Safer Lincolnshire Partnership

A Domestic Abuse Death Related Review
Executive Summary

Mary
Died December 2022

Dr Russell Wate QPM
(August 2025)

1. Introduction and participating agencies:

1.1 For this report, the victim's name, which was chosen by the chair of the panel, is the pseudonym of the name Mary. The chair felt it was right and proper that he, or the panel, chose the name, rather than Mary's only family member, her father, with him being named as the perpetrator throughout the report. The chair did not want it to be seen as him controlling this aspect of the review. The chair did though confirm with the father that this name did not have any other connections or conflicts for the family. It is important to ensure that Mary has a voice throughout this review and that this report is faithful to her legacy. This review will not specifically refer to the death of Mary as being suicide as this was not the verdict of the Coroner's Inquest in this case, but the verdict was that of misadventure through the taking of a deliberate overdose. Mary's note that she left, presumed that following her overdose she would end up in hospital but at the same time she did not rule out that the overdose might also take her life.

1.2 At the end of December 2022, Lincolnshire Police attended a sudden and unexpected death. Mary, aged 50 years, was found deceased at her home address by her father Simon, who was living at a separate address. The police reported that the death was not suspicious, and it was referred to HM Coroner for the area.

1.3 The Independent Chair and author of this review would like to thank the IMR authors and the practitioners from both statutory and voluntary agencies that have assisted in reviewing and compiling the information culminating in this report.

1.4 The participating agencies are:

- Lincolnshire police
- Lincolnshire County Council Adult Social care
- Lincolnshire Community Health Services
- Lincolnshire Domestic Abuse Specialist Service (EDAN Lincs)
- East Midlands Ambulance Service
- Lincolnshire Integrated Care Board on behalf of GP Practice
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Trust
- Department for Works and Pension
- ADHD Centre
- District Council
- ACIS Housing Group
- Lincolnshire Recovery Partnership (We are With You)

2. Purpose and terms of reference for the review

2.1 In addition to the generic terms of reference set out in the domestic homicide review guidance that describe the purpose of these reviews and this review, the additional and specified areas for examination have been agreed by the panel chair and the panel with their agencies. These are:

- To examine patterns of abuse and coercive and controlling behaviours perpetrated by Simon (father) against Mary (daughter-victim).
- To examine the risk of domestic abuse victims taking their own life through suicide and self-harming.
- To examine where in this case an interdependent relationship between father and daughter existed, where at times they acted in a caring capacity for each other, can be supported to break any abusive part of that relationship.
- To consider how women with additional needs, in this case, a victim with Adverse Childhood Experiences, Mental Health and ADHD who are experiencing domestic abuse, can access information, are provided with services and support.
- To examine the impact of Covid-19, in particular (legally enforced) lockdowns, on both an individual's ability to access information and support and agency responses.
- To consider potential gaps in service provision, alongside potential barriers to accessing services.

2.2 The scope for this review is to focus on the period from the 10th of March 2019 to the end of December 2022. The reason this period was chosen was because this period starts when EDAN Lincs made a referral to the LPFT Section 75 Mental Health Social Care team. Which is the first mention of any agency considering the challenges in the relationship between Mary and her father, and the impact this may have had on her. It concludes at the time of Mary's death.

3. Agency contact and information from the review process.

3.1 Although the timeline for this review has been determined as being the 10th of March 2019 to December 2022, it is apparent that there is a much wider background to consider. This includes Mary's adverse childhood experiences and her earlier life, which is important in looking holistically at her as a victim and service user, but also in making sure the review hears and the report echo's Mary's voice. The author has broadened the analysis to encompass some previous history to highlight some earlier practice events that have relevance to the victim's journey.

3.2 To professionals, Mary had often described her childhood as being traumatic. She was an only child in a household where she reported that her mother was an alcoholic and would deliberately self-harm by overdosing on medication, and that her father was physically and emotionally abusive towards her, and her mother, and that this continued throughout her childhood.

3.3 These adverse childhood experiences appear to have had a profound effect on Mary, and the dynamics of the family is indicative of the presence of domestic abuse, parental alcoholism, parental mental health issues and child development neglect.

3.4 It is likely that the physical and emotional abuse that Mary was exposed to when in 2013 she returned to the family home after having lived away and been married twice, this return to the home re-ignited those experiences and compounded her cognitive functions as she was again under the dominant influences of her father and the expectations that he had for her supporting him and her chronically ill mother.

3.5 Mary was open to the community mental health team in Lincolnshire, as early as 2013, and this continued until the time of her death. From then on, she became well known to LPFT, which holds extensive records regarding Mary's involvement with them. For example, the records show that there are more than six-hundred direct contacts with Mary dating from 2013 until her death in 2022.

3.6 In May 2014, Simon made an emergency call to the Lincolnshire Police, reporting that Mary had been drinking and threatening to take her own life by suicide. Officers attended promptly. Mary was arrested and detained by the officers to prevent a breach of the peace. The police did not complete a risk assessment of her, although on release, Mary was signposted with contact details of numerous agencies.

3.7 On 31st of July 2014, Simon telephoned Lincolnshire Police reporting that Mary had left his house having consumed three bottles of wine and was believed to be going to buy more alcohol. Simon asked for help as he was concerned that as well as consuming the alcohol she was on prescribed medication for her mental health and thought that she may have overdosed. The incident was recorded as a *'concern for safety'* and officers swiftly attended the address, which Mary had returned to. She was found to be communicative and did not appear to be any risk to herself or others. There was no risk assessment made by the attending officers.

3.8 In August 2014, Mary was admitted to emergency department when she attended with an *'unintentional'* overdose of Nurofen tablets and alcohol. Mary denied any suicidal intent stating that she had been taking the medication daily as they made her feel better. She was given treatment on admission and discharged home the same day.

3.9 In November 2017, a Consultant Psychiatrist working for LPFT, recorded a diagnosis of Bipolar Disorder for Mary, which was treated using a prescribed anti-psychotic medication as a mood stabiliser.

3.10 On the 4th of July 2018, East Midlands Ambulance service (EMAS) attended Mary's flat following an emergency call by Simon as he was unable to contact her by phone. The mental health crisis team was consulted and advised the ambulance crew of her previous and current health conditions. The crew found evidence of over the counter medication and empty wine bottles. Mary alluded to her exposure to verbal abuse from her father. The crew made a safeguarding referral for domestic abuse and possible sexual abuse. She was only partially clothed and repeatedly covered her genitals with her hands. She was admitted to hospital for a suspected overdose and mental health assessment, she remained there for several days, during which time a police investigation was commenced.

3.11 The flat was reported as being cluttered, the bedroom could not be accessed, half of the living room was inaccessible, and the bathtub was filled with clothing, rubbish and assorted belongings. All the kitchen surfaces were cluttered and a clutter rating of 6 was recorded. (The rating goes from 1- low to 9- very high). The referral was shared with Adult Social Care, the GP and Lincolnshire Fire and Rescue Service. There is evidence the crew recognised domestic abuse and ensured that Mary was not left alone with her father and given space to express her feelings.

3.12 Lincolnshire Police were alerted to concern for a potential serious sexual offence against Mary following her admission to hospital. Mary was not speaking at all, which raised concerns amongst the practitioners that an assault of a sexual nature may have occurred. A supervisory officer from the police sexual offences investigation team was consulted and advised that a crime of rape should be recorded, based on the reported circumstances. A sexual offences examination of Mary did not take place as she would not communicate, and any such examination required her consent. She had not made any disclosures or made any allegations of an assault, the recorded crime accorded with police recording standards.

3.13 The Lincolnshire police officers searched Mary's address concerning this potential sexual offence, they observed that the property was in a dirty condition with a large amount of property in all the rooms. The police concluded that it was impossible to identify if a disturbance or assault of any kind had taken place due to the very poor living conditions. Body worn video was taken by officers at that time.

3.14 Mary was revisited by officers at hospital over the coming days, but they were unable to engage with her. The report was filed with no further action taken. Simon was not interviewed as either a witness or suspect. The police did not submit a safeguarding referral for partnership sharing. The hospital (ULHT) did submit a safeguarding referral.

3.15 Mary first came to the attention of the Lincolnshire County Council's, Adult Social Care (Adult Care and Community Wellbeing -ACCW) service in July 2018, when the service received the safeguarding report made by the EMAS and the hospital regarding the incident report of self-neglect, possible sexual abuse and verbal abuse, by Simon, who was named as the perpetrator. The safeguarding concern did not progress to an enquiry as the duty under Section 42, Care Act 2014, was stated by them in their records as not met.

3.16 Mary was open to the LPFT Section 75 mental health social worker team from 2018. Her 'Needs Assessment' included the following information which is deemed relevant for consideration for this review. Mary's confirmed diagnosed conditions were Bipolar Disorder type 2, PTSD (childhood/ family trauma), OCD, Anxiety and Depression.

3.17 Mary's mother died in August 2018. There is little documented history concerning the death of her mother, although in the latter part of 2018, Mary disclosed to practitioners at LPFT both CMHT and Section 75 social worker of having made attempts to distance herself from her father since her mother's death. Mary stated that this proved difficult to achieve as her guilt was that her father was her only living relative. She therefore felt a duty towards maintaining contact with him.

3.18 On the 24th of April 2019, Mary gave the Community Mental Health Team (CMHT) a written letter of permission to liaise with her father about her care and finances. On the 10th of May 2019, Mary provided a letter to the ACCW which she had signed to say her father could request information about her care and support needs.

3.19 On the 10th of May 2019, a Section 75 mental health social worker made a referral to Ending Domestic Abuse Now (EDAN Lincs), who are the provider of support for people experiencing

domestic abuse across Lincolnshire. Mary was wanting to become more financially independent from Simon and had agreed to discuss this with EDAN Lincs. One month later, Mary was advising community mental health staff that she wanted more financial independence from her father. The practitioners did ensure that there was no increased contact or information shared with Simon after receiving this letter of authorisation from Mary.

3.20 On the 20th of May 2019, an EDAN Lincs support worker contacted Mary by telephone as planned, to complete a pre-assessment. However, Mary responded that she was not up to completing the assessment as her head felt *"muddled."* She was offered an alternative appointment. On the 24th of May 2019, EDAN Lincs contacted Mary and completed the pre-assessment for domestic abuse services. The assessment provided an opportunity for Mary to share her experience of domestic abuse and to enable a shared understanding between the EDAN Lincs worker and herself. Mary disclosed how her father demanded a lot of support from her, constantly contacting her and getting her to perform chores and shopping. He expected her to do everything for him and since her mother had died, she felt that it had got worse. When asked, what was worse, she stated '*that he angrily shouts at her and calls her names that make her feel like she is "worthless"'.*

3.21 The EDAN Lincs support worker explored if there were any other members of the family that could help to support her. Mary stated that she was the only person. She left home at 30 years old and since her return her dad controlled her bank account. There is no record of this being explored more at the time to understand the content of the information and whether it was economic abuse.

3.22 On the 7th of June 2019, Mary contacted EDAN Lincs and stated that she was feeling overwhelmed with the volume of her appointments and asked if the referral could be put on hold for one month. This was agreed.

3.23 In November 2019, Mary cancelled her appointment with the community mental health team in order that she was able to support her father's treatment for lung cancer, which had further caused her distress as it had re-emerged from ten years previously. She was again prioritising her father to her own detriment.

3.24 On the 4th of December 2019, a targeted awareness of domestic abuse was completed by EDAN Lincs with Mary. During the session Mary did not make any new disclosures but stated that she feels that she must be with her father at his hospital appointments, but she was attempting to install boundaries to reduce her contact with him.

3.25 On the 20th of February 2020, an EDAN Lincs support worker conducted sessions of the Safe Programme as Mary was keen to complete all her sessions and she wanted support to allow her to do so. During that specific session, Mary disclosed that Simon had been verbally abusive to her at the hospital, and this made her feel like no one believed she was supporting him. She was worried about how health professionals would see her because Simon would tell lies about her.

3.26 The Adult Care and Community Wellbeing (ACCW) IMR identifies that there were multiple occasions during 2020, where it was clear that Mary began to provide a caring role for her father following his cancer surgery. Under the Care Act 2014, local authorities are required to offer and

carry out a carers assessment where it appears that a carer may have needs for support at that time, or in the future. There is no note in the records that a Carers Assessment was considered or offered to Mary.

3.27 On the 1st of May 2020, Mary contacted EDAN Lincs in an emotional state, she was crying because she and her father had argued, and he shouted at her and told her to get out of his house.

3.28 On the 21st of September 2020, Mary explained to a social worker that she had been having difficulty with her father and said he can be *"very cruel".*

3.29 On 30th of November 2020, in a phone conversation with her Section 75 mental health social worker, Mary also alluded to the fact that she had not been able to get out for some time and that she spent most of her time in her bedroom. She discussed the death of her mother and her father's cancer and that she believed she had been *"pulled too far"* and her *"brain was not good."* She also spoke of feeling isolated and had a fear of letting people into her home. Mary had taken overdoses in the past, but the last time was '*some weeks ago'* and said that she had no intention to end her life but '*wanted things to change.'* The social worker referred the details of this contact onto Adults Supporting Adults (ASA), who in response stated that there had been no direct contact with Mary for four weeks.

3.30 On the 29th of May 2021, Mary had an initial assessment at a private ADHD clinic, which was booked by Simon and completed via a media platform at his email address. It appears that this was funded by Simon. The documents reference a history of symptoms in childhood. Six further appointments were conducted with Mary, the final one was a shared care appointment on the 12th of November 2022. The results were shared with Mary's GP who had not identified any safeguarding risks of concern with the clinic at any stage. Whether Simon was present at these meetings is not clear, although it was his IP address that was used on each occasion.

3.31 On the 16th of July 2021, in contact with the Section 75 mental health social worker, Mary requested for her care not to be discussed with her father at that time. She disclosed verbal abuse from him but there are no records that a DASH risk assessment was considered or completed. Mary also spoke of taking an overdose due to her not being able to cope but declined seeking any GP support. Mary was advised to speak with the Mental Health Crisis Team or Samaritans or seek support from the Police should she have any concerns regarding her father. The social worker contacted EDAN Lincs, LPFT Safeguarding Team and Mary's allocated CPN.

3.32 On the 21st of August 2021, EMAS attended Mary's address following a report from her father that she was unconscious and fitting. Mary had not been communicating by text with Simon, he was worried and so he had gone to her address and found her unresponsive. She was assessed by the attending crew who found it difficult to get suitable and effective access to her due to the extreme household hoarding. The crew recorded they deemed the patient to lack consciousness at that time and it was in the patient's best interest to be conveyed to hospital for a further assessment. A safeguarding referral was made by EMAS which stated that the major concern was for her living conditions (Lincolnshire protocol clutter rating 8-very high) and her associated poor health.

3.33 During her stay in ICU between the 21st of August and the 2nd of September 2021, Mary was informed of the recent events including her father finding her unresponsive in bed. Mary stated, *"the man must have attacked me again."* The documentation demonstrated that the nursing staff attempted to further explore the comment on numerous occasions during her stay, however, Mary would not disclose the identity of the man nor expand further on her comment. The IMR author suggests that it proved difficult to involve other agencies e.g. Lincolnshire Police, due to Mary's refusal to share the identity of *"the man."*

3.34 Whilst in hospital, the section 75 mental health social worker was informed by Mary that due to her ADHD diagnosis, her CPN had told her that she may no longer be supported by the CMHT, as her current (mental health) diagnosis would not be primary and they were not commissioned to provide ADHD support. Mary was concerned about losing her financial and other support if this were to happen and spoke of an upcoming appointment with her psychiatrist.

3.35 Following her discharge from hospital, Lincolnshire Fire and Rescue service visited Mary's address and noted the conditions and evidence of hoarding. What the EMAS referral and the Fire and Rescue service visits identified was what appeared to be an escalation of the hoarding, which had incrementally increased.

3.36 Upon review of the records, a safeguarding screening tool was used by a practitioner (Training Nurse Associate) from LPFT CMHT on the 24th of January 2022, which asks the direct question *"has the service user experienced physical, sexual, organisational, financial or material, psychological, domestic or emotional abuse, self-neglect, neglect and acts of omission at any time in their life",* this was completed, but appears to have been looking at the historical as opposed to Mary's current circumstances. This shouldn't have prevented that practitioner from exploring further whether there was any current risk around her relationship with Simon. The Trust's procedures, safeguarding clinical documents and training are designed to ensure that staff always ask the direct question regarding abuse, but this may not have taken place on this occasion.

3.37 During June 2022, the LPFT records state that Mary had attempted to cease contact with her father, however, he had refused to accept this, stating *"I don't care, do what you want".* Simon had then continued to drop off food parcels through Mary's cat-flap and he would text message her *"being kind."* This is a good example of the degree of manipulation and control that Simon exerted upon Mary, resulting in her saying that she was "*feeling it was not the right time to leave,"* as he had said that his physical health was declining.

3.38 On 24th of June 2022, Simon had gone to a neighbour's address, appearing upset, saying that Mary had cut her own hand during an argument and had *"gone a bit crazy".* He asked the neighbour to call an ambulance and the police. The police response was graded as priority but as there were no officers available for immediate despatch, the force control room contacted EMAS as it was also an apparent medical emergency. EMAS attended as the first responders.

3.39 When the EMAS crew attended, Mary was the only one present and she was unable to find her house keys as it was believed that her father had taken them. She contacted him, but he did not

answer, but then returned, handed her the keys and left again. In the interim, the EMAS notified the police that although there had been a heated argument, it had now calmed down.

3.40 Mary tells the EMAS crew that she had recently returned from her holiday with her father and that her father had been to her house approximately 90 minutes earlier and had grabbed her around the throat which had caused bruising. She also told them that the same thing had happened when they had been on holiday and that he manipulated her and says, '*horrible things.'* The EMAS crew acknowledged the report of strangulation and reported back to the police that there was an escalation of concern and that an officer should attend.

3.41 When the officers attended, Mary was in the process of being taken to the ED by the ambulance. The attending officer spoke to Mary and noted the injury to her hand. She informed the officers that her father had taken hold of her by the throat and caused a red mark on her neck, although she declined to make a complaint of assault. The significance of this allegation was not acted on. It was clearly suggested that Simon was responsible for the strangulation.

3.42 The Police IMR confirms that an officer did speak to Simon who said that Mary had caused the mark herself by *'tying a bathrobe chord around her neck.'* He denied any involvement. A crime of assault was recorded but Simon was not interviewed or arrested in relation to the incident as Mary had refused to make any formal complaint of assault. Officers did complete a Police Protection Notice (PPN) which incorporates the Domestic Abuse Stalking and Honour Based Violence questions (DASH) and risk assessment. Within this, Mary said her father was, *'controlling and that he liked to get his own way and if she disagreed with him then it caused problems.'* The risk level was graded as medium.

3.43 The Police Safeguarding Hub (PSH) reviewed and then shared the PPN with Mental Health Single Point of Access and EDAN Lincs, endorsing the risk category. No further action was taken by the police.

3.44 The North Lincs and Goole Hospital (Nlag) IMR identifies that Mary was treated at ED and their records indicate: Mary was examined and assessed whilst in the emergency department and disclosed that she has been assaulted by her father and previously had multiple arguments, both locally, and whilst on a recent holiday. Mary stated that her father had grabbed her by the throat, and this had resulted in her choking, there was no loss of consciousness. She felt pain on swallowing. The examining doctor noted multiple abrasions on her neck. The belief was that these had also been inflicted by her father.

3.45 The Police IMR author comments that there is no reason recorded as to why Simon was not arrested, although the lack of independent corroborative evidence, no witnesses, and him giving a credible account for how Mary's injuries were caused may be defining factors of the attending officer's decision making. This was coupled with Mary not wishing to make a complaint.

3.46 On the 27th of July 2022, Acistance contacted Mary by telephone following a note that had been raised by ACIS Customer Contact Centre to contact her. It was reported that Mary was struggling with her mental health; '*she says she does not know if she wants to be here anymore - she*

has no specific plan.' When Mary was asked about the specifics, she told the volunteer that she was struggling with her father and his attitude towards her, and she has told him not to contact her for a while. She was unsure if it was due to her poor mental health or caring fatigue. The service referred this to the CPN given their concerns for her personal safety. The CPN responded back to ACIS that Mary was still having sessions. DASH risk assessment was completed

3.47 In an entry recorded by the LPFT on 29th of July 2022, Mary disclosed that she was continuing to feel low in mood and that she had been looking up efficient ways in which to end her life, but the record suggests that this was "*more of a curiosity"* than an intent. She gave assurances to Trust staff that she did not have a plan to end her life.

3.48 The LPFT IMR reports that on the 24th of September 2022, Mary took a mixed overdose of medication, *'with an express intent to end her life'*. This followed an incident whereby she was assaulted by a neighbour's daughter at a party, and she disclosed that this had brought back her symptoms of PTSD along with emotions from her childhood where she had been *"groomed"* by her father. This incident does not appear to be known by other agencies as they have no record of it.

3.49 On the 30th of September 2022, Mary was seen by an advanced nurse practitioner at her GP practice. The notes reference that she had been assaulted four weeks previously (the assault by a neighbour) and that the police were involved (there is no record that they were.) She indicated that the incident had affected her mental health and had also resulted in her having suicidal thoughts. She was referred to the community mental health team concerning the potential suicide ideation.

3.50 In October 2022, in contact with a community psychiatric nurse, a discussion took place with Mary about the complexity of her relationship with her father; The practitioners notes of this meeting, who was the third CPN (CPN-3) appointed to Mary's case, and had not previously had any contact with Mary, are comprehensive; *"Her father was her abuser, he was the only person that she had in her life and she loved her dad…she wanted to get away from her dad, but then she was torn with the fact that she'd be left with nobody".*

3.51 The notes continued highlighting Mary's hopes for change*, 'there was a good ¾ of her being that wanted to get away from him, wanted to distance herself but there was that little bit that was clinging onto that relationship and hoping for change.*' The LPFT IMR identifies that this quote showed the power of the relationship and the level that Mary was willing to tolerate in the hope that she could have a safe and loving future relationship with her father. The reporting practitioner recorded the relationship as being, *"like a carer and carer relationship, he cared for her in a lot of ways and she also cared for him, so I feel she felt trapped by guilt, carers guilt that if she wasn't there for her father, then nobody else would be."*

3.52 In the meetings with the CPN-3, Mary disclosed that in respect of the incident in June 2022, she believed that "*it was kind of dismissed (by police) as her dad was saying she's got mental health issue, so it was sidestepped again".* She went on to say that after the strangulation, *"the emotional manipulation continued,"* he would threaten her because she lived in a house he owned, she would feel frightened and there was the threat of "*I'm going to lose my house and everything, if I don't do what dad says."*

3.53 It took a further five weeks working with her before the practitioner (CPN-3) could make a full and informed assessment of Mary's needs, risks and planning. The LPFT safeguarding team's advice to the CPN in October was that a DASH risk assessment should be completed, whether Mary consented or not, given the concerns raised by the CPN about the high levels of coercive and controlling behaviour identified, which was perpetrated by her father. The DASH risk assessment was not shared with other agencies outside of the LPFT.

