A Domestic Abuse Death Related Review
Overview Report

Mary
(Died December 2022)

Independent Chair and Author: Dr Russell Wate QPM
(August 2025)

Contents

1.0 Introduction

The victim – Mary

Mary was described to the panel chair as a kind and loving person. She was very artistic and talented. Mary did well at school, passed her exams and obtained a degree in Urban Development. Mary was interested in and enjoyed all aspects of fashion and design.

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. The nature of the term suicide has a specific connotation, and 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, which was 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 did not rule out that the overdose might also take her life.

1.2 The death of a person, in particular when not through a natural cause, is a tragedy that has an immediate and profound effect, not just on those close to the deceased, but also resonates across communities and with professionals who have encountered the individual. The inquest verdict in Mary's case has determined her death as misadventure. This review will endeavour to establish whether any gaps exist in practice, across agencies, that may present intervention opportunities to reduce self-harm or suicide ideations for those subject to domestic abuse from persons of a non-intimate partner relationship and prevent individuals from self-harming or taking their own life.

1.3 The review chair and panel ensured that this report has at it's very beginning a picture of whom Mary was. She was a person who had complex needs, beginning in childhood where she was an only child within a household of alcoholism and domestic abuse. A childhood rightly described as an Adverse Childhood Experience (ACE.)[1] Mary was 50 years old when she died.

1.4 Mary had been married on two occasions, both marriages having ended in divorce due to, in Mary's words, incompatibility. She had no children from either of those relationships. Mary had lived both within Lincolnshire and Avon and Somerset. When she moved to Avon and Somerset, she was married for the second time and was the proprietor of a retail clothing business. Mary had no further contact with either husband and nothing is known about them and no contact details are known for them.

1.5 In 2013, she returned to Lincolnshire to support her father in caring for her mother, who was in very poor health. Mary later moved into a property owned by her father. Her mother

[1] The term 'Adverse Childhood Experiences ' is credited to Dr Vincent Filletti who carried out a study in the United States of over 17,000 people in the 1980's. His study was the first to identify the relationship between experiences in childhood and problems with health and social integration throughout a lifetime.

passed away in mid-2018. Other than her family ties to her parents, she appears to have led a relatively isolated life with few if any friends and no significant employment history, when she returned to live in Lincolnshire. Mary had been on assistance payments since 2014 and was categorised as being eligible for continued support being no longer able to engage in work related activities due to the impact on her of her mental health.

1.6 On behalf of the Lincolnshire Community Safety Partnership, the author wishes to acknowledge the essential involvement given to this review by the perpetrator, but also the professionalism and engagement by the respective panel members, agencies and the IMR authors in their support and understanding, the lessons to be learned and changes to practice suggested. Any decisions to change practice and undertake the recommendations made will rest with the partnership.

1.7 This review is not about apportioning blame, but to look at where both individual agency professional practice can be improved or enhanced, and where changes to how agencies work together will provide further safeguards for those service users, not least those like Mary who are most vulnerable.

The Perpetrator – Simon

1.8 Simon, the pseudonym selected for him by the panel chair, is the biological father of Mary. He was, at the time of Mary's death, 75 years old and currently lives alone. He has no criminal record. He will be referenced throughout the report as Simon.

1.9 Simon had been employed for many years as the owner of his own business. He had been married and was a widower, they had the one child, Mary.

2.0 The Report - Process

2.1 This report has been commissioned by the Safer Lincolnshire Partnership (SLP). This is a statutory partnership which brings together agencies with the aim of reducing crime, disorder and anti-social behaviour across the County area of Lincolnshire. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity.

2.2 One of the key roles of the partnership is that of examining and reducing domestic violence and supporting victims of domestic abuse. Relevant policies are enshrined in each of the statutory agencies' practices within the partnership and within the voluntary agencies who have participated in this review. These individual policies will not be individually examined other than where contextually relevant to the key findings of this review.

2.3 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.

2.4 On the 14th of February 2023, the Lincolnshire Partnership Foundation NHS Trust (LPFT) notified the Chair of the Safer Lincolnshire Partnership of the death, as per the Lincolnshire Domestic Homicide Review (DHR) Protocol. The Chair of the Strategic Board considered the

case in conjunction with other key agencies that had contact with the deceased and her family. It concluded that the case met the criteria and justification for a Domestic Homicide Review.

2.5 Consequently, further panel meetings were convened to discuss the proposed process of the completion of a domestic homicide review, where it was finally determined that the circumstances did not meet the criteria. In July 2023, the Home Office DHR section was notified that a review would not be commissioned and the panel was stood-down. However, the Home Office responded on the 26th of July 2023, to the partnership, advising that the circumstances, as reported, should be further considered by the partnership before a final decision not to conduct a review was made, as there appeared to be a background of familial domestic abuse.

2.6 In order to contextualise the timeline of this case, the dates of the respective panel meetings held were:

- 15th March 2023
- 31st March 2023
- 20th June 2023
- 12th July 2023, where the decision not to review was determined based on the Coroners verdict of misadventure.
- 3rd October 2023, where a new panel chair was appointed as the previously appointed chair was no longer available.

2.7 The purpose of this review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.8 Significant amendments to criminal law concerning domestic abuse have taken place in the period of the date parameters determined by this review's terms of reference. The Domestic Abuse Act 2021 now defines domestic abuse within statute in support of the pre-existing cross-government definitions. This legislation became enshrined in law commencing from October 2021, and sections of the legislation have been phased into statute. This will be contextually referenced but specifically includes the offences of non-fatal strangulation and suffocation[2], which came into force on 7th June 2022. The offences do not only apply in a domestic abuse context but include similar acts carried out in non-domestic situations.

2.9 Non-fatal strangulation, which is relevant to what happened to Mary, occurs when a person intentionally strangles or affects their victim's ability to breathe to control or intimidate

[2] In May 2024, new sentencing guidelines were introduced to reflect the serious nature of the offences.

them. Non-fatal suffocation occurs when a person uses unlawful force on a victim, whether intentionally or recklessly, that affects the victim's ability to breathe, for example, by putting a hand over the victim's mouth or compressing the chest. No physical injuries need be caused for the offences to be committed.

2.10 This overview report has been compiled with specific reference to the [comprehensive] Individual Management Reviews (IMRs) prepared by experienced practitioners and authors from the key agencies, both statutory and non-statutory, contributing to this process. Each of the IMR authors is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from agencies or professionals have been received as part of the review process and all the agencies has actively participated in this review process throughout.

2.11 Since appointment the independent overview author has fulfilled a dual role and has chaired the panel meetings and authored the report. This is recognised as good practice and has ensured a continuity of guidance and context for the review process throughout. There have been several useful professional discussions arising and the DHR panel meetings have been narratively recorded and minutes prepared and approved for transparency. The professionalism of the panel members and the overall quality of the responses has been of a high standard with continued dialogue along with professional observation and critique throughout. This has emphasised the resolve of the participants to this review and has embraced both the partnership approach and the transparency of purpose to learn lessons.

Terms of reference

2.12 In addition to the generic terms of reference set out in the domestic homicide review guidance, the additional and specified areas of examination have been agreed by the panel chair and the panel with 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 was 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.

2.13 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 Social Care team[3]. 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. Then concludes at the time of Mary's death.

DHR Panel members

2.14 The following individuals are totally independent of practice in this case and form the DHR panel and represent the agencies involved in this review:

Agency	Advisor	Job Title	Panel Role
United Lincolnshire Hospitals NHS Trust	Elaine Todd	Named Nurse for Safeguarding Children and Young People	Representing Local Hospitals
Lincolnshire County Council (LCC), Adult Social Care	Angela Copestick	Interim Head of Service for Safeguarding	Adult Care and Community Wellbeing Services
District Council	Emma Waters	Safeguarding Coordinator	Representing the District Council
Lincolnshire Partnership NHS Foundation Trust	Jessica Howland	Interim Head of Safeguarding	Representing Local Mental Health services
Lincolnshire Community Health Services	Jennifer Parker	Named Nurse for Safeguarding	Representing Local Community Health
Lincolnshire Integrated Care Board	Sara Dutton	Safeguarding lead nurse for children and adults	Representing Local GP Commissioning Services
Lincolnshire Police	Rachael Cox	DCI Lincolnshire Partnership Safeguarding Hub	Representing Local Police Service

[3] Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. LPFT operates a Section 75 agreement with the Lincolnshire local authority to deliver delegated mental health social care duties on behalf of Lincolnshire County Council.

Lincolnshire Fire and Rescue Service	Dan Moss	Manager for Prevention and Protection	Representing Fire and Rescue Service
East Midlands Ambulance Service	Charlotte Salt	Named Professional for Safeguarding Adults	Representing Local Ambulance Service
Lincolnshire Recovery Partnership ('We Are With You')	Olivia Armstrong	Quality and Governance Manager	Representing Local Alcohol and Drugs services
Lincolnshire Domestic Abuse Specialist Service (At time of review were EDAN Lincs)	Sharon Walker	IDVA Manager	Representing Local DA Services (Voluntary sector)
ACIS Housing	Mandy Snee	Customer Service Manager	Representing housing association in partnership with Shine Charity
RJW Associates LTD	Russell Wate James Bambridge	Chair/Author Support to Chair	
Support to the Panel			
Legal Services Lincolnshire	Toni Geraghty	Legal advisor to the review	
LCC	Jade Thursby	Domestic Abuse Business Manager	
LCC	Teresa Tennant	DHR Senior Administrator	

Overview Author

2.15 Dr Russell Wate, QPM has significant experience in partnership working within numerous safeguarding environments, conducting Child Safeguarding Practice Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having chaired

and authored several such reviews across the country, as well as internationally. He has completed the Home Office DHR training, the Sequeli and NSPCC training and the Standing Together and AADFA DHR training. He presents training to agencies, both nationally and internationally, on the conduct of and carrying out of Statutory Safeguarding Reviews.

2.16 Dr Wate is entirely independent of all agencies in this process having no connection with the Safer Lincolnshire Partnership other than previously providing professional and independent services in respect of unrelated Domestic Homicide Reviews and other statutory safeguarding reviews.

Contributors to review

2.17 The following agencies have contributed to this review:

Agency	IMR	Report
Lincolnshire Police	➢	
Lincolnshire County Council Adult Social Care	➢	
Lincolnshire Community Health Services	➢	
EDAN Lincs [Ending Domestic Abuse Now]	➢	
East Midlands Ambulance Service	➢	
Lincolnshire Integrated Care Board on behalf of GP Practice	➢ (X2)	
Lincolnshire Partnership (NHS) Foundation Trust	➢	
DWP	➢	
We Are With You		➢
United Lincolnshire Hospitals NHS Trust		➢
ADHD Centre		➢
Northern Lincolnshire and Goole (NHS) Trust		➢
ACIS Group	➢	
District Council		➢

Timescales

2.18 To ensure the review into the circumstances that led to the death of Mary was dealt with in a timely manner, the Safer Lincolnshire Partnership and the DHR panel have now established momentum of the review, taking account of the initial inhibitors to the process and the relevant communication with the Home Office. Since then, there has been clear impetus expedited to the review to accord with good practice where possible to minimise any further delays to the process, following the decision to conduct this review.

2.19 The review process fully commenced in November 2023 and the final report was agreed by the panel and SLP in November 2024.

Confidentiality

2.20 The findings of this review document are confidential. Information is available only to participating professionals and their line managers from the participating agencies and the Home Office, QA Panel. This matter has not been discussed other than in closed and minuted confidential meetings with appropriate representatives present in person or remotely, or where unable to actively participate, have been informed of progress in their absence. As well as the victim, and the perpetrator, no names have been used in the report to protect the identity of other individuals and professionals involved.

Involvement of family

3.0 Unexpected deaths are tragic not just for the family, but also for friends and work colleagues, and this review process has worked hard to attempt to include their respective thoughts and views throughout. In support of the information received from agencies, the panel chair has engaged extensively, meeting with the perpetrator- Simon. It is apparent that there are no other family members, this may also support the thinking in this case that suggests that Mary was a very lonely and isolated individual, her principal contact being with the perpetrator, other than from many professionals and practitioners.

3.1 The review chair has maintained open communication channels for all contributions that both Simon, and any other relevant parties may wish to make. There are though as mentioned above for Mary, no other family members, friends or employers that are able to contribute to the review. Simon has been kept updated about the progress of the review process. Exclusively this has been Simon, who has been visited by the panel chair and who has tried to provide significant information with which to inform this review. Simon has also, on occasions, called the panel chair because he has remembered something else of Mary's life.

3.2 It was made quite clear to Simon by the review author that although he is the father and the only family member or even friend for Mary, that the report and the process will be looking at him as the perpetrator of the domestic abuse to Mary. This is a point that he does understand and accepts.

3.3 The Home Office leaflet concerning the procedure of the Domestic Homicide Review process (now domestic abuse related death review) was sent to Simon and the letter that

accompanied it also emphasises the opportunity to access an advocate. This point has further been stressed at a meeting between the chair and Simon.

3.4 The potential enduring effects of the tragic death of Mary, emphasises the need for the balance between the learning and future considerations for those agencies participating in this review or vicariously involved within the overall safeguarding arena.

Parallel reviews

3.5 The inquest into the death of Mary, which was held in April 2023, led to the following conclusion by the Senior Coroner for Lincolnshire:

> *"Mary died in December 2022 as a consequence of a mixed drug overdose. She had a complex past medical history which included extensive current treatment for mental health issues as well as past treatment for addiction to medication. Following concerns for her welfare her property was visited and her body was found. She appeared to be living in a single room. There was evidence of various medications, some had been prescribed to her, others had not and on balance had been sourced independently. There was no direct evidence of suicidal ideation. Conversely she had a history of self-medicating beyond the regime prescribed to her and of using excess medication as a coping mechanism. Her death resulted primarily from the combination of medications taken, although some of them had been taken in excess quantities. On balance of probabilities her death resulted from a deliberate ingestion of excess medication taken to treat the symptoms of her underlying illness."*

3.6 The inquest conclusion was death by misadventure.

Equality and diversity

4.0 The DHR panel has scrutinised the IMR's, discussed and examined the nine protected characteristics in accordance with the Equality Act 2010. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are recognised as being.

