tenancy agreement service access. Attendance of cookery and management finance course in conjunction with HARV food bank service. View to designing a recipe book for cooking on a budget. Partnership with community solutions in extending the reach with HARV service users. For HBC to link in with DWP to issue guidance debt management	Evaluation of case studies Creation of pathways Hiring chef, photographer and publisher Housing Options to develop training alongside tenancy for all residents	Completion of course Use HARV ambassador to promote the book Devise a policy regarding housing options and money management		Completed	Jan 2025 Policy target date - 2025-6
3) That Pennine Lancashire Community Safety Partnership requests Lancashire and South	LSCFT	Jo Morrison						

Cumbria NHS Foundation Trust to advise on the steps it plans to take, or has already taken, to ensure that documenting formal capacity assessments which take into account the nature of coercive and controlling behaviour are at the foundation of clinical decision making for people experiencing domestic abuse.								
4) *That Pennine Lancashire Community Safety Partnership shares the learning in respect of fabricated pregnancy with both the local Safeguarding Children Partnership and Safeguarding Adults Board and that when the Community Safety Partnership disseminates the learning from this DHR the learning in relation to fabricated pregnancy is highlighted to professionals.*	Hyndburn Borough Council/ Pennine CSP Safeguarding Boards	Linda McCarthy Medina Patel – LCC Abdul Ghiwala - BwD	The Pennine Lancashire CSP is working collaboratively with Domestic Abuse services and Safeguarding Boards across Lancashire. The learning is being incorporated into training, 7-minute briefings and disseminated through the partnership. HARV & HBC to link with relevant Public Health professionals and midwifery NHS services to develop of a program to look about CSAP progressing further	Lancashire Safeguarding Partnership - 7 Minute Briefings	Partners are aware of the heightened risk to victims during pregnancy and fabricated pregnancy needs to be incorporated		Completed – further development of a DHR learning report for partners	April 2024

5) *That Pennine Lancashire Community Safety Partnership requests Lancashire and South Cumbria NHS Foundation Trust to work with relevant partner agencies to develop a robust approach to multi-disciplinary discharge from hospital of patients at risk from domestic abuse which ensures that discharge planning is informed by the patient's history that the discharge plan is comprehensive and addresses reasonable contingencies.*	LCSFT	Jo Morrison - LSCFT						
6) *That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Council Public Health so that the learning from this review, in particular the corrosive impact of prolonged controlling and coercive behaviour on a victim's mental health and the increasing evidence of a link between domestic abuse and suicide, can inform future suicide prevention plans.*	LCC Public Health	Marie Demaine Debbie Thompson Diana Hollingworth	Lancashire County Council is taking a proactive approach to addressing both suicide and domestic abuse. By monitoring real-time surveillance and continuously reviewing data to gain deeper insights and improve interventions. We will continue to work collaboratively to deliver suicide awareness training to domestic abuse services. Also, through the recently commissioned domestic abuse provider relevant and targeted training including coercive control and adopting a trauma informed approach will be delivered.	Training - PAC	Domestic abuse providers to increase uptake of suicide awareness training, trauma informed and coercive control		Completed - Continue to monitor data and review training participation and completion	February 2025

APPENDIX E – HOME OFFICE QUALITY ASSURANCE FEEDBACK:

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

23rd October 2024

Dear Lindsay,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Nicole') for Pennine Lancashire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 18th September 2024. I apologise for the delay in responding to you.

The QA Panel is grateful for sight of your detailed, well-written and comprehensive report into what was clearly a challenging case. In particular, the QA Panel commended the thinking around methods of control, financial abuse and managing the threat which the perpetrator may pose to future partners. It is clear that you had looked to engage the family as far as possible, and the report sensitively and compassionately reflected the victim's lived experience.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The Panel noted that there was no public health/mental health/suicide prevention representative on panel, to provide the lens of domestic abuse, self-harm, mental health and links to suicidality. The CSP may wish to consider this for any future DHRs undertaken.

- Paragraph 3.13 on parallel reviews should refer to the Serious Incident Review conducted by Lancashire & South Cumbria NHS Foundation Trust, which is mentioned elsewhere in the report.

- The Strategic Recommendations in Section 8 should be supported by an Action Plan directed at the agencies concerned, following the format of the

- Some of the actions appear to be suggestions rather than actual recommendations and could be further strengthened.

- Paragraph 3.14 should refer to the potential equality & diversity issues relating to the perpetrator which are outlined at paragraph 5.4.

- Any pseudonyms chosen for the victim's children should ensure that their sex remains undisclosed.

- Details of Maundy Relief seem to be missing at footnote 1. Brief information about the role of Maundy Grange at 5.84 would also be helpful.

To ensure anonymity: Please remove the date of death (5.142, 5.145, 5.196, 5.197, 6.115, 3.77, 3.98, 3.100 and 4.32 and 3.100 in Executive Summary).

SafeNet's formal actions may include the actual initials of the victim and perpetrator, which should be checked to ensure anonymity.

- As it stands the links provided for references (8) and (16) on p.103 do not seem to work.

- A copy of the report should be sent directly to the Lancashire Police & Crime Commissioner: the dissemination table at 3.15 currently lists only their Police and Partnerships Manager.

- The report requires a thorough proofread.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel