Safer Lincolnshire Partnership

Domestic Homicide Review

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Independent Chair and Author
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Preface

Pseudonyms, as agreed with the sister, are utilised throughout the review except for the author and panel members.

The independent author and review panel extend their heartfelt condolences to everyone impacted by Liam's terrible passing and thank them for their support and efforts during this procedure.

A Domestic Homicide Review (DHR) is undertaken to gain lessons from a domestic abuse-related fatality. Professionals must grasp each situation to learn these lessons thoroughly. What must change most to prevent a tragedy?

The author appreciates the panel's time, patience, and cooperation, as well as those of the individuals who provided chronologies and material.

"He loved many things in life, but most of all, he loved trees."

1.1 Introduction

1.1.1 Following Liam's tragic death in June 2021, Lincolnshire Police reported the death of Liam to the Safer Lincolnshire Partnership (SLP). As a result, a partnership meeting was held on 21 July 2021 to review the case. The criteria for the Domestic Homicide Review were met, as determined by the partnership panel.

1.1.2 Section 9(3) of the Domestic Abuse, Crimes and Victims Act 2004, enacted in 2011, introduced Domestic Homicide Reviews (DHRs).

1.1.3 The review followed the Multi-Agency Statutory Guidance for Domestic Homicide Reviews from the Home Office (revised December 2016)[1].

1.1.4 Section 2 of the statutory guidance outlines circumstances which indicate a DHR:

‘*Where a victim took their own life (suicide), and the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*’

1.1.5 The review examines agency responses and support offered to Lincolnshire resident Liam before he died in 2021. Liam was in a relationship with Zoe when he died.

1.1.6 The review will also explore Liam's last years (October 2016 – June 2021) to identify any relevant history, indicators, or episodes of abuse before his death and if he accessed community support and any barriers to doing so.

1.1.7 This review does not substitute criminal or coroner's courts, nor is it disciplinary.

1.1.8 Liam’s parents found him hanged in the home’s conservatory, which he shared with Zoe. Zoe was away at the time of his death.

1.2 Case Summary

1.2.1 Liam was under the Mental Health Crisis Resolution Home Treatment Team (CRHTT) following an assessment in May 2021 at the A&E Lincoln County Hospital (LCH).

1.2.2 The assessment was precipitated by Humberside police contacting Lincolnshire police to inform them Liam had been at the Humber Bridge, intimating suicide. They believed he was heading back to Lincolnshire. Lincolnshire police contacted Liam.

1.2.3 Liam attended A&E accompanied by his mum, requesting to see CRHTT due to feeling suicidal.

1.2.4 The Mental Health Liaison Team (MHLT) at LCH assessed Liam. He reported wanting to feel normal and hates what he sees in the mirror. He disclosed being a victim of

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

domestic abuse, being in a volatile relationship with his partner, as well as having a problematic relationship with alcohol.

1.2.5 His parents had previously paid for a two-week stay at an alcohol rehabilitation unit. He had been abstinent following attendance. However, he started drinking again.

1.2.6 While he was living with his supportive parents, Zoe occupied a house registered in his name. He perceived himself to have little control over the situation.

1.2.7 CRHTT assessed Liam at his parents' home. He was concerned he was being depicted as a victim and felt Zoe needed help like him; however, she could not recognise this. He reported that Zoe would create Facebook profiles to contact him, know his break times at work, and call him at these times. She was on bail on the condition that she did not contact Liam. Liam informed the team that she had breached this, and he had reported this to the police to get Zoe help.

1.2.8 CRHTT referred Liam to Steps to Change[2] (S2C); the service provides a range of talking therapies for depression, anxiety, post-trauma reaction, panic, phobia, and obsessive-compulsive disorder.

1.2.9 Towards the end of May 2021, Liam moved back in with Zoe. Liam discussed his future goals and explored courses to study forestry. He reported that the prescribed medication had stabilised his mood, but he felt numb.

1.2.10 Liam was discharged from CRHTT at the beginning of June 2021.

1.2.11 Liam agreed to a referral to the Independent Domestic Abuse Advocate (IDVA) Service.

1.2.12 Four days before Liam's tragic death, Liam texted the IDVA, stating, "I need crisis team, please delete this." As a result, Liam was re-referred to CRHTT.

1.2.13 Liam contacted CRHTT two days before his death; he reported drinking small amounts of whiskey, was tearful and kept referring to having a plan of hanging himself. He spoke about the pressure from Zoe, and she would be mad at him as she wanted him to drive her to and back from an out-of-county event. He accepted an assessment from CRHTT and reported, "You're not going to like what you see." Liam agreed to attend the Psychiatric Clinical Decision Unit (PCDU).

1.2.14 Liam was admitted to PCDU; he was fixated on Zoe, believing she needed help.

1.2.15 Liam received a Mental Health Act Assessment (MHAA) in PDCU one day before he died. The assessment concluded that Liam was not detainable under the Act. He was discharged home to receive a follow-up from CRHTT. His parents collected him from PCDU.

[2] https://www.lpft.nhs.uk/steps2change/home

1.2.16 Liam's mum spoke to CRHTT a day before his death and informed them he was "More clear and chipper," which she thought was bizarre. A plan was made to visit Liam at home the next day.

1.2.17 Liam's mum and dad found Liam hanged in the conservatory and called Lincolnshire police. Liam's dad informed the attending police officers that Liam had departed their home around 2230hrs the night before and appeared depressed. The following day, they called around to check on his welfare.

1.2.18 Police officers commenced an investigation into the circumstances of his death. There was no suicide note left, and the coroner was notified. The result of the post-mortem examination showed the cause of death by hanging. Additionally, the toxicology report showed alcohol intoxication tetra-hydro cannabinol and other cannabis metabolites at death, which may affect motor and cognitive functions.

1.2.19 There were no suspicious circumstances.

1.3 Background Information about Liam

1.3.1 Liam had one sister, Sophie, and lived with his parents in Lincolnshire.

1.3.2 In year six, Liam had a teacher who thought he would be good at playing the saxophone. Unfortunately, this teacher died unexpectedly. Nevertheless, Liam continued to learn and was considered a talented player by Sophie.

1.3.3 Liam was expelled from school at 15 because of behavioural concerns related to attention deficit hyperactivity disorder[3] (ADHD). He studied music technology at a BTEC level and played several instruments.

1.3.4 Liam's father was a sidecar racer, and the family supported him. Liam began racing and riding with his father at the age of sixteen. They would go away for race meets on weekends and stay over. This was one of Liam's interests. Unfortunately, he ceased racing in the last few years owing to seizures.

1.3.5 Due to the disagreements between Liam and Zoe, Liam's father stopped going with him to the race events.

1.3.6 Liam's friends were essentially people he and Zoe knew. Liam spent most of his time with Zoe. He has two friends who continue to visit his mother and father after his passing. Sophie suggested the friends would be too emotional to contribute to the review.

[3] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

1.3.7 Liam had several jobs that did not last long; they were either temporary or he could not drive due to seizures. Sophie stated that reasonable adjustments would not be suitable in light of Liam's poor mental health.

1.3.8 Liam got along better with his sister once she left home at 18, with Liam telling friends that Sophie is the only one who understands him.

1.3.9 Sophie had no idea when Liam began consuming alcohol and said he was not doing so when she was home. However, she knows their parents confiscated his bank card with his permission to prevent him from purchasing whiskey.

1.3.10 The family had arranged for a private ADHD therapist. However, Liam does not believe it is beneficial, and Sophie is unaware of the reasons for this.

1.3.11 Liam was passionate about music, sidecar racing, and forestry. As a result, his ashes were planted in a tree.

1.3.12 In his honour, the family also conducted a fundraiser, with the earnings going to the National Trust to plant trees.

1.4 Timescales

1.4.1 According to police records, Liam and Zoe were involved in multiple domestic abuse episodes. These incidents began in 2016, with the most recent incident in January 2021, followed by several concerns about safety occurrences. Following Liam’s death, a referral was made to SLP to consider a DHR into the circumstances surrounding Liam’s untimely death.

1.4.2 SLP considered the 2016 Multi-Agency Statutory Guidance for Domestic Homicide Reviews. It commissioned this DHR after deciding to proceed in July 2021.

1.4.3 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews outline chair and author criteria. This review combined the chair and author positions.

1.4.4 The independent author was commissioned on 22 November 2021. SLP approved the completed report on 9 June 2023.

1.4.5 The author held the first-panel meeting on 6 April 2022.

1.4.6 A learning event with front-line practitioners took place on 9 September 2022 to review the themes of the review.

1.4.7 The panel met a total of 6 times. The meetings allowed all to present challenges and request clarifications on the information shared and the overview report.

1.4.8 The Home Office guidance recommends completing the DHR, including the overview report, within six months of the date of the decision to proceed.

1.4.9 Delays were caused by appointing an author and hampered by staff sickness and annual leave. Two practitioner events were held to supplement the review's learning. The author and panellists also desired family participation and confirmation that Liam's voice was captured.

1.5 Confidentiality

1.5.1 This review's findings are confidential until the overview report has been approved for publication by the Home Office Quality Assurance Panel. Therefore, information is available only to contributing officers/professionals and their line managers.

1.5.2 The review has been anonymised per Home Office Domestic Statutory 2016 Guidance. The pseudonyms have been agreed upon with the sister and used to protect individuals' and others' identities. The date of death has been removed, and only the independent author and review panel are named.

1.5.3 To protect the individual's and the partner's identities, the following anonymised terms have been used throughout this review:

- The victim: Liam
- Sister: Sophie
- Partner: Zoe

1.6 Terms of Reference

1.6.1 Section 3.2 highlights the full terms of reference (ToR). This review intends to learn from Liam's case and provide recommendations to improve the support provided to victims who present to services in a circumstance similar to Liam's.

1.6.2 On 29 April 2021, the Domestic Abuse Bill received Royal Assent. The Act provides a Legal definition of domestic abuse:

> ***The behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:***
>
> *(a) A and B are each aged 16 or over and are personally connected, and*
> *(b) the behaviour is abusive.*
> *Behaviour is "abusive" if it consists of any of the following—*
> *(a) physical or sexual abuse;*
> *(b) violent or threatening behaviour.*
> *(c) controlling or coercive behaviour.*
> *(d) economic abuse;*
> *(e) psychological, emotional, or other abuse and it does not matter whether the behaviour consists of a single incident or a course of conduct.*
> *"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—*
> *(a)acquire, use or maintain money or other property, or*
> *(b)obtain goods or services.*

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship with the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 The Home Office guidelines[4] prescribe how to conduct a DHR.

1.7.2 The first review panel met on 6 April 2022 and briefly shared their agency contact with Liam. It was agreed that agencies would provide a chronology to determine what was needed to produce an Independent Management Review (IMR).

1.7.3 Thirty-five agencies were contacted to ask about their involvement with Liam. Ten submitted chronologies and five submitted IMRs.

1.7.4 The IMRs were authored by professionals independent of the case management or service delivery. The IMRs allowed the panel to analyse their contact with Liam and produce the learning for this review. In addition, on the IMR presentation day, agencies offered challenges on the IMR reports. As needed, agencies were sent additional questions to enhance the review. Two IMRs made recommendations of their own. The IMRs have informed the recommendations in this report. In addition, the IMRs have helpfully identified changes in practice and policies over time and highlighted areas for improvement not necessarily linked to the ToR for this review.

1.7.5 The panel established the review period from October 2016 to June 2021. October 2016 was the first police contact concerning domestic abuse.

1.7.6 **Documents reviewed concerning Liam**:

1. Multi-Agency Risk Assessment Conference (MARAC) minutes, including the action plans
2. The police DASH[5] assessment
3. Adult Notification forms

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[5] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

4. A copy of the Mental Health Act Assessment
5. Worn Body Video Footage from the police

1.7.7 The panel met six times, with the first meeting on 6 April 2022.

1.7.8 The 9 September 2022 was a learning event for practitioners who worked with Liam or service users in circumstances similar to Liam's. The learning event explored the themes of the review and their impact on their practice.

1.7.9 Once a draft report and recommendations had been developed, a second session with practitioners was held to elicit their perspectives on them and determine if they had any further opinions regarding any recommendations that should be included in the final report.

1.7.10 The author called Zoe, but she declined to participate. Liam's parents were contacted. They first consented to a conversation with the author but withdrew their agreement, requesting just email communication.

1.7.11 Liam's mum emailed the author to seek her withdrawal, stating that she did not feel it was in her best interest to participate.

1.7.12 On 12 January 2023, Liam's sister, Sophie, emailed the author requesting participation in the review, and communication was established from that point forward. The report was shared with her, and beyond what she had already contributed to the review, which is contained in the next section of the report, she did not seek to make any additional contributions.

1.7.13 The report was forwarded to the Crown Prosecution Service (CPS) for review.

1.8 Involvement of Family and Friends

1.8.1 The author and the review panel acknowledged the vital role that Liam's family and Zoe could play in the review. All of them were emailed the Home Office's DHR leaflet with details about an advocacy service: Advocacy After Fatal Domestic Abuse.

1.8.2 The author contacted Liam's dad in April 2022, who agreed to a phone call after the Easter break. The author called Liam's mum and dad and spoke to them both. Neither felt they required support from an advocacy service or any other organisation.

1.8.3 The parents were concerned about Liam receiving a medical diagnosis so that they could understand his behaviour better and provide him with healthy coping strategies. However, they did not always perceive Liam as a victim of domestic abuse from Zoe.

1.8.4 The parents summarised Liam's difficulties, namely his diagnosis of ADHD and felt this eventually drove him to end his life. They said Liam was initially diagnosed with ADHD and Asperger's when he was young, but the symptoms altered as he grew older. They

described Liam as having poor impulse control and would drink to cope with his mental health. As a result, they felt Zoe would drink to cope with Liam.

1.8.5 Both parents felt the wait for an NHS diagnosis to reconfirm ADHD and the subsequent treatment he could receive from adult services was too long. In addition, they believed That when mental health services reviewed Liam, he would tell them what they wanted to hear. They felt Liam was dishonest with services and, as such, services could not offer him anything further.

1.8.6 The parents remain in contact with Zoe; they felt Liam "needed her, and they loved each other deeply". They do not believe Zoe was abusing Liam. However, they and Zoe are concerned that this review may highlight domestic abuse and feel this would be inaccurate.

1.8.7 Mum agreed to maintain communication via email and sent the author a picture of Liam to keep him in mind during the review.

1.8.8 The author contacted mum via email to inform her of the progress and requested a discussion to give the author an insight into Liam's life. Mum emailed to state she did not wish to revisit the circumstances of Liam's death, and she and her husband were moving on with their grief.

1.8.9 The author received an email from Sophie (12 January 2023), who stated that she had seen the email exchange between her mum and the author and wanted to participate.

1.8.10 Sophie knew Liam had long-standing alcohol issues and depression and had accompanied him to appointments. She had also been the one to complete the forms for him to attend S2C.

1.8.11 She commented on the accessibility of services for someone with depression and ADHD like Liam. She indicated that Liam would not go if she or her parents were not involved and that it was unrealistic to expect him to self-refer.

1.8.12 She added that she had spoken with Liam about medication for depression, and his response was, "I don't want to take medication because I won't be Liam anymore".

1.8.13 She stated that she was informed that Liam was awaiting a call from the crisis team when he died but did not receive one. When Liam was scheduled to be visited by the crisis team, he was tragically discovered hanged.

1.8.14 She agreed to support the review and wished to be informed of its progress. However, she did not want to comment on Liam's relationship with Zoe.

1.8.15 Sophie confirmed that her mother did not want a copy of the report.

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution-Chronology/IMR
Crown Prosecution Service	Reviewed Report
East Midlands Ambulance Service	Chronology
East Midlands Special Operations Unit (Lincolnshire Police)	Chronology and IMR
Ending Domestic Abuse Now in Lincolnshire *A registered charity commissioned service from August 2018 until March 2023. They also the provider of Lincolnshire Independent Domestic Abuse Advisor Service (IDVA), which provides specialist service for males and females aged 16 and over referred to a MARAC and assessed as high-risk for short-term intervention.*	Chronology and IMR
Hull University Teaching Hospital is a large Acute NHS hospital trust serving patients in Hull and East Yorkshire. It operates *from two sites: Hull and Castle Hill.*	Chronology
GP	Chronology and IMR
Lincolnshire and District Medical Services *Extended Access Services for several GP practices in Lincolnshire.*	Chronology and Summary Report
Lincolnshire County Council Adult Care and Community Wellbeing (Adult Social Care): *Adult social care is the support, including safeguarding, provided to adults with physical or learning disabilities or mental illnesses.*	Chronology
Lincolnshire Partnership NHS Foundation Trust: *Established on 1 June 2002, this trust provides social care and health services formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust. Its purpose is to create new mental health and learning disabilities services*.	Chronology and IMR
Northern Lincolnshire and Goole NHS Foundation Trust*: Hospitals in Grimsby, Scunthorpe, and Goole provide services to more than 450,000 people in North and North East Lincolnshire, East Riding of Yorkshire, and East and West Lindsey.*	Chronology
United Lincolnshire Hospitals NHS Trust: *It is in Lincolnshire and is one of England's biggest acute hospital trusts.*	Chronology and Summary Report

1.10 The Review Panel Members

1.10.1 The independent panel members for this review were the following:

Name	Role	Organisation
Parminder Sahota	Independent Author & Chair	P.S Safeguarding LTD
Rachel Crook	Deputy Head East and West Lincolnshire	Probation Service
Claire Tozer	Head of Safeguarding Adults and Primary Care	Lincolnshire Integrated Care Board (ICB)
Gemma Cross	Head of Safeguarding	Lincolnshire Community Health Services NHS Trust
Linda MacDonnell	Head of Safeguarding	Lincolnshire County Council Adult Care and Community Wellbeing
Jane Keenlyside	MARAC (DMR) Manager	Ending Domestic Abuse Now Lincs
Liz Cudmore	Children and Young Person Safeguarding Lead	East Midlands Ambulance Service

Rachel Freeman	Head of Service, Children's Services	Lincolnshire County Council Children's Services
Richard Naulls	Police Regional Review Officer	East Midlands Special Operations Unit (Police)
Sarah Norburn	DA Coordinator, PVP Crime	Lincolnshire Police
Tony Mansfield	Head of Safeguarding Public Protection and Mental Capacity	Lincolnshire Partnership Foundation Trust

1.11.2 The support to the Panel for this review was the following:

Name	Role	Organisation
Jade Thursby	DA Business Manager	Lincolnshire County Council
Toni Geraghty	Legal Advisor	Legal Services, Lincolnshire
Teresa Tennant	DHR Administration	Lincolnshire County Council

1.10.2 Liam was noted to be a male victim by the panel; EDAN Lincs represented this cohort. In addition, the review determined that Liam's gender did not impede agency responses; hence, it did not endorse a domestic abuse agency that exclusively supports males.

1.11 Chair and Author of the Overview Report

1.11.1 Chair and independent author Parminder Sahota has worked in domestic abuse and safeguarding for the past ten years. In 2021, she earned DHR Author training from Advocacy After Fatal Domestic Abuse. She is a mental health nurse with over 20 years of experience working for the NHS. Her expertise includes crisis intervention and working with adults diagnosed with personality disorders. She is the director of safeguarding, prevent, and the domestic abuse lead and is currently employed at an NHS Trust.

1.11.2 Parminder Sahota is independent of all agencies involved and had no prior contact with family members or SLP.

1.12 Parallel Reviews

1.12.1 The inquest was held in April 2023, and the outcome was recorded as Suicide.

1.12.2 No parallel review or investigation is taking place by Lincolnshire Partnership Foundation Trust (LPFT). The Trust would usually undertake a Serious Incident Review (SI) where there is a death or suicide of a person accessing Trust services.

As is the usual process when that death meets the threshold for a statutory review, the multi-agency review process takes precedence over the single-agency SI. However, the ToR for this review were shared with the quality lead for the relevant division within the Trust for comment. They confirmed that the ToRs would be satisfactory in ensuring the intended outcomes of both processes were met by this IMR.

1.13 Equality and Diversity

1.13.1 The review author and panel considered all the protected characteristics under the Equality Act 2010: age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation, and disability.

1.13.2 The review considers disability, age, and sex.

1.13.3 Liam was a 25-year-old male of white British origin. He was unmarried, had no children, and did not subscribe to any religion. Liam dated Zoe, his first and only girlfriend, for ten years.

1.13.4 In 2004, Liam was diagnosed with Asperger's syndrome; in 2006, he was diagnosed with ADHD. Both disorders have some symptoms that overlap, and it is common for people to have both. Asperger's syndrome, also known as Autism Spectrum Disorder, is characterised by social and communication impairments, whereas ADHD is characterised by hyperactivity, impulsivity, and concentration issues.[6] ADHD is a neurodevelopmental disorder[7]. It typically presents in childhood and lasts into adulthood. ADHD causes problems with focus, behaviour, and movement. Liam described having difficulties with his mood; he would cry for no apparent reason or be quiet and unresponsive. He took medicine for ADHD from 2006 until 2010, after which he stopped asking for repeat prescriptions and no further contact with the paediatricians was made from April 2010.

1.13.5 People with ADHD may experience relationship challenges, including anger because of stress and anxiety, which may be unrelated to the relationship.

1.13.6 Adults with ADHD likely experience anxiety, depression, bipolar disorder, or other pre-existing psychiatric disorders.[8] Liam reported difficulties with his mood, and it is believed he used alcohol to cope.

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[6] https://chadd.org/adhd-weekly/adhd-and-aspergers-syndrome-learn-more-about-both-to-make-good-treatment-decisions/#:~:text=Since%202013%2C%20the%20Diagnostic%20and,careful%20coordination%20for%20proper%20treatment.

[7] Neurodevelopmental disorders (NDDs) are multifaceted conditions characterized by impairments in cognition, communication, behaviour and/or motor skills resulting from abnormal brain development.

[8] https://adaa.org/understanding-anxiety/related-illnesses/other-related-conditions/adult-adhd

1.13.7 A 2018 study linked severe ADHD with early-in-life consumption of alcohol and a higher risk of binge drinking.[9] For example, Liam reported drinking one litre of whiskey over a week; on other occasions, he reported drinking ½ litre a day.

1.13.8 Alcohol abuse or illicit drug use increases the risk of psychological and intimate partner abuse perpetration and victimisation, regardless of ADHD symptoms.[10] For example, Liam and Zoe had an abusive relationship and were arrested for assault.

1.13.9 A consultant psychiatrist's clinical impression of Liam was cyclothymia. The essential characteristic of cyclothymia is a chronic, pervasive, fluctuating mood disturbance. These oscillations are described as periods of distinguishable depressive and elevated episodes. Depressive symptomatology may include depressed mood, irritability, hopelessness, helplessness, insomnia, fatigue, anhedonia, avolition, the negativity of affect, headaches, neurasthenia, and suicidal ideation.[11] Liam had trouble sleeping and suicidal thoughts. The consultant prescribed Quetiapine in April 2021 as a mood stabiliser.

1.13.10 A study indicated that Quetiapine for mood stabilisation was effective after eight weeks, changing the Montgomery-Asberg Depression Rating Scale score[12]. Liam had collected a repeat prescription. However, agencies could not confirm that he had always been compliant. He was due to be reviewed in August 2021, which did not occur due to his tragic, untimely death.

1.13.11 Liam was found hanged at 25; suicide statistics in England and Wales indicate that men are three times more likely to take their own lives than women.[13] The government has published reports on the prevention of suicide.[14] However, England recorded more than 5,000 deaths in 2021. For men under fifty, suicide was the leading cause of death. It has also been suggested that individuals with ASD may be more likely to succeed in their first suicide attempt, may use more lethal means and may be less connected to support services than other at-risk groups.[15]

1.13.12 The Office for National Statistics estimates that 1.6 million women and 757,000 men reported abuse in 2020. Mankind Charity registered that in 2021, just fifty-eight out of 238 refuge spaces supported male survivors. Statistics on the number of men facing domestic abuse may not always portray the whole reality. Male victims of

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[9] https://pubs.niaaa.nih.gov/publications/arh26-2/122-129.htm

[10] Wymbs BT, Dawson AE, Suhr JA, Bunford N, Gidycz CA. ADHD Symptoms as Risk Factors for Intimate Partner Abuse Perpetration and Victimization. J Interpers Abuse. 2017 Mar;32(5):659-681. doi: 10.1177/0886260515586371. Epub 2016 Jul 10. PMID: 26025345.

[11] https://www.ncbi.nlm.nih.gov/books/NBK557877/

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4423161/

[13] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations

[14] https://www.gov.uk/government/publications/suicide-prevention-in-england-fifth-progress-report

[15] Hedley and Uljarevic 2018

domestic abuse are two and a half times less likely to tell anyone about the abuse they are experiencing, meaning it may never be recorded.[16] Liam and his family did not always view him as the victim of domestic abuse.

1.13.13 Bristol University[17] identified reasons why males in abusive relationships might not seek assistance. Liam's care for his partner's well-being is one of these obstacles. According to the findings, specialised training is necessary to address the unique needs of men and build more robust levels of trust.

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- The family
- Safer Lincolnshire Partnership
- All Agencies that contributed to the review
- Lincolnshire Police and Crime Commissioner
- Domestic Abuse Commissioner

BACKGROUND INFORMATION

2.1 The Facts

2.1.1 Liam had an on-and-off relationship with Zoe. They had been together since he was 15 and Zoe 13.

2.1.2 In the last five years of their relationship, they came to the attention of the police for domestic abuse-related incidents. The incidents highlighted Liam and Zoe as both perpetrators and victims.

2.1.3 Liam recognised he needed support concerning his mental health and agreed to cognitive health assessments and received a formal Mental Health Act assessment the day before he passed.

2.1.4 Liam struggled to recognise that he was a victim of domestic abuse and would ask agencies to ensure Zoe was receiving help.

2.1.5 Liam contacted the Independent Domestic Abuse Advocacy (IDVA) service twice, in January 2021 and June 2021. He declined interventions from the service as he felt he did not require these. The service attempted to support Liam in recognising his

[16] https://www.mankind.org.uk/statistics/
[17] https://www.bristol.ac.uk/primaryhealthcare/news/2019/male-victims-of-domestic-abuse.html

relationship as unhealthy, and although he accepted this, he felt Zoe was the one who needed help.

2.1.6 Liam took his own life in late June 2021. The method used was hanging.

2.2 Combined Chronology May 2020 to May 2023

2.2.1 **October 2016**—Liam and Zoe travelled to North Yorkshire. During their stay at a hotel, they had a dispute that resulted in a call to the police, which resulted in their departure from the hotel. Liam and Zoe had been drinking and stated that their disagreement was with the hotel, not one another. A DASH was completed, and Liam and Zoe's local police force, Lincolnshire Police, was notified.

2.2.1 **March 2018** – Telephone communication with Liam's mum and GP – Liam was suicidal but not actively contemplating suicide. His mum brought him to the GP practice.

2.2.2 **March 2018** – Liam was anxious, depressed, and emotional during his visit with his GP; he reported to have been unhappy for some time. He lived with his girlfriend and worked as a school caretaker. He was unable to explain his depression and would cry in a corner. He had contemplated suicide. He stated, "I wouldn't even consider it. I don't want to, and I won't do it." The GP prescribed Liam 20mgs of Fluoxetine, informed him of the side effects and advised him to self-refer to S2C. Liam was given a prescription for 30 days but did not return for a repeat prescription. Fluoxetine is the recommended first-line treatment for depression[18].

2.2.3 **June 2018** – Zoe notified the police of domestic abuse. She had been with Liam since she was thirteen; the last two years had been exceptionally turbulent. She stated they are "equally bad" and "give as good as they get." Zoe disclosed that they both experienced poor mental health and were unwilling to seek assistance. She claimed that Liam had attempted to strangle her multiple times and had struck her with a whiskey bottle a year prior, leaving a scar above her left eye. The disclosures made by Zoe led to Liam's arrest. She refused to provide police with statements or to receive police assistance.

2.2.4 Zoe arrived at the police station and was extremely abusive and enraged that Liam remained in custody. Zoe attempted to flip the desk over and hit it. The officers quelled her anxiety and explained why Liam was arrested. She said she would resume her relationship with Liam and refused to provide a statement. Liam did not consider the offences when questioned and said that he and Zoe had argued after drinking; he

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18 https://pubmed.ncbi.nlm.nih.gov/15597466/#:~:text=In%20term%20of%20health%2Dcare,of%20treatment%20for%20depressive%20disorders.

reported that he did not physically assault her. Liam was served with a Domestic Abuse Protection Notice (DVPN) [19] containing no-contact provisions with the condition that he appear before the magistrates.

2.2.5 **June 2018** – Zoe was referred to MARAC, with Liam identified as the perpetrator. The DASH score was seven; according to the guidelines, MARAC referral criteria are met with a score of 14 or higher; however, referral decisions can also be made based on professional judgment. Zoe declined an IDVA[20] referral. The referral noted Zoe's violent behaviour toward Liam and her anger at the police station while he was detained. The officer remarked, "It is clear that Zoe cannot see the domestic abuse taking place and is unaware of her controlling and violent behaviour." She refused a referral to any form of Addiction services for her alcohol use. "She can see it as a trigger but states that she is not dependent."

2.2.6 **June 2018** – The IDVA reviewed the police's notes, which stated that Zoe had refused all interventions and was in control of Liam during the incident.

2.2.7 **June 2018** – The magistrate granted the DVPO against Liam. Liam left the court without receiving a copy. Zoe was opposed to the DVPO. The police visited Liam at Zoe's home; Zoe confirmed that Liam was not present and was staying with his parents. The police visited the parent's home and served him with the DVPO for 28 days, detailing the consequences of a violation.

2.2.8 **July 2018** – Liam was named the alleged perpetrator during the MARAC meeting. The IDVA service closed the case as Zoe declined to engage.

2.2.9 **November 2018** – Liam and Zoe's neighbour called the police via 999 to report a domestic dispute in progress and a female screaming. Officers attended and were aware of the previous MARAC referral. Liam and Zoe reported a verbal argument, with Zoe stating they are a "bit shouty" and need to deal with disagreements better. The officers engaged Zoe in a DASH assessment, to which she replied "no" to most of the questions. However, she became upset when asked about the children and went to Liam for support, crying to the point that she could not speak. Liam stated she had recently had a pregnancy loss, and consequently, he felt inadequate, which had led to arguments. It is unknown if Liam blamed himself for the pregnancy loss or if he received any support.

2.2.10 The attending officers submitted a standard-graded Public Protection Notice (PPN) for both Liam and Zoe. They were informed of the Freedom Programme and encouraged

[19] https://www.gov.uk/government/publications/domestic-abuse-protection-orders/domestic-abuse-protection-notices-dvpns-and-domestic-abuse-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

[20] https://safelives.org.uk/what-is-an-idva

to contact it for conflict resolution and mutual support. The domestic abuse police officer was notified of the incident as it was flagged as a MARAC case, and the MARAC database was updated the next day.

2.2.11 **February 2019** – A member of the public called the police to report a male assaulting a female. The male punched and threw the female into the garden. The male was overheard saying, "Just let me into my own house," The female replied, "No, you will only beat me again." Another member of the public intervened and pulled the male away from the female, at which point the female turned aggressive, and he retreated.

2.2.12 Police were provided with a description of the male. Following the account given by a member of the public and Zoe's visible injury, police arrived and arrested Liam. Zoe was described as uncooperative, as she initially refused to answer the door, claimed she lived alone and refused to complete the DASH. When the police arrested Liam, she began to scream at the officers. Liam appeared in court in May 2020 and was found not guilty of assault.

2.2.13 The officer in charge of Zoe's case attempted to speak with her, but she refused to give a statement. A PPN included all DASH questions, and Zoe's consent to share information was denied. The initial grade was medium but changed to high after a supervisor reviewed previous incidents and MARAC involvement. The matter was again referred to MARAC.

2.2.14 **February 2019**—Zoe was referred to MARAC; she was unaware of the referral. The DASH was recorded as refused, and Zoe did not consent to work with the IDVA. Zoe stated that the injury to her face was due to a fall at work. The case was closed.

2.2.15 **April 2019** – With Zoe, Liam sought assistance for their relationship at Lincolnshire and District Medical Services (Extended GP cover - LADMS). He reported that the relationship had deteriorated over the past two years and that he frequently experienced anger. The GP detected a strong odour of alcohol, and both patients admitted to having an alcohol problem. Every night, they consumed one litre of alcohol between them. In addition, they reported financial difficulties because of their reduced work hours. The GP informed them about relationship counselling, addiction services, and the Citizens Advice Bureau.

2.2.16 **July 2019** – The GP conducted a telephone consultation with Zoe. She stated she wanted to stop drinking alcohol and thought she was drinking too much, ruining her relationships with friends and family. She was advised about her alcohol consumption and to contact addiction services.

2.2.17 **July 2019** – NAVIGO[21] (providing NHS mental health services to North East Lincolnshire) contacted Zoe; she reported a low mood following the breakup with her partner. Due to their location outside the county, NAVIGO is uninformed of the MARAC case. However, this indicates a possible risk, as information may be missed. The MARAC shares information with agencies in accordance with their MARAC operating protocol (MOP), which does not extend to inviting or notifying agencies outside of the county as a standard. However, if MARAC is made aware of other counties' involvement, they are invited on a case-by-case basis.

2.2.18 **July 2019** – CRHTT contacted Zoe and discharged her from the service after it was determined that she did not need support.

2.2.19 **July 2019** – S2C assessed Zoe, who reported missing her ex-boyfriend (Liam).

2.2.20 **November 2019—Zoe called the police to report that her ex-boyfriend's (Liam) dad had thrown her out of his property. She was crying and distressed and screaming down the phone. The police officers attended Liam's parents'** address. Zoe reported that her ex-boyfriend's dad had pushed her out of his house. The police learned that Liam and Zoe had broken up in June 2019.

2.2.21 Zoe had drunk to excess and invited Liam to her address, where they drank alcohol. This resulted in a verbal argument, and Liam left the address by climbing out of a window and running away to his parent's home. Zoe walked to Liam's parent's house and tried to push her way into the house. Liam's dad refused to let her in, and Zoe grabbed Liam's dad around his throat during the ensuing scuffle. In response, he pushed her out of the house and closed the door. Zoe's dad attended and took her home, where he remained with her. There were no formal allegations or complaints of any criminal offences nor independent corroborative evidence. The officers submitted a crime report for Zoe's assault on Liam's dad, and he declined to make a formal complaint or provide a statement.

2.2.22 The officers submitted two PPNs about the incident, one concerning Zoe's mental health and excessive drinking and a second concerning the domestic side of the incident. The notice was graded as standard and shared with Zoe's consent to Lincolnshire Adult Customer Service Centre and Lincolnshire Mental Health Single Point of Access. Liam did not answer the DASH questions or give consent to refer the matter to any support service.

2.2.23 **February 2020** - Liam self-referred to S2C and reported having ADHD, feeling depressed, experiencing a low appetite, sleeping a lot, and drinking more alcohol. He was offered an assessment and signposting to alcohol services.

[21] https://navigocare.co.uk/

2.2.24 **February 2020** – Liam had a telephone appointment with his GP; he had lost his job, had a neurologist appointment, and experienced brief thoughts of self-harm.

2.2.25 **February 2020** – S2C completed a mental health assessment with Liam following the self-referral. Liam reported feeling low in mood for a couple of years; he could not identify any triggers and reported having been in a 'bad relationship' which had ended; he had also reported an increase in his alcohol intake. However, the assessment could not be progressed due to alcohol intake; Liam reportedly drank 1 litre of whiskey across the week. As a result, he was signposted to addiction services.

2.2.26 **July 2020** – The police received a call from Liam's parents. Zoe was at the address; she reportedly bit Liam's dad on the arm and refused to leave. Upon police arrival, Zoe left and returned home. Liam and Zoe had argued the previous evening, and Zoe had assaulted Liam, causing him a swollen lip and bloody nose. A further argument ensued the following day, and Zoe told Liam to leave and called his parents to collect him. When the parents arrived, Zoe scuffled with them, trying to stop them from leaving. They left the scene, and shortly after they got to their address, Zoe turned up, went inside and was abusive to everyone. When Liam's dad tried to remove her from the house, she bit him on the arm. None of the family wished to complain, and there was no independent corroborative evidence. A DASH risk assessment was completed. However, he refused permission for it to be shared.

2.2.27 **August 2020** – Zoe reported Liam missing to the police; he had threatened suicide. Liam had left the property following an argument with Zoe; he had gone for a walk and returned of his own accord. The police officers described Zoe's behaviour as volatile and angry.

2.2.28 **October 2020**—Zoe called the police. Liam had smashed the window following an argument. He left to go to his parents' house, and Liam's dad helped repair the damage. The police officers attended. Liam and Zoe had been drinking and arguing, and Liam had punched the small pane of glass in the door. A PPN was conducted, and Zoe declined to answer the DASH questions.

2.2.29 **November 2020** – Zoe called the police via 999; she was heard on the phone screaming, "No, don't, I'm ringing the police". Police attended, and Liam and Zoe confirmed that this was not a domestic incident and that Zoe was experiencing a mental health breakdown, which caused her nose to bleed. However, they wished to stay together; the police provided contact numbers for CRHTT. Zoe confirmed she would contact them if needed.

2.2.30 **December 2020** – Liam called the police. He was trying to get his property back from Zoe, but she refused to give it to him. He was advised that this was a civil matter and that the police could not get involved.

2.2.31 **December 2020** – Liam called 111, talking of suicide, explained he has ADHD, drinks 1/2 Litre of whiskey a day, and thinks everyone is against him. He was referred to CRHTT. CRHTT called Liam; he had moved back with his parents following a break-up with his ex-partner. He told CRHTT he loved his new job working in a factory. However, his mood was up and down, and his family struggled to cope with him. He described having ADHD and becoming agitated, silent, and unresponsive. He reported his preference to talk face-to-face as he struggled to speak on the phone. Liam's dad was concerned about his behaviour.

2.2.32 **December 2020** – Liam attended a face-to-face appointment with his dad at CRHTT. Liam expressed he has ADHD and was not prescribed medication for this. He was struggling to adjust following the end of a nine-year relationship. He was no longer working (seasonal employment) and would like talking therapy. Therefore, Liam was not experiencing a crisis and was referred to S2C.

2.2.33 **December 2020** – Liam informed the GP that he had a history of ADHD and had not tolerated the prescribed medication. His mum felt Liam needed to be under the adult ADHD team, and he had been experiencing low moods for two years with mood swings. Liam reported drinking four to five beers and smoking two cigarettes daily. No recreational drugs were reported. A referral for an ADHD assessment was made. The GP noted a referral in August 2020, which referenced Liam's alcohol intake, and the recommendation from the team was to provide an up-to-date report concerning Liam's alcohol use. He would need to be within recommended weekly limits and actively engage with alcohol services; until then, they could not accept him. Liam was informed that the ADHD referral was rejected due to alcohol use. His dad reported that Liam abused whiskey due to his low mood and was given advice regarding local addiction services.

2.2.34 **December 2020**—Zoe requested disclosure to the police concerning Liam under Clare's Law (Domestic Violence Disclosure Scheme). The police had no additional information except what Zoe already knew. Zoe contacted the police and withdrew the request. No disclosure was required.

2.2.35 **January 2021** – S2C assessed Liam using the PHQ-9[22], indicating severe symptoms of depression. The assessment concluded that Liam required longer-term psychological support from the Community Mental Health Team (CMHT), which is not within the remit of S2C. Subsequently, he was referred to the CMHT.

2.2.36 **January 2021** – Zoe hailed a police car outside her home. She reported having a dispute with Liam and that he had broken her phone. Officers entered the residence,

[22] https://patient.info/doctor/patient-health-questionnaire-phq-9

one speaking with Liam and the other with Zoe. It was agreed that Liam would spend the night with his parents to settle down. Zoe grew quite angry at hearing this and sought to force past the officers to reach Liam. She yelled and screamed, telling Liam that he could not leave. Zoe attempted to push past the officers to Liam to stop him from going. When prevented from doing so, she hit one of the officers in the chest and was arrested for assaulting an emergency worker.

2.2.37 Zoe was wearing only a dressing gown; due to the assault on the police officer, Zoe remained in handcuffs. The male officers asked Liam if he could assist in putting her trousers on, as she should be transported to Skegness police station. While Liam attempted to do this, Zoe kicked him and was arrested on suspicion of assault.

2.2.38 Following Zoe's removal from the property, one of the officers sat with Liam and completed the DASH questions. He was initially reluctant to answer the questions, continually saying he did not want to "grass" on Zoe and get her into trouble. However, he disclosed that Zoe's behaviour was controlling and coercive. He disclosed two historic assaults that resulted in him receiving a cut to his head and two broken thumbs. Zoe was further arrested for the assaults, controlling, and coercive behaviour mentioned in the DASH answers. Liam did not wish to lodge a formal complaint, maintaining that Zoe needed help and not him; throughout his interactions, he stated that he did not want to get Zoe in trouble. Zoe was released on police bail with conditions not to visit the address or contact Liam. Officers submitted a PPN graded high and made a referral to MARAC. Liam was handed the EDAN Lincs business card. Zoe was formally charged in February 2021 for the assault on Liam and the assault on the emergency worker; she was bailed to attend Lincoln Magistrates Court in March 2021.

2.2.39 The author observed the body-worn footage of the incident and would want to note the officer's excellent conduct in engaging Liam in the DASH risk assessment. The video footage revealed that Zoe was confrontational and argumentative with the police officers and Liam.

2.2.40 The case was submitted to the CPS for a decision regarding the charge in January 2021. A lawyer who specialises in domestic abuse reviewed all available evidence, including the officer's testimony and the incident's body camera footage. Zoe was charged with both the assault on the police officer and the common assault on Liam.

2.2.41 **January 2021** – MARAC meeting held; consent for an IDVA was not explicit. The IDVA emailed the police requesting further information before contacting Liam. The IDVA contacted Liam; he confirmed he had not consented and did not require their intervention.

2.2.42 **February 2021** – The GP provided Liam with a telephone consultation. Liam's parents financed a 14-night stay at a rehabilitation facility, where he was discharged after excessive alcohol consumption. On discharge, he was instructed to continue attending the addiction service for assistance and weekly aftercare through Zoom. During his stay, he was prescribed Melatonin, requested a repeat prescription, and required a fitness note. He was advised that Melatonin was recommended for seven days, not for long-term use. A one-month medical note was issued.

2.2.43 **February 2021** – Liam reported abstaining from alcohol for four weeks following his discharge from the rehabilitation facility; he spoke to the community psychiatric nurse (CPN) about domestic abuse from his ex-partner, Zoe, who was not allowed to contact him. However, he dropped the charges as he did not want to get her in trouble. As a result, Liam did not meet the CMHT criteria. However, the CPN requested a consultant appointment concerning adult ADHD.

2.2.44 **April 2021** – The consultant assessed Liam during an outpatient appointment. Liam reported stress related to money and relationships. He stated he had a supportive partner; however, they had arguments. Liam had previously punched himself and had been head-banging for 5-6 years; this had reduced recently. He reported thoughts of suicide but no plan or intent. He was prescribed Quetiapine[23] as a mood stabiliser to be reviewed in four weeks. The clinical impression was that Liam was experiencing Cyclothymia[24] with some personality traits.

2.2.45 **May 2021** – A call to the police. The caller abandoned the call, the police called the number from which the call originated, and Liam came on the line. Liam sounded distressed. He was adamant that he did not want police officers to attend, saying people were there and things were happening. He stated that when the police attend, bad things happen, and they terrorise him, stating that someone who is meant to love him they are scaring him. He told the police the people were hiding behind the fence. Officers attended, searched the house outside, and knocked on neighbours' doors – no answer and no other person was found at the address.

2.2.46 **May 2021** – Humberside Police contacted Lincolnshire police: Liam had been at the Humber Bridge, intimating suicide; Humberside police believed he was heading back to Lincolnshire. Liam returned home and was taken by his parents to Lincoln Hospital; Liam was seen at the hospital by the mental health liaison service and discharged home with his parents. The clinical notes and risk assessment reference Zoe's domestic abuse and MARAC's involvement. The local crisis team for Liam had been

[23] https://www.medicines.org.uk/emc/files/pil.4170.pdf
[24] https://www.nhs.uk/conditions/cyclothymia/

notified for follow-up. No new DASH was generated since no new disclosures were made.

2.2.47 **May 2021**—Zoe was further arrested for breaching the court bail conditions by returning to Liam's address. Officers found her attempting to hide within the property. The following day, she was produced at Lincoln Magistrates Court and released on bail with the same conditions. The CPS concluded that no further action was taken concerning the assault on Liam in January 2021 as it was not in the public interest.

2.2.48 **May 2021 -** Liam was referred to MARAC by Lincolnshire Police; he informed the police he had been subjected to numerous assaults by Zoe and believed she would kill him one day. However, Liam continued to seek support for Zoe's mental health. The IDVA contacted Liam two days after the referral.

2.2.49 **May 2021** – CRHTT saw Liam at his parent's home; he disclosed he has friends through his sidecar racing and felt brighter. Liam spoke of control from Zoe. For instance, she would choose what he ate and ignore his views and wishes. Liam struggled with identifying himself as a victim of domestic abuse and spoke of loving Zoe and yearning for her. Liam was aware of the referral to MARAC and consented to the involvement of the IDVA.

2.2.50 **May 2021** - CRHTT referred Liam to EDAN Lincs. The referral suggested that the relationship between Liam and Zoe had broken down, and they had been separated for a few months. Liam was living with his parents. He had been in a relationship with Zoe since age fifteen and experienced coercion and control throughout. The EDAN Lincs outreach service attempted one unsuccessful telephone call to Liam.

2.2.51 **May 2021** - Zoe pleaded guilty to assaulting the police officer at her initial hearing but denied assaulting Liam, claiming that the kick did not connect. Liam attended this hearing and indicated that he would not serve as a defence witness at any future trial, stating that there was no contact and that the officers were mistaken. The case was postponed so that consideration could be given to whether or not to proceed with the assault charge against Liam.

2.2.52 **June 2021** – CRHTT saw Liam; he reflected on his positive changes and did not feel at risk from Zoe. He was discharged to engage with the IDVA to continue medications, and a referral to social prescribing[25] for self-esteem and isolation was made.

2.2.53 **June 2021**—Liam contacted the IDVA service and stated that Zoe is always calling him at work and scrutinising him as soon as he gets home to find out what he has been doing. As a result, he was staying at his parents' house.

[25] https://www.england.nhs.uk/personalisedcare/social-prescribing/

2.2.54 **June 2021** – IDVA discussed healthy relationships and control with Liam via telephone and asked whether Zoe would engage with Make a Change[26]. He stated that when anyone calls, she says everything is fine.

2.2.55 **June 2021** – EDAN Lincs[27] IDVA contacted the police; they had received a text from Liam saying, "I need the Crisis Team; please delete this". The IDVA informed the police that Liam had recently returned to his partner, who used to abuse him domestically, and Liam is a high-risk MARAC. Officers attended his home. Liam was in bed, and his partner was with him; he was given the CRHTT number. CRHTT contacted via IDVA and attempted to call Liam to no avail.

2.2.56 **June 2021 (two days before Liam hanged himself)** – Liam spoke with the IDVA, concerned about his partner, who he stated would not understand why he could not drive her to the out-of-county social event. He thought of suicide, saying, "If I wasn't here, it wouldn't be a problem; if I die, I die, let me do it; I can't deal with the pressure from me." He was referred to CRHTT due to a plan to hang himself, and he did not wish to elaborate further except to say, "You're not going to like what you see." The assessing team noted that Liam could sometimes recognise Zoe's controlling behaviour toward him. However, he would retract this and focus on her being the one who needed help: "The only way Zoe will see what she is like and get the help is if I kill myself." He further described a tree he would use and had wanted to grind seeds to turn to cyanide. He added, "I've thought of killing myself with a noose and have been practising. I've let Zoe down by not taking her to the race meeting. I know I need help, and I wish Zoe would see my point of view." He was subsequently admitted to the PCDU. An email to the Trust Safeguarding Team and IDVA was sent regarding concerns about Liam's safety from Zoe. Liam consented to his mum being informed of the admission.

2.2.57 On arrival at the unit. Liam requested to leave; Liam referred to a suicide note on his phone to CRHTT; neither CRHTT nor the panel saw a suicide note. An MHAA was arranged. Liam's Mum called the unit and said that Liam is acting out of character and does well when he lives with her and his dad, and things deteriorate when he goes back to live with Zoe. Mum knew Zoe wanted Liam to drive her to the race meeting, but he did not want to do this. Mum describes the relationship as 'toxic.' Mum would be happy to have Liam stay with her.

2.2.58 **June 2021 (one day before Liam hanged himself)**– Liam was assessed under the MHAA and found not detainable under the Act. He was subsequently discharged to

[26] https://www.makeachange.uk.net/lincolnshire
[27] https://Ending Domestic Abuse Nowlincs.org.uk/

receive a follow-up from CRHTT. Liam reported that he experiences suicidal thoughts when he has the pressure of attending a racing event with Zoe. He said he used to go motorbike and sidecar racing with his dad, and now Zoe does this. It has become her thing. He described Zoe as controlling, demanding to know what he was doing, even when he got up to go to the toilet. He said he loved Zoe and wanted the relationship to work. At the assessment, he reported no intentions to act on the suicidal thoughts. Liam's parents agreed to pick him up.

2.2.59 **June 2021 – One day before Liam hanged himself-** CRHTT called Mum, who had spoken with Liam, and he was described as "more clear and chipper", which she thought was bizarre. Mum felt Liam had not been right since moving back with Zoe at Christmas.

2.2.60 **June 2021** – Liam hanged himself.

3.1 Analysis of Agency Involvement

3.1.1 This section examines the key organisation's management reviews and information.

Lincolnshire Police

3.1.2 The key events list twenty contacts between Liam, Zoe, and the police.

3.1.3 The police response revealed a practical and thorough comprehension of domestic abuse. They independently met with Liam and Zoe to gather information. However, the DASH was declined by both Liam and Zoe following domestic abuse, such as police calls to Liam's parents' home. Due to Liam's wish to seek help for Zoe and his reluctance always to acknowledge that he was a victim of domestic abuse, Liam declined intervention.

3.1.4 In December 2022, the CPS issued a statement declaring its commitment to tackling domestic violence.[28] According to the report, 20% of their caseload is due to domestic abuse. However, referrals have declined annually. According to the statement, men account for one-third of the 2.3 million victims of domestic abuse between the ages of 16 and 74. According to the CPS's review of the report, the numbers are gradually rising, and the Police and the CPS in the East Midlands are collaborating to increase these numbers through joint training and scrutiny panels examining police and CPS decision-making to ensure that investigative opportunities are not missed.

3.1.5 Moreover, the Domestic Abuse Act (2021) aims to ensure that victims feel comfortable disclosing abuse, and the state should support them.

[28] https://www.cps.gov.uk/publication/domestic-abuse-policy-statement

3.1.6 Zoe was not served a DVPN after the assault and arrest, during which the police conducted a DASH risk assessment with Liam, and it was clear that the police considered him a victim of domestic abuse. However, Liam was issued a DVPN after his arrest and a DVPO when he appeared before the magistrates. Due to Liam being identified as a domestic abuse victim and Zoe's assault on Liam and subsequent arrest, even though bail conditions were in place, the author believed a DVPN/O could have also been issued.

3.1.7 To note, a DVPN may be granted without the victim's agreement if the victim is believed to be subject to coercion and control.

3.1.8 The Office of National [29]Statistics indicated that 78 DVPNs were granted in Lincolnshire, 72 DVPOs were requested, and 70 were granted in Lincolnshire during the year ending March 2022. Within the same period, there were 1,981 arrests.

3.1.9 According to research, agencies do not adequately respond to male victims of domestic violence. Although it was clear that Lincolnshire police assisted Liam in gaining access to services, they did not contemplate a DVPN. However, the bail conditions would mirror the DVPN.

Crown Prosecution Review

3.1.10 A CPS lawyer ruled that the evidence would determine the case. Therefore, Liam was not required to appear in court. The lawyer applied the Code for Crown Prosecutors[30] and the CPS policy and guidance. Based on all available evidence, the lawyer determined that there was sufficient evidence to provide a realistic chance of conviction based on the statements of the responding police officers and the body-worn video that corroborated their accounts.

3.1.11 The CPS reviewing this report stated there was sufficient evidence to charge Zoe with the alleged offences, and the charge level was commensurate with the evidence presented by the investigating officers.

3.1.12 After the initial hearing, the case was reconsidered in light of the trial issue raised by the defence during case management and Liam's comments and opinions at this hearing.

3.1.13 The lawyer’s review confirms that no injuries were sustained during the incident, and given Zoe's guilty plea to the assault on the emergency worker (an either-way offence for which the court has greater sentencing powers), a trial for Liam would not have a significant effect on the resulting sentence.

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[29] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseandthecriminaljusticesystemappendixtables

[30] https://www.cps.gov.uk/publication/code-crown-prosecutors

3.1.14 It was noted that Liam did not support the prosecution but intended to attend the trial as a witness for the defence supporting Zoe's account, and no restraining order was necessary.

3.1.15 The CPS stated that the decision not to proceed was correct under these circumstances. Due to the factors above, the reviewing lawyer determined that it was not in the public interest.

3.1.16 The CPS also believes that there was no longer a realistic prospect of conviction on an evidential basis, which is the first limb that must be considered and met in the Code. This is because the officers' evidence of the assault on Liam would be significantly undermined by his account at trial.

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3.1.17 Zoe and Liam were both in contact with the IDVA service. In June 2018, Liam was identified as the alleged perpetrator of domestic abuse against Zoe. The police provided additional information, stating that Zoe was abusive and controlling towards Liam. Zoe was deemed ineligible for service and did not require IDVA intervention.

3.1.18 Five days before Liam's unexpected death, he sent a text message to the outreach service stating, "I need the crisis team; please delete this." The service contacted the crisis team, and the crisis team agreed to contact Liam. The service notified the police of the message and highlighted Liam's controlling relationship when no response was received.

3.1.19 The following day, after hours, a text message arrived at the IDVA service: "I don't know whom to reach out to; I'm desperate, and no one is listening."

3.1.20 The IDVA texted Liam, informing him that they were concerned about him and requesting that he call them immediately; if he did not comply, they would contact his mum or the police to ensure his safety.

3.1.21 Liam called within the timeframe and stated, “I regret sending that message.” The IDVA asked Liam if he wanted to harm himself. He was vague: “I’ve got a plan that works,” adding, “They don’t take me seriously, and I wasn’t ready to be launched into the world on my own.”

3.1.22 Liam spoke fondly of his dad and how he used to cook for everyone at the race meets on his big BBQ, which they do not do anymore due to Zoe’s behaviour. However, he did not expand on this and stated that Zoe does not recognise her behaviour and that she is a good person, saying, “It’s like watching your kids mess up.”

3.1.23 Liam discussed his alcohol consumption and going to rehab. He had begged Zoe to do the same. However, she did not. Liam was concerned that Zoe needed help. However, she would not accept any form of support.

3.1.24 Liam contacted the IDVA the same day and stated he was panic-stricken about how Zoe would react when he told her he could not attend the race meet. He told the IDVA he had thrown himself in front of cars and had bounced, “Why didn’t I die? I knew how fast they were going. Why didn’t I die?.” Liam was preoccupied with telling Zoe he could not make the trip out of the county. He could not understand how she could not see that “I am tethering on the edge, why she could not see her boyfriend killing himself” and that “her not recognising it is costing someone their life in the process.”

3.1.25 During the call, Liam randomly said: “I’m good at tying knots” The IDVA asked if he had been practising, to which he replied: “I’m not going to answer that one.” The IDVA clarified if Liam had active plans to do anything; Liam stated he did, and the IDVA informed Liam she would contact another service to help him.

3.1.26 The IDVA contacted CRHTT and the police to inform them of the above.

3.1.27 The service followed its procedures and policies and ensured Liam was safe. Consent from adults is required to access the service. This can be challenging, especially when the adult does not believe they are the victim. Liam did not always regard himself as a victim, and male victims are three times more likely than female victims to conceal their abuse.[31]

3.1.28 Save Lives has published a report titled "Getting it right the first time,"[32] emphasising that every encounter should allow the victim to disclose abuse and obtain assistance. Liam was able to call for help when he experienced a mental health crisis and spoke to the IDVA about his relationship. However, there was a barrier that prevented Liam from accessing support. He may have felt incapable of speaking further as a male victim because of the preconceptions and beliefs surrounding male victims.

3.1.29 The government publication[33] "Supporting Male Victims" acknowledges that negative perceptions are barriers to reporting and seeking assistance. However, it emphasises the need to ensure male victims/survivors have timely and appropriate access to support. The IDVA service contacted Liam following the referral and responded to his calls for help.

3.1.30 The purpose of EDAN Lincs is to help and empower victims of domestic abuse. Liam called the IDVA in times of crisis. In addition, he appeared to have developed a rapport with the IDVA by revealing his feelings. A relationship of trust between the victim/survivor and the advocate is essential for empowerment.[34] Liam expressed his

[31] http://www.mankind.org.uk/wp-content/uploads/2018/03/35-Key-Facts-Male-Victims-March-2018.pdf
[32] https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf
[33] https://www.gov.uk/government/publications/supporting-male-victims/supporting-male-victims-accessible#identification-and-reporting
[34] https://doi.org/10.1093/bjc/azab069

preference for face-to-face communication as he struggled with the telephone. Unfortunately, Liam's only interaction with the IDVA was by telephone.