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

4.1 In this case, Mary is identified as being white and British as has been determined by records held by contributors to this review process. Any disabilities referenced herein are reflected within information provided by healthcare practitioners and other professionals. The key characteristic identified within the agency IMRs is that Mary suffered with significant mental health issues, which is duly acknowledged by this review. Mary had no known or identified religion or beliefs.

4.2 Evidence has shown that domestic abuse is a gendered crime and research supports the theory that men commit more acts of domestic abuse than women and statistically, women are more likely to be victims of domestic abuse. The Crime Survey for England and Wales in December 2023[4], estimated that 5.1% of people aged 16 to 59 years experienced domestic abuse in the previous year.

4.3 Statistically, approximately some 1.4 million victims were women and 750,000 were men, although it is a consistent picture that women were more likely to be the repeat victims of abuse and men are more likely to be repeat perpetrators. A change in the recording of harassment and stalking offences, may identify part of the reduction in the recorded figures.

4.4 There were 100 domestic homicides recorded in the year ending March 2023. Women remained as being more likely to be killed by someone they knew than men, for example, of the 100 domestic homicide victims in the year ending in March 2023, 70 were women. However, those statistics do not include 'suicide' figures where the victim had a known or suspected background of domestic abuse. Those figures may be known by the Home Office when the amended statutory guidance for Domestic Abuse Related Death Reviews (DARDR) to replace the current Domestic Homicide Review process, is adopted nationally during 2024.

4.5 The Vulnerability Knowledge and Practice Programme (VKPP) which commenced in 2020, has been integrated into the College of Policing (CoP) since April 2024. They provide what are currently understood to be, a more accurate representation of how police forces working with safeguarding partners across England and Wales are responding to domestic abuse. This programme has examined coercive and controlling behaviour which is identified as being one of the top five risk factors for homicide, including non-intimate familial homicide and suspected victim suicide by domestic abuse (SVSDA.)

4.6 In the VKPP year three report[5], April 2022 to March 2023, police forces reported a total of 242 domestic abuse related deaths, 93 of which were suspected that the victim took their own life through suicide arising from domestic abuse. Year on year, this is an increase of the figure for 2021 of 51, and 72 from 2022, but this may not suggest an empirical increase, but might suggest moreover an awareness by police forces of victims suicide where there is, or was suspected to be a background of domestic abuse. There was also of relevance to this review an increase in non-fatal strangulation of victims by the respective identified suspect

[4] The Crime Survey for England and Wales (CSEW) provides a more reliable measure of long-term trends for domestic abuse than police recorded crime data.

[5] https://www.vkpp.org.uk/news/report-reveals-scale-of-domestic-homicide-and-suicides-by-victims-of-domestic-abuse/

before death, but this appears to be where there was an intimate relationship, as opposed to a familial relationship.

4.7 A key factor in the academic research by the VKPP identifies that a similar proportion of victims and suspects were known to non-police agencies and comment, *"The fact that over one-third [of the victims] continue to be known to agencies other than the police, underscores the key importance of multi-agency response to homicide prevention."*

4.8 Although the figures for SVSDA identify a low figure arising from abuse by non-intimate family members, the predominant risk factor was from coercive and controlling behaviour on the part of the perpetrator.

4.9 Legislation concerning coercion and control, as a criminal offence, has been in statute since late December 2015, but there remain gaps in national practice to ensure that coercive controlling behaviour is recognised as a significant factor in examining all domestic abuse cases, which can be overlooked or in some cases, entirely hidden.

4.10 The use of the Domestic Abuse Risk Assessment (DARA) process, which has been adopted by numerous police forces and is being phased in in others, has been recognised as providing a more effective tool in the identification of coercive and controlling behaviour, as it does not rely on the 'tick-box' process that comprise the Domestic Abuse Stalking Harassment (DASH) risk assessment process and encourages the use of a narrative from the reporting practitioner, which appears to encourage a more informed perspective through the narrative and a more considered identification of the level of risk.

4.11 It must be noted that The Safer Lincolnshire Partnership does adopt a robust position in discussing and examining the deaths of victims who have taken their own life and where domestic abuse was known or suspected, as exemplified in this case. This is good practice.

4.12 In 2023 The Institute for Adressing Strangulation published a report, 'ONS Data on Non-Fatal Strangulation & Suffocation June - December 2022.'[6] Which is the key period within which Mary was the victim of non-fatal strangulation. The report states: *'There were 470 female victim/survivors of non-fatal strangulation and suffocation caused by a family member other than an intimate partner.*' If we consider that the legislation had only just began during this period that this shows to professionals that this form of domestic abuse is not an isolated occurrence. The report also highlights: '*The data raises important issues regarding non-fatal strangulation and suffocation and warrants further exploration. 5. The high rates of cases that do not proceed in the criminal justice process due to 'evidential difficulties' particularly those pertaining to cases labelled 'suspect identified; victim does not support police action.'* Although as stated in this paragraph that these findings were early in the process nonetheless more must be done to prosecute offenders of this form of abuse like Simon to his daughter Mary.

Dissemination

[6] ONS-Data-on-Non-Fatal-Strangulation-Suffocation.pdf

5.0 This anonymised report and the accompanying executive summary have been prepared by the author and panel for consideration of publication in accordance with the policy of the Safer Lincolnshire Partnership, following the completion of the review process. In any event, the report will be shared with the Police and Crime Commissioner for Lincolnshire and all relevant statutory and voluntary agencies, supporting victims of domestic abuse, within Lincolnshire. The report will also be shared with Domestic Abuse Commissioner's Office. This report will be provided to the HM Coroner on request, given that the inquest has been completed.

5.1 The author wishes to assure all parties that any publication will be made with due regard to any potential ongoing sensitivities and recommends that any publication of the findings of this report are treated with due consideration to all those affected and those involved in this review process. Any decision made to publish this report whether in full or in a redacted format will be made by the Chair of the SLP.

Section Two – The facts

6.0 Circumstances

Key practice events

6.1 Although the timeline for this review has been determined as being the 10th of March 2019 to the 18th of 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. This has also been supported by the contribution of Simon to the review process.

6.2 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.

6.3 In a risk assessment in October 2022 by LPFT, Mary, talking about her childhood is quoted as saying that her father, "*would control every element of my life, hit me and threaten me (in order) to keep our home life a secret from school. My mother was depressed and took multiple overdoses where my father would not care and I would be left watching her breathing all night and make sure she woke up the next day*."

6.4 Mary referred to the abuse she suffered from both of her parents from around the age of nine and cited, "*We don't talk about what happens at home*," indicating that this has been

drummed into her during her childhood. She also disclosed verbal abuse towards her from her mother and Simon. Mary's mother, who died in 2018, was chronically ill and an alcoholic, but the inference is that her lifestyle behaviours were predicated by domestic abuse by Simon. The picture painted is that of a dysfunctional and insular household, entirely dominated and controlled by Simon.

6.5 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.

6.6 It is likely that the physical and emotional abuse that Mary was exposed to when she returned to the family home in 2013, 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. She returned to live in her parent's home. At no time did the family offer any support to Mary, rather the expectation was that she would provide support to them, and it seems that became her role. The reports tend to suggest that she had no choice, and frequently required support from various agencies.

6.7 Having been well educated, it is reported that Mary had previously had a successful career managing an estate agency and following this, working in business management at a university. She had also been the owner of a retail clothing business in the West of England, although the business had closed for financial reasons.

6.8 It is important to remember these historical events in Mary's life as they seemed to be re-commenced from 2013 when she returned to live in the family home. There was no mention from the Safer Lincolnshire Partnership enquiries with other areas, of any incidents happening between family members while Mary lived away from her family elsewhere in the country.

6.9 When Mary returned to the Lincolnshire area in the latter part of 2013, she was not working. It appears that this immediately compounded her isolation in that her social circle was singularly composed of her father and her mother, whom she was expected (by her father) to be a full-time carer for.

6.10 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.

6.11 The Department of Work and Pensions (DWP) IMR, identifies that Mary claimed Employment Support Allowance (ESA) from the 22nd of February 2014, until her death was reported on the 18th of December 2022. The health conditions recorded, provide the evidence that was considered by the reporting healthcare practitioner in support of her claims for the relevant benefits, stated that she had psychosis. This appears to have emanated from a diagnosis following a hospital admission in early February 2014, the date

of which is a useful benchmark in respect of Mary's journey within local services and which was shortly after her return to Lincolnshire.

6.12 The DWP records also note that the healthcare practitioner referenced that the available evidence suggested that improvement of her medical condition was '*unlikely in the longer term.'* Consequently, Mary was awarded Limited Capability for Work- and Work-Related Activities, due to physical or mental health risk. She was also in receipt of Personal Independence Payment (PIP). (From 2019, Mary received a mobility element to that allowance, which enhanced the payment.)

6.13 On the 13th of May 2014, Simon made an emergency call to the Lincolnshire Police, reporting that Mary had been drinking, was throwing bottles around and threatening to take her own life by suicide, no weapon was involved but there was broken glass. Officers attended promptly. Simon appeared more concerned about his property and damage that may result if Mary remained at the premises, rather than her welfare. Due to Simon's concerns about what *might* happen next, Mary was arrested and detained by the officers to prevent a breach of the peace. Mary was held overnight in police custody and released the following morning, without charge. The police did not complete a risk assessment of her, although on release, Mary was signposted with contact details of numerous agencies including adult support, victim support, mental health crisis team and alcoholics anonymous.

6.14 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. He added that Mary had been picking up knives and had been threatening to harm herself. 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. Having initially said that he did not want Mary back in the house, Simon changed his mind, and no further action was taken by the officers. There was no risk assessment made by the attending officers.

6.15 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. It is recorded that her father had called the ambulance and that Mary had been living with her parents for a few months.

6.16 Mary was engaged in treatment with 'We Are With You' (WAWY) [7] from the 9th of February 2015 to address her over the counter and illicit prescribed medication use. Although she engaged with the service for a period of more than two years, following a series of non-contact with her she was discharged from the service on the 8th of November 2017 and had no further engagement.

[7] Drug, alcohol and mental health service operating nationwide and now known as 'With You'.

6.17 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[8].

6.18 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, so visits her address, where he could only communicate with her by talking through the cat flap. It transpired that Mary has missed a psychiatric outpatient appointment that day. 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 and he was invited to step aside so she could be spoken to alone. The crew made a safeguarding referral for domestic verbal abuse and possible sexual abuse. She was only partially clothed and repeatedly covered her genitals with her hands. The crew informed the patient that this referral was being made with her consent. She was admitted to hospital for a suspected overdose and mental health assessment, where she remained for several days, during which time a police investigation was commenced.

6.19 The EMAS safeguarding referral identified that there was a possibility of large quantities of tablets missing as there were numerous empty blister packets and evidence of her buying large quantities of codeine. It was noted that she appeared '*uneasy and concerned when father present,'* and he was seen to regularly place his hands on her calves and ankles, tapping and stroking them, which the crew stated in their view was inappropriate. She informed the crew that she was registered with a domestic violence and abuse professional.

6.20 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[9]. 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. At that time EMAS did not have a referral pathway into domestic abuse services, which since 2023, has changed and a pathway has now been established.

6.21 On July the 5th 2018, following contact by the Community Mental Health Team, Lincolnshire Police were alerted to concern for a potential serious sexual offence against Mary following her admission to hospital the previous day. When she had been examined at the Emergency Department, Mary's body was described as in a general state of neglect with sores and moisture around the breasts and several cuts and sores on her legs. She was reported to be in a poor hygienic state. By comparison, her genital area was very clean, which was thereby remarkably different to the rest of her body and appeared unusual. Mary was not speaking at all, which raised concerns amongst the practitioners that an assault of a sexual nature *may* have occurred.

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[8] A later review was conducted given the side effects of some medication being prescribed over a prolonged period.

[9] Lincolnshire hoarding protocol 2020 (The rating goes from 1-low to 9- very high).– see analysis section.

6.22 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. It was decided that Mary's home address should also be searched for evidence of an offence. 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 of any nature, but the recorded crime accorded with police recording standards.

6.23 Her home address was searched by the police for any relevant evidence of an assault. The police IMR author has viewed the body worn video of the 'crime scene' and confirmed that the conditions were such that it was "*impossible to tell if a disturbance of any kind had taken place."* The investigating officers made enquiries into past police involvement with Mary and Simon; the police had no record of any previous safeguarding concern.

6.24 The Lincolnshire police officers who searched Mary's address concerning this potential sexual offence, and observed that the property was in a dirty condition with a large amount of property in all the rooms. There was evidence that Mary, the sole occupier, had been sleeping downstairs on the sofa. The police concluded on that occasion, that it was impossible to identify if a disturbance or assault of any kind had taken place due to the very poor conditions. Body worn video was taken by officers at that time.

6.25 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.

6.26 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 the records as not met.

6.27 Mary was open to the LPFT Section 75 mental health social worker team from December 2018. Her 'Needs Assessment' by them 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. Mary also suffered from blackouts and had memory loss leading up to the blackouts. Mary believed these were due to stress and reported awaiting tests to confirm the cause[10]. Upon discussion of her personal history, Mary identified that she was single but had two previous marriages, the first of which was within Lincolnshire. Her second marriage was in the West Country, and she suggested *"it did not go well towards the end,"* but it does not appear that this information was probed further by additional discussion.

[10] Later clinical tests found no underlying cause to the blackouts.

