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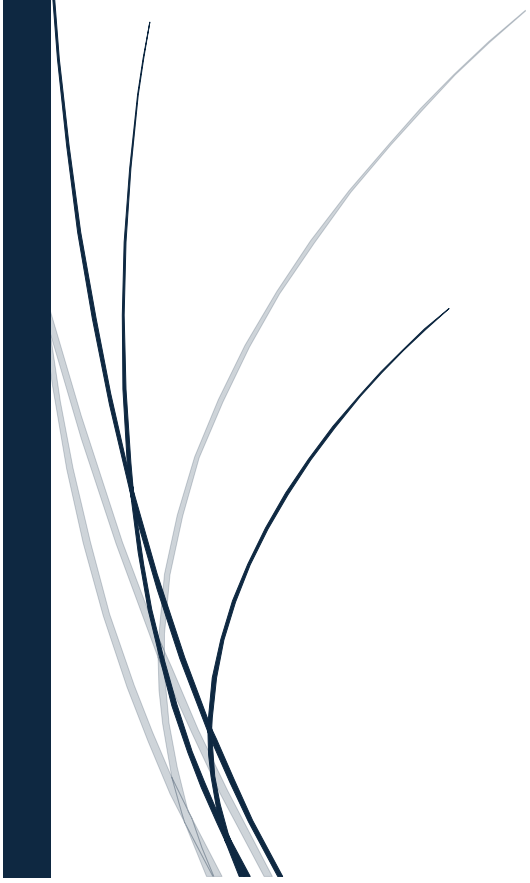
Safer Lincolnshire Partnership

DHR: Liam



Preface

The independent author and review panel extend their sincere condolences to everyone affected by Liam's tragic death and gratefully acknowledge their efforts and support during this procedure.

The main objective of a Domestic Homicide Review (DHR), when domestic abuse or violence is known to have happened in the relationship, is to allow lessons to be learned from the victim's death. Professionals must understand what happened in each case for lessons to be broadly and effectively conveyed.

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

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

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Section One: The Review Process

1.1.1 This summary outlines the process undertaken by the Safer Lincolnshire Partnership domestic homicide review panel in reviewing the death of Liam, who was a resident in their area.

1.1.2 The following pseudonyms have been used in this review for the victim and partner to protect their identities:

- The victim: Liam
- The sister: Sophie
- The partner: Zoe

1.1.3 Tragically, at the age of 25, Liam died by suicide at his home. His parents and one sister have survived him.

1.1.4 Liam was a multi-instrumentalist and a gifted musician. His family raised funds following his death for the National Trust in his honour, as forestry was another area of great interest to him. Sidecar racing was introduced to him by his father, and the family would frequently attend race events. Initially a passenger with his father, he started racing at sixteen. Liam lived between his parent's home and with Zoe. Liam was unemployed at his death, although he had had various jobs.

1.1.5 As a child, Liam was diagnosed with ADHD[1]. His last medication issue occurred in November 2010. Liam did not attend his review in April 2010, and the paediatrician made no further contact.

1.1.6 Since Liam and his family suspected he had ADHD as an adult, they requested an assessment. The assessment was postponed because of Liam's alcohol dependency. Liam's parents had the belief that he self-medicated his ADHD symptoms with alcohol.

1.1.7 Sophie left home at 18 to pursue higher education; she maintained communication with Liam while his parents encouraged him to seek help for his alcohol and mental health issues and attended his medical appointments.

1.1.8 Liam first accessed support around his mental health in January 2020. He initially self-referred owing to long-standing anxiety and depression and reported diagnoses of ADHD and Asperger's Syndrome.

1.1.9 Following suicide ideation, Liam was assessed at the Psychiatric Clinical Decision Unit the day before his death. Liam did not satisfy the requirements for detention as stipulated

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

in the Mental Health Act[2], as determined by an assessment under the Act. His discharge home was consequently accompanied by a follow-up appointment with the Crisis Resolution Home Treatment Team (CRHTT).

1.1.10 The Domestic Homicide Review process commenced on 21 July 2021 at the Safer Lincolnshire Partnership meeting; all potential agencies that may have had interactions with Liam and Zoe before his death were contacted and requested to confirm any connection they may have had with them.