3.54 On the 2nd of December 2022, the DASH risk assessment in respect of Mary, which was commenced in October 2022, was completed and submitted by the CPN to the Trust's safeguarding team. This was just 16 days prior to the discovery of her being deceased. The completed DASH risk assessment was graded as high by the practitioner. This was a particularly comprehensive and informative assessment, with the accompanying notes narrating Mary's most up to date feelings of the many years of abuse that she had suffered from her parents, but specifically from her father.

3.55 At the end of December 2022, the East Midlands Ambulance Service (EMAS) received an emergency call, made by Simon, reporting that he had discovered his daughter at her home, she was not breathing and appeared to have taken an overdose. An ambulance crew attended and discovered the patient laid in bed fully clothed, but she was assessed as being asystole and the crew declared that life was extinct.

3.56 Lincolnshire Police received a call from Ambulance Control that they had attended an unexpected death. The entire property, a one-bedroomed flat, was extremely cluttered. Mary was the sole occupier and appeared to have been living in just one room of the house, the remainder being somewhat uninhabitable through evidence of hoarding. There was apparent evidence that the hoarding was not of specific items, but of everyday items and was indicative of self-neglect and that the situation appeared to have been ongoing for an extensive period.

3.57 Officers discovered various notes that had been written on several mailing envelopes, seemingly made by Mary, these included references to her father's behaviour towards her. The notes inferred that Mary was being left alone to deal with her problems and that she put her father before herself, but the notes did not appear to constitute what might be usually referred to as a 'suicide note.' As already mentioned, Mary had written that she thought that she might survive the overdose and end up in hospital but at the same time she did acknowledge the prospect that she may die. Officers found no suspicious circumstances and the death was referred to the Coroner.

4. Key issues arising from the review

4.1 The root cause of her issues was her childhood, her father, whom although known to have been the 'source,' was never challenged nor questioned in any formalised setting or process. Simon's version of events was believed without questions being raised.

4.2 Mary, on many occasions told professionals that she was overwhelmed by the amount of people that were working with her. Mary's case, in the review authors opinion, is one that desperately needed a lead professional to coordinate on behalf of Mary, who was trying to offer

services/advising her at any one time. The panel member for LPFT is of the view that the role of care coordination should have been undertaken by the community mental health team. The Care Programme Approach was a national policy for people with severe and enduring mental health problems throughout the period that Mary engaged with the CMHT.

4.3 There is unequivocal evidence that the risks to Mary manifested many years before she felt that she could tell anyone her concerns. When she did so, although her voice was heard in that respect, little was done to counter those aspects of her childhood suffering. The domestic abuse, including coercion and controlling behaviour to her by her father went relatively unnoticed, which is a significant learning point for all agencies. The review report shows that domestic abuse was transparent over a period of almost a decade. The lack of recognition of controlling and coercive behaviour is evident given that numerous agencies have not identified it and acted upon it.

4.4 On no occasion did any multi-agency discussion take place on how best to help and support Mary and keep her safe from her father. This, when it happened, was on an individual basis. Simon was never, ever, spoken to about his behaviour to tell him quite clearly that his behaviour was domestic abuse. No one advised him on how to alter his behaviour to his daughter. The panel chair in conversation with Simon did challenge him by telling him this behaviour was not what he was describing as a caring parent but would be seen as abusive.

4.5 Controlling behaviours were very evident in how Simon controlled and monitored Mary's daily activities and behaviours. His control of her finances is evident. There is evidence that he opened and managed her bank account, that she had no access to her bank unless it was through him. Further controlling elements of economic abuse related to Mary's home, as Simon owned the home she lived in, the effect of his control was incessant.

4.6 The strangulation allegations were of utmost concern; Mary's risk was incrementally increased in the first attack and the allegation of the three attacks made on her by her father (if there was an incident in the September, but no one enquired further to establish this), are indicative of a significant potential threat to her life.

4.7 It is a fair assessment that Mary had suffered a severe psychological effect from the attack on her by her father in June 2022, but rather than her being considered the victim, his version of events, that she had used a dressing gown cord around her neck, were believed. It is possible that the bias applied at that time by the police officers was because Mary was known to have psychological issues, as opposed to understanding the root cause of those issues. A further critical learning point is that the police PPN DASH risk assessment of the 22nd of June 2022, was only assessed as being a medium risk. The panel chair poses the question that surely, the risk based on the allegation of strangulation alone, was high, not medium.