6.28 Mary also believed she may have been sexually abused as a child, that the perpetrator was a teacher, but she had blocked this away in her mind. She was offered further support services, however, she stated she was being supported with this via her Community Mental Health Team Psychologist, (The LPFT records have no record of a psychologist being involved, so this might just mean the CPN-that Mary is referring to here.) Mary's presenting needs were identified and recorded as being family, friends and support networks, mobility and getting around the environment, personal care, eating and drinking, running the home, participating in the community, maintaining health and wellbeing and living safely and taking risks.

6.29 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 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, whilst also feeling as though she wanted to distance herself from him and the abuse that he perpetrated towards her. This manifested in her providing a caring role towards him when he became ill in 2020 with lung cancer, Mary's feelings then were that she wanted to *'simply be his daughter and for him be a father to her.'*

6.30 In late December 2018, Mary was provided with eight hours of care and support, split between three days per week. Adults Supporting Adults (ASA) were the contracted provider and the record summary states that Mary identified the following outcomes that she would like to receive support with; building her confidence and accessing the community to make friendships, management of her hoarding to make her home less dangerous for trips and falls, personal care support to increase her confidence in accessing hairdressers and laundrettes, decrease her anxiety about food shopping and cooking, managing her incomings herself and accessing bereavement counselling following the death of her mother. Mary was also in receipt of a cleaning service to help maintain her home.

6.31 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. It is not clear if this is the same, or similar letter she had provided in April to the CMHT, but it would appear that it was probably the same one. Mary stated that she had not been coerced into signing the letter and was seen alone during this discussion, not in the company of her father. The letter was clear in noting that Mary understood that this did not mean her father would be able to make any decisions on her behalf but that she wanted and would allow him to collate and file information for her regarding such decisions.

6.32 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.

6.33 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, they believed that this did not negatively impact on her care in any way. The CMHT practitioners did explore supporting Mary with managing her finances herself. However, she declined this as she wished to address one thing at a time and intended for it to be something addressed in the future. They did not make a link to economic abuse and coercive and controlling behaviour, this could have been explored with Mary more directly by completing a DASH risk assessment and with appropriate safety planning implemented.

6.34 The LPFT IMR author identifies that social workers in the mental health social care team, spoke about how Mary would frequently decline services being suggested that were designed to support her in developing her independence. Specifically, this centred about her wishing to move out of her home to other accommodation, but she stated that she was not able to do so, "*because of her cats*."

6.35 On the 14th of May 2019, EDAN Lincs triage, contacted Mary following receipt of the referral from the LPFT. During the contact, by telephone, the EDAN Lincs support triage worker explained the service and the support to anyone effected by domestic abuse. Mary was referred for an assessment on the 20th of May.

6.36 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.

6.37 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 mum 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."*

6.38 Mary also said that, *"it's always been like this,"* and went on to disclose that as a child she was subjected to verbal and physical abuse by both her mum and father and she still struggled with the abuse that she had experienced as a child. She described feeling like her father was reliant on her and he expected her to support him alongside his continual blaming of her for her mum's mental health. Mary inferred that there was a frequency of her giving support to her father, where he would then demean her as it did not come up to his expectations.

6.39 When asked to recall a specific abuse, she recalled an incident, being at her mum's bedside following her mum taking an overdose, and that her father would make her say sorry to her mum because he blamed Mary. 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.

6.40 On completion of the pre-assessment, EDAN Lincs advised Mary that she could be supported both emotionally as well as practically with resources to help increase her awareness of domestic abuse and for her safety planning. The accompanying DASH risk assessment completed was graded as being a standard risk, with coercive controlling behaviour being the main indicator of risk. This was not shared back with LPFT the original referrer.

6.41 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.

6.42 Upon first review of Mary's care and support plan on the 9th of June 2019, by the Section 75 Mental Health Social Worker, Mary appeared to be building trust with her named key workers from Adults Supporting Adults and was noted to have made positive improvements, but she requested a pause on one of the three days' support she was allocated, as she had a 'lot of ongoing involvement from other services'. She requested to flexi these hours between the remaining two days.

6.43 On the 1st of July 2019, Simon was seen for a face-to-face visit with a community psychiatric nurse assigned to him, and they spent time talking about his relationship difficulties with his daughter which he was hoping to improve.

6.44 On the 6th of August 2019, Simon contacted ACCW expressing his concerns that the care package in place for Mary was not working, reporting that she was stressed before the visits took place which was thereby affecting her mental health. He had discussed with Mary, cancelling visits and that although he believed that she wanted to become independent, he considered that she was unable to cope. When asked, Simon confirmed Mary was aware of her contribution to the care costs and he stated that this was another worry of hers. The social worker confirmed the CPN would continue to have fortnightly visits with Mary and would text her once a week to check on her welfare. The Social Worker contacted Mary directly to discuss her care package and booked an appointment for the 30th of August 2019 with Adults Supporting Adults (ASA) included in the meeting to discuss the care package. The outcome of this review was that Mary wished to continue to use her eight hours flexibly over two days. It was agreed that Mary would then receive annual reviews unless an earlier review was required.

6.45 On the 30th of August 2019, EDAN Lincs attempted to call Mary to discuss a potential start date for the group Safe programme[11]. Mary answered the phone to say she was in a meeting with her social worker. It was agreed for the EDAN Lincs support worker to send her a text to remind her to call at a convenient time.

6.46 Between the 2nd of September 2019 and the 1st of October 2019, there was ongoing correspondence between the Penderel's Trust[12], the social worker, the finance team at Lincolnshire County Council, Mary and Simon, as Mary was in arears for her contribution to

[11] EDAN Lincs have an internal hybrid safe programme which can be accessed by victims at their own pace to increase awareness of domestic abuse, improve resilience and develop improved safety planning strategies.
[12] A Charitable trust, that supports several local authorities across England and Wales in the provision of advice, support and services for vulnerable persons independent living.

her care. Mary first advised the social worker that she had emailed and resolved her contribution to care with the Penderel's Trust, however, she later revealed her father had been trying to arrange this and this had not been completed. It was agreed that Mary would pay a lump sum and small monthly top-up payments to resolve the outstanding payments.

6.47 On the 6th of September 2019, the DWP received further supporting medical information for Mary's continuing benefit claims from her GP and a letter from her father, confirming his concerns regarding her health conditions and that she required additional support.

6.48 By October 2019, a further outpatient's appointment for Mary with a consultant psychiatrist at LPFT, recorded that the clinical impression was of Bipolar Affective Disorder Type 2 with PTSD-related symptoms. An alternative anti-psychotic medicine from that which was prescribed in 2017 was made to stabilise Mary's mood by reducing her symptoms of mania.

6.49 On the 8th of November 2019, EDAN Lincs sent a text message to Mary to offer her an initial assessment on the 19th of November (At Mary's request EDAN Lincs had put on hold their involvement with her and this was to re-initiate contact). The face-to-face appointment was arranged for her to attend a safe location. Mary replied to the text message to say that her father had been diagnosed with lung cancer and had an appointment on the 12th of November, she felt morally it was right to support her father to attend the appointment but would also attend the meeting as proposed.

6.50 On the 19th of November Mary attended the initial assessment with an EDAN Lincs support worker. Mary said she was feeling anxious because she did not want anyone to see her attending an appointment and she wanted assurance that EDAN Lincs would not share information with her father. An agreed client led support plan was developed and the EDAN Lincs support worker reviewed details and disclosures as discussed on the pre-assessment and checked if anything had changed. Mary disclosed that her father had a recent diagnosis of lung cancer and consequently she felt that he was *more* demanding of her and he expected too much. There were no other family members to help support him, so she felt morally it was *her job* to support him. She shared examples of how he demanded and expected that she would collect his medication, go shopping and complete household chores, yet still she experienced verbal abuse from him whilst in his company and he would text her constantly. She disclosed that Simon had told her that she was not allowed to leave her door key in the door of her own house, presumably so that he had easy access.

6.51 Mary disclosed that Simon made sexual comments in relation to his and her late mother's sex life that she stated were offensive and that those would frequently follow on from when he was angry with her or annoyed that she was not with him. A plan was agreed with Mary, consisting of her accessing the counselling hub or a Steps to Change referral for her emotional wellbeing. Advice was also given in that as she was the tenant of the property she was living in; she could choose to leave her key in the door if it was her preference.

6.52 Also 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. On top of having a serious mental illness, the impact on Mary's mental health around these times when Simon had cancer was seen as significant.

6.53 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. The EDAN Lincs support worker explored future volunteering opportunities with Mary to increase her social network and reduce her isolation. Mary expressed throughout the support that she wanted to remain in contact with her father and she was now the only family member who could support him now that her mother had died.

6.54 On the 9th of December 2019, Mary sent a text message to EDAN Lincs to cancel an appointment because she had to attend an appointment with her father at hospital for his cancer screening results. EDAN Lincs support worker responded by text message reassuring Mary, and the case notes demonstrate empathy and offered reassurance to her that she could call an EDAN Lincs support worker if she needed to talk. Mary responded by text message that she had an *'awful weekend'* but the case notes do not provide any further detail.

6.55 On the 10th of January 2020, Mary sent a text message to the EDAN Lincs support worker to apologise for not responding to messages or contacting them over the previous few weeks. Mary indicated that her father had suffered with blood clots, so she had been supporting him.

6.56 On the 17th of January 2020, during a face to face support session with EDAN Lincs, Mary stated that her father had requested that she should move in with him following his anticipated cancer surgery. This was discussed at length to consider the risks, and impact on her, along with safety planning if she chose to move in with him. The case notes advise that Mary was aware that moving in with her father was likely to increase the risks of verbal abuse. She did not intend to give up her own property.

6.57 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. She also shared that visiting the hospital raised her bad memories of being a child at her mum's bedside and she described flashbacks that were impacting on her mental health. The EDAN Lincs support worker requested Mary's social worker's contact details. Mary also stated that she always felt like people were negative about her and she did not like others to think '*bad*' about her, and since her father's operation she had an increased anxiety about how others may view her.

6.58 During telephone welfare checks, made by a social worker assistant within the Section 75 Mental Health team for the period 31st of March 2020 to the 5th of May 2020, Mary spoke of having moved in with her father on a temporary basis to care for him, following him having

surgery for lung cancer in March 2020. The reason for the welfare checks was to comply and support people during the Covid-19 pandemic. This was also the reason that Mary moved in with Simon was to comply with the then in place Covid-19 regulations.

6.59 From March 2020, respective records confirm that Mary was supporting her father following his diagnosis with lung cancer. She informed her social workers that as he was her only surviving family member, she needed to care for him and that she temporarily moved into his home. She later informed the social worker that she had moved out and returned to her home, although the date is unclear. Following that, she reported to numerous services that the support she had provided to him had had a significant impact on her mental health.

6.60 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.

6.61 On the 15th of April 2020, in a contact with an EDAN Lincs support worker by telephone, Mary disclosed ongoing emotional abuse from her father, and she was trying to get carers in to support him. She was open to talking to the health service to seek advice, but the emotional and verbal abuse from him was having an impact on her wellbeing and she stated that this brought back the historical abuse she had suffered from him.

6.62 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. She stated that her father could get other people to help him but he still demanded for her to do everything for him. The support worker discussed gains and losses if she took back some personal control and managed the situation by moving back to her own property, so she had a safe space. Mary continued to make her decisions based on what she believed to be 'morally' right as a daughter and was not willing to leave. The EDAN Lincs support worker attempted to empower her, but Mary's strong family values were understandably acting as a barrier to her leaving.

6.63 During a welfare check by a social work assistant within the Section 75 Mental Health Team, on the 12th of May 2020, Mary said that she had got her father to agree for a 7 to 10-day break from him so she could concentrate on herself and *'chill out'*, but despite this arrangement, she said that he had then called her the day following that arrangement, making demands and requesting support with things which she viewed were not important.

6.64 On the 19th of May 2020, EDAN Lincs closed Mary's case, but on the 21st of May, Mary sent a text message to EDAN Lincs that she was in '*a bad way'* and needed to have a conversation with a support worker. In response to the text message the EDAN Lincs support worker sent a reply by text to advise her she needed to contact her GP or ring 999 if it was an emergency. The Mental Health Crisis team number was also shared by text message. As a voluntary service, once the case is closed to EDAN Lincs, it can only be re-opened by a new referral.

6.65 On the 26th of May 2020, a welfare call check was completed with Mary by a social worker, where she explained she was angry that the counselling she was receiving through EDAN Lincs had ceased as she had a change in her worker who had then, almost immediately discharged her, but she was under the impression she was due to receive more sessions. Mary explained that she required continued support to discuss her being abused in her past which was predominantly from her father. The notes indicate that she felt somewhat bound to her father.

6.66 On the 5th of June 2020, an EDAN Lincs support worker made a follow up call with Mary, who confirmed that she had a CPN and key worker. She was advised to continue her support with mental health services and that her support was now closed to EDAN Lincs. Mary described the EDAN Lincs support worker as a *"beacon of light."*

6.67 During Mary's Care and Support Plan Review on the 9th of June 2020 with her social worker, she requested a break in care from Adults Supporting Adults (ASA) as her father had been unwell and she had again been caring for him, resulting in her being unable to engage in support for herself.

6.68 On the 1st of July 2020, in a medication review carried out with a GP, Mary reported that she was caring for her father "*all the time"*. Her mental health was noted as stable, and no concerns were raised. Her medications were changed from weekly to monthly collections.

6.69 Mary received a further Care and Support Plan Review on the 19th of August 2020 to discuss and evaluate her care package. She recognised the benefit of the ASA support, but by the same token, she reported a decline in her mental health resulting in her being unable to maintain her living environment which had become cluttered.

6.70 On the 16th of September 2020, EDAN Lincs took a new repeat referral for Mary from the ACCW. Following four unsuccessful attempts to contact her, she contacted EDAN Lincs on the 25th of September and a pre-assessment was arranged for October 2020.