3.1.31 The IDVA demonstrated good practice involving agencies and following up to ensure Liam and Zoe had support.

GP

3.1.32 Liam registered with the practice in 1996; his contacts focused on his physical health. The contact in March 2018 concerned Liam's mental health; his mum reported Liam had been feeling down for a few years and was contemplating suicide. The GP scheduled a face-to-face appointment on the same day. Liam provided a history of feeling anxious, low, emotional, and unhappy. He was living with his girlfriend and working as a caretaker at a school. He reported not feeling tired; he was motivated and enjoyed work. "I don't know what makes me emotional," he said.

3.1.33 GP explored the suicidal thoughts; Liam said: "I wouldn't consider doing it, I don't want to, I won't do it." Liam was prescribed Fluoxetine 20mgs (an antidepressant) and to self-refer to S2C. Liam's sister informed the author that he would need assistance contacting services because he could not do so independently. Liam was reported to be depressed. While he indicated motivation for his work, it would have been advantageous to engage in a conversation regarding how he would contact support services, considering his ADHD. For example, when he planned to self-refer and what he would say. Liam did not self-refer to S2C.

3.1.34 Liam said he felt vulnerable, and the GP discussed the CRHTT referral process. Liam responded to the risk of harming himself: "I know myself; I will not do anything of that nature." He was to be reviewed in two to three weeks. Liam did not attend or request a further supply of medication. Liam's sister said he feared being admitted to a mental health unit, and to prevent this from happening, he would do and say what he felt services wanted to hear. Therefore, it would be essential to ensure that information about services is supplied in an accessible format and that the justification for recommending these services is underlined in terms of what assistance is available and what this would entail.

3.1.35 The referral to CRHTT was assessed as unwarranted, and no referral was made to the mental health service. The GP did not follow up on Liam's non-attendance, and the panel agreed this was inadequate. Sadly, this was the beginning of Liam not meeting the service criteria. This resulted in the expectation that Liam would continue managing his mental health without support from healthcare experts.

3.1.36 The GP practice has noted the feasibility of using a scheduled task for a telephone review where such concerns are raised in the future.

3.1.37 Liam called the surgery in March 2019 after his mum had witnessed a seizure. He had been standing and talking to his mum; his eyes rolled back, and then he started general shakes; it took one to two minutes to come around, and he was halfway to NL&G Hospital before realising where he was. Liam was a postal worker and was advised not to drive and report the seizure to DVLA. Per their standard practice, the GP did not write to the DVLA. Instead, the GP made an urgent referral to the First Seizure Clinic.

3.1.38 In January 2020, Liam attended the surgery with his sister; he reported a history of anxiety and mood problems. He had had medication and thought he might need some again. He had received counselling during school and found it helpful. He reported no thoughts of self-harm or suicide. He was diagnosed with anxiety and depression and prescribed Sertraline (an antidepressant) and Cyclizine (an anti-sickness medication); he was given information concerning S2C and advised to self-refer. Liam's sister said she had made this referral on his behalf, as he could not do so.

3.1.39 In January 2020, Liam and his mum received a telephone consultation and a face-to-face appointment with the GP. Liam had been in the hospital the previous day following a seizure. Liam had received multiple tests, including unremarkable brain scans, and left the hospital. Once at home, he had another seizure. Liam reported drinking excessive alcohol. The advice was given concerning his lifestyle, alcohol, diet, and not driving until he saw the neurologist. It was noted that the seizures could be related to excessive alcohol. He was prescribed Thiamine and Vitamin B Compound.

3.1.40 Liam requested a repeat prescription of Sertraline in February 2020.

3.1.41 In February 2020, during a telephone consultation with his GP, Liam revealed he had lost his job as he had a seizure and was awaiting a neurology appointment; however, he was feeling better with his emotions. As a result, a further two-week prescription of Sertraline was prescribed.

3.1.42 Liam and his parents made additional contact with the GP concerning the seizures. Liam was prescribed Lamotrigine (to treat epilepsy) at the University of Leicester Hospitals. Liam reported consuming one litre of whiskey daily but had not had any since the weekend. On Monday, he did drink a few cans of beer. Alcohol withdrawal seizures and excessive alcohol use were discussed.

3.1.43 In March 2020, Liam's mum reported to the GP that Liam had suffered another seizure. They had visited neurology at Lincoln and were informed that the hospital did not have Liam’s medical record and could not assist him. A request for referral to the neurology department at the NL&G Hospital was made. In addition, Liam's mum requested a referral for his ADHD; the GP advised that due to Liam’s excessive alcohol consumption, he would not be offered treatment for ADHD and would need to seek help for this first. Mum understood. It is expected that Liam would continue to self-

medicate with alcohol, given his second refusal of assistance and the absence of any mitigation to assist him with his symptoms. Mum had claimed that alcohol was used for this objective.

3.1.44 In May 2020, Liam's mum received a telephone consultation from the GP concerning Liam's excessive alcohol consumption; contact details for addiction services were given, and she agreed to contact them. However, there was no record of any contact being made, and the GP did not follow up on this.

3.1.45 Liam received a telephone consultation with the GP in August 2020. Liam had met with a private therapist who believed he displayed symptoms of adult ADHD. There were no reports of inattention or hyperactivity, but he was impulsive. As a child, he was diagnosed with ADHD and Asperger's syndrome and would like medication for ADHD to be prescribed. He was informed that he would require a formal assessment. Sadly, it is the standard for such assessments to take some time inside the NHS. Therefore, Liam should have been given information by his GP on how and where to get support should his symptoms develop and how to manage these symptoms.

3.1.46 In January 2021, the GP processed an information request regarding MARAC, the initial notification of domestic abuse.

3.1.47 Liam was discussed at the MARAC and the GP practice safeguarding meeting in March 2021. No additional entry was required on his notes.

3.1.48 Concerning Liam's mental health and alcohol abuse, the GP advised Liam to self-refer.

3.1.49 Once the GP learned of the MARAC, a meeting to discuss patient safety was convened, identified as an area of good practice for the GP.

3.1.50 Most of Liam and his family's contacts with the GP were requests for assistance in managing his ADHD symptoms, alcohol consumption, depression, and anxiety. He was prescribed medication and told to self-refer to S2C. However, Sophie believed that Liam would be unable to self-refer and would require assistance with self-referral and subsequent appointment attendance. Therefore, the family should have been given guidance on what they might do to support Liam. For instance, a contingency plan for a crisis.

Lincolnshire and District Medical Services

3.1.51 Liam contacted the service in April 2019; the practitioner who reviewed Liam and his partner in April 2019 did not observe any domestic abuse or controlling and coercive behaviour indicators. Moreover, they reported not receiving any information to inform them of this. However, this may be due to the presence of the alleged perpetrator and the victim's inability to disclose concerns.

3.1.52 The consultation identified concerns regarding excessive alcohol consumption and marital and financial issues, which were forwarded to relevant agencies. Regarding marital concerns, requesting a private meeting with Liam and enquiring about domestic abuse would be appropriate practice.

3.1.53 A greater investigation into Liam and his partner's 2019 presentation may have led to a domestic abuse enquiry. Due to the risk, however, such questions should be posed without the potential offender present.

Lincolnshire Partnership NHS Foundation Trust

3.1.54 Liam engaged with S2C, CRHTT, CMHT, MHLT and the PCDU, all services provided by the Trust.

3.1.55 Liam self-referred to the S2C in January 2020 for assistance with his longstanding anxiety and depression, ADHD, and Asperger's syndrome. He had difficulty eating, fatigue, and compulsive behaviours. Liam was sent an opt-in letter.

3.1.56 Opt-in systems are used to reduce missed appointments, so Liam was responsible for confirming he needed the appointment. However, because he did not respond, he was excluded from the service, and as an unexpected result, he did not receive an assessment or treatment.

3.1.57 According to The Priory[35], 40% of men are unwilling to discuss their mental health, which impedes receiving assistance. Instead, they discovered that suicidal or self-harming ideas compelled them to seek help.

3.1.58 Liam's sister referred to STC because she believed he would not have done so alone, which explains why he did not opt-in. However, based on the statistics from The Priory, it is possible that Liam would not have sought help until he felt suicidal, which is when he did seek assistance from the IDVA.

3.1.59 In February 2020, Liam referred to S2C again, citing ADHD, depression, poor sleep and appetite, and increased alcohol consumption. Due to his alcohol consumption , a telephone assessment was offered, but he was not accepted for treatment due to his high alcohol use. Instead, he was referred to local addiction services after being discharged from S2C. Unfortunately, Liam once again did not satisfy the criteria for the service; he self-medicated with alcohol, and his alcohol use was unlikely to alter without additional support.

3.1.60 In December 2020, Liam was seen face-to-face by CRHTT and triaged; he struggled with his recent relationship breakup and was forced to move back in with his parents. He requested psychotherapy, reported no past or present suicidal ideation or intent,

[35] https://www.priorygroup.com/blog/40-of-men-wont-talk-to-anyone-about-their-mental-health

and was transferred to S2C. Since Liam was ineligible for S2C eight months ago owing to alcohol consumption, the CRHTT would be required to assess his alcohol use.

3.1.61 In January 2021, S2C transferred Liam to the CMHT. At the time of his death, Liam was under the care of CRHTT. The referral indicated that two suicide attempts had occurred within the previous five months. Liam described a lack of self-control and impulsiveness. He thought he would be better off dead and devised a plan.

3.1.62 In February 2021, an assessment was conducted; Zoe was on bail and was prohibited from contacting Liam. Liam became guarded when discussing domestic abuse because he did not want Zoe to get in trouble. Liam was eager to receive support and medication for ADHD; he reported nil mental health issues and claimed his impulsivity was related to his abstinence from alcohol. The Priory[36] emphasised that men's embarrassment or belief in the stigmatisation of mental health prevented them from seeking assistance. ADHD was a disorder with which Liam was familiar, and he was certain that his problems were related to it.

3.1.63 The team offered an outpatient appointment with the psychiatrist. Liam requested support for ADHD, which was satisfied by referring him to an outpatient consultation with the CMHT.

3.1.64 Liam was seen at the outpatient clinic, where he reported abstaining from alcohol and having a supportive girlfriend; however, they had disagreements. The clinical impression was of cyclothymia (a mild mood disorder) and personality traits, including impulsivity and self-harm. Quetiapine was prescribed with a plan to review.

3.1.65 The MHLT saw Liam and his parents at LCH in May 2021 following a crisis attendance. Since the report of a volatile relationship with his ex-partner, Zoe, Liam had undergone detoxification at a rehabilitation facility. According to the MARAC notes, Zoe posed a threat to Liam. The assessment had the support and participation of Liam's parents. However, the parents believed they lacked the knowledge and skills to manage their son's distress. A request was made for a response from CRHTT. Liam's parents were described as supportive and providing him with informal care. CRHTT offered them a carer's assessment (Care Act 2014).

3.1.66 The next day, CRHTT visited Liam at his parent's home. Liam was concerned that he was being portrayed as a victim and that Zoe required assistance, even though she did not see this (the detail of this is within the key events). Liam had fleeting suicidal thoughts and intended to jump from the Humber Bridge, leading to the hospital's crisis attendance.

[36] https://www.priorygroup.com/blog/40-of-men-wont-talk-to-anyone-about-their-mental-health

3.1.67 The psychiatrist met with Liam and discussed the emotional, physical, and psychological effects of domestic abuse on him. The psychiatrist suggested daily CRHTT visits and referred Liam to EDAN Lincs with his consent.

3.1.68 Liam's assessment at the PCDU is described in detail in the key events. During the admission, Liam's mum enquired about Liam's relationship with Zoe. The parents expressed concerns regarding the relationship, and the PCDU staff expressed concerns about coercive control and physical abuse, with the agreement being that CRHTT would review this further with Liam in the community. Unfortunately, this did not occur, as Liam was found deceased the following day after discharge.

3.1.69 The parents questioned the relationship. Although they informed the author that they did not believe their son was a victim of domestic violence, it indicates they wanted guidance to comprehend Liam and Zoe's relationship.

3.1.70 During the panel discussions and LPFT's presentation of information, it was clear that the CRHTT engaged with Liam to aid in his mental health recovery and prevent domestic abuse. The panel had discussions and recognised alcohol usage as a barrier to Liam receiving access to an assessment of adult ADHD.

United Lincolnshire Hospitals NHS Trust

3.1.71 Liam presented to A&E in May 2021 with suicidal ideation and a request to see the crisis team. His parents were with him. Liam did not want to discuss his suicidal ideation with the staff. However, a mental health emergency triage form (risk assessment) was completed. He was rated as posing a moderate risk of self-harm. It was documented that Liam's parents were supportive. A referral was made to the MHLT.

3.1.72 Liam’s referral to mental health was appropriate.

3.2 Analysis of Terms of Reference

This report section analyses the Terms of Reference (ToR) to confirm that they have been addressed and met.

3.2.1 Liam received input from the following agencies during the period under review:

1. Lincolnshire Police
2. Independent Domestic Abuse Advocate
3. GP Practice
4. Lincolnshire and District Medical Services
5. Lincolnshire Partnership NHS Foundation Trust

6. Lincolnshire County Council Adult Care and Community Wellbeing
7. United Lincolnshire Hospitals NHS Trust

3.2.2 **TOR 1**: To what extent did COVID-19, lockdown, and potential isolation impact Liam and his partner accessing support, e.g., domestic abuse, alcohol misuse, or mental ill-health services?

Analysis:

3.2.3 On 23 March 2020, the Prime Minister announced the first Lockdown, advising citizens to remain at home, and Lockdown measures went into effect on 26 March 2020.

3.2.4 On 19 July 2021, most legal restrictions on social contact in England were lifted, and the final closed sector of the economy reopened.

3.2.5 The police response during the pandemic did not negatively impact any of the service requests regarding Liam.

3.2.6 Liam contacted his GP via telephone in February 2021 regarding medication and received a face-to-face appointment in March 2021 for his COVID-19 vaccination.

3.2.7 The GP practice continued to triage all patients, and if necessary, the patient was offered a face-to-face review. During the COVID-19 Lockdown, no patient was denied a face-to-face assessment if clinically indicated.

3.2.8 Liam used the services of the (LPFT). Liam was contacted at home, on the base, and by telephone. Liam's primary contact throughout COVID-19 was CRHTT. The team continued to see patients in person. If an appointment was cancelled due to staff illness, it was rescheduled with another team member, or Liam maintained telephone contact to continue risk monitoring. Liam received care as usual; the CRHTT Coordinator confirmed that the team's care during COVID-19 did not affect the delivery.

3.2.9 Liam had access to services and kept in touch with his parents. Uncertain if he felt alone during COVID-19. Liam struggled to recognise himself as a victim of domestic abuse fully. His parents attempted to obtain assistance for him to address his poor mental health, which they believed was affecting his relationships and resulting in his excessive alcohol consumption.

3.2.10 **TOR 2**: Consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review, assuming when these actions were implemented within the agency.

Analysis

3.2.11 No recurring recommendations are relevant to this review.

3.2.12 **TOR 3**: Identify any signs of domestic abuse or coercive and controlling behaviour determined by or disclosed to agencies.

Analysis

3.2.13 Domestic abuse-related incidents reported to the police were identified. However, not all resulted in a DASH risk assessment. Liam and Zoe did not always participate in the DASH process nor allowed their information to be shared with partner agencies. However, when they responded to questions or interacted with staff, the staff correctly identified alleged controlling and coercive behaviour, and crime reports were filed on two occasions.

3.2.14 Domestic abuse was first disclosed to the LPFT through the MARAC meeting in January 2021. The MARAC meeting minutes and MARAC referrals were uploaded and contained within the electronic patient record document repository. Consequently, they are available to any practitioner or team working with Liam or Zoe. In addition, alerts were added to both parties' records to inform the practitioner that domestic abuse was present in this relationship and that Liam and Zoe had been heard at MARAC.

3.2.15 Liam had not disclosed domestic abuse directly to LPFT before the MARAC's January 2021 meeting. This is common, as statistics indicate that half of the male victims (49%) fail to tell anyone they are victims of domestic abuse and are 2.5 times less likely to do so than female victims (19%). As a result of stereotypes and a fear of not being believed, men and boys may find it particularly difficult to report abuse. Male victims may be less likely to admit that they are being abused or to recognise that they are victims of domestic abuse because they may believe that the term domestic abuse applies only to women. [37]

3.2.16 Liam cited difficulties adjusting to the loss of the relationship as the primary reason for his referral to CRHTT in December 2020 but did not disclose abuse. NICE published a Quality Standard (QS116)[38] in February 2016, with the first Quality Standard Asking about domestic abuse. Multiple reports have reaffirmed the necessity of implementing routine enquiry; admittedly, these have centred on women. However, according to a report by Agenda,[39] the term encompasses all genders: Routine enquiry refers to frontline staff asking all service users about their experience of domestic abuse regardless of whether there are indicators of or suspicions of abuse. To implement routine enquiry, staff must be competent and confident in their ability to enquire. A pilot project[40] with GPs revealed an attitudinal change that had made them more

[37] http://insight.cumbria.ac.uk/id/eprint/4367/1/Impact%20and%20perceptions%20paper%20final.pdf
[38] https://www.nice.org.uk/guidance/qs116/chapter/quality-statement-1-asking-about-domestic-abuse-and-abuse
[39] https://weareagenda.org/wp-content/uploads/2020/12/Ask-and-Take-Action-report_upd.pdf
[40] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf

comfortable asking about domestic abuse. In addition, Safe Lives[41] defines the difference between routine and clinical enquiry for GPs. Finally, the Domestic Abuse Statutory Guidance[42] outlines the responsibilities of individual agencies to identify and respond to domestic abuse, recommending that agencies invest in specialist training to ensure victims receive effective and safe responses.

3.2.17 Liam discussed and explored domestic abuse during his CMHT assessment in February 2021.

3.2.18 Liam was guarded when discussing domestic abuse during the initial CMHT assessments, stating that he did not want to get Zoe into trouble and made no direct disclosures. No DASH was completed on this contact because information about recent abuse had already been shared within the appropriate MARAC forum. At this time, bail conditions prevented the couple from communicating. Liam did not imply that there had been any communication with Zoe. The CMHT did discuss EDAN Linc's support. The CMHT provided information per the Trust's policy and procedure regarding domestic abuse and responded accordingly.

3.2.19 In May 2021, the Trust recorded Liam's annoyance as being labelled a victim of domestic abuse, stating that he believed Zoe required assistance. Domestic abuse and risks around this were followed up with further discussions in May 2021. Liam gave examples of Zoe's controlling and coercive behaviours in making fake social media accounts contact him. As a result, the Trust referred Liam to EDAN Lincs.

3.2.20 Liam and the CRHTT consultant psychiatrist discussed domestic abuse in May 2021. Liam discussed his experience with direct physical abuse, including strangulation (all of which had been discussed previously at MARAC), and the broader context of Zoe's coercive and controlling behaviours. Liam consented to a referral after receiving information about EDAN Lincs from the CRHTT consultant psychiatrist. EDAN Lincs subsequently contacted Liam in late May 2021.

3.2.21 In May 2021, Lincolnshire police referred Liam to MARAC. The referral was followed up within two days. Liam wished to maintain his relationship with Zoe. However, he recognised that she required assistance, which she refused to accept. Liam had characterised the relationship as "brilliant." They met through mutual friends and fell in love with one another. Liam wished to devote all his time to Zoe and avoid his friends. Liam stated that this was all he knew about relationships and that he was aware he needed Zoe's permission for everything.