1.1.11 Ten of the thirty-five agencies confirmed contact with Liam and/or Zoe and were asked to secure their files.

Section Two: Contributors to the Review

2.1.1 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 are 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: *A large Acute NHS hospital trust serving patients in Hull and East Yorkshire and operating 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*	Chronology

[2] https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

with physical or learning disabilities or mental illnesses.	
Lincolnshire Partnership NHS Foundation Trust: *Established on 1 June 2002, social care and health services, formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust, were created to create new mental health and learning disabilities service*s.	Chronology and IMR
Northern Lincolnshire and Goole NHS Foundation Trust*: Hospitals in Grimsby, Scunthorpe and Goole provide services to a population of more than 450,000 people across North and North East Lincolnshire, East Riding of Yorkshire, 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

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

Section Three: The Review Panel Members

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

Name	Role	Organisation
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
Hazel Griffiths	Interim Independent Management Review Co-Ordinator	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

3.1.2 The support for the panel 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

3.1.2 The panel met a total of six times.

Section Four: Author of the Overview Report

4.1.1 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over 20 years. She is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

4.1.2 Parminder Sahota is independent of all agencies involved and had no prior contact with family members or the Safer Lincolnshire Partnership.

Section Five: Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in June 2021 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Liam.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

- Ensure that Liam's voice is heard regarding his lived experiences and the impact of the domestic abuse on his mental health. Allowing his journey to be told and identifying the lessons that may be learnt.

5.1.2 The period covered by the review was from October 2016 to June 2016. The timeline that was chosen reflected the initial interaction between Liam and Zoe and the police in connection with domestic abuse.

5.1.3 The panel agreed on twenty-one terms of reference.

Section Six: Summary Chronology

6.1.1 Liam met his first and only girlfriend, Zoe, when he was 15. They were together for ten years, the final five of which they interacted with the police for domestic abuse incidents in which they were both perpetrator and victim at different times.

6.1.2 **October 2016**: Due to an argument, police were called to the hotel where they were on holiday. Liam and Zoe had been drinking and claimed their dispute was with the hotel, not each other. The police conducted a DASH[3] risk assessment and notified their local police.

6.1.3 **June 2018:** Zoe reported domestic abuse from Liam to the police. She remarked that the previous two years had been turbulent and were as bad as each other. Liam was arrested due to the disclosure; however, Zoe refused to submit a statement or receive police assistance.

6.1.4 **June 2018:** Zoe was referred to the Multi-Agency Risk Assessment Conference (MARAC)[4]. She declined interventions from services. It was also noted that Zoe was violent towards Liam. An officer commented, "It is clear she cannot see the domestic abuse taking place and is unaware of her controlling and violent behaviour".

6.1.5 **June 2018:** The magistrate granted a Domestic Violence Protection Notice[5] against Liam.

6.1.6 **July 2018:** Liam was named the alleged perpetrator during a MARAC hearing. The Independent Domestic Violence Advocate (IDVA)[6] closed Zoe's case as she declined to engage.

[3] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf
[4] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf
[5] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010
[6] https://safelives.org.uk/what-is-an-idva

6.1.7 **November 2018**: Liam's neighbour contacted the police to report a domestic disturbance and a female screaming. The officers conducted a DASH risk assessment, Zoe answered 'no' to most of the questions.

6.1.8 **February 2019:** A member of the public reported a male assaulting a female to the police. When they interfered with pulling the male away, the female became aggressive, and they retreated. Zoe refused to complete the DASH risk assessment or provide a statement. The case was re-referred to the MARAC. The case was closed to the MARAC; Zoe did not consent to work with the IDVA.

6.1.9 **April 2019:** Liam and Zoe sought help from the extended GP service with their relationship. Liam stated that the relationship had deteriorated and that he was frequently irritated. The GP detected a strong odour of alcohol and recommended relationship counselling, addiction treatment, and the Citizens Advice Bureau to help with the financial troubles revealed.

6.1.10 **November 2019:** The police were called Zoe. She claimed to have been thrown out of the house. She'd drunk too much and asked Liam back to her house. An altercation occurred, and Liam exited via a window to return to his parents' house. Zoe went to Liam's parents' house and tried to force her way in, grabbing his father by the throat. Zoe's father arrived to take her home. There was no formal complaint or statement provided.

6.1.11 **July 2020:** The police arrived at Liam's parents' house. Zoe allegedly bit Liam's father on the arm and, the previous evening, had assaulted Liam. No formal complaint was made to the police.