6.71 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".*

6.72 On the 8th of October 2020, in the pre-assessment with EDAN Lincs, Mary disclosed that over the previous six months her mental health had declined, which had led to her taking an overdose. Mary was at this time open to CMHT, having regular appointments, including a face to face appointment on the 7th October 2020, and had been during the period that Mary mentioned, so she would have had a care plan in place. Mary had not disclosed to the community mental health team that she had been taking overdoses of medication and therefore they were unable to risk assess the cumulative effects. She had also been diagnosed with Bi-Polar and was feeling very isolated, disclosing ongoing emotional abuse from her father and that she was still caring for him. He had told her that, if she got carers in to attend to his care and support needs, she was '*leaving him to die.'* EDAN Lincs provided details and contact number of Steps to Change (S2C) for mental health support and Samaritan's as an additional resource if she needed to talk, especially out of normal working hours.

6.73 On the 14th of October 2020, an EDAN Lincs case worker attempted contact with Mary and then sent a text message to her phone. Mary replied the following day that she was unable to answer the call at the time as it was "*not a safe time,"* the inference being her father was nearby at the time.

6.74 On the 19th of October 2020, EDAN Lincs made further attempts to call Mary and arrange an appointment. Mary sent a text asking if the support was face to face or phone. It was confirmed that due to the Covid restrictions, all support was by phone only, this accorded with practice and policy at that time. Mary responded by text that she had lots of forthcoming appointments with mental health services and hospitals.

6.75 On the 26th of October 2020, Lincolnshire Community Health Services (LCHS) Neighbourhood team, received a referral from a community psychiatric nurse (CPN). Mary was, and had been, receiving support through the Community Mental Health Team since February 2018. The specific request in the referral was for support in increasing confidence and her social networking. The referral was closed on 28th of October 2020 as it was identified that Mary already had key workers through LPFT and a direct payment with Adults Supporting Adults, eight hours a week, for social input. The case notes do not indicate if this decision was based purely on the information provided, or through having further conversations with the other professionals involved.

6.76 On the 11th of November 2020, EDAN Lincs conducted an assessment with Mary to agree her level of support. The advisor completed a DASH risk assessment, which was assessed at a medium risk level. The information that informed the DASH was that Mary stated, she was feeling very isolated, she had no friends and no support around her. She had difficulty leaving her home as she felt low in mood. She wanted to consider moving within the County, but further away from her father as she was afraid of him, when he gets angry he would shout at her. She stated her father tried to be controlling towards her driving, he was making her sell her car because of all the medication she was on for her mental health. She also stated that historically, her father would let himself into her home if she did not answer her phone, to check on her. Safety planning was completed to increase her feeling safe in her own home.

6.77 During a phone call on the 30th of November 2020, with her Section 75 mental health social worker, Mary extensively discussed her PTSD, her traumatic past, where she disclosed being shouted at, pulled by the hair, and covered in her mother's blood due to cuts made from self-harm, witnessing her mother's mental health deteriorate and the trauma she experienced resulting from the multiple intentional overdoses that her mother took. Mary believed she was blamed for her mother's mental health, her inference being that this blaming was by both her mother and father.

6.78 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.

6.79 On the 2nd of December 2020, an EDAN Lincs contacted Mary who said she had been self-isolating having tested positive for Covid-19 after experiencing a breakdown, citing her father as a contributory factor. She stated her self-esteem was low and she had taken an overdose and had not left her home for weeks. EDAN Lincs notified the Section 75 mental health social worker to share this information by leaving a message for the social worker to call EDAN Lincs.

6.80 This was followed up by a further message on the 4th of December, again, without response from the social worker. However, there is no record that the Section 75 Mental Health Social Worker received either of these calls. Mary was advised by EDAN Lincs to contact her mental health social worker and call the crisis team if immediate mental health support was needed. Further contact was offered for the following week to ascertain how Mary was and if she wished to continue with support, but Mary did not engage with EDAN Lincs, and no onward referrals were made.

6.81 EDAN Lincs closed the case on the 15th of December 2020, at Mary's request, as she stated that she wished to focus on her mental health. As a voluntary service EDAN Lincs accepted her wishes without challenge.

6.82 On the 21st of January 2021, Mary reached out to her GP surgery due to her struggling with her mental health and her blackouts, reported by her as becoming more frequent. She was seen by a GP the same day.

6.83 On the 29th of May 2021, Mary had an initial assessment at a private ADHD clinic, which was booked by Simon and completed via 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 in response 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.

6.84 On the 8th of June 2021, Mary's GP was updated of the new diagnosis of ADHD following Mary's referral and assessment from the private clinic. No other issues were raised.

6.85 Adult Care and Community Wellbeing (ACCW) contacted Mary in mid-June 2021, she did not initially wish to engage but on the 29th of June 2021 in further telephone contact, Mary stated that she was feeling better than she had been the previous week and she enquired about costings for one care visit per week rather than three, as she could not financially support all three. She said she was feeling lonely, the social worker suggested regular telephone support which Mary agreed to consider. Mary confirmed that the cleaning service was not in place but that she intended to contact them and '*get things sorted.'*

6.86 On the 8th of July 2021, in a follow-up call with the Section 75 mental health social worker, Mary expressed that the thought of having people in her home made her go into a panic. It was confirmed that further telephone support would be offered to aim towards a visit with her in August 2021.

6.87 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.

6.88 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) and her associated poor health. Access and egress were significantly hindered, making the home dangerous. The referral in line with procedures in place at the time was shared with Adult Social Care, the Fire Service and the GP practice.

6.89 The ULHT IMR covering the admission identifies the following. Mary was admitted to the Emergency Department (ED) via ambulance, with a suspected overdose of medication. It was reported she had last been seen 2-3 days prior and had been found by her father, at home, in a catatonic state. She remained unconscious during her ED attendance; therefore, it was not possible to obtain a direct account from her. Investigations showed a diagnosis of pneumonia, likely caused by aspiration. Due to this she was transferred and admitted to the Intensive Care Unit (ICU) for further management and treatment.

6.90 During her stay in ICU between the 21st of August and the 2nd of September, 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."

6.91 Whilst in hospital, the 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.

6.92 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 (from level 6 to level 8 on the clutter scale), as opposed to have diminished with the support she had been receiving to tidy and sanitise her home. It must also be borne in mind that this was during Covid-19 restrictions. Adults Supporting Adults (ASA) may not have been visiting face to face at the time and for some time and support may have been limited due to contact outdoors only as an example. The level of services willing to complete deep clean and similar would also have been significantly impacted due to concerns about Covid-19.

6.93 On the 6th of September 2021, Mary was referred to the Urgent Treatment Centre (UTC). She was accompanied by Simon. She reported her left foot hurt and queried the presence of a foreign body, potentially glass from two weeks prior. No further questions were asked, or curiosity demonstrated as to how the injury occurred two weeks previously, although it notes "*extensive MH history*." Mary was asked to present for a review in two days with a view to doing an x-ray to see if any foreign body was visible. Simon stated that he was not available in two days and therefore the appointment was moved back to a date suitable to his availability. No rationale is available within the records as to why, or if, Mary required her father to attend with her.

6.94 On the 9th of September 2021, Mary further attended the UTC with her father accompanying her. An x-ray revealed a foreign body, identified as glass, which was removed. There are no notes as to how the injury had occurred in the first instance.

6.95 On the 6th of January 2022, a Section 75 mental health social worker contacted Mary to complete her Care and Support Plan Review. Mary explained that the cost of her cleaning service was expensive, the social worker advised that a financial assessment may support her with payment of this. She explained she had removed some of the clutter in her home herself which made her home more manageable. Mary is noted to have been open to Social Prescribing and she felt their regular support was proportionate to her needs. Mary explained that if anything happened to her father, she would likely need the support of services again. Mary was closed to ACCW (Section 75 mental health social work team) at this time and was sent a letter to confirm details for re-referral.

6.96 On the 20th of January 2022, Acistance[13] (ACIS) contacted Mary to arrange her signing up to the service, following a referral by LPFT. This was followed by further contact with her on the 26th of January when Mary disclosed that on occasions she struggles to get out of bed, but it was better than it used to be when she could spend weeks on end in bed. She was caring for her father who had had a lung removed and she worries about what life would be like on her own as she has no siblings or family that she knows well. She was a hoarder and had support for this, through a cleaning service. She worried about her finances and frequently had no food in stock. She was informed that arrangements could be made for a

[13] Acis Group was delivering the new one-year Acistance scheme through Shine Lincolnshire's Community Asset Development Fund in partnership with Lincolnshire County Council and Lincolnshire NHS Clinical Commissioning Group. The support provided will come through a mix of wellbeing interventions, such as one-to-one sessions, social engagement events and group workshops, designed to help increase confidence, self-esteem, and general wellbeing.

food parcel if it got to a level that she was struggling to buy food. Mary agreed for fortnightly contact by Acistance.

6.97 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. Mary frequently made references about her father in the past tense and specifically commented on her the abuse being by both her mother and her father during her childhood. 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 directly ask the direct question regarding abuse, but follow up exploration of ongoing abuse from her father does not appear to have been asked on this occasion. The note in the running record on this date records that Mary was positively discussing work with Social Prescribers and the activities she had planned through the week

6.98 On the 7th of February 2022, in a contact call with Acistance, Mary informed the case worker that the landlord was having her home valued and this was causing 'a lot of stress for her.' The notes of the contact reference that Mary had been 'manically tidying everywhere,' and selling items on an auction site as she was short of money. Mary talked about her past life, that she was a carer for her alcoholic mum at the age of ten, as her father was unable to manage the situation. She also informed the worker that she had married the brother of a friend and when they separated, she lost all her friends. It was noted specifically, 'She worries why the landlord is having the home valued.' This suggests that Acistance were not aware that the landlord was in fact, her father.

6.99 On the 7th of March 2022, in a contact call with Acistance, Mary stated she had experienced a tough couple of weeks, was struggling with making friends and feeling isolated and had worries about returning to the days when she stayed in bed for days on end and did not go out.

6.100 On the 4th of April 2022, Mary spoke with Acistance and said that she was struggling with her mental health and her ADHD and did not find her GP to be understanding as he had told her to contact her psychiatrist. Her medication had been reviewed.

6.101 On the 23rd of May 2022, Mary spoke with Acistance and said that she had recently fallen out with her father concerning finances, but they were now talking again.

6.102 On the 9th of June 2022, Mary made a self-referral into Steps to Change[14] (S2C), stating that she had been recommended to do so by both her psychiatrist in London for her attention deficit hyperactivity disorder (ADHD) as well as her LPFT psychiatrist. She reported struggling with different aspects of her mental health and was seeking support to address

[14] The service was rebranded and re-named to Lincolnshire Talking Therapies (LTT) in May 2023 as part of a national project to better explain what the service offers

this through talking therapies. The service then attempted to contact Mary to arrange a telephone assessment without success. A telephone assessment was then arranged, subsequently cancelled by the trust and rescheduled for 23rd September 2022. In the interim, Mary was notified by letter declining the referral as she was already in receipt of the trust's care via the CMHT. Steps to Change contacted the CMHT to advise them that they had declined Mary's referral as she was already receiving CMHT care.

6.103 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.

6.104 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 neighbour went to see Mary, taking with him a first aid kit whilst the neighbour's partner made an emergency call to 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.

6.105 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.

6.106 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.'* She reported that she had recently stopped receiving mental health support which in her view was due to the staff member she was communicating with being promoted, however she had stated she had other commitments between her appointment on 30th May 2022 and a follow up appointment had been booked for 27th June 2022, which was attended, with the same practitioner that she had been seeing since November 2021. On examination there were superficial scratches to her wrist. 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.

6.107 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.

6.108 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.

6.109 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.

6.110 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. On examination, it is recorded that Mary had right sided neck abrasions, also left side scars, abrasions. No other injuries were noted. It is also recorded that the police were called and spoke to her father, but that Mary did not want to press charges.

6.111 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.[15]

6.112 In the PPN shared with Mental Health Single Point of Access and EDAN Lincs, completed by the police, Mary was asked whether she was feeling depressed or having suicidal thoughts. Her response was that she was feeling *very depressed*, but it is not recorded on the PPN that she was having suicidal thoughts.

6.113 The LPFT IMR indicated that details from the PPN shared with the Trust identified that there was an apparent escalation in violence towards Mary from Simon. Mary had disclosed that Simon had strangled her whilst they were on holiday, then later reported that she had attended hospital following an incident and had reported the strangulation to the police but had not wished to prosecute her father. On receipt of the PPN on the 27th June 2022 Mary was contacted by her worker in the community mental health team earlier than the planned appointment at 15:00 hrs the same day, to explore the risk that had been shared. During this contact Mary stated that she "*felt suicidal as a result of this,"* as a direct result of her father putting his hands around her throat, as she described the incident. She shared that she had

[15] The College of policing approved professional practice recommends officers use the national decision making model with which to make assessments alongside force policy and procedure.

cut her risks while on holiday but confirmed no "*intent or desire"* to repeat this, she confirmed acceptance of EDAN referral and future appointments with the community mental health team.

6.114 The ACCW did not receive a PPN relating to this incident. On the 27th of June 2022, Mary contacted Adult Care and Community Wellbeing advisor (ACCW), reporting that she had been strangled by her father (referring to the incident on the 24th of June) and that the police were involved. During the discussion she confirmed she had no care and support needs and neither did her father. Mary also confirms that he did not have any cognitive impairment or dementia that caused him to be violent towards her. Adult Social Care had no further involvement in this incident following this discussion.

6.115 On the 27th of June 2022, EDAN Lincs received a new repeat referral from the community mental health team for Mary, following the disclosures of the strangulation whilst on holiday. On the initial contact with EDAN Lincs, Mary shared that on the 16th of June 2022, whilst on holiday she and her father had an argument and he put his hands around her throat causing bruising. The neighbours called the police on hearing her screaming. It is believed that this details two occasions of strangulation, once when on holiday and then after returning home.