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[41] Pathfinder GP practice briefing.pdf (safelives.org.uk)

[42] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

3.2.22 Liam told the IDVA about an incident three years ago; Zoe had accused him of being abusive, which went to court and was reported in the news. Zoe yelled at Liam and asked, "Who are the police going to believe – the screaming girl or you?" Liam described the relationship as a cycle in which they would quarrel. He would return to his parent's house and reconcile a few weeks later, at which point he would return to Zoe. He was aware that this could not continue and felt Zoe required support. He described how the disagreements would begin over nothing and then escalate. He became emotional and declined further discussion.

3.2.23 Manipulation was identified as a behaviour that prevents male victims from seeking help, creating a dependence on the perpetrator and reinforcing the denial that males can be victims.[43]

3.2.24 Liam expressed his dependence on Zoe to the IDVA: "I want to be with her; I can't not be with her. I want to make her happy." He believed, "If she is happy, then I'm happy." Liam described Zoe: "She is scary when she gets going; I think at that moment she could hurt me." According to him, she could inflict physical and emotional pain and destroy items of significance to him. He said he used to go motorcycle racing with his dad and that she had taken this over. Liam reported that Zoe was extremely jealous and would accuse him of infidelity, describing an incident in which she discovered a hair that was not hers on him and "went mad about it."

3.2.25 During his contact with CRHTT in early June 2021, Liam disclosed that his guitar had been broken; he was uncertain about this but suspected that Zoe was responsible. Liam may have known more about this incident but feared disclosing it due to his ambivalence about being perceived as a victim of domestic abuse and how he felt this affected Zoe's ability to access support.

3.2.26 **TOR: 4** To establish whether procedures relating to domestic abuse were followed and what action was taken.

Analysis

3.2.27 Lincolnshire police force has domestic abuse policies and procedures based on The College of Policing's Approved Professional Practice[44]. Officers have gained proficiency in addressing domestic abuse. They are always urged to take proactive measures and ensure the safety of all parties involved, whether victim, witness, or offender.

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[43] http://insight.cumbria.ac.uk/id/eprint/4194/2/Egg%20shells%20paper%20final%20pdf.pdf

[44] https://www.college.police.uk/guidance

3.2.28 Lincolnshire police, as are the other agencies in this review part of the SLP,[45] will collaborate to respond to domestic abuse.

3.2.29 Liam and Zoe have both been victims and alleged perpetrators in the incidents that have been reported. Lincolnshire police also adhere to the Approved Professional Practice regarding 'Arresting the Right Person and Dual Arrests.'[46] This identifies the best practice for ensuring that officers obtain a complete picture of the circumstances before deciding on an appropriate course of action, ensuring that the desired results are achieved.

3.2.30 Bidirectional domestic abuse implies that both partners may engage in aggressive behaviour during a dispute. However, this may not be the case for every conflict episode and may not be symmetrical.

3.2.31 However, granting a DVPN, in addition to the bail conditions that were in place, was not considered when Zoe was arrested after the police witnessed the assault and the DASH risk assessment was completed on Liam.

3.2.32 The GP practice responded appropriately to the information requests from MARAC, and Liam was subsequently discussed at the practice safeguarding meeting. However, LADMS had not held a separate talk with Liam or recommended that his usual GP follow up on this.

3.2.33 Domestic abuse-related LPFT policies, procedures, and flowcharts are outlined in the Safeguarding Policy, which is discussed in training and accessible to practitioners in their clinical environments and via the Intranet. All practitioners must respond to any disclosure of domestic abuse by completing a DASH risk assessment and forwarding it to the Trust Safeguarding Team for review and advice. The policy also describes how to access victims of domestic abuse safely and when to share information. For example, consider the scenario where practitioners are aware of domestic abuse, but no disclosures are made. In this case, they are expected to continue to monitor this risk, seek guidance from the Trust Safeguarding Team, and share pertinent information with the multiagency, as necessary.

3.2.34 LFPT did not complete a DASH risk assessment since they knew that Liam had been referred to MARAC and that the forum already had access to the material they held.

3.2.35 In addition to the support held within the Trust, the Department of Health has published a resource pack to support Health's Response to Domestic Abuse.[47]

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[45] https://www.lincolnshire.gov.uk/crime-prevention/safer-lincolnshire-partnership

[46] Arrest and other positive approaches | College of Policing

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

3.2.36 No direct disclosures of domestic abuse were made to the LPFT until January 2021 after the MARAC. Those who rarely make direct disclosures have encountered barriers, such as not being asked, fear of repercussions, being judged, or insufficient time to build trust with the professional.[48]

3.2.37 The thorough documentation of the risk of domestic abuse throughout Liam's contacts demonstrates that practitioners adhered to domestic abuse policies and procedures. Through the clear documentation in Liam's record, any practitioner working with Liam would be aware of domestic abuse in the relationship and up to date on the actions taken.

3.2.38 Following the disclosure, the CRHTT practitioner requested an outpatient consultation with the CRHTT consultant psychiatrist to obtain a medical opinion and treatment recommendations. During the outpatient meeting, the consultant psychiatrist discussed domestic abuse with Liam and the assistance provided by EDAN Lincs. Liam agreed to this, and he was subsequently referred to EDAN Lincs. Liam informed CRHTT in late May 2021 that he had spoken with the IDVA, resulting in additional police action. This is a clear demonstration of how procedures relating to domestic abuse were followed and the effort that was taken.

3.2.39 LFPT practitioners were expected to share information in some instances but failed. For example, a home visit was attempted in May 2021, but Liam was absent. Liam's dad informed them that he had spent the night with Zoe. The CRHTT practitioner then called Liam to confirm that he had returned to Zoe and was staying at her home. A face-to-face meeting was scheduled to investigate Liam's risk further. The chances of resuming the relationship were discussed, and Liam acknowledged some of Zoe's flaws but justified them by describing her as "perfect." A study[49] found that a typical pattern of domestic abuse, particularly between intimate partners, is that the perpetrator alternates between violent, abusive, and apologetic behaviour with sincere promises to change and that the abuser is typically charming. Liam did note, however, that he had been bowling with his dad the previous evening and that Zoe did not appear pleased, but he did not elaborate.

3.2.40 As Liam had returned to live with Zoe, the CRHTT practitioner documented safeguarding concerns and a plan to contact the LPFT safeguarding team for further guidance. However, there is no evidence that they did. The CRHTT coordinator could not explain why this occurred but believed it was an oversight. If this had happened, the Trust Safeguarding Team's advice would have centred on information sharing with

[48] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8248429/
[49] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4768593/

EDAN Lincs and the police to update them on Liam's return to live with Zoe, as this would have represented a significant escalation in risk. Since Liam's passing, the CRHTT coordinator has reflected on how information sharing with other agencies could have been improved in this instance.

3.2.41 Early in June 2021, Liam and Zoe were heard at MARAC for a second time. Following LFPT policy, the Trust Safeguarding Team contacted CRHTT via email in early June 2021 to inform them that Liam was scheduled to be heard at MARAC as a victim of high-risk domestic abuse and to request that he not be discharged from CRHTT until after the MARAC, as CRHTT may be assigned follow-up actions. The CRHTT responded to the email, stating that the discharge plans would proceed. Liam had consented to a comprehensive discharge plan for post-discharge support for referrals to S2C for interpersonal therapy and social prescribing.

3.2.42 According to the CRHTT consultant psychiatrist, Liam displayed positive signs that his risk to himself had diminished. He had begun medication with some positive effects, and his mood was becoming more stable. In addition, Liam was not drinking and had not recently endangered himself through impulsive behaviour. At this point, he was discharged from CRHTT with a plan for ongoing support through other LPFT services.

3.2.43 According to the American Practice Guideline for The Assessment and Treatment of Patients with Suicidal Behaviours,[50] there may be an increase in suicide risk as depressive symptoms begin to improve but before they are entirely resolved. Patients are more likely to act on suicidal impulses due to the enhanced energy and motivation accompanying depression relief. It has been contested. However, mood swings are fundamental to the risk of suicide.[51] To support Liam's recovery regarding his mood and alcohol use, it was essential to continue monitoring and implementing processes that would aid his rehabilitation.

3.2.44 In addition to the clinical impression of cyclothymia, Liam was also drinking excessive alcohol. There is a strong correlation between chronic or acute alcohol abuse and suicidal ideation, suicide attempts, and suicide death.[52] Consequently, the author believes that ensuring Liam received assistance from alcohol services should have played a significant role in his discharge plan.

3.2.45 Before Liam's discharge, CRHTT suggested they assess his relationship-related capacity. Although a formal capacity assessment was not performed, Liam's capacity was considered in every interaction. The coordinator of the CRHTT stated that the team had no reason to doubt his capacity. This conforms to the first principle of the

[50] https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
[51] https://pubmed.ncbi.nlm.nih.gov/3183647/
[52] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872355/

Mental Capacity Act 2005[53]. This is reflected in the discharge risk assessment dated early June 2021, in which the CRHTT practitioner notes that the risks associated with Liam's return to Zoe were discussed and that he did not feel at increased risk from Zoe; in addition, he was aware of the risks and could make this decision. Regardless of whether the risk of controlling and coercive behaviour had increased, it remained. Zoe did not engage in any support services to address her needs; therefore, it is safe to assume that the relationship's initial concerns had not changed. As a result, Liam remained in an abusive relationship, and LFPT continued to work with him to establish safety plans and referred him to domestic abuse services.

3.2.46 The Trust was assigned two actions following MARAC at the beginning of June 2021. First, provide Liam with feedback. This was accomplished expeditiously by CRHTT. Liam stated during feedback that he did not believe Zoe would participate in 'Make a Change' as recommended by MARAC. The Trust should have communicated its concerns regarding her potential non-engagement with agencies through the information-sharing agreement, a component of the MARAC operating protocol. This did not happen. It is difficult to predict whether this would have significantly impacted the outcome. Make a Change is a voluntary support programme that relies on consent, which Zoe was not providing. Also, it would be reasonable to assume that if agencies had advised her to attend Make a Change, they would be aware that she was not engaging. Regardless, agencies working with Zoe may have benefited from being made aware of this information, which may have encouraged them to converse with her.

3.2.47 The second action was for LPFT to review Liam's alcohol use and consider any necessary referrals (such as We Are With You[54]). Liam disclosed drinking two to three glasses of whiskey daily in late May 2021; however, during his next contact, Liam stated that he had not consumed alcohol since the weekend. The CRHTT multi-disciplinary team (MDT) documented a plan to investigate a possible referral to We Are With You. Liam abstained from alcohol, according to the subsequent discharge risk assessment dated June 2021. Therefore, We Are With You would not have been indicated for subsequent referrals. In addition, Liam had declined support for alcohol use. Nonetheless, a substantial risk factor for his impulsivity was his relationship with alcohol, which was highlighted in his risk assessment and shared with his GP, and revisiting this during his meetings with LFPT.

[53] https://www.legislation.gov.uk/ukpga/2005/9/section/1
[54] https://www.wearewithyou.org.uk/services/lincolnshire-lincoln/

3.2.48 Liam disclosed to CRHTT that he had consumed two to three glasses of whiskey, had stopped drinking by discharge and declined to be referred to We Are With You. Therefore, no referral was made; however, ensuring he receives abstinence support would be reasonable. It is accepted that this was difficult because Liam refused alcohol help.

3.2.49 Two days before Liam's death, the IDVA referred him to CRHTT in response to text messages received that morning. Due to the nature of the risk, the CRHTT accepted the referral and scheduled a home assessment. Liam expressed suicidal thoughts with a plan. Liam revealed that Zoe was refusing assistance, not engaging with Make a Change, deflecting her problems onto him, and continuing her abusive behaviour. The CRHTT practitioner followed the procedure and asked Liam if Zoe had assaulted him physically, but Liam refused to respond. Instead, Liam provided examples of her controlling behaviour, such as stating that Zoe told him he could not attend university because it would not provide them with a stable enough income.

3.2.50 The Domestic Abuse Act 2021 states that behaviour is abusive if it consists of the following:

- Physical or sexual abuse.
- Violent or threatening behaviour.
- Controlling or coercive behaviour.
- Economic abuse.
- Psychological, emotional, or other abuse.

According to the Act, Liam was a victim of domestic abuse, regardless of whether this was physical or not.

3.2.51 The risk assessment dated two days before Liam's death notes that he had disclosed struggling with his mood and that Zoe had displayed coercive control by telling Liam not to speak to anyone or have anyone over to the house because she wanted to go to the out of county event. Following these disclosures, attempts were made to plan for safety, and Liam became fixated on wanting to end his life so Zoe would realise she needed assistance. Liam expressly stated that he wished "to end his life today" and that he "had let Zoe down" and wanted “to end his life to prove to Zoe that she needs help." Liam reiterated these beliefs the day before he died, stating that he still believed Zoe would receive support if he took his own life.

3.2.52 The CRHTT practitioner refuted these beliefs, noting that Liam could justify them by stating, "She will be Juliet; she may kill herself." The CRHTT coordinator clarified this point by explaining that Liam was alluding to Romeo and Juliet and that if he died by

suicide, Zoe might follow suit. This remark was challenged, and the CRHTT practitioner noted that Liam understood that suicide was not the answer to his described problem.

3.2.53 In response to this escalating risk, the CRHTT practitioner referred Liam to the PCDU two days before his death for further review and safety planning considerations. In the clinical risk assessment two days before Liam's death, the CRHTT practitioner notes that Liam disclosed ongoing abuse but did not provide further details and that MARAC and IDVA were recently involved. The disclosures revealed he was a victim of domestic abuse, and the involvement of MARAC and IDVA indicated his risk was high. It is possible to hypothesise that asking Liam to disclose more of his experiences may have made him feel insufficient and unable to defend himself. In addition, it reinforced the masculine stereotype of not wanting to be a victim.

3.2.54 The government issued a position statement titled Supporting Male Victims[55], which identified barriers preventing men from seeking assistance and cited a study that found "male victims were told their perpetrators mocked them for not being sufficiently manly." The statement mandates that all victims and survivors access timely and adequate support. Liam was referred to the appropriate agencies.

3.2.55 CRHTT followed their procedure by investigating domestic abuse directly with Liam in response to safety concerns, documenting this, reducing Liam's risk of harm, and sharing the information with the IDVA and the Trust Safeguarding Team. It should be noted that a DASH was not completed on this occasion (as would typically be the case), as the escalating risk to self took precedence. Liam was experiencing a high-risk crisis. The CRHTT practitioner responded by removing him from his home, where he had indicated he had prepared a noose, and transporting him to a place of safety (PCDU), thereby mitigating the immediate risk.

3.2.56 The WHO[56] has identified suicide prevention strategies restricting access to lethal means. CRHTT attempted to check on the location where he had prepared the noose. However, he did not allow access to this. This would have been a challenging situation, and the CRHTT practitioner determined that Liam's life was more important than anything else at the time.

3.2.57 Domestic abuse was considered, and the PCDU was planned to complete a DASH risk assessment after ensuring Liam's immediate safety. Both progress notes and email correspondence demonstrate clear evidence of liaison between the IDVA, CRHTT, and Trust Safeguarding Team, with actions and responses proportional to the

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55 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1073565/Supporting_male_victims_2022.pdf

56 https://www.who.int/news-room/fact-sheets/detail/suicide

escalating risk. On this date, the Trust's safeguarding screening tools were also completed, reflecting that Liam had answered "yes" to the question about the abuse but had not provided additional information.

3.2.58 EDAN Lincs' practices are consistent with policies and procedures. Liam was also provided with additional support options, such as access to Refuge, Mankind, and mental health specialists.

3.2.59 **TOR 5:** To identify whether there were any barriers for Liam in seeking support for domestic abuse, alcohol misuse, or ill mental health.

Analysis

3.2.60 Liam did not wholly regard himself as a victim of domestic abuse; he informed all agencies with whom he had contact that Zoe required assistance and became annoyed when he felt agencies were portraying him as a victim. His parents believed that Liam needed help with his poor mental health and treatment for ADHD, which they felt would favour his relationship with Zoe. Liam's inability to accept fully that he was a victim would have affected the ability of any agencies to help him. In addition, Sophie indicated that Liam would not have self-referred per the GP's recommendation. Thus, she completed this on his behalf.

3.2.61 During Liam's interactions with the police, no barriers were identified that prevented him from seeking assistance for domestic abuse, alcohol abuse, or mental health. All victims of domestic abuse are helped by informing them of the available support services. If they do not consent to share their information with the respective agencies, no referrals or updates are made, leaving them to consider contacting the agency themselves. However, there are times when consent is overridden.

3.2.62 Safe Lives[57] provides advice on sharing information and states: “If you have assessed a victim of domestic abuse to be at high risk of serious harm or homicide (i.e., meeting the MARAC threshold), then you will have grounds for sharing information in law.” Liam was referred to MARAC.

3.2.63 Upon learning of Liam's contact with MARAC, the GP practice safeguarding meeting discussed Liam. It was suggested that Liam self-refer to services for his excessive alcohol use. Sophie noted that Liam was unlikely to self-refer and would require assistance to interact with services; hence, it is likely that the GP should have made the referral instead.

[57] https://safelives.org.uk/sites/default/files/resources/A%20Practitioner%27s%20Guide%20to%20GDPR%20-%20England%20%26%20Wales%20version.pdf

3.2.64 Liam was hospitalised for seizures and later discharged himself. In addition to being an inpatient at the private inpatient facility for alcohol treatment, he was referred to local alcohol services.

3.2.65 The ADHD assessment referral was denied because of his alcohol abuse. The rationale for this was discussed with him and his mum, and additional alcohol reduction advice was provided.

3.2.66 Unfortunately, it is often the case whereby services see substance use as the problem and will not work with someone until they stop using substances, which is unrealistic and adds to the stigma surrounding alcohol.

3.2.67 Dame Carol Black completed an independent review concerning drug treatment and recovery. She highlighted the need for a coordinated approach with multi agencies to invest in and improve treatment, employment, housing, and how people with addictions are treated in the criminal justice system.[58]

3.2.68 Regarding access to mental health support, Liam faced no direct obstacles. Ten times within eighteen months, Liam was referred to LFPT for assistance with his mental health. As a result, Liam could access mental health support.

3.2.69 Within these referrals into LPFT, Liam and Zoe's alcohol misuse was identified as a prevalent factor in their relationship. Liam disclosed to the CMHT in February 2021 that he had received private alcohol detox treatment and was engaging with community alcohol services within Nottingham. However, the Trust continued to monitor Liam's alcohol use, which was frequently discussed alongside domestic abuse and the resulting risk to his mental health, with an increase in alcohol use recorded as a mental health relapse signature. Liam did not wish for referrals to alcohol services.

3.2.70 It could be argued that Liam's ambiguity about himself as a victim of domestic abuse functioned as a barrier to seeking help for domestic abuse. For example, Liam avoided discussing domestic abuse with LPFT in February 2021 because he "didn't want Zoe to get in trouble." Moreover, in the MARAC referral heard in January 2021, Liam disclosed to police that he had been in a relationship with Zoe since he was 15 years old and 'knows nothing else,' indicating that he had become desensitised to and accustomed to the abuse he was enduring.

3.2.71 In May 2021, it was documented that Liam felt 'irritated' that the focus was on him as a victim, which he perceived to be preventing Zoe from obtaining support. Two days before his death, when he was seen at home by CRHTT, Liam asserted that he wished to reveal what Zoe had been doing to him but was afraid that doing so would prevent

[58] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

her from receiving the necessary support. Liam's ambivalence in recognising himself as a victim of domestic abuse is evident throughout his interactions with the Trust. Liam consented to a referral (for himself) to EDAN Lincs in May 2021, demonstrating some acceptance that he was a victim of domestic abuse and recognition that he required support.