6.1.12 **August 2020:** Zoe reported Liam missing to the police. Following an argument with Zoe, Liam went for a walk. Zoe's behaviour was described as volatile and angry by the police.

6.1.13 **December 2020**: Liam attended a face-to-face appointment with CRHTT. He reported struggling to cope following the end of his nine-year relationship.

6.1.14 **January 2021**: Zoe summoned a police car outside her house. She stated that she disagreed with Liam, who had damaged her phone. It was arranged that Liam would spend the night at his parents' house. Zoe became enraged and attempted to push past the officers to approach Liam. She assaulted both the officer and Liam and was arrested. Liam was subjected to a DASH risk assessment, which revealed two past assaults, a cut to his head, and two broken thumbs. Following the disclosures, Zoe was further arrested. Liam revealed controlling and coercive behaviour from Zoe. Liam was referred to the MARAC and given details of the Ending Domestic Violence Now Lincolnshire[7] information.

6.1.15 **February 2021:** Liam reported domestic abuse from Zoe to CRHTT. He had dropped the charges against her because he did not want to get her into trouble.

[7] https://edanlincs.org.uk/

6.1.16 **April 2021**: Liam disclosed to the CRHTT consultant that he was under financial and relationship stress. He mentioned a supportive girlfriend, but they had arguments.

6.1.17 **May 2021:** Zoe was arrested for violating her bail conditions; she was prohibited from contacting Liam and had returned to his address.

6.1.18 **May 2021**: Liam was referred to MARAC by the police because he had been subjected to several assaults by Zoe and felt she would kill him one day. On the other hand, Liam continued to seek help for Zoe's mental health.

6.1.19 **May 2021**: Liam told CRHTT about Zoe's controlling behaviour; he struggled to admit he was a victim of domestic abuse and expressed his love for her and yearning for her. He did, however, consent to IDVA's involvement. Liam spoke to the IDVA and described experiencing coercion and control throughout his relationship with Zoe.

6.1.20 **June 2021:** Liam phoned the IDVA and stated that Zoe was always phoning him at work and questioning him about what he was doing when he got home; as a result, he was staying at his parents' house.

6.1.21 Two days before his death, Liam called the IDVA, concerned about Zoe and explaining that she would not understand why he couldn't take her to an out-of-county social event. He mentioned suicidal ideation and was referred to CRHTT. He told CRHTT, "The only way my girlfriend will see what she is like and receive help is if I kill myself".

Section Seven: Key Issues arising from the Review/Lessons Learned

7.1.1 **Trauma Bond**

7.1.2 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 her 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.

7.1.3 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.[8]

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

7.1.4 **Male Victims**

7.1.5 The review uncovered outstanding agency practices highlighting Liam as a male victim of domestic abuse. However, his gender had no bearing on his service, and Liam continued to receive assistance.

7.1.6 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.

7.1.7 **Bidirectional Abuse**

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

7.1.9 **Trilogy of Risk**

7.1.10 Liam and Zoe experienced problematic alcohol use and episodes of poor mental health. Their relationship was marked by domestic abuse. Liam had sought assistance for his alcoholism. However, this issue remained until his passing. As a child, he was diagnosed with ADHD.

7.1.11 **Coercion and Control**

7.1.12 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.

Section Eight: Conclusion

8.1.1 Liam was 25 and had one intense heterosexual relationship in which Zoe used coercion and control throughout.

8.1.2 Liam and his family sought a diagnosis of adult ADHD. However, this was not possible due to Liam's alcohol consumption. The practitioners noted that alcohol frequently impedes support, and they believed that agencies should collaborate to help individuals with poor mental health and alcohol use.

8.1.3 Sophie feared that due to Liam's ADHD, resources were inaccessible to him and that the medicine he was prescribed and treatment supplied would not assist his mental health. Liam was also frightened of being admitted to a mental health unit.

8.1.4 The suicide timeline of Jane Monkton Smith[9] was utilised to facilitate learning and highlight the potential for agency engagement.

1. **The perpetrator has a history of abuse.**
   Liam and 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.**
   Liam stated that when they first started dating, they were never apart, 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 completely 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.**

8.1.5 The report was shared with Sophie, and the lessons learned will be shared with the agencies engaged in the review.

Section Nine: Recommendations from the Review

9.1.1 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.

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

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.

9.1.2 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.

9.1.3 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.[10]

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[10] (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.*
- *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.*

9.1.4 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.

9.1.5 **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.[11]

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.

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