6.116 Mary was given full support by EDAN Lincs following the referral. The case notes record conversations with Mary in which she demonstrated the motivation to understand what constitutes domestic abuse. She was also open to understand civil orders.

6.117 On the 4th of July 2022, Mary disclosed to a Training Nursing Associate from the CMHT that there had been **two** incidents where her father had strangled her whilst on holiday, and again when they returned, but did not provide any dates or further details concerning those incidents. No DASH risk assessment was made and EDAN Lincs were not contacted to provide the updating information that a third incident of strangulation had been disclosed since the referral on the 27th June 2022, which meant that other services were not notified of the potential seriousness and escalation of what were disclosures of assault. However, other services for example EDAN Lincs were aware, having been told by Mary herself. The Police though had not been told by Mary or other services of the second incident.

6.118 On the 11th of July 2022, Mary also informed a support worker at Acistance that her recent holiday with her father had been '*a disaster'*. She described her father's behaviours as odd, and that he drank a lot. Mary alluded to the incident at her home where she was assaulted, she was admitted to hospital following their return from holiday, and that the police were called. Acistance followed internal safeguarding protocols for this, but nothing was referred externally as it was accepted that the police were already involved.

6.119 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 she 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 CMHT given their concerns for her personal safety. The call was received by the medical secretary in the CMHT not to the CPN and they agreed to pass information to the Training Nurse Associate (TNA.) They make a record that on the 27th July they attempted to call Mary on three occasions that day with a successful call made by TNA to Mary, who gave assurances of her safety, explaining she thinks about ending her life but does not have any plans to do so, agreed to appointment on the 29th July and to call the crisis mental health team if her mood worsened.

6.120 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 and support telephone numbers were offered and further appointment made for the 5th August 2022.

6.121 The DWP, Personal Independence Payments (PIP) received a letter dated 2nd of September 2022, from a doctor from the LPFT outpatients' department stating that Mary had informed a healthcare practitioner on 30th of August 2022, "*Mary told me she was doing very well until an incident of domestic violence by her dad who had attacked her physically. He put his hands around her neck and pushed her. It caused skin breach and she had to attend A&E and stayed there overnight."* Following this letter, the DWP spoke to Mary's father on the 4th of October 2022. This involved him asking for an extension for the return of a form, which was for Mary's benefits. The DWP IMR reports that he, "*did not ask DWP for any information about his daughter's claim, nor is there any information suggesting he was controlling or coercive during the call."*

6.122 The DWP policy is that unless Mary's father had requested a more formal position regarding his daughters claim, such as becoming her appointee, more enquiries would have been made, but based on the contact, this was entirely acceptable, despite the recent information on file from the outpatient's department. This does show that Simon maintained a prominent position within Mary's finances, specifically her benefit payments. He did not have any power of attorney. Whilst the DWP indicates it did not suggest that he was controlling and coercive, this review report in the analysis section does identify and emphasise control on his part.

6.123 On the 9th of September 2022, Mary engaged in discussion with EDAN Lincs, she agreed to self–refer to Steps to Change. Mary questioned whether her father had mental health disorder that caused him to behave so badly to her. She was given safety planning advice.

6.124 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. Mary reported this to the community mental health team during a planned appointment on 4th October 2022, stating she had not attended

hospital or the doctor's but indicated she had alerted her father to this, it is not known whether she had told him at the time or after the event.

6.125 On the 26th of September 2022, in a call with Acistance, Mary appeared 'chaotic and disorganized' and reported that she had struggled with sleep since the assault at the party. She had fallen out with the neighbour's, and this was playing on her mind.

6.126 In a text communication sent to an LPFT practitioner (TNA) on the 27th of September 2022, Mary expressed her thoughts and feelings following a misunderstanding by her concerning her impending discharge from the community mental health team (CMHT).

6.127 On the 28th of September 2022, in a contact with EDAN Lincs, Mary disclosed that she had helped her father to fill out some paperwork, he became angry and aggressive so she shouted back at him and told him to leave her property. Her father did leave the property shouting comments at her as he exited. Mary was provided with the details of a free legal service to discuss options around pursuing a civil order against her father.

6.128 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.

6.129 The same day, Mary made a call to CMHT, discussing the recent incident at the party and requesting more time to talk and be supported with it. The CMHT manager agreed to provide her with a CPN to revisit some of the supportive work that had already been undertaken. Mary was offered a further three sessions.

6.130 Also, on the 30th of September 2022, a duty practitioner from the LPFT answered a phone call from Mary. The practitioner stated that this was the first, and only time that she had spoken with Mary herself, and that she believed there to be "*an elderly gentleman in the background that I rightly or wrongly presumed was Dad…she disclosed a lot of childhood adversity and I think referenced being groomed by Dad…he was interjecting (not in the call), I could hear him speaking to Mary and I think Mary was relaying what he was saying*."

6.131 On the 20th of October 2022, EDAN Lincs closed Mary's case as all work with her was completed. The community mental health team as the referring agency was notified of the closure.

6.132 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*".

6.133 The notes continued highlighting Mary's hopes for change, 't*here 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*."

6.134 The associated risk assessment highlighted that Mary reported her father to be, *"The only person within my life"* but this also highlighted how she felt conflicted about her relationship with her father. On one hand, she appears to resent him for the abuse that he perpetrated, that she and her mother experienced, but on the other hand, she stated, *"He is my dad and the only person I have left, if he wasn't alive, I wouldn't see the point in living anymore, there would be nothing left for me*."

6.135 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 his house, 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*".

6.136 It took a further five weeks working with her before the practitioner 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.

6.137 In October 2022, the CPN had referenced the strangulation of Mary by Simon, as part of the risk assessment, but this had not been recorded in the previous LPFT risk assessment dated July 2022, which was only one month after the non-fatal strangulation, reported to the police. The key fact is that none of the risk assessments explicitly recorded that Mary was at risk from domestic abuse and missed the significance of the strangulation, which is known to have occurred on more than one occasion. The LPFT IMR references; *"Whilst, it is important to balance the known risk versus the inclusion of a victim in their risk assessment and follow up care, in this case there were significant risks already indicated in Mary's clinical records."*

6.138 The DASH risk assessment was not shared with other agencies outside of the LPFT[16].

6.139 On the 28th of October 2022, a referral form was received by IPS[17], identifying that Mary was struggling with a lack of purpose and structure in her life which was impacting

[16] For context, the LPFT safeguarding Team processed 1318 DASH referrals in 2022/23.

[17] Individual Placement and Support Employment Service (IPS) offers encouragement and practical support to help service users find suitable paid work, apply for a job and stay employed. IPS does this by working with a service user from the start of the whole process. They are commissioned by LPFT to provide this service.

upon her self-esteem. Safeguarding issues with her father were recorded in the referral form, therefore, it was recommended that any visits be conducted away from her home. Mary was accepted into the service on the 31st of October 2022, and placed on the waiting list and notified of the waiting of some six to eight weeks for an appointment. (She passed away before an appointment was possible.)

6.140 On the 4th of November 2022, Mary was seen personally by her GP concerning her reporting hair loss. The notes record an assault, which may have been an indicator of domestic abuse. However, there are no details recorded in relation to the alleged assault.

6.141 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 scoring of the completed DASH risk assessment was felt to meet the MARAC threshold by CPN3. 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.

6.142 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 within three minutes and discovered the patient laid in bed fully clothed, but she was assessed as being asystole and the crew declared that life was extinct at 2.31pm.

6.143 Lincolnshire Police received a call from Ambulance Control that they had attended an unexpected death, a suspected overdose of medication, and the father of the deceased was at the scene. Officers attended and the deceased was identified by her father as being Mary. The attending officers discovered three empty bottles of wine and an array of empty medication blister packs by the bed. There was various other detritus, including a bin containing urine, empty ready meal cartons and cat faeces in the room.

6.144 The entire property, a one-bedroomed flat, was extremely cluttered and unsanitary. 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.

6.145 It was established that Mary's father had regular contact with her, but having not heard from her for several days, which was out of character, he had gone to her address, but in getting no answer, had used his key to gain entry as the door was locked. He was the owner of the property but did not reside at the premises.

6.146 Officers discovered various notes that had been written on several mailing envelopes, seemingly made by Mary, which 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.

6.147 A post-mortem examination found that there was no underlying disease and subsequent toxicology identified that the cause of Mary's death was likely to have been the result of a mixed drug overdose with quantities of numerous medications being present.

6.148 Mary was 50 years of age at the time of her death. Whether she had intended to take her own life remains, as her note suggests, something that may happen. The 'cocktail' of prescription and non-prescription drugs ingested does suggest that at that time she felt she was in a hopeless situation. As her body lay undiscovered for several days, it is impossible to determine if she had attempted to summon any help before the effects of the medication overcame her.

Section Three – Overview and analysis

7.0 Overview

7.1 There are numerous contacts with various agencies in respect of Mary. The review author has extracted what are the key events of relevance to the terms of reference, given the voluminous nature of the material provided and presented for review in this case. The review author would like to thank those agencies which have been asked to provide clarity or additional information in addition to the material provided.

7.2 The relationship between Mary and Simon is biological father and daughter. There were no other siblings. Mary had no religious beliefs. The family network is non-existent.

7.3 The date parameters were agreed by the panel, it has been important that this review can see the real Mary through her needs, expectations and who she was. Several of the IMRs refer to her childhood experiences, which are intrinsic to understanding and illuminating the life of Mary. This is key to gaining an understanding of how and where services were, or were not directed, and the wider consideration of her relationships and experiences over a more substantial timeframe.

7.4 It is clear that Mary had experienced a traumatic childhood by both her father and mother. It is acknowledged that adverse childhood experiences (ACEs) will often shape adulthood and the future. Clinical research[18] has identified that individuals who have experienced adverse childhood experiences are less likely to explore new opportunities and that it could be helpful for professionals working with them to understand that experiences of trauma can be associated with a reluctance to try new things.

[18] A study of ACE – Psychology today, journal of *Psychological and Cognitive Sciences.*

7.5 Statistically, the greatest risk to victims of domestic abuse is from an intimate, as opposed to a non-intimate relationship. Familial domestic abuse is not often considered to be the most symptomatic cause of serious injury or death, either directly, by homicide, or where the victim self-harms or takes their own life. It is a hidden dimension that may not lead to professionals exploring the full perspective of a non-intimate relationship against that of an intimate relationship. This case has highlighted that on innumerable occasions, that perspective was either overlooked, or often not considered.

7.6 Controlling and coercive behaviour by Simon towards Mary is the significant factor for this review.

7.7 Mental ill-health can take many forms and there is a body of evidence for this review that Mary suffered from numerous mental health related illnesses over an extensive period. Mary also had incidents of deliberate overdose and discussions were held with her about suicide ideation.

8.0 Analysis

8.1 The key specific terms of reference for this review are:

- To examine the risk of domestic abuse victims taking their own life through suicide and/or self-harming.
- To examine where, in this case, an inter-dependent relationship existed between father and daughter. Where at times they acted in a caring capacity for each other and can they 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 was experiencing domestic abuse, can access information, are provided with services and support.
- To examine the impact of Covid-19, in particular, 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.

8.2 This analysis seeks to explore the questions raised holistically as opposed to referencing these individually, alongside the generic terms of reference in the statutory guidance for domestic abuse related deaths.

8.3 Within the relevant scoping period, Mary was engaging with, or had contact with the following agencies.

- Services from the LPFT were the Section 75 mental health social care team, the local Community Mental Health Team (CMHT) Steps to Change (S2C) and briefly the Individual Placement and Support Employment Service (IPS)
- Other services were from the Lincolnshire Police, The DWP, GP, EMAS, Adult social care (Adult Care and Community Wellbeing), Adults supporting Adults, ULHT, EDAN Lincs, Lincolnshire Community Health Services (LCHS), We Are With You (WAWY), Acistance.

8.4 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. There is no indication in the record that Mary was registered on CPA throughout her care, this would be mandatory following a hospital admission until review, but optional for people receiving community treatment where there is complexity. The Care Programme Approach offers a framework in which the person has a "care coordinator," as a registered mental health professional, usually within a community mental health team, who will lead on care planning, bringing together everyone involved in the person's care, through six monthly multi-disciplinary team reviews and involving the person, and where appropriate their family/carers. Where a person is receiving care but not on CPA, LPFT policy would still expect that a six monthly review takes place and that there is an identified lead healthcare professional. Outside of CPA processes, for which national policy has now changed to individualised care and support planning, LPFT do not have a specific policy for meetings, however it is common and expected practice for the lead healthcare professional or care coordinator to either arrange review meetings with the person receiving care or a professionals meeting where there is a need to clarify and agree professional roles and responsibilities to be shared back to the patient with clarity. It is reasonable to expect that there should have at a minimum been meetings involving the Section 75 mental health social care, the community mental health team and the psychiatrist to align plans and review risk assessments. It would be usual to expect such meetings would have been extended to EDAN Lincs and Adult Supporting Adults (ASA) to ensure effective information sharing, collaboration and consistency as well as supporting all agencies to effectively engage Mary. The LPFT panel member is of the view that from 2019 there is clear information individually to the teams involved that Mary was finding it difficult to coordinate appointments and at times to engage with aspects of her care, particularly with ASA and to not have met to explore this is outside of usual practice within LPFT.

8.5 Whilst many of the IMR's show that Mary was at risk of harm as early as 2013, fundamentally, she was exposed to risks much earlier, as her adverse childhood experiences clearly identify. She was subject to witnessing domestic violence at a very young age between her parents, her mother's alcoholism, which is linked to the domestic abuse suffered by her from Simon, parental neglect, both physical and developmental. Although Mary was removed from this cycle when she was married, when she returned to Lincolnshire, she stepped back into the control of her father which effectively returned her to those adverse experiences.