3.2.72 Zoe's coercive control sometimes prevented Liam from receiving assistance for domestic abuse, alcohol, and mental health. Safe Lives[59] provides examples of coercive control; the perpetrator demonstrates dominance over the victim by limiting or isolating them from others, preventing them from accessing care and controlling their daily lives. For example, early in June 2021, CRHTT reported that Zoe was present during a home visit with Liam and had no concerns regarding his mental health. However, in the risk assessment dated two days before Liam's death, Liam disclosed that he had been struggling with his mood for some time and that Zoe had instructed him not to see anyone or have anyone in the house, which demonstrated her continued control over Liam's interactions with services and his receipt of support.

3.2.73 Early in June 2021, CRHTT visited Liam at his home, with Zoe overheard in the background. CRHTT offered Liam a one-on-one appointment at their base the following day, which he accepted. Zoe then reminded Liam of activities "he would be doing" that day, revealing her control over him. The appointment was rescheduled for later that afternoon at Zoe's home, where she may or may not be present. The CRHTT coordinator and the consultant psychiatrist recommended that Liam be asked where he wished to be seen. On most occasions, he was seen alone upon his request. As stated by the CRHTT Coordinator, it is standard practice to enquire as to where patients would prefer to be seen, demonstrating person-centred care

3.2.74 EDAN Lincs requires consent; however, after Liam's initial referral, the service contacted him directly to discuss support. This is recognised as good practice; despite needing explicit consent, the service contacted Liam to ensure he was aware of what the service offered and fully aware of the support they could offer.

3.2.75 **TOR 6:** Identify the opportunities for professionals to identify and support Liam or his partner.

Analysis

3.2.76 In the case of domestic abuse-related incidents, the responding officers will complete a PPN to record the specifics of the incident, the parties involved, the DASH questions

[59] https://safelives.org.uk/practice_blog/introduction-coercive-control#:~:text=What%20is%20coercive%20control%3F,ex%2Dpartner%20or%20family%20member.

and answers, the action taken, and any advice given. It will also include the officer's initial risk assessment and justification. The PPN also instructs officers to investigate a person's history of domestic abuse and inform them of the Domestic Violence Disclosure Scheme and any partner agencies that may be able to assist them. Officers can also provide victims with EDAN Lincs cards and offer to show them a video[60] describing their service.

3.2.77 When an officer completes a PPN, it is flagged for a supervisor's review. After consulting with the submitting officer, the supervisor will review the incident and either concur or modify the risk classification. The authorised form is then sent to the Police Safeguarding Hub for additional review to bring the information to the attention of a partner agency.

3.2.78 In other instances where officers have concerns about a person's mental health, they can fill out a Mental Health Monitoring form after assisting the individual. This form is submitted to the Police Safeguarding Hub for sharing with the Single Point of Access LFPT.

3.2.79 Due to an oversight, the officer and supervisor should have submitted the PPN regarding the August 2020 incident. However, the officer correctly managed the missing person aspect of the incident and did not consider the administration of a PPN submission at that time.

3.2.80 The panel is satisfied with the police officers' awareness of PPN's relevance. In addition, the current Domestic Abuse Matters training and targeted internal communications will remind all officers of this fact.

3.2.81 However, it was unclear to the author why a DVPN was not considered in this case.

3.2.82 LPFT practitioners had numerous opportunities to assist Liam and Zoe to a lesser extent. When domestic abuse is identified, the Trust will help with mental health needs, subsequent risk management, and assistance with domestic abuse. However, it should be acknowledged that, despite the Trust's efforts to assist individuals in regaining their mental health, the impact of these efforts will be limited if a person remains in an abusive relationship or environment. Sustaining their mental health improvements is difficult. People may be exposed to controlling and coercive behaviours that harm their mood and motivation.

3.2.83 According to the National Domestic Abuse Hotline[61], leaving an abusive relationship is never simple or the safest option. On average, abuse survivors return to their abusers seven times before leaving for good. Women's aid provides insight into the numerous

[60] https://www.lincs.police.uk/police-forces/lincolnshire-police/areas/campaigns/campaigns/end-domestic-abuse-now/

[61] https://www.nationaldahelpline.org.uk/

obstacles preventing a victim from fleeing. Liam stated he had been with Zoe since the age of fifteen, so he may have struggled to comprehend a healthy relationship; he was subjected to controlling and coercive behaviour and may have experienced low confidence; he also had difficulty accepting he was a victim. As such, it is assumed that health services would care for victims who remain in abusive relationships. The work of health is to support the victim, using safeguarding principles[62] as a framework for assisting abuse victims.

3.2.84 Liam informed LPFT multiple times that he believed Zoe required assistance but needed to be more specific about why. According to the CRHTT coordinator, Liam thought Zoe may have needed help with her anger issues. However, the record does not confirm this.

3.2.85 Working with perpetrators of domestic abuse is challenging; the first step, as with those who misuse and abuse alcohol, is to recognise that they require assistance. Liam reported that Zoe did not believe she needed help; consequently, communicating with Zoe regarding this matter would be difficult.

3.2.86 Based on the information shared at MARAC, Zoe's behaviour was erratic, impulsive, and violent. Liam may have rationalised this abuse because he believed her behaviour was justifiable. "After all, she required assistance; it was not her fault." In progress notes dated two days before Liam's death held by LPFT, He used the phrase "she has her own problems" to justify her behaviour. This cognitive distortion enabled Liam to rationalise her abusive behaviour towards him and others, and the cycle of abuse continued.

3.2.87 When a person remains in an abusive relationship or hostile living environment, their mental health will likely suffer. Therefore, Liam's continuing help from LPFT was appropriate, yet his unchanging circumstances would continue to be difficult and negatively affect his recovery.

3.2.88 LPFT and the IDVA worked to enable Liam to acknowledge the unhealthy relationship and accept support from domestic abuse services.

3.2.89 **TOR 7**: Identify any concerns raised regarding the partner's mental health, including whether she posed a risk to herself or others.

Analysis

3.2.90 If police officers are concerned about a suspect's mental health, they have multiple options. These include detention under Section 136 of the Mental Health Act of 1983, the submission of a mental health form analogous to a PPN, and, in the event of an

[62] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

arrest, access to healthcare professionals to confirm that the individual is fit for detention. In addition, there is an option for detainees to be voluntarily referred to partner agencies that can provide mental health, substance abuse, or alcohol abuse support.

3.2.91 Following Zoe's participation in incidents where they had mental health concerns, the police officers submitted mental health forms regarding her.

3.2.92 Zoe communicated with LPFT on five occasions.

3.2.93 Zoe was detained under Section 136 in a Health-Based Place of Safety. During her time in the suite, Zoe was uncooperative and resistant, necessitating police intervention.

3.2.94 Zoe assaulted a police officer whose assault was captured by a bodycam during a domestic incident involving Liam, according to information leading to the initial MARAC referral. This led to Zoe being charged, appearing in court, receiving a £50 fine, an alcohol tag, and probation supervision. Consequently, evidence suggests that Zoe's propensity for abuse extended beyond Liam to include those in authority and was occasionally indiscriminate.

3.2.95 Throughout his interactions with the Trust, Liam was convinced that Zoe required assistance. However, he did not elaborate, suggesting he was unaware of her needs.

3.2.96 Liam's parents were concerned about Zoe and her potential risk to Liam. Two days before Liam's death, Liam's mum contacted the PCDU to report that Zoe had "an almighty temper," had previously bitten Liam's dad, and required restraint. When Liam returned to live with Zoe, "things would quickly deteriorate" compared to when he was at home with his family. Mum described their relationship as "toxic", and one day before Liam's death, she informed CRHTT that Liam had "not been himself since he returned to live with Zoe after Christmas." This information provided CRHTT with additional opportunities to challenge Liam's views regarding Zoe and the nature of their relationship. After hearing mum's concerns, the CRHTT practitioner spoke with Liam directly.

3.2.97 To further highlight the concerns raised by Liam, the suicide timeline of Jane Monkton Smith[63] is used:

1. **The perpetrator has a history of abuse.**
   Zoe had multiple contacts with the police, and even when she was alleged to be the victim, the officers described her as aggressive and controlling of Liam.
2. **The Relationship starts quickly or intensely.**

[63] https://twitter.com/JMoncktonSmith/status/1495129374886174728

Liam stated they were never apart when they first started dating; he lost contact with friends, and Zoe took over his love of sidecar racing. She had also broken his guitar and convinced him not to study forestry.

3. **There is a relationship dominated by control.**
   Liam disclosed coercion and control by Zoe.
4. **The victim starts to disclose as they become more distressed by abuse or violence**.
   Liam admitted to domestic abuse but was not wholly accepting of his victim status, stating that Zoe would seek support once he killed himself.
5. **The victim seeks help from agencies like the Police, Mental Health Services, GPs, or Independent Domestic Violence Advocates.**
   Liam accepted a referral to the IDVA service, yet he continued to seek support for Zoe.
6. **The victim starts talking about ending their life as abuse and stalking are persistent and intense.**
   Liam indicated that he intended to end his life by suicide to help Zoe.
7. **The victim says they feel completely trapped by the perpetrator and will never be free.**
   Liam reported he could only be happy if Zoe were happy.
8. **There is a suicide.**

3.2.98 **TOR 8:** To establish the extent to which agencies had robust domestic abuse and safeguarding policies and procedures in place, both individually and on a multiagency basis, and identify gaps in and recommend any changes to the policy, procedures, and practices of the agency and inter-agency working.

Analysis

3.2.99 All participating agencies acknowledged that they have domestic abuse and safeguarding policies in place.

3.2.100 Liam and Zoe met with the LADMS to discuss their relationship problems, and it was agreed that this should have caused LADMS to meet with them separately to discuss domestic abuse.

3.2.101 The police and LFPT were the primary agencies that dealt with Liam concerning domestic abuse.

3.2.102 The Domestic Abuse Policy of the Lincolnshire police is updated every two years, is accessible to all officers and was last updated in March 2022. It is a comprehensive policy containing detailed procedures and guidance for addressing concerns about domestic abuse, including risk assessment guidelines. The primary

objectives are to adopt a proactive multi-agency approach and to reduce domestic abuse.

3.2.103 The domestic abuse policies and procedures reflect national guidance and Approved Professional Practice and have been deemed adequate by the professional community. They were revised and implemented following the release of the NPCC (National Police Chiefs Council) and the new definition of domestic abuse and abuse. The force's policies and procedures reflect national policy and guidance.

3.2.104 Due to regular meetings and reviews like this, inter-agency collaboration is continually examined, and practices are modified as needed. Lincolnshire police actively participate in the SLP, Domestic Abuse Partnership Board, and sub-subgroups. Additionally, the force actively engages in the Safeguarding Children and Adults Boards.

3.2.105 During the timeline, the LPFT's safeguarding policies and procedures were robust and professionally accepted as current, including domestic abuse and safeguarding legislation and best practice guidance. This includes all statutory definitions of safeguarding and all Trust processes for identifying and responding to abuse, including adult, child, and domestic abuse.

3.2.106 The Trust's Head of Safeguarding, Public Protection, and Mental Capacity reviews and revises this policy annually to ensure its effectiveness. The Trust legislative committee, comprising the trustees, then reviews and approves the document. The Trust Quality Committee, which includes the Trust Executive Lead for Safeguarding and the Trust Non-Executive Lead for Safeguarding, conduct an additional review before publication.

3.2.107 **TOR 9**: To confirm what training is available and accessible to staff in identifying and responding to domestic abuse, alcohol misuse, mental health (the trio of vulnerabilities), and adverse childhood experiences.

Analysis

3.2.108 On their initial entry into the organisation, police officers and relevant staff who have contact with the public or are involved in domestic abuse cases receive training, followed by ongoing professional development throughout their service.

3.2.109 New laws, such as non-fatal strangulation and introducing controlling and coercive behaviour in 2022, are communicated to all employees via internal communications and mandatory online training courses, if applicable.

3.2.110 Lincolnshire police are currently amidst a Domestic Abuse Matters training update for relevant personnel (the aim is to get to 75% of first responders in the first

rollout, followed by a further 3 x DA champions courses). The following are the specific objectives of the DA Matters course:

- Explain the term “coercive control” and how to discover evidence of coercive control using appropriate questions and communication techniques.
- Describe the effect of multiple controlling behaviours on victims, other vulnerable persons and children impacted by the perpetrator’s behaviour.
- Identify why victims can find it difficult to leave an abusive relationship and how hard perpetrators work to resist their victims leaving an abusive relationship.
- Identify the stages of changing a victim’s experiences when in and preparing to leave an abusive relationship and how this impacts them as responders.
- Describe what intervention responders can provide to a victim at each stage of an abusive relationship.
- Explain best practices when recording and reporting the responses to domestic abuse incidents, which can maximise evidential value and minimise victim blaming.
- Describe the tactics perpetrators may use to manipulate first responders.
- Describe the importance of securing evidence at a domestic abuse incident scene.
- Identify the need and potential options to safeguard victims and children.
- Explain how intersecting social identities impact victims’ experience of domestic abuse and discrimination.

3.2.111 The GP uses Blue Stream online training[64]. The GPs have also received level three safeguarding training from the CCG’s safeguarding team, which includes instruction on Adverse Childhood Experiences, domestic abuse, and risk factors, such as alcohol and mental health.

3.2.112 The LPFT safeguarding team provides training on domestic abuse to all staff members. This training covers the definition of domestic abuse, its impact, the local context, and what to do in response to a disclosure of abuse, including the Trust procedure and services that staff can refer to, such as Make a Change, Sexual Assault Referral Centre (SARC), EDAN Lincs, and RESPECT. The training also covers DASH risk assessments and how to complete them, Clare's Law, safety apps, safety planning, and MARAC.

3.2.113 At the time of the scoping period, the national definition of Domestic Abuse, according to which LFPT staff were trained, was "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, abuse or abuse between those aged

[64] https://www.bluestreamacademy.com/

16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional." This includes but is not limited to, psychological, physical, sexual, financial, and emotional abuse.

3.2.114 In addition to the training, all clinical and patient-facing services must make the LFPT Domestic Abuse Flow Chart visible and accessible to staff. This states that staff should complete a DASH Risk Assessment tool "for all disclosures of current domestic abuse, including where there is a pattern of stalking or harassment behaviour." Since 2010, this has been the Trust Policy.

3.2.115 If Liam had disclosed domestic abuse, the LPFT staff would have known what to do.

3.2.116 The routine enquiry would enable LFPT staff to provide a safe environment for all services to disclose domestic abuse incidents.

3.2.117 LPFT safeguarding team provides training on Safeguarding Children to all staff, which includes discussions on the interaction between mental health, alcohol abuse, and adverse childhood experiences and how these may increase an individual's susceptibility to abuse.

3.2.118 All participating agencies can access free online training provided by the Local Safeguarding Children Partnership and the Local Safeguarding Adult Board, enhancing their knowledge and abilities.

3.2.119 The EDAN Lincs staff must complete the Local Safeguarding Children Partnership e-learning mandatory training modules within six weeks of their induction training. Internal training is provided during the induction period. EDAN Lincs accepts any offers for additional ad hoc training made by agencies participating in the partnership and has previously participated in the ASIST Suicide Prevention Training.

3.2.120 Once established, Safe Lives will provide IDVA-accredited training to IDVAs, and any additional training will be offered through the Local Safeguarding Children Partnership platform.

3.2.121 **TOR 10:** To identify any opportunities to respond to concerns raised by family and friends regarding disclosures of domestic abuse, ill mental health, alcohol misuse, and adverse childhood experiences, and to what extent these could have been used to enable professional intervention.

Analysis

3.2.122 All known requests for assistance from Liam, Zoe, and their respective families were met by the police.

3.2.123 Regarding Liam's alcohol use and mental health, his parents and sister helped him communicate with the GP practice. It is evident that Liam was aware of their concerns, and permission was on file to speak with his mum. All concerns expressed were addressed.

3.2.124 The IDVA contacted LFPT in response to Liam's communication regarding the risk to himself. Although they did not have his family's contact information, their response was appropriate, and LFPT contacted the family.

3.2.125 While Liam received care from CRHTT and the PCDU, his parents had multiple contacts with services. Liam's mum expressed concern regarding his relationship with Zoe. Mum was informed of the action plan, which included a home visit to his parent's home, additional discussions regarding alcohol abuse, and the relationship with Zoe. Liam's mum thanked CRHTT for their assistance and guidance. Upon speaking with them, she felt reassured. Two days before Liam's death, Liam's mum expressed concern, and the MDT meeting was scheduled for the following day. However, Liam tragically ended his life by suicide on this date. Each time Liam's parents contacted the Trust, they were informed of how to access services in an emergency or if they had additional concerns about Liam.

3.2.126 **TOR 11**: To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to Liam and his partner's needs.

Analysis

3.2.127 Except for the omission to complete a PPN following the incident involving a missing person, the police adhered to the applicable guidelines and made appropriate referrals when available.

3.2.128 However, DVPN was not considered, and therefore, the author suggests that the protocols for responding to domestic abuse should include DVPN to safeguard victims from alleged perpetrators.

3.2.129 Inter- and multi-agency responses to Liam's mental health needs were deemed timely and appropriate by the LPFT. For instance, following Liam's contact with CMHT in February 2021, the assessment indicated that Liam was the victim of domestic abuse and that the case was scheduled to be heard at MARAC, indicating its high-risk nature; in addition, Zoe and Liam were prohibited from contacting one another under bail conditions. This assessment was then sent to Liam's GP with recommendations for ongoing care and who would be responsible for this (i.e., onward referral to S2C). The assessment and subsequent referral were sent to S2C with a clear clinical

justification. This demonstrates effective interagency collaboration, ensuring care continuity and service-wide transparency.

3.2.130 In response to Liam's needs, interagency and multiagency procedures were followed and reviewed by the MHLT in May 2021. This was evidenced by the completed risk assessment, which outlined a plan to consult with CRHTT to request follow-up support, refer Liam to S2C for longer-term support after CRHTT support ended, send Liam information on the recovery college, and inform Liam's GP of the circumstances leading to his MHLT assessment.

3.2.131 When the IDVA referred Liam to CRHTT two days before his death. The CRHTT received the referral, determined a high risk to life, and scheduled an in-person assessment for the same day. Information was then shared between CRHTT and IDVA, ensuring the IDVA was informed of the assessment's progress and outcome. In this instance, Liam's risk to himself had risen to the point where he required informal admission to the PCDU for a thorough assessment. During this assessment, the PCDU sought the CRHTT's opinion on the risk associated with Liam's discharge. The PCDU also coordinated with Liam's parents, including them in all safety planning (with Liam's permission). The safety plan included staying with parents following discharge, maintaining engagement with CRHTT, and, if necessary, contacting services (such as We Are With You and S2C). Liam and his parents agreed with this plan. As is customary, once Liam had been assessed at PCDU, details of this assessment were sent to Liam's GP to ensure that the GP was aware of the circumstances leading to Liam's admission to PCDU and the associated risks and safety plans.