4.8 The panel chair fully accepts that this is his hindsight view but follows with him having reviewed all of the information available and having spoken to Simon, that the panel chair does not agree with those sentiments in that Simon was perceived by agencies to be a loving and caring parent, because in reality, he was manipulating Mary and always gaining more control over her, his behaviours were

hiding in plain sight for many years. He was able to effectively convince a range of professionals and was never challenged.

4.9 It is perhaps also useful to consider what opportunities and interventions were made to Mary concerning her propensity to hoard. Hoarding is the excessive collection and retention of any material to the point that living space is sufficiently cluttered, precluding activities for what they are designed for. Hoarding disorder is a persistent difficulty in discarding, or parting with possessions because of a perceived need to save them. It is known to be frequently associated with self-neglect.

4.10 In 2018, The World Health Organisation (WHO) classified hoarding as a recognised disorder. In the UK, research suggests that between 2% to 5% of the population hoard. This equates to at least 1.2 million households across the UK, but it is estimated that approximately only 5% of hoarders come to the attention of statutory agencies. There are various reasons why people hoard, but there is a significant difference between those who are collectors and those who essentially do not, or cannot, dispose of any items.

4.11 Any suicide ideation, especially where it is accompanied by the individual taking steps to look up how, should be seen as a significant warning flag. Mary had, on a few occasions, deliberately overdosed, on both prescribed and over the counter medication.

4.12 There were several disclosures of suicide attempts mentioned by Mary. When disclosures were made, Mary's mental health was prioritised. On every occasion when Mary had disclosed previous suicide attempts, she confirmed that she no longer felt the same, not why she felt the need to do it in the first place.

4.12 What work went on in the background in support of Mary and her suicide ideations, given that she had overdosed on several occasions, is not clear. Again, the attempts appear to have been associated with her mental health as opposed to finding the root cause to that mental health issue and any defined link, for example, from coercive control -domestic abuse to those attempts.

4.13 In an annual report produced by the National Domestic Homicide Project (funded by the Home Office), Dr Bates identified an increased rate in suspected suicides by domestic violence victims (March 2024). Dr Bates reviewed 242 domestic abuse related deaths which were recorded between April 2022 and March 2023. This included 93 suspected victim suicides following domestic abuse. Furthermore, across their three- year dataset, Dr Bates also found that the most commonly identified antecedent risk factors for all suspects in domestic homicides and the perpetrators of prior domestic abuse in suspected victim suicide cases was coercive and controlling behaviour and mental ill health, which is in keeping with Mary's life. Finally, that coercive and controlling behaviour was the most common risk factor in suicide cases in year 3 of the data, demonstrating that this risk factor is more common in these cases than any other typology.

5. Learning themes

5.1 The review has identified key themes which in summary are:

There was a lack of a lead professional, which led to a lack of co-ordination and a lack of a multi-agency approach.
There are missed instances when Mary may have met the criteria for a Carer's Assessment and consideration of this should have been made.
Recognition of coercive control in cases of familial domestic abuse.
A lack of understanding in this case of Domestic Abuse where the victim is suffering from Mental Health issues, and a need to ensure that professionals do not dismiss a victims account because of their behaviours due to their mental health condition.
Understanding the risks associated with non-fatal strangulation
DASH risk assessments not being completed.
Knowledge of childhood trauma including ACEs in domestic abuse cases.
Impact of domestic abuse on a victim's mental health.
Impact of hoarding on a victim's mental health.
Self-harm (through overdose) and risks of suicide in cases of domestic abuse.

6. Conclusions

6.1 Opportunities to have addressed a more thorough understanding of the perpetrator's risks towards Mary were missed on innumerable occasions where the warning signs for safeguarding were consistently overlooked, or were not recognised, by several different professionals operating within numerous agencies.

6.2 There was very little, in fact no co-ordinated activity. 'Responsibility' was frequently deferred to other agencies without a holistic approach to looking at Mary's case from an informed perspective. What is apparent from the information presented by the contributing agencies, is that there has been little joined-up activity in the overall safeguarding of Mary. That is not to say that respective agencies have not delivered levels of support commensurate with their own practice and policy, but there has been little functional joint-working demonstrated in this case.

6.3 Moreover, there were numerous opportunities for agencies to have intervened, whether any formal outcome may have been achievable, but the lack of effective action served only to empower Simon and thereby allow Mary to continue to be subjected to this abuse.

6.4 Accepting that this view is based on having seen all of the information provided and presented by agencies that on analysis there is evidence that the perpetrator exercised almost complete control over Mary, manipulated her, but also influenced other agencies. He wasn't hidden, and often he appears to have taken subtle control assuming the predominant role and responsibility as her father.