8.6 One of the trauma's from Mary's childhood is that she mentions that she was subjected to sexual abuse. Psychology Today published an article in 2021[19] which is relevant and helps with understanding the life that Mary subsequently led especially in adulthood. 'The Long-Lasting Consequences of Child Sexual Abuse' (CSA). The article states: *'Many studies have examined the long-term psychological impact of CSA. A recent research review of over*

[19] The Long-Lasting Consequences of Child Sexual Abuse | Psychology Today

four million people found that those who experienced CSA are between two and three times more likely to experience the following disorders compared to adults who were not abused:

- *Borderline personality disorder*
- *Depression*
- *Anxiety*
- *Post-traumatic stress disorder (PTSD)*
- *Eating disorders*

CSA is also strongly linked to drug and alcohol use, and those who experienced CSA are about 2.5 times more likely to make a suicide attempt than people who have not been abused.'

8.6 The Vulnerability Knowledge and Practice Programme (VKPP) '*Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021'*, a joint research project between the Home Office and the Nation Police Chiefs Council, identified that of the 215 deaths from 2,028 incidents sampled between the 23rd of March 2020 and the 31st of March 2021, 49% of deaths concerned current or ex-intimate partner, rather than the familial relationship between Mary and Simon.

8.7 The VKPP report 'Domestic Homicides and suspected Victim Suicides 2020-2023, year 3 report '[20], identified that strangulation, (including hanging) was the most common method of death across the three-year dataset.

8.8 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.

8.9 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. This review report shows that domestic abuse was transparent over a period of more than 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.

8.10 The below table demonstrates a small example from the records shared, just how many professionals were told by Mary of her father's domestic abuse towards her, in particular his coercive and controlling behaviour, which Mary was suffering from:

[20] 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

Childhood	LPFT-Plus others	"*would control every element of my life, hit me and threaten me [in order] to keep our home life a secret from school.*
July 2018	EMAS	Mary alluded to her exposure to verbal abuse from her father.
May 2019	Edan Lincs	Mary disclosed how her father angrily shouts at her and calls her names that make her feel like she is "worthless." it's always been like this" and went on to disclose that as a child she was subjected to verbal and physical abuse by both her mum and father and she still struggled with the abuse that she had experienced as a child. she left home at 30 years old and since her return, her dad controlled her bank account.
Nov 2019	Edan Lincs	Mary shared examples of how father demanded and expected that she would collect his medication, go shopping and complete household chores, yet still she experienced verbal abuse from him whilst in his company.
Feb 2020	Edan Lincs	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.
May 2020	Edan Lincs	Mary contacted them 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.
September 2020	Section 75 mental health social worker	Mary explained to a social worker that she had been having difficulty with her father and said he can be *"very cruel."*

July 2021	Section 75 mental health social worker	Mary requested for her care *not* be discussed with her father at that time. She disclosed verbal abuse from him.
21st and 2nd September 2021	LPFT-ULHT	Mary was informed of the recent events including her father finding her unresponsive in bed. Mary stated, *"the man must have attacked me again."*
June 2022	LPFT	June 2022, the LPFT records state that Mary had attempted to cease contact with her father, however he had refused to accept this, Simon had then continued to drop off food parcels through Mary's cat-flap and he would text message her.
June 2022	EMAS	Mary tells the crew that she had recently returned from her holiday with her father and that her father had been to her house 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.'*
June-September 2022	Lincs Police- North Lincs and Goole Hospital Trust- Edan Lincs- GP- LPFT- Section 75 mental health social worker-Acsicetence.	Seven more agencies, were also all told the same information by Mary that her father had strangled her while on holiday and then when they returned home.
September 2022	DWP	*'Mary told me she was doing very well until an incident of domestic violence by her dad who had attacked her physically. He put his hands around her neck and pushed her. It caused skin breach and she had to attend A&E and stayed there overnight.'*
September 2022	Edan Lincs	Mary disclosed that she had helped her father to fill out

		some paperwork, and he became angry and aggressive so she shouted back at him and told him to leave her property. Her father did leave the property shouting comments at her as he exited.
October 2022	CPN-3	"*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*"
October 2022	CPN-3	Mary disclosed that is 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 his house, 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*".

8.11 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.

8.12 The first time that LPFT practitioners identified the controlling and coercive behaviour as being domestic abuse was in 2018, where reference is made to referring Mary to local domestic abuse services. There was no accompanying DASH risk assessment. Given that the LPFT had the most contact with Mary, this is disconcerting. The first time that LPFT, raised a DASH risk assessment for Mary was in December 2022, when in fact, most of the

information contained in that DASH risk assessment was known previously, but had never been broadened into being shared for a multi-agency discussion until then.

8.13 The examples of the serious effect of the abuse on the victim are prevalent within Mary's clinical records, which the LPFT IMR author comprehensively identifies as; stopping or changing the way someone socialises, mental deterioration, being monitored and having to report back to the perpetrator, having their financial independence restricted, becoming socially isolated, emotional and psychological harms including anxiety, depression, PTSD, being punished and living in fear of punishment. This was further emphasised in Mary's disclosures which also included physical violence and threats of physical violence as well as physical intimidation, emotional and psychological abuse in the form of verbal abuse, constant criticism, intentionally undermining and manipulation about her own mental illness. When considering those matters, Mary's life was beset with abuse from her father.

8.14 Aside from the fact that there were opportunities for Mary to have been safeguarded as a victim of serious crime (non-fatal strangulation) during 2022, not one agency made a referral to MARAC then, or before. There is little doubt that Mary could have been referred to MARAC, on occasions, following the June and July disclosures by Mary of assault by strangulation. At no time did key statutory and voluntary services work together and examine her case holistically.

8.15 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. Serious crimes of this nature do not require a victim to consent to prosecution, rather there is the opportunity for the police and any other agency capable of providing supporting evidence, to pursue an evidence led prosecution. This relies on agency communication and an understanding by professionals of the need to ensure that victims of this serious crime, which can lead to other serious illness, and/or death, are afforded support as victims and the perpetrator are targeted accordingly.

8.16 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, which he claimed was done because she had lost documents and was unable to manage her own finances. He frequently became her voice in contacting agencies such as the DWP to check on her benefits. Although Mary reportedly provided signed authorities to the CMHT and adult social care for her father to have access to her information, the inference is that those are likely to have been at his demand, and within weeks she stated that she wished for financial independence.

8.17 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. Simon would attend medical appointments with her and her with him, but this was all part of the bigger picture in that he was relentless in his exercise of control. When Mary felt able to minimise her contact with him, he would portray himself as the victim and play on her weaknesses and make her feel sympathetic towards him and thereby acquiescing to him.

8.18 Simon further restricted Mary by isolating her from others and demonstrated threatening behaviour towards her on innumerable occasions. He continually harassed her and made her feel worthless, and that also appears to reflect on her childhood treatment. There is no evidence that Mary had a network of friends and no other family members.

8.19 The Home Office's statutory guidance on controlling or coercive behaviour, originally published in 2016, and more recently updated in 2023, is primarily aimed at statutory and non-statutory bodies working with victims, perpetrators and commissioning services, including the police, criminal justice agencies and other agencies. This guidance provides information on controlling or coercive behaviour, to assist in identifying, evidencing, charging, prosecuting and convicting the offence. This guidance also provides information on: reducing the risk of harm to and supporting the victim and their family, including how other agencies and support services can assist; and managing the perpetrator and the serious effect of behaviours to a victim. It is notable that only one agency, the LPFT refers to this valuable guidance and its integration to safeguarding policy and training.
The offence of strangulation became a specified recordable offence on June the 7th 2022. Sentencing guidelines from the Sentencing Council stipulates, '*Strangulation or suffocation are very serious offences and can create a real and justified fear of death, causing the victim to experience a high degree of psychological harm from the encounter, even where no physical injuries are visible.'*

8.20 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. Without doubt, Mary did have mental health issues, which were on occasions severe, but she had managed to cope with this with at times significant input from a range of practitioners and volunteers. 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.

8.21 Although the response by agencies to the initial disclosures of June 2022, was superficial, there were further opportunities for the latter disclosures to have been referred. Mary notified practitioners at the Section 75 mental health team, LPFT CMHT and to EDAN Lincs in July 2022, of the strangulation assaults within a short timeframe. This does not appear to have been widely shared, further minimising the impact of the disclosures. The question asked again is why were no DASH risk assessments and referrals made in view of the serious nature of the allegations? Mary voice was loud and clear here and was asking to be heard and she later commented in December 2022, that she had considered the police were disinterested at the time of the report.

8.22 When Acistance spoke with Mary in July 2022, when she disclosed the '*disastrous*' holiday with her father and the assaults, Acistance did not raise a separate risk assessment on the basis that the police and other agencies had the matter in hand; '*Internal Safeguarding protocols were followed following this disclosure – it was agreed internally that all necessary services had been notified (Police, Domestic Abuse services, Ambulance*

crews) and incident recorded'. It appears that Mary had disclosed further information, *her dad's behaviour was very odd, and he drunk a lot and generally she was unhappy and spent a lot of time in the hotel room.'* This presented other opportunities to explore those disclosures alongside the disclosures concerning the assaults, but again, the agencies did not share or discuss the information.

8.23 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. *'Awareness of the significance of non-fatal strangulation is increasing in health and justice settings. While approximately half of patients strangled will sustain no immediate physical injury, strangulation has potential significant sequelae such as carotid dissection, hypoxic brain injury and laryngeal injury. Non-fatal strangulation by an intimate partner increases homicide risk by 7.48 times*.'[21] There is no doubt that on those merits alone, but also when taken alongside the coercion and control, that this met the criteria for a referral to MARAC as a high risk.

8.24 The LPFT IMR identifies that; '*Father's escalation of verbal abuse may trigger self-harm*,' was recorded in patient assessments within the scoping period. The risk management plan for this was for Mary to engage in distress tolerance work with a view to later commencing trauma therapy, to engage in outpatients' appointments and to utilise the CMHT outside of her appointments if additional support was needed. No specific domestic abuse support was offered. On occasions, 'past abuse' was referenced when it was apparent that the abuse was current and ongoing. The IMR identified that Mary disclosed domestic abuse from her father throughout her adult life. She would typically refer to arguments with him and verbal abuse from him with Simon calling Mary names such as 'bitch.' The Trust recognised abuse but did not label this behaviour as domestic abuse until 2019, when the first referral was made to Lincolnshire's domestic abuse service. References throughout the records were made to verbal abuse or emotional abuse only.

8.25 Mary had been in sufferance of her father's behaviours for many years. It was doubtlessly escalating and had been incrementally doing so, however, by mid-2022, it was at a critical level. This was almost entirely overlooked by the agencies best placed to have intervened at that time. The police recorded a crime of assault when it was in fact an allegation of strangulation and the police also failed to identify the prevalence of coercion and control, a further crime, which went un-recorded. These are critical missed opportunities and become emphasised by further disclosures made by Mary in the days and weeks following the incident of June 22nd 2022, when she also alluded to EDAN, Section 75 Mental Health social worker and the LPFT CMHT, that there had been at least three occasions when her father had attacked her, grabbing her by her throat, the earlier of the incidents occurring when they had been on holiday.

8.26 The police IMR identifies that that although Mary was alleging controlling behaviour on June 22nd 2022, a crime was not raised. It was commented on in the police IMR that Simon and Mary were father and adult daughter who lived in separate houses*. 'Mary was a potentially suicidal alcoholic who suffered from depression so the officers would have*

[21] https://www1.racgp.org.au/ajgp/2022/november/management-of-non-fatal-strangulation

considered whether Simon was exhibiting genuine parental concern rather than control and/or coercion. Mary lived a chaotic lifestyle in a house owned by Simon so some degree of legitimate control on his part was understandable.'

8.27 The IMR also comments, '*Since 2018, and possibly earlier, Mary and Simon lived in different addresses and there is no evidence from police attendance that their relationship was claustrophobic. Simon allowed Mary to live in a property owned by him and opened a bank account for her when she had lost the required documents to open one herself. It would appear that Simon was acting as a supportive caring parent for his vulnerable daughter.'*

8.28 The panel chair fully accepts that this is his hindsight view but follows 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. The panel chair has a belief that the police entirely missed the prevalence of the key issues and that their response was superficial, with assumptions being made which displayed confirmatory bias and a lack of professional incision, although to be fair to them relatively speaking, the Lincolnshire Police only had sporadic engagement with Mary and Simon in comparison to other services.

8.29 One area that provided the largest contrast in responses to the VKPP consultation for their research, from police forces was the awareness of domestic abuse perpetrators attempting to manipulate the narrative and processes after a death. This is something that many forces acknowledge requires further training and intelligence checks to understand both victims and perpetrators. The panel chair has not allowed this to happen in this case and as a result very little has been written by the panel chair of Simon's views of events that he shared with the panel chair or what he has said to professionals and is recorded in their records.

8.30 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.

8.31 The Section 75 mental health social work team also indicated that Mary reported her mother's attempts of suicide on innumerable occasions, which she believed was due to her father's abuse. This team was aware that Simon had control of her finances. Through the social worker's involvement, Mary discussed on multiple occasions her father's verbal abuse. She highlighted historic incidents from her childhood and believed she had PTSD from her 'traumatic family dynamics.'

8.32 The below table indicates the number of known times (it is disclosed by Mary of other overdose attempts, not covered below) of overdose or talking about suicide.

2014	ULHT	Mary was admitted to an accident and emergency

		department when she attended with an *'unintentional'* overdose of Nurofen tablets and alcohol.
July 2018	EMAS	Mary was admitted to an accident and emergency department when she attended with an *'unintentional'* overdose of Nurofen tablets and alcohol.
October 2020	Edan Lincs	Mary disclosed that over the previous six months her mental health had declined, which had led to her taking an overdose.
November 2020	LPFT Section 75 MH social worker	She 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 at the point of calling but '*wanted things to change.'*
August 2021	ULHT	Mary was admitted to the Emergency Department via ambulance, with a suspected overdose of medication.
June 2022	ACIS -Customer Centre	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.'*
July 2022	LPFT	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.
24th September 2022	LPFT	On this date, Mary took a mixed overdose of medication, 'with an express intent to end her life.' She informed LPFT on the 4th October 2022.