3.2.132 There were two opportunities for the Trust and other involved agencies to share information that needed to be included. First, CRHTT documented a plan in May 2021 to consult with and seek advice from the Trust Safeguarding Team regarding the risk of Liam returning to live with Zoe; however, there is no evidence that this was completed, and the CRHTT coordinator explains that this was likely an oversight on the part of the staff involved. If this had occurred, the Trust Safeguarding Team would have advised the service to share information with the relevant agencies and could have assisted if necessary. Similarly, Liam stated in early June that he did not believe Zoe would engage with Make a Change. Sharing this information would not have affected Zoe's decision to consent to the referral. Still, it could have affected how agencies perceived Liam's risk, as Zoe was not actively acknowledging or altering her behaviour. It would have allowed probation to facilitate a conversation with Zoe about this.

3.2.133 When necessary, EDAN Lincs involved the appropriate agencies and followed up to ensure that Liam received the required assistance.

3.2.134 **TOR 12:** Consider the efficacy of IMR Authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC) process.

Analysis

3.2.135 Lincolnshire police referred Liam and Zoe to MARAC as part of the MARAC process.

3.2.136 LPFT's safeguarding team reviews and authorises all MARAC referrals from within the Trust before sending them to the MARAC administration for processing. Once MARAC has heard a case, the shared information is relayed to the team working with the victim, the offender, or their children, along with potential actions to be taken. In addition, all agency MARAC representatives attend and present cases, sharing relevant risk information with the multiagency where victims and perpetrators are identified.

3.2.137 Liam and Zoe were heard at MARAC twice, and this procedure was adhered to.

3.2.138 Domestic abuse alerts are placed in the agency's records for the victim to reflect the MARAC hearing and its date. According to the Lincolnshire MARAC operating procedure, these are removed a year after hearing the case.

3.2.139 LPFT was aware that Liam was a victim of domestic abuse, and the risk to Liam was reviewed and discussed with him regularly. Liam had declined consent for an IDVA following the initial MARAC. Nonetheless, the CRHTT could engage him in conversations regarding EDAN Lincs support, and a referral was made. Priority in his care at the point of escalation was managing his risk of suicide, and CRHTT responded accordingly. Liam also disclosed that Zoe had breached her bail conditions and that he had reported this to the police so that she could receive assistance for her own needs.

3.2.140 LFPT could have referred Liam's case back to MARAC on one occasion because the information he disclosed met the repeat criteria. This was in response to his partial disclosure to the CRHTT that Zoe had done "something," but he would not reveal what because he did not want her to get in trouble. Assuming that what he was referring to was a criminal act and therefore reportable to the police, the Trust could have completed a DASH and referred the case to MARAC at this time. However, Liam's risk to self took precedence at this point, and an MHAA was requested. Upon Liam's discharge from the PCDU, the CRHTT was to pick up these safeguarding issues and investigate his partial disclosures. Unfortunately, this did not occur as Liam took his own life.

3.2.141 S2C referred Liam to the CMHT in January 2021 (before the MARAC) and scheduled a review for February. In February 2021, CRHTT assessed Liam, with MARAC risk information documented in the practitioner's notes and risk assessment.

3.2.142 The outcome of the initial MARAC was for Liam to receive mental health support, as evidenced by the CMHT assessment and subsequent referral to S2C. The result of the second MARAC was for the CRHTT to provide Liam with feedback and investigate alcohol issues, making any necessary referrals; both tasks were completed.

3.2.143 LPFT services communicated with Liam's IDVA in the days preceding Liam's death.

3.2.144 EDAN Lincs is represented at the MARAC. The IDVA describes the case intervention with referred high-risk victims and provides the victim's voice to the attending agencies.

3.2.145 Liam's Outreach Case Management System (ECINS) case with EDAN Lincs was appropriately flagged as a MARAC case. If Liam had accessed support, a caseworker would have been aware that he had been identified as a high-risk individual, with Zoe as the alleged perpetrator. This would have facilitated the notification of a repeat MARAC and information sharing with his partner agencies.

3.2.146 **TOR 13:** Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /multi-disciplinary team meeting regarding Domestic Abuse (where relevant).

Analysis

3.2.147 All participating agencies of this review are members of the LDAP and actively collaborate. Regular meetings and reviews such as this are used to examine the processes continually. For example, the MODUS records (MARAC system) reveal that Liam and Zoe were each heard twice at MARAC.

3.2.148 While Liam was receiving care from CRHTT, the relationship between Liam and Zoe was discussed in an MDT forum. This was partly due to the high-risk nature of the case, as Liam had returned to live with Zoe, and Liam's mum had expressed concerns the day before her son's death. The CRHTT coordinator and consultant psychiatrist clarified that the MDT discusses cases daily and actively encourages such discussions. The CRHTT coordinator explained that the MDT meets on Monday mornings to discuss the current caseload. Within the CRHTT, this MDT comprises the team coordinator, consultant psychiatrist, nurses, social workers, and occupational therapists. A daily handover follows these weekly MDT discussions to discuss what needs to be followed up or acted upon for the day and to provide a forum for staff to

raise any concerns or issues regarding a specific case. The CRHTT coordinator reported much team discussion regarding Liam because of the numerous problems, especially after returning to Zoe's home.

3.2.149 While Liam was receiving treatment at the PCDU, multidisciplinary discussions regarding Liam and the risk posed by Zoe continued. In addition, there is unmistakable evidence of liaison between the PCDU, CRHTT, IDVA, and Liam's parents, in which they discussed relationship-related concerns and their impact on Liam's mental health.

3.2.150 **TOR 14:** Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /multi-disciplinary team meeting regarding Liam and his partner's mental health and alcohol misuse.

Analysis

3.2.151 When Liam was initially referred to the LPFT, he disclosed receiving alcohol detox treatment at a private rehabilitation facility in Nottingham. However, a review of the records indicated that this information was not confirmed. While not required by any Trust policy or procedure, it would have been advantageous to comprehensively understand Liam's drinking, how it affected his mental health and relationship with Zoe, and how it was being managed or reviewed.

3.2.152 Liam reported abstaining from alcohol throughout most of his interactions with the Trust. However, when the MHLT saw Liam in May 2021, the risk assessment indicated that he consumed large quantities of alcohol. Still, he was not referred to alcohol support services and was encouraged to self-refer. Two days before his death, Liam confirmed that he had consumed "small amounts" of alcohol that day, suggesting discrepancies between what Liam had previously reported and the practitioner's review of this issue.

3.2.153 In the CRHTT risk assessment conducted two days before Liam's death, alcohol use is documented as a 'relapse signature' because Liam had previously stated that he used alcohol as a coping mechanism and frequently discussed his abstinence from alcohol following his detox. Liam's resumption of alcohol use may have been interpreted as a sign that his risk to himself was increasing; therefore, the PCDU safety plan included a recommendation to contact We Are With You.

3.2.154 The consultant psychiatrist reflected on the significance of team discussion, particularly in Liam's case, "as there were many concerning issues," and discussed Liam's reduced risk to self at the time of his discharge from the team in early June 2021. Liam had begun medication after an outpatient appointment and experienced positive results. As a result, his mental health had shown signs of increasing stability, including decreased impulsivity, abstinence from alcohol, and improved sleep.

However, due to the short-term nature of the CRHTT's involvement, the team must collaborate closely to ensure that the work is focused and targeted, allowing the individual to overcome the immediate crisis. This was accomplished for Liam at the time of his discharge from the CRHTT. In addition, a plan for ongoing support was developed to address the longer-term factors contributing to his instability (career opportunities, accommodation, self-esteem, for example). Consequently, CRHTT successfully achieved their objectives with Liam due to their multidisciplinary teamwork.

3.2.155 When the request for an MHAA was made, the multiagency considered Liam's deteriorating mental health. The PCDU contacted the CRHTT to enquire about their perspective on Liam's discharge risk. Given Liam's escalating risk to himself, the CRHTT determined that he could not be safely discharged home and agreed with the PCDU that an MHAA was the most appropriate course of action. The PCDU contacted the emergency duty team to request an MHAA (the emergency duty team is the after-hours service of the local authority through which a professional or layperson can report concerns for another person's health and request an MHAA.) When requesting an MHAA, it is customary to provide information about the individual's current circumstances, the risk to self, and the risk to others (if applicable) so that the rationale for the assessment is clear. The PCDU senior nurse stated that once the Approved Mental Health Professional (AMHP) arrived at PCDU, they provided a verbal handover outlining Liam's presenting circumstances, including the reason for his referral to the PCDU, his escalating risk to himself, his suicidal intentions, and information regarding his alcohol history and relationship problems with Zoe. The information regarding MARAC was accessible to the AMHP, which had access to monitoring systems within the Trust and Lincolnshire County Council that alert practitioners to instances of high-risk domestic abuse. MARAC is also mentioned in the AMHP report. The PCDU discussed the risk posed by Zoe to Liam with the attending AMHP in the context of Liam returning home if he was not detained while Zoe was away for the weekend.

3.2.156 **TOR 15:** Establish whether relevant single-agency or inter-agency responses to concerns about Liam and the risk assessment to him and others were considered appropriate.

Analysis

3.2.157 The risk assessments undertaken by LPFT (MHT, MHLT, CRHTT, and PCDU) demonstrate that Liam's history of domestic abuse was considered, and the risk of Zoe's continued control and coercion within the relationship was made clear. MARAC and subsequent IDVA engagement were also apparent in each risk assessment,

suggesting that any practitioner or team associated with Liam's care was aware of the domestic abuse concerns and the high-risk nature of the case. The risk assessment was discussed with the GP, and parents were contacted.

3.2.158 S2C completed a risk assessment that did not reveal domestic abuse. Liam indicated in the review that he had a "difficult on/off relationship" with Zoe but answered "no" when asked if there was a current or historical risk from others. Therefore, there was no evidence that S2C should have addressed domestic abuse earlier.

3.2.159 In the risk assessment completed by the CMHT in February 2021, it was documented that Liam's primary presenting issues were excessive alcohol (which he reported actively seeking support and addressing himself, with no further request for assistance from the Trust) and ADHD, for which he was actively seeking help. The risk assessment indicated that this was not the responsibility of the CMHT; however, the assessing practitioner would discuss this with the team's consultant psychiatrist and request an outpatient appointment for Liam so that this need could be further explored. A subsequent outpatient appointment was scheduled, and the psychiatrist saw Liam with a plan to initiate an appropriate medication, meeting this need appropriately.

3.2.160 The CRHTT risk assessments are detailed and exhaustive, reflecting the time the team spent with Liam and how well they had come to know him; the assessments are transparent concerning the risk Zoe posed to Liam. Control and coercion are mentioned, along with information about where practitioners can find additional details shared at MARAC. In the risk management plan, liaison between the CRHTT, the Trust safeguarding team, and IDVA is noted, along with a plan for PCDU to conduct further investigation into the possible assaults Liam had inferred (but did not disclose) before his admission.

3.2.161 The PCDU's risk assessment was comprehensive, reflecting the level of complexity and the fluctuating risk Liam posed while on the unit.

3.2.162 Liam stated on the PCDU that he said "silly things this morning that were taken out of context" and reported no risk to himself, stating that he always says these things (referring to suicide) but does not intend them. Liam's presentation during the MHAA was reportedly calmer and more coherent than when he arrived at the unit. He stated again that he wished to return home and had no plans to end his life. Liam expressed ambivalence toward suicide and "that he was unlikely to act upon his thoughts" (AMHP report). He requested to return home and was content for his mum to spend the night with him.

3.2.163 After completing the MHAA, the AMHP determined that Liam did not meet the criteria for detention under the Mental Health Act. The discharge plan included Liam's wish to return home, with his parents picking him up and his mum spending the night

with him. The risk assessment indicated that the PCDU had communicated with Liam's parents and approved his discharge home. Due to Liam's reluctance to discuss these matters further during the MHAA, the risk assessment also documented that CRHTT would pick up the partial disclosure of domestic abuse for further exploration and action. On Monday morning, the CRHTT MDT was to address these issues. However, Liam had tragically ended his life by that point.

3.2.164 A review of the completed risk assessments revealed that they had been completed appropriately, identifying Liam's concerns and addressing the identified needs. NCISH (2022) recommends that the CMHTT, CRHTT, and PCDU consider the risk of domestic abuse when assessing suicide risk. During a discussion with the AMHP about Liam's return home, the PCDU nurse indicated that Zoe was away over the weekend. Therefore, this reduced Liam's immediate risk. The MHLT's consideration of his parents as carers was the one area that could have been managed differently, such as offering a carer assessment. However, they were later offered a carer assessment by the CRHTT.

3.2.165 EDAN Lincs appropriately triaged Liam and coordinated with the appropriate agencies.

3.2.166 **TOR 16:** Establish whether relevant single-agency or inter-agency responses to concerns about the partner and the risk assessment to her and others were considered appropriate.

Analysis

3.2.167 Zoe was arrested following the assault on Liam. The case was dismissed due to no evidence being offered.

3.2.168 Liam was referred to domestic abuse services after risk assessments revealed he was a victim of domestic abuse perpetrated by Zoe.

3.2.169 Zoe was referred to support services but did not engage with them.

3.2.170 **TOR 17:** To what extent were Liam's (and, where relevant, significant others') views appropriately considered to inform agency responses?

Analysis

3.2.171 The police listened and considered the perspectives of Liam, Zoe, and their respective families when determining the appropriate response, such as their stances on filing formal complaints regarding potential criminal offences. However, there were instances in which officers acted contrary to their wishes when independent corroboration evidence was present to uphold the law and for the safety and well-being of all concerned.

3.2.172 It is evident from a review of the LPFT that Liam's voice was reflected in direct quotes throughout his notes, care plans, and risk assessments. For example, when Liam requested to reschedule his appointment with the CRHTT following some contact with EDAN Lincs, he stated that he felt "emotionally drained" from the telephone conversation with EDAN Lincs; therefore, a new appointment with the CRHTT was scheduled for him so as not to overload and overwhelm him. In another example from a conversation with the CRHTT coordinator, they stated that Liam frequently requested to be seen alone, so appointments were offered at the base or scheduled for times when he was likely to be alone. Liam would also inform the team of any information he did or did not want to be shared with his parents. The CRHTT coordinator reflected that Liam's position on consent was quite fluid, as he would sometimes like the team to speak with his parents and others not, and the team responded accordingly.

3.2.173 The family's concerns were heard and addressed after CRHTT conversed with them. During Liam's engagement, the CRHTT and the PCDU communicated via telephone with his parents. CRHTT also stated that Liam's parents were present during home visits when available and at his request. The Trust maintained regular contact with Liam's parents to keep them apprised of decisions regarding Liam's care and how their concerns would be addressed at the MDT with Liam moving forward. Additionally, Liam's parents reached out to the Trust to share and discuss concerns as needed.

3.2.174 **TOR 18**: Identify areas where agency involvement's working practices had a significant positive or negative impact on the course or the outcome.

Analysis

3.2.175 From the couple's perspective, the police's actions could have a negative impact since neither partner desired action against the other. During one of the incidents, Zoe stated that she hesitated to reveal certain information to the police because they would go against her wishes and take Liam away from her. Nonetheless, the police acted appropriately based on the evidence and information gathered.

3.2.176 The CRHTT coordinator discussed regular communication with Liam's parents – at Liam's request, ensuring they were "kept in the loop" regarding Liam's care. This typically occurred face-to-face when Liam's parents were present during home visits, but it also appeared occasionally over the phone. This collaborative effort prompted Liam's parents to express satisfaction with his care. ‘Mum thanked the team for their assistance and said it was the best he had ever received, adding that they are ecstatic with Liam’s service’.

3.2.177 LPFT’s representation at MARAC should be highlighted as a good working practice. On both occasions, MARAC heard Liam and Zoe, and the Trust's

Safeguarding Team was present, sharing information with the multiagency and acting as Liam's designated team. CRHTT was promptly informed of the risk information discussed at the MARAC, allowing the team to complete the assigned actions. In addition, the Trust Safeguarding Team contacted CRHTT before the MARAC to ensure that practitioners knew Liam was to be heard and requested that Liam's discharge be delayed until after the MARAC. This helped to ensure that Liam remained under the care of the Trust when he returned to live with Zoe during this particularly high-risk period.

3.2.178 After receiving Liam's concerns, the IDVA promptly referred him to CRHTT, which resulted in Liam receiving an MHAA.

3.2.179 Liam’s care received at PCDU should also be highlighted as a positive practice. During his admission, Liam wished to leave and return home. Given the severity of the safety concerns, practitioners at the PCDU contacted the CRHTT to seek their opinion on the risk of his being discharged home and whether Liam's request for appropriate safety planning could be implemented. CRHTT was highly concerned for his safety if he were discharged. Through triangulation of information sharing, the PCDU and the CRHTT agreed that a formal assessment under the MHA would be the most appropriate course of action. Liam was informed of this decision and kept abreast of the procedure, his rights as an informal patient in PCDU, and the possible outcomes of the MHAA. Liam agreed to remain in the unit based on this conversation and the advice of professionals. His family was also informed with Liam's permission, and Liam's mum expressed concern about Zoe's volatility. Information-sharing was crucial to requesting an MHAA from the emergency duty team. This was difficult for practitioners to manage, as they had to balance Liam's desire to leave with his views, the risk he posed to himself, and the concerns of his family and other professionals. Nevertheless, the team exerted significant effort to convince Liam to remain within the unit.

3.2.180 Although the outcome was tragic, all Trust processes were followed while Liam was at PCDU, and staff on the unit and at CRHTT did everything possible to protect and safeguard Liam.

3.2.181 Information sharing could be cited as a potential improvement area in terms of work practices that could have been enhanced. However, this did not significantly affect Liam's overall care or outcome. Teams have considered ways to improve information sharing.

3.2.182 **TOR 19**: Identify gaps and recommend any changes to the agency's policy, procedures, practices, and inter-agency working to safeguard better adults where the trio of vulnerabilities is a feature.

Analysis

3.2.183 There were no identified gaps in the participating agencies' current policy, procedure, or practice that would have improved Liam's safety, considering the domestic abuse, mental health, alcohol, and issues he was experiencing.

3.2.184 However, as alcohol is a key risk factor, the author suggests collaborating with alcohol services to encourage engagement among service users in similar situations to Liam.

3.2.185 Suicide prevention is an issue that is nationally recognised and continually evolving. Over the past two decades, the National Confidential Inquiry into Suicide and Safety in Mental Health NCISH[65] (2022) has been compiling data to aid in the understanding and response to suicide and self-harm. According to the NCISH's annual report, approximately 6,000 people die by suicide annually in the United Kingdom, with two out of every three suicide victims being male. In their research, NCISH (2022) discovered that many patients were experiencing depression, and 47% had alcohol problems, both of which were prevalent in Liam's case. More than a quarter of patients who died by suicide were hospitalised, had recently left, or received home treatment. The National Consortium for the Study of Suicide and Homicide[66] (NCISH) suggests in its recommendations stemming from this study that domestic abuse should be included in the assessment of suicide. Consequently, Liam's circumstances were not unique and can be seen in other cases where individuals end their lives by suicide. However, these issues were not overlooked; they all played a role in Liam's assessments, care planning, and decisions.

3.2.186 Predicting and preventing suicide, despite knowing and assessing these risks, is difficult and complex, and no organisation can tackle this issue alone. Occasionally, a person with no mental illness or who is not detainable under the MHA and agreeable to all safety planning will still end their life by suicide.