6.5 At no time, despite many risk assessments practice by agencies and more importantly where her DASH risk assessments were assessed, was Mary considered as being a high risk. CPN-3 did see the risk to her as high.

6.6 There are multiple points during the involvement with Mary (2020) where it is clear she began to provide a caring role for her father following surgery. Under Section 10, Care Act 2014, it requires Local Authorities to offer and carry out a carers assessment where it appears that a carer may have

needs for support at that time, or in the future. There is no note in records that a Carers Assessment was considered or offered to Mary

6.7 The VKPP report 'Domestic Homicides and suspected Victim Suicides 2020-2023, year 3 report '[1], identified that strangulation, (including hanging) was the most common method of death across the three-year dataset.

6.8 Of the key findings across the three-year dataset, the most commonly identified antecedent risk factors for all suspects in domestic homicides and the perpetrators of prior domestic abuse in SVSDA were:

- Coercive controlling behaviour (CCB).
- Mental ill health.
- Alcohol and drug misuse, and.
- Threat/fear of, or actual relationship ending/separation.

Mary's life encompasses all of these findings.

6.9 This review will recommend that the respective leads for the strategies, review the current guidance in recognition of the fact that there is a link between domestic abuse and suicide and how that should be integrated into policy and practice to ensure that both practitioners, and the wider community, are aware of the emerging trend and support that the respective strategies offer.

6.10 The analysis of Mary's life has shown that she displayed an absence and denial of her hoarding. She appeared to have been accepting of her living environment despite the associated risk to her health, and when she was given help and support, she used several diversionary responses not to have the assistance.

6.11 Although the next comment is made by the LPFT IMR author this could equally apply to a number of other agencies and is being used here because it makes a comment that other agencies involved in this case also need to take account of. The LPFT IMR is transparent and informative and concludes '*The Trust's staff working with Mary and Simon were not wholly effective in identifying the domestic abuse which persisted over decades, and which was disclosed by Mary since 2013. They did not support Mary as the Trust would expect in terms of safeguarding her, educating, and empowering her. The Trust's first holistic assessment of the risks posed to Mary by the domestic abuse from her father was in December 2022. The potential effectiveness of this action was subsequently halted by the Trust's Safeguarding Team who did not accurately assess the risk to Mary as being high risk of serious harm or homicide and therefore Mary's case did not progress to MARAC as it should have done.'*

[1] https://www.vkpp.org.uk/assets/Files/Domestic-Homicides-and-Suspected-Victim-Suicides-2021-2022/Domestic-Homicides-and-Suspected-Victim-Suicides-Year-3-Report_FINAL.pdf

7. Recommendations

7.1 There are a number of agency specific recommendations in addition to the following key practice recommendations:

Recommendation 1: The Safer Lincolnshire Partnership should seek assurance from LPFT to ensure that in similar cases where a number of services are being provided to the same client, that there is a lead professional in place to help coordinate support and appropriate interventions.
Recommendation 2: (i) The Safer Lincolnshire Partnership must ensure that there is a better understanding in their area of coercive and controlling behaviour in cases of familial domestic abuse. (ii) The Safer Lincolnshire Partnership must ensure that awareness is raised with professionals in their area regarding a) Confirmatory Bias and Apparent Competence in cases of Domestic Abuse when the victim is suffering from Mental Health issues. And b) The importance of professionals to not dismiss a victims account because of their behaviours due to their mental health condition.
Recommendation 3: The Safer Lincolnshire Partnership should consider commissioning a programme for familial domestic abuse perpetrators. (It is appreciated that the numbers maybe too small to make this viable.)
Recommendation 4: The Safer Lincolnshire Partnership should consider providing a communication in relation to adverse childhood experiences and advising that practice is delivered in a trauma informed manner.
Recommendation 5: The Safeguarding Adult Board in company with The Lincolnshire Fire and Rescue Service should consider reviewing the hoarding protocol, to also include consideration of hoarding in relation to the trauma of domestic abuse. This needs to be communicated across all agencies so that professionals understand the rationale of the protocol.
Recommendation 6: The group that leads for the Lincolnshire Suicide Prevention Strategy, should ensure it incorporates within the strategy the link between domestic abuse and suicide. The Safer Lincolnshire Partnership should promote the refreshed Suicide Prevention Strategy to ensure it is understood within all agencies and professionals.
Recommendation 7: The Safer Lincolnshire Partnership needs to seek assurance from partners that there is now in place within the partnership a greater understanding of non-fatal strangulation and the harm that this causes and how the non-fatal strangulation is often a risk factor for escalation to homicide.