30th September 2022	GP Nurse Practitioner	Mary indicated that the incident (with neighbour) 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.

8.33 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.

8.34 There was 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. On the 23rd of June 2021, when Mary explained herself to be in crisis at the point of contact, she was advised to contact her CPN and the Crisis Team, who were also contacted by the social worker, which shows a joined-up process in practice.

8.35 Research[22] has identified that there are 3 stages of suicide:

- Stage 1 - The "ideation" stage; During this stage, the person who takes their life will consider the consequences and be unsure of whether they will go ahead.
- Stage 2 – The "planning" stage; The person feels compelled to plan suicide (thus moving into Stage 3) or not to at that time; a decision that most people do not discuss with loved ones and often wrestle with in isolation.
- Stage 3 - The decision to suicide; The moment the decision is made, it goes "unconscious", and the person goes on "auto-pilot." People in Stage 3 are imminently lethal; however, they seem more "normal" than they have seemed in a long time. At this point, the depression seems to suddenly lift because the person has made the decision to die and is no longer wrestling with the decision. Unfortunately, most mental health professionals and family members are not trained to recognise "auto-pilot," as the patient seems so much better, not realizing they will take their own life. People on "auto-pilot" typically attempt suicide within a short timeframe, statistically the next 48 hours.

8.36 Mary had not disclosed any obvious intent to end her life to the CPN-3 in the extensive work undertaken with her between October and December 2022, which led to the completing of a DASH risk assessment. When we examine her openness and trust of this professional over that timeframe, on reflection, she appeared to have been by this sharing

[22] https://www2.psych.ubc.ca/~klonsky/publications/3ST.pdf

with the CPN, cleansing herself of her history of abuse and almost coming to terms with matters.

8.37 It is a statistical fact that thousands of people in the UK end their lives by suicide every year, and one in five of us will think about suicide in our lifetime. Every suicide is an individual tragedy and has a devastating impact upon family, friends, and the wider community. There is no single reason why people die by suicide. It is often a very tragic response to difficult situations and feelings. There is, as has been exemplified in the empirical research by the VKPP, an increase in suicide linked to domestic abuse in recent years.

8.38 In an annual report produced by the National Domestic Homicide Project (funded by the Home Office)[23], 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.

8.39 The rate of suicide in Lincolnshire (12.1 per 100,000 people) is higher than the average rates in England (10.4) and the East Midlands (10.3). Lincolnshire has a suicide prevention strategy. The County wide strategy is well established, the current guidance 2024-2028 has been updated to reflect the current trends and statistics for the county. These are:

- 37% of people who died by suicide made at least one previous attempt
- 64% were known to have experienced some form of mental ill health
- 56% were in contact with Mental Health Services at the time of their death
- Men are approximately three times more likely to take their own life by suicide than women
- Recent trends reveal the greatest increases in mortality in Lincolnshire are among younger men aged 20–24 and women aged 40-44

8.40 LPFT has a publicised campaign to the Suicide SAFE and Suicide Prevention Strategy, which signposts steps for individuals and others to support, including links to mental health helplines. Both strategies are comprehensive and although supported by numerous statutory and charitable agencies, neither of the strategies recognises the link between domestic abuse and suicide.

8.41 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

[23] Bates, L., Hoegar, K., Gutierrez-Munoz, C., Edwards, T & Blackwell, L (2024) Executive Summary, Findings and Recommendations: Domestic Homicides and Suspected Victim Suicides Year 3 Report (2020-2023).

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.

8.42 When support was provided by Acistance to Mary in January 2022, their IMR identified that *'project work is more difficult when the participant is not already known to us as one of our customers. We had little or no background information at the commencement of our support and we relied on the participant in the project to give us the information when the relationship was new.'*

8.43 This leads to the question of information sharing, its usefulness and reliability. Whilst it is undoubtedly the way for agencies to gain an informed perspective of the service user's needs, Acistance appear to have relied entirely on Mary to personally provide details of herself and background, when in fact they should have been more informed by the referring agency. This project was a Shine charity funded project to support people with 'low level mental health' and the Acistance author comments, *'We now know that the definition of low-level Mental health is very subjective and should have been more specific.'*

8.44 The LPFT IMR also observes that with the cyclical nature of Bipolar Disorder, a person's engagement with services is likely to be impacted by this in some way. It would be reasonable to expect that there would be times that a person with Bipolar Disorder would be more able to engage with mental health services and times when they are less able. Research finds that engagement with services typically increases around the time that people experience the depressive episodes within Bipolar Disorder. If multi-agency meetings had happened in this case these behaviours could be explained by the CPN to other professionals working with Mary to help to inform their engagements and suitable interventions.

8.45 Staff from the LPFT Section 75 mental health workers who worked with Mary between 2018-2020 noted with hindsight, that Mary's father was frequently present when they saw her at home and commented that her presentation would be observably different from when they saw her alone. "*Her demeanour was different. She was less likely to speak. He would speak for her. She would look at him before she said anything, whereas when he wasn't around, she would speak to us freely."* The LPFT IMR also refers to the decision to allocate Mary to a trainee, which leads to the assumption that the CMHT did not see Mary as a 'complex case.' There could be a myriad of reasons as to why this was, but in doing so, the CMHT probably demonstrated a lack of understanding around the complex mental health needs that Mary had. The care plan between Mary and the Trainee Nursing Associate also focused, on her self-identified goal, of social inclusion and graded exposure to build her confidence accessing her community, this was relatively successful with Mary accessing groups and engaging with peers, which could have had a beneficial effect on her being able to cease contact with her father and protect herself from abuse, as she at times indicated a desire to do, but the purpose of this intervention was to treat her apparent anxiety and low self-esteem and is a further example of the abuse, as the likely root cause, not being recognised.

8.46 Mary worked with three different community psychiatric nurses over the scoping period and the LPFT author identifies, that although it is with their hindsight, that it is evident

throughout her engagement with all three of them at different times, that prolific domestic abuse was occurring and was being disclosed by Mary and this was seriously impacting on her mental health. None of the risk assessments completed by the LPFT identified the risk presented by the physical violence towards Mary from Simon. The risk assessments do, however, record that Mary's ability to cope with familial stressors and situations within the family presented a significant and on-going risk to her ability to protect herself and her physical and mental wellbeing.

8.47 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.

8.48 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.

8.49 The Care & Support Statutory Guidance 2014, identifies what constitutes potential self-neglect and which identifies what constitutes possible self-neglect as a wide range of factors, covering:

- Neglecting to care for one's personal hygiene
- Neglecting to care for one's health
- Neglecting to care for one's surroundings
- **Hoarding**

However self-neglect also needs to be considered within the Care Act Section 42 duty, which was not met based on the information received by ACCW at the time..

8.50 The Lincolnshire multi-agency hoarding protocol, 2020, is supported by a wide range of agencies under the leadership of the Lincolnshire Safeguarding Adults Board (LSAB) The protocol narrates that, *"There is an expectation that everyone in partnership with the protocol engages fully to achieve the best outcome for the individual while meeting the requirements and duties of their own agency or board".*

8.51 Guidance and fact sheets for front-line staff are produced and distributed by the Lincolnshire County Council. This guidance suggest that hoarding has nine stages, numerically 1 to 9, with 9 being the severest. The IMRs referencing Mary's hoarding indicate that the minimum level was 6, with the highest placed at 8, although this was some two-years later (EMAS and Fire and Rescue Service respectively) but does suggest a progressive hoarding profile, and although Mary was offered and had accepted professional cleaning support, she rarely accepted this support, seemingly referencing Covid-19 and her father's needs for isolation as a reason not to engage. Although only two agencies that

engaged with Mary classified the hoarding, the hoarding was seen by more than that number.

8.52 The analysis of Mary's life has shown that she displayed an absence and denial of her hoarding and 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. Those included reducing her cleaning support because of the financial implications; She was anxious when strangers came into her home; She used Covid-19 as a reason for not using the support from services. On one occasion, she indicated that she was dealing with the issues and was looking for private support to do so, when she had no apparent intention of doing so.

8.53 It is also important to acknowledge that managing a person's hoarding is not an applied science and an immediate clearance is frequently inappropriate and may have a resounding and longer-term negative impact to the individual. The Lincolnshire protocol recognises that currently[24] there are no 'hoarding' specialists or practitioners as such in the county to refer to, but research and pilot projects are being undertaken in other parts of the country to identify and work with people who present with hoarding behaviours.

8.54 It will be a recommendation that this useful and informative hoarding protocol is reviewed and brought up to date, but moreover that it is also widely known across all agencies so that agencies comply with the rationale of the protocol. For example, the police reports did not quantify the level of hoarding but did refer to the *'very poor conditions.'*

8.55 Although the police are encouraged in accordance with professional practice to use body worn video to capture domestic abuse incidents, this was not done on the attendance of the 22nd of June 2022, on the premise that it does not appear to have been considered as being a domestic abuse incident, although photographs were taken of the marks to Mary's neck. Looking broader, the use of body worn video taken by police attending incidents, could also be used to support their referrals to other agencies, in particular, where there is no evidential requirement for the use of that material under disclosure rules. On this occasion, the footage would have served a number of purposes and may have triggered other agencies to have challenged the response.

8.56 The lack of DASH risk assessments over the review period is indicative that practitioners are either lacking in awareness, or failed to identify the necessary components of safeguarding. When internal risk assessments were made, the key fact is that none of the risk assessments explicitly recorded that Mary was at risk from domestic abuse and missed the significance of the strangulation, which is known to have occurred on more than one occasion. The LPFT IMR references; *"Whilst, it is important to balance the known risk versus the inclusion of a victim in their risk assessment and follow up care, in this case there were significant risks already indicated in Mary's clinical records."*

8.57 In October 2022, the CPN had referenced the strangulation of Mary by Simon, as part of the risk assessment, but this had not been recorded in the previous LPFT risk

[24] Last iteration 2020.

assessment, dated July 2022, which was only one month after the non-fatal strangulation, reported to the police.

8.58 The LPFT Safeguarding Team has evaluated their current practice in relation to how DASH risk assessments are graded, particularly when there is disagreement between the Trust Safeguarding Team and the practitioner working directly with the individual. The Trust's Safeguarding Team will implement changes and ensure that on occasions where there are disagreements in level of risk, direct contact is made with the relevant practitioner to ensure that the full extent of the risk is understood. The Trust's Safeguarding Team is also currently undergoing additional training with an external consultant for learning around DASH risk assessments, safety planning, advising staff and the MARAC process. The Trust's Safeguarding Team will consider more fully the impact of familial abuse on a victim.

8.59 The review author supports the proposition made by the LPFT concerning the practice to be implemented in respect of disagreements concerning the levels of risk, however, the review makes comment concerning the use of the DASH risk assessment process in that the use of DARA across the safeguarding partnership may be more beneficial as it is more likely to identify patterns of controlling and coercive behaviour[25].

8.60 The CPN-3 had worked tirelessly during the period of her involvement and was clearly sensitive to Mary's needs, gaining her trust and taking the necessary time to get her to engage. The practitioner commented to the LPFT IMR author at interview that she spoke openly about how their '*appointments were lengthy….I never wanted to rush her. I wanted her to get everything out that she had stored in her head and just try to unpick little things from it*.' As a result, Mary's '*engagement was incredibly good'.* The bigger rhetorical question is, why had this not happened until this point, when numerous agencies and practitioners had the capability to have done so in the past.

8.61 The chair of the panel is of the opinion, that given the time and effort made by the CPN-3 to develop a strong relationship with Mary, this was a significant opportunity. However, the result was that when the referral was assessed by the LPFT safeguarding team, the high level of risk was endorsed by them as being '*medium'* and it was not referred to external agencies outside of the trust, nor was it referred to MARAC.

Section four – Conclusions, Learning Themes and Recommendations

9.0 Conclusions

9.1 Mary's intention may not have been specifically to take her own life but as her note advised, Mary did realise the taking of her deliberate overdose may have led to her dying. The partnership should therefore learn lessons as a result of Mary's domestic abuse related death.

[25] Approved professional practice for domestic abuse – College of policing November 2022. Police better equipped to identify controlling and coercive behaviour using the DARA risk assessment framework.

9.2 There is little information concerning Mary's overdose on the 24th of September 2022, and the narrative that she had an express intention to take her life on that occasion. This should have been explored further.

9.3 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 S10, 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.

9.4 The DASH risk assessment analysis of December the 2nd 2022, highlights a litany of abuse by her father on Mary, and appears to have been the most enlightening DASH risk assessment analysis throughout any agency or professional contact with her, but this was not shared with other agencies by LPFT. This was a missed opportunity to have escalated Mary's case.

9.5 Examining the last DASH risk assessment, it appears to have illuminated Mary's life, viewpoint and probably for the first time, heard her voice more intimately than before. However, when the DASH risk assessment by the CPN which had a visible high risk indicators was reviewed by the LPFT safeguarding team, and their assessment was that it scored '*medium*. Whilst the review author accepts that it contained no additional or new information that was not already within the extensive records held by the LPFT, it added significant context to what was already recorded. Notably, it was the first time that the Trust's practitioners had completed a DASH risk assessment in respect of Mary, which when taken in context, should have happened much earlier given the volume of information and disclosures of abuse that had been gathered over the preceding years, in particular the escalation of more recent times, with the non-fatal strangulation.

9.6 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. 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.