3.2.187 The Trust has appointed a Suicide Prevention and Self Harm Reduction Lead who oversees the issue and directly supports clinical services for their 'zero suicide' action plans. This lead was interviewed for the Trust IMR and advised that "low-risk" individuals who may not meet MHA detention criteria are nationally recognised. In

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[65] https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/#:~:text=Our%202022%20annual%20report%20provides,those%20in%20the%20general%20population.

[66] https://nspa.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report-2022-uk-patient-and-general-population-data-2009-2019-and-real-time-surveillance-data/

addition, people frequently do not meet the criteria for specialised mental health services, necessitating a system-wide solution. In Liam's case, it was evident that all pertinent Trust policies and procedures were adhered to when offering him support, assessing his mental state at the appropriate junctures, managing the existing risk, and developing patient-centred plans. Despite this, Liam tragically died by suicide.

3.2.188 The Vulnerability Knowledge and Practice project[67] discovered that coercive and controlling behaviour is a significant risk factor in both intimate partner homicides and suspected victim suicides where there is a history of domestic violence. Furthermore, it has been demonstrated that the new DARA risk assessment tool better identifies coercive and controlling behaviour.

3.2.189 While the DASH should still be used by specialised police officers and professionals undertaking a secondary risk assessment, DARA is to be used by front-line police officers.[68]

3.2.190 When there is a history of domestic abuse, coercive and controlling behaviour is a significant risk factor for intimate partner homicide and suspected victim suicide. It has been demonstrated that the new Domestic Abuse Risk Assessment Tool better identifies coercive and controlling behaviour.

3.2.191 LPFT's Suicide prevention strategy will be reviewed in the Autumn of 2023. It will adhere to the guidelines and recommendations of the revised National Suicide Prevention Strategy. In addition, according to NCISH and NHS England, the plan must incorporate domestic abuse. This will ensure that the Trust remains compliant with national suicide guidance and stays abreast of new knowledge.

3.2.192 **TOR 20:** Establish whether there are lessons to be learned from the case about how local practitioners and agencies carried out their responsibilities and duties and worked together to manage risk and safeguard Liam, his family, and the wider public.

Analysis

3.2.193 The GP practice uses an internal "Task" system to communicate with the larger team. Within the patient record, a 'Task' sends a message to another NHS employee who is relevant to the patient and serves as a communication audit trail for the individual's medical records.

3.2.194 Based on an examination of the records held by LPFT, there were two opportunities for broader information sharing across agencies that could have better protected and safeguarded Liam. This report has discussed these opportunities for

[67] https://www.vkpp.org.uk/

[68] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

sharing information at various points, and it does so again here. The failure to share information at these points may not have significantly impacted the overall outcome. Nevertheless, it improved the overall practice quality and should be highlighted for future study.

3.2.195 **ToR 21:** If the partner failed to engage with the IMR author's agency, what strategies, policies, or procedures did your agency follow to engage with him? Were there any barriers to his accessing services? Were there particular reasons your agency was not appealing? Did contact diminish after the initial engagement?

Analysis

3.2.196 EDAN Lincs explains that it can be challenging to continue working with the IDVA service after the initial engagement with a victim who remains in a relationship with and lives with the alleged perpetrator. At the initial point of contact, IDVA will explore safe times and connections with the client, discuss the safe word, and explore opportunities to work with the client outside the abusive home, such as GP visits and mental health appointments. IDVAs will not increase the victim's risk if they live with the alleged perpetrator.

3.2.197 Liam consented at the most recent MARAC and was committed to resuming his relationship with Zoe.

3.2.198 Zoe was referred to MARAC, but she did not consent to the MARAC or IDVA service despite the Domestic Abuse Officer of the Lincolnshire police revisiting this with her at the time.

3.2.199 Liam and Zoe approached the police. They appeared content to contact them to report incidents, even though concerned officers would take actions with which the couple did not necessarily concur. Occasionally, they did not make formal complaints or respond to DASH questions, but they still contacted the police when they had a problem.

3.2.200 Zoe's engagement with LPFT was brief. Her primary point of contact between July 2019 and January 2020 was with S2C.

4.1 Conclusions

4.1.1 The purpose of this analysis is to determine the circumstances surrounding Liam's death in June 2021 and to 'articulate life through the eyes of the victim[69].

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

4.1.2 The panel discovered good practice amongst the agencies, as they all identified domestic abuse and referred Liam to the appropriate services.

4.1.3 The challenges faced by agencies were Liam's inability to recognise himself as a victim fully and his focus on Zoe's mental health, alcohol use and abusive behaviour.

4.1.4 The inability to recognise this is a 'Trauma Bond'[70], a connection between an abusive person and the individual they abuse. It reflects a bond formed through the repetition of physical or emotional trauma with positive reinforcement. It can be challenging to spot and even more difficult to escape.

4.1.5 It is suggested that these bonds are formed during childhood; Liam and Zoe began dating when he was fifteen, and he described not knowing any different. His relationship with his family was described as supportive, and once he started dating Zoe, he appeared to have become withdrawn and unwilling to spend time with his friends. In addition, Zoe had taken over his interest in sidecar racing, and he described needing her permission to do anything.

4.1.6 Liam reported that he had lost his sense of self when he stated that if Zoe was happy, so was he. Liam enjoyed music and sidecar racing. Liam thought Zoe had broken his guitar, which was assumed to be his pastime. Liam's attachment to and reliance on Zoe was deemed unhealthy by his parents and agencies. However, Liam had compassion for Zoe, stating she was not a "nasty person" and required support. Agencies attempted to assist Zoe and informed her of the Make a Change service. Nonetheless, she declined.

4.1.7 Liam's preoccupation with Zoe prevented him from receiving adequate assistance. Liam had requested talking therapy because he recognised it as a way to obtain help. However, he insisted that Zoe required assistance.

4.1.8 Women's Aid[71] highlighted a few reasons why a victim does not leave the perpetrator:

- Danger and Fear – Liam had left the relationship on several occasions. On one occasion, Zoe came to his parent's house and physically assaulted his dad. Liam had stated he was concerned Zoe would kill him one day.
- Isolation—Liam reported that when he began the relationship with Zoe, he did not want to spend time with friends. During the relationship, he described Zoe as jealous, and she wanted to know what he was doing and with whom he was spending time. As a result, Liam reported having few friends. However, his parents remained supportive of him.

[70] https://www.abuseandrelationships.org/Content/Survivors/trauma_bonding.html
[71] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

- Shame, embarrassment, or denial – Liam believed Zoe needed help and stated that if he died, she would get the help she needed.
- Trauma and low confidence – as described above – Trauma Bond

4.1.9 Zoe had reported Liam as a perpetrator of abuse. At times, the relationship could be perceived as abusive on both sides. Elizabeth Bates[72] characterised it as:

'*Bidirectional or mutual abuse can be prevalent and unrelenting in big and small matters. It suggests that both partners can display aggressive behaviours during a conflict. However, this may not be the case with each conflict episode and may not be symmetrical.'*

4.1.10 The evidence indicates that Liam physically assaulted Zoe, as witnessed by a member of the public. This further complicates the relationship and the assistance required by both parties. Liam had sought help. However, he acknowledged that Zoe was unwilling to receive support. Therefore, the assumed relationship would remain unchanged.

4.1.11 Liam was a male domestic abuse victim. Historically, male victims have been underserved and receive relatively little attention in research on intimate partner abuse. However, it is essential to note that this is in no way intended to minimise the experiences of female victims but rather to develop a more comprehensive and nuanced perspective on the topic that accounts for various occasions. Gender-based assumptions of domestic abuse, for instance, exclude scenarios involving a female abuser or reciprocal abuse between both partners and fail to account for diverse couplings, such as LGBT or non-monogamous relationships. Moreover, gendered assumptions of domestic abuse disregard the experiences of male victims, making them more likely to ignore or minimise their experiences and less likely to seek help.[73]

4.1.12 In March 2022, the Government issued a revised Male Victims Position[74] addressing male victims of domestic abuse and other crimes, including sexual abuse and forced marriage. The Statement included the following:

"Harmful stereotyping and popular myths and misconceptions around male victims can be additional barriers to reporting and seeking help. For example, stereotypes around masculinity can have a significant role in a male victim's experience of domestic abuse. As a result, male victims may be less likely to disclose that they are being abused or may not recognise they are victims of domestic abuse as they may believe the term 'domestic abuse is only applicable to women."

[72] http://elizabethbates.co.uk/uncategorized/why-we-need-to-investigate-experiences-of-bidirectional-intimate-partner-abuse/
[73] https://link.springer.com/content/pdf/10.1007/s43545-021-00263-x.pdf
[74] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1073565/Supporting_male_victims_2022.pdf

4.1.13 Liam recognised that he required support for alcohol abuse, and his family paid for his inpatient rehabilitation. Male victims of intimate partner abuse were examined in a study by Hines and Douglas[75] to determine if there was a correlation between alcohol/drug abuse and enduring intimate partner abuse. Alcohol and drug misuse are risk factors for men committing intimate partner abuse against their female partners. A further explanation of alcohol use is to manage and reduce their emotions. To self-medicate, Liam used alcohol to cope with his feelings and ADHD, as recognised by his parents.

4.1.14 The study supported the hypothesis that intimate partner abuse is associated with higher levels of alcohol abuse. However, men who had experienced common couple abuse had the highest alcohol abuse and frequency of intoxication within the previous year compared to men who did not experience intimate partner abuse. In addition, men who experienced intimate abuse had higher levels of alcohol abuse within the past year but did not report a greater frequency of intoxication. An explanation for not seeking help was that men are less likely than women to seek help for a wide range of psychological, social, and physical health issues; moreover, men are even less likely to seek help for an issue that is non-normative for men.

4.1.15 Liam described being controlled by Zoe, who would contact him via phone calls and Facebook profiles. The Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

4.1.16 Under current law, coercive behaviour must seriously impact the victim to constitute a criminal offence. It is defined as causing the victim to fear that the abuse will be used against them at least twice. Alternatively, a criminal act has been committed when the pattern of behaviour of conduct has had a "substantial adverse effect on the victim's day-to-day activities" (CPS, 2015). For example, Liam informed agencies multiple times that he did not wish to get Zoe into trouble and was not a 'grass.'

4.1.17 Sophie believed that ADHD was a factor in Liam's death, the help he received was inappropriate, and that alcohol was a barrier to him participating in services. The expectation to cease drinking was unrealistic, especially since he had no other way to cope with his symptoms.

5.1 Lessons to be Learnt

5.1.1 A practitioner event on the themes was organised to support the learning from this review. Practitioners from EDAN Lincs, the GP practice, LPFT, and an IDVA attended.

[75] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3315600/

All parties agreed with the themes, and immediate action was taken to support the partnership work.

5.1.2 The review highlighted five themes:

5.1.3 Trauma Bond

5.1.4 Liam began a single intimate relationship in 2013. He stated that this was all he knew, and his mum said they could not survive apart. Liam believed Zoe was the one who required support and thought his service requests would allow Zoe to receive help. Liam did not always perceive himself as a victim, which presented challenges for agencies that had identified him as a victim of domestic abuse.

5.1.5 Individuals in a trauma bond have a deeply rooted attachment, making it difficult to leave the relationship due to the basic desires for security and attachment. For example, Liam stated that he did not know how to cope and said, "…I wasn't ready to be launched into the world on my own."

5.1.6 Liam had spoken about happiness and believed he could only be happy if Zoe were also content. This is illustrated by the term 'co-dependency,' which emphasises the addiction to caring for the other person and putting their needs ahead of one's own. A person cannot be happy in a co-dependent relationship unless they support their partner at all costs, including their safety and well-being. This behaviour frequently enables the other partner to continue abusive or destructive behaviours with the co-dependent person.[76]

5.1.7 Trauma bond relationships can have an impact on service delivery. The workshop revealed that practitioners felt disempowered and frustrated because they could not do more to support Liam in his relationship. This has had a significant impact on practitioners who are still affected by Liam's death.

5.1.8 Male Victims

5.1.9 The review uncovered outstanding agency practices highlighting Liam as a male victim of domestic abuse. His gender did not affect his service responses, and Liam continued to receive support.

5.1.10 The theme has been brought up to support and strengthen service responses to male victims of domestic abuse. The practitioner event revealed that practitioners were unaware of men's refuges and out-of-hours assistance. The attendees were able to respond and agreed to share information following the event.

5.1.11 Bidirectional Abuse

5.1.12 The review revealed instances of bidirectional abuse, with Liam appearing in court. However, he was acquitted.

[76] https://apn.com/resources/how-to-heal-from-a-trauma-bond-relationship/

5.1.13 As previously stated, bidirectional abuse has been found in many domestic abuse relationships. In addition, unidirectional abuse is frequently associated with the gendered model of domestic abuse and may affect a victim of bi-directional abuse who seeks assistance.[77]

5.1.14 Self-defence, which can appear to be abuse, is an additional complication of bidirectional abuse; it should be recognised as the victim's response to survival.

5.1.15 Trilogy of Risk

5.1.16 Liam and Zoe misused alcohol, experienced poor mental health, and their relationship was marked by domestic abuse. Liam had sought assistance for his alcohol use. However, this issue remained until his passing. As a child, he was diagnosed with ADHD.

5.1.17 Despite the best efforts of services, Liam's mental health continued to be impacted by his alcohol use. His ADHD referral was declined due to his alcohol consumption. Although Liam regularly referred to himself as having ADHD, he requested medicine for it and felt it was the cause of his mood swings. His mum assumed he drank to relieve the symptoms of ADHD.

5.1.18 During the practitioner event, it was determined that alcohol frequently impedes receiving support and that agencies needed to work and collaborate to assist individuals with poor mental health and alcohol use.

5.1.19 In England, an estimated 589,000 people are dependent on alcohol. Approximately one-fourth of them are likely to receive medication for mental health, primarily for anxiety and depression, but also for sleep problems, psychosis, and bipolar disorder.[78] Public Health England[79] has established two fundamental principles regarding this issue: Working together and no wrong door.

5.1.20 Coercion and Control

5.1.21 Liam acknowledged Zoe was controlling and provided services with examples. He insisted, however, that she was the one who needed help to see what she was doing.

5.1.22 Mankind[80] published a report on male victims' experiences with coercion and control. The report emphasises the need for services to recognise males' unique risks, such as false allegations, which Zoe had threatened Liam with: "whom are the police going to believe – the screaming girl or you?."

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[77] https://www.researchgate.net/publication/341337322_But_Who_Is_the_Victim_Here_Exploring_Judgments_Toward_Hypothetical_Bidirectional_Domestic_Abuse_Scenarios

[78] https://ukhsa.blog.gov.uk/2020/11/17/alcohol-dependence-and-mental-health/

[79] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[80] https://www.mankind.org.uk/wp-content/uploads/2021/07/Male-Victims-of-Coercive-Control-2021.pdf

5.2 Recommendations

5.2.1 All agencies considered domestic abuse referred Liam to the appropriate services and assisted him in recognising his unhealthy relationship with Zoe.

5.2.2 The review identified themes that may support practitioners in responding to adults presenting in similar circumstances to Liam. These have been used to support the following recommendations:

5.2.3 Recommendation One – Trauma Bond

To strengthen their response to domestic abuse, all services must recognise the Trauma Bond and teach victims how to identify unhealthy relationships, how it supports co-dependency and the need to please the abuser.

1.a The senior leadership of agencies represented must invest in developing a trauma-informed strategy. The leadership team designs an organisational plan that takes trauma into account. This involves a focus on patient participation, clinical and non-clinical staff training, and establishing a safe environment.

1.b Lincolnshire Domestic Abuse Partnership will seek assurances from partners regarding the availability of trauma-informed training for their staff and to receive feedback where possible on the training delivered.

5.2.4 Recommendation Two – Male Victims and Bi-directional Abuse

2.a Lincolnshire Domestic Abuse partnership should ensure ongoing campaigns to promote awareness of healthy relationships to support male victims/survivors and practitioners in identifying and responding to domestic abuse.

2.b Lincolnshire Domestic Abuse Partnership will develop a partnership-based strategy for addressing bidirectional abuse.

2.c Lincolnshire Domestic Abuse Partnership is tasked with developing a resource toolkit that the partnership can access to aid in the identification of bidirectional abuse and the availability of support for victims/survivors.

5.2.5 Recommendation Three – Coercion and Control

3.a Lincolnshire Domestic Abuse Partnership to receive assurance from partners regarding their duties under the Controlling or Coercive Behaviour Statutory Guidance Framework.[81]

[81] (This guidance primarily aims at statutory and non-statutory bodies working with victims, perpetrators and commissioning services, including the police, criminal justice, and other agencies.)

- *The police should follow local protocols and guidance, including risk assessment procedures. Police should refer victims to professional support services, such as multi-agency risk assessment conferences, crisis hotlines, and Independent Domestic Violence Advocates, as necessary.*

5.2.6 Recommendation Four - Alcohol, Mental Health, and complex pre-existing conditions (additional needs: diagnosed and undiagnosed needs)

4.a Public Health to ensure the local suicide prevention strategy will consider the impact of alcohol abuse and dual diagnosis on the risk of death by suicide.

5.2.7 Recommendation Five - Agencies should review the accessibility of their self-referral options for individuals with additional support requirements such as ADHD.

Health Services Recommendations:

5.a People who experience alcohol problems concurrently should not be prohibited from receiving psychological counselling services. This is consistent with the NHS Access to Psychological Therapies Improvement Manual for 2021.[82]

5.b To involve service users in collaboratively deciding on their care and facilitating access to services. Information to service users must be provided in an easily accessible format.

5.c To raise awareness of the link between domestic abuse and pre-existing conditions and the possible increase in the risk of domestic abuse.

- *A referral or self-referral to a perpetrator programme should only be undertaken in consultation with specialised advisors and after a thorough risk assessment.*
- *A variety of agencies and support services may possess information that could give relevant evidence to aid in the construction of a criminal case. For instance, medical records and case notes from other services, including mental health, drug and alcohol services, financial services, and the family justice system. Housing services may also provide contextual evidence, such as property damage records, holes in the walls or complaints from other renters.*
- *The police, in conjunction with other organisations, can play an essential role in identifying children who require assistance and protection due to domestic abuse, including controlling or coercive behaviour, and ensuring they receive the necessary support.*

[82] https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf

Glossary of Terms

Attention Deficit Hyperactivity Disorder	ADHD
Community Mental Health Team	CMHT
Crisis Resolution & Home Treatment Team	CRHTT
Community Psychiatric Nurse	CPM
Crown Prosecution Service	CPS
Domestic Homicide Review	DHR
Domestic Abuse Protection Notice	DVPN
Domestic Abuse Protection Order	DVPO
Ending Domestic Abuse Now Lincs	EDAN Lincs
East Midlands Ambulance Service	EMAS
Independent Domestic Abuse Advocate	IDVA
Individual Management Review	IMR
Lincolnshire and District Medical Services	LADMS
Health-Based Place of Safety	HBOS
Lincoln County Hospital	LCH
Lincolnshire Partnership Foundation Trust	LPFT
Mental Health Liaison Team	MHLT
Mental Health Act Assessment	MHAA
Multi-Agency Risk Assessment Conference	MARAC
Multi-Disciplinary Team	MDT
National Confidential Inquiry into Suicide and Safety in Mental Health	NCISH
Northern Lincolnshire and Goole Hospital	NLGH
Public Protection Notice	PPN
Psychiatric Clinical Decisions Unit	PCDU
Safer Lincolnshire Partnership	SLP
Senior Acute Care Nurse	SACN
Steps2Change	S2C
Terms of Reference	ToR