9.7 There was Confirmatory Bias[26] on innumerable occasions which effectively suggested that because Mary had numerous mental health issues, without the exploration of the cause and effect, and that this behaviour towards her by her father was the background for her illness. There was little understanding of Mary as a victim of domestic abuse, specifically of coercion and control, harassment and assault, all perpetrated by her father. His control of

[26] Selective information that supports existing views, ignoring contrary information, or when the interpretation of ambiguous evidence supports existing attitudes and beliefs.

her finances, was frequently noted by professionals, tentatively challenged, but again, confirmation bias allowed him to predicate that behaviour. Added to this was his omnipresence at her medical appointments, his communications with benefit advisors and social workers. It is difficult to distinguish between any genuine concern that he had and his dominant behaviour.

9.8 In addition to this Confirmatory Bias, there might be in Mary's case that at times she displayed to professionals, 'Apparent Competence'[27] which *'essentially is appearing to be able to cope with situations and problems on the outside, but internally experiencing extreme distress and emotional dysregulation.'* Professionals need to be aware of this and have the skills to read between the lines and support their patient, in this case Mary who did at times say she was managing her father's controlling behaviour when she might not have been, as her cry for help was very loud at times.

9.9 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.

9.10 Mary repeatedly focused on the belief that she required psychiatric support to navigate through the trauma she had experienced in the past to support her mental health. She told professionals that her father was the cause of a significant amount of this trauma. Mary narrated her mother's attempted suicides and alcohol abuse on multiple accounts and believed this was also due to her father's abuse. Mary was doubtlessly dominated by her father's coercion and control over many decades.

9.11 When her mother passed away in 2018, Mary's caring role did not cease but became by his design, transferred to her father and his domination of her continued unabated. Despite her recognising her father's abuse and sharing this with professionals, Mary felt she had no option but to acquiesce to Simon's control throughout. She was given no tangible support to have broken free from her father's control. Despite her father's directed abuse to her, which continued for nearly a decade after she returned to Lincolnshire, Mary believed that she had an obligation to assist her father, but the reality is that she had been conditioned into this way of thinking over many years.

9.12 Mary regularly sought to be understood, but by the same token, the sheer volume of her treatment and contact with mental health and other services became a significant negative contributory factor to her real needs, as she felt overwhelmed. The signposting for her of support, as a result of these multiple contacts turned out to be ineffective. Put simply, Mary needed to have a lead professional to help her manage all of these various inputs from multiple services and achieve safety from abuse and sanctuary from her father.

9.13 The action taken by the police in June 2022 lacked a victim centred approach. This is in comparison to the incident in July 2018, where the police were incisive and pro-active in response to a potential serious sexual offence. However, on that occasion too, Simon was not interviewed and the facts concerning that occurrence remains somewhat ambiguous. In

[27] https://eymtherapy.com/blog/apparent-competence-dialectical-behavior-therapy/
https://dbtvancouver.com/apparent-competence/

further evaluation of the incident of June 22nd 2022, there were clearly at least two criminal offences disclosed by Mary to the attending practitioners, in fact Mary told so many different professionals about it. Although a crime of assault was raised by the attending police officers, this entirely missed the bigger picture of domestic abuse. It is transparent that Simon's account was taken at face value when in fact, he was implicated as the perpetrator, and added to that was the imperative of the coercion and control allegation against him.

9.14 This ambivalence and the associated PPN DASH risk assessment of medium, was poorly judged and when later reviewed by the police safeguarding hub, it remained as medium risk. This decision in supervision of the referral has parallels with that made in December 2022 by the LPFT safeguarding team. This fact has been recognised by LPFT and ideally should be formalised with an escalation procedure embedded in safeguarding policy.

9.15 Mary was frightened of her father and that fear may have contributed to her reluctance to provide testimony. However, she was entitled to special measures in accordance with statutory legislation[28] which would have ensured her continued safeguarding and progressive protection from her father.

9.16 The police decision not to have formally interviewed, if not arrested the perpetrator following the incident of June 22nd 2022, must have sent an entirely negative impression to Mary. The police response lacked a thorough understanding and consideration of Mary's personal and immediate safeguarding needs.

9.17 The review author does acknowledge that the legislation to tackle non-fatal strangulation was newly introduced, having been enshrined under the Domestic Abuse Act 2021, and only coming into force on the 7th of June 2022, just two-weeks before the relevant report. It is also acknowledged that police forces across England and Wales, took some time to gather momentum in recognition of the legislation taking effect and this may have been an influencing factor. The most concerning comment by the police is that Simon's account was believed as credible, yet the allegation of strangulation, combined with Mary orating her fears concerning his control, were significant warning signs. Had the PPN DASH risk assessment been more widely shared, but more importantly, raised to MARAC, the agencies could have worked together with appropriate interventions. It is also important to identify that when Mary made those further disclosures of assaults on holiday to other agencies, no DASH risk assessments accompanied those disclosures. In effect, the agencies worked in isolation.

9.18 Legislation to tackle domestic abuse offences committed by a perpetrator was introduced under the Domestic Abuse Act 2021, in June 2021, which allows for a perpetrator to be prosecuted for certain specified offences, which includes section 76 Serious Crime Act of coercive and controlling behaviour. Again, this was overlooked and could have been explored further.

[28] In accordance with section 17 YJCEA.

9.19 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. Mary was never referred to the MARAC process, which can be made on professional judgement, irrespective of the risk scoring high within the respective assessments.

9.20 This review suggest that Mary's case could have reached the threshold for MARAC, on at least three occasions, based on the facts as presented. The predominant facts in issue were her risk of serious physical harm and the associated controlling and coercive behaviour predicated by her father and the escalation of violence from June 2022. Those occasions are:

- July 2018, arising from the incident of 4th July.
- June 2022, arising from the incident of June 24th.
- December 2022, arising from the referral of December 2nd.

9.21 Throughout the span of this review, it is apparent that a considerable amount of time and effort was made in support of Mary's mental health, there were occasions when it was joined up, but this lacked a defined and targeted multi-agency approach. Referrals were made but not a holistic consideration of what the cause and effect was and how Mary's mental health was linked to her being a victim of domestic abuse.

9.22 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. There were no occasions when Mary had lacked capacity. Her case, it was stated in the Adult Social Care IMR, never met the threshold for a section 42 enquiry, which is acknowledged as based on the information that was used by them to make this decision. The context however of that is that Simon was frequently intervening in her financial affairs, as well as intervening in her medical appointments, along with having input to her benefit assessments and payments. He had no power of attorney and it may be prudent for agencies to consider where 'consent' is given by individuals, whether this consent is legally, as opposed to morally considered. It is more than possible based on the evidence discovered in this review that on occasions, Simon coerced Mary into signing her consent in his favour.

9.23 It is apparent from Mary's GP practice IMR, that there was little or no recognition of domestic abuse by coercion and control and there is no tangible evidence that Mary was asked specifically about domestic abuse. The fact that she was frequently accompanied by her father to her medical appointments, was not perceived as predisposing his control, rather his support. It is important that the patient is seen alone wherever practicable for appropriate safeguarding questions to be asked.

9.24 The legislation for both the Serious Crime Act 2015 and the Domestic Abuse Act 2021, clearly defines domestic abuse as being from a person being 'personally connected', where they are relatives. (A) repeatedly or continuously engages in behaviour towards another

person (B) that is controlling or coercive, (b) at the time of the behaviour, A and B are personally connected, (c) the behaviour has a serious effect on B, and (d) A knows or ought to know that the behaviour will have a serious effect on B. This needs to be more widely understood, acknowledged and acted upon as learning from this case, especially in those non intimate but familial relationships.

9.25 The phrase 'professional curiosity' has become synonymous with statutory safeguarding reviews. This review makes the observation that what this curiosity equates to in this case is that there have been numerous occasions where practitioners and agencies have not considered the wider implications and thinking 'professional curiosity'.

9.26 The impact of Covid-19 was of significance in this case in three ways. During the lockdown periods Mary moved back in with her father for a period due to the restrictions and the need to form a 'bubble' with him. This in essence meant she was 24/7 in close proximity of the person who was the perpetrator of her DA. The second way was that Covid restrictions meant that there was for Mary a real lack of social interactions that impacted her feelings of isolation. Finally the lack of face-face meetings with professionals impacted on them being able to see Mary and being able to assess her mental state rather than just what they were being told by her.

9.27 Learning Themes

- 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 victims mental health.
- Self-harm (through overdose) and risks of suicide in cases of domestic abuse.

10.0 Recommendations.

10.1 Individual Agency recommendations:

Lincolnshire County Council Adult Social Care (Adult Care and Community Wellbeing)

1) Review and refresh (if required) current guidance regarding carers assessment duties for Section 75 LPFT mental health social work team & ACCW Social Care and embed in practice through current training, guidance circulation and a 7 min briefing.

2a) A feedback and reflection session with the Section 75 mental health social work staff member involved during the disclosure of abuse.

2b) Provide a briefing to Section 75 LPFT mental health social work teams and ACCW regarding revisiting a DASH's risk assessments when disclosures are made.
3) Complete an Internal Review of this case to explore learning and wider themes and trends which may include risk assessment of closing cases and contingency planning.
4) Review of the guidance in place for Customer Services Staff when referrals do not meet the criteria for consideration under Section 42 duty.

Lincolnshire Partnership (NHS) Foundation Trust

1) Relevant local CMHT team to have specialist training sessions on the Trust's safeguarding duty, therapeutic relationships and safeguarding, domestic abuse including the definition of 'personally connected', and the actions and processes to be taken upon disclosure of domestic abuse and controlling or coercive behaviours, including non-fatal strangulation, the completion of DASH risk assessments and safety planning including Refuge provision.
2)Trust will add suicide and self-harm to the domestic abuse training and processes regarding the definition of serious harm.
3) For research on mental illness, suicide and domestic abuse to be included in the both the Trust's domestic abuse and risk assessment and management training; with a Trust wide communication to reflect this.
4) As the main provider of mental health services, the Trust must ensure that the pertinent mental health questions 5, 24 & 25 in the DASH risk assessment (including question 11 of the stalking – DASH) are focused on, in all of the Trust's domestic abuse training, thus improving the decision making about risk and ensuring that the multi-agency have the Trust's mental health expertise when managing high risk cases.
5) The Trust's Safeguarding Team to receive specialist training to refocus and upskill them on their analysis of DASH and S-DASH risk assessments, decision making regarding high risk including suicide, and cases that are high risk of serious harm or homicide, requiring multi agency presentation at MARAC, this will also include a refresher on the Trusts role at MARAC.
6) The Trust's Carer Lead and Safeguarding Team to work together to ensure that all of the Trust's carers information and communications include the safeguarding of the carer and those cared for.
7) For the Trust's to identify a pathway for trauma informed care for people with secondary mental health diagnoses which is commensurate and accessible to all, aligned to NICE guideline [NG116] Post-traumatic stress disorder. This should include how to manage trauma in people currently experiencing abuse.
8) The Trust's Safeguarding Team restructure to create a Safeguarding Hub with increased staffing and a co-ordinating lead, so that review of DASH risk assessments, MARAC referring and advice on cases are less likely to be passed between safeguarding staff and that staff are better equipped and supported to safeguard patients and the public.
9) The Trust would like the DHR panel and author to consider access to Refuge provision for victims of domestic abuse who have a serious mental illness, as the lack of access to this in Lincolnshire and the United Kingdom prevents Trust staff from being able to readily access safety for victims, using this route.

Lincolnshire Domestic Abuse Specialist Service (formally EDAN Lincs)-

1) They will share reviewed partnership Information Sharing Agreement at point of signoff.
2) With the new DHR threshold including DA Homicides linked to suicide, Edan have embedded suicide and risk as a key element to risk assessments throughout support.
3) Access to training to increase knowledge on supporting neurodivergent clients.

Lincolnshire Police -No recommendations were made.
East Midlands Ambulance Service- No recommendations made.
'We are With You.' - No recommendations were made.
North Lincolnshire and Goole (NHS) trust-
1) Contact details have been shared with all staff working in the emergency department for the local authorities surrounding NLAG and this is reinforced during supervision and training.
2) NLAG now have a Domestic Abuse Coordinator in post who is actively reviewing NLAG's training offer around domestic abuse and coercive control. This will include revisiting with staff what the definition of domestic abuse is, and in what situations it can occur, such as in this case of father / daughter domestic abuse. The training will also include when and how to complete a DASH assessment.
DWP- No recommendations were made.
GP Surgeries
1) Implement Comprehensive Domestic Abuse Training: Provide mandatory training for all staff on recognizing and responding to signs of domestic abuse and coercive control, with a focus on subtle indicators and appropriate response protocols. This training should empower staff to effectively support patients experiencing abuse and ensure their safety and autonomy are prioritized.
2) Enhance Mental Health Follow-Up Procedures: Develop and implement robust follow-up protocols for patients reporting mental health concerns, ensuring prompt and thorough support. This may include multiple contact attempts, alternative communication methods, and coordination with mental health services to provide timely interventions and prevent escalation of issues.
3) Strengthen Patient Autonomy Policies: Review and strengthen policies related to patient autonomy and confidentiality, particularly in situations where family members may be involved in the patient's care. Emphasize the importance of obtaining explicit patient consent for involvement of family members and establish clear guidelines for safeguarding patient autonomy in decision-making processes.
ULHT- No recommendations were made.
LCHS-
Focus is being place on professional curiosity throughout all of our safeguarding interactions, and specific focus is being given to this area through our training packages for all clinical staff across LCHS. This training is currently in place and will continue to be delivered as part of mandatory training. This training also covers topics such as 'think family', understanding domestic abuse and focusing on understanding the motivators behind people's behaviours/actions in order to have a more holistic understanding of their needs.
Acistance-
Any future projects that we deliver will consider how we can get all the information we require at the onset of support. This may mean a joint meeting with the referrer and the potential participant to ensure we have all the information we need prior to acceptance to ensure it is "the right thing for that individual.

10.2 Overview Report 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.