# London Borough of Bexley Community Safety Partnership

## Domestic Homicide Review

## Executive Summary into the death of Marilyn - April 2022

**Independent chair and author of the report: Dr Liza Thompson**

**Report completed: May 2024**

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# EXECUTIVE SUMMARY

## 1. The Review Process

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Marilyn, a resident of Town A, prior to her death in April 2022.

1.2 On that day, Marilyn was found deceased in her garden by her niece.

1.3 Approximately four months prior to Marilyn's death she had reported historic rape to the Metropolitan Police Service (MPS) perpetrated by her ex-husband in 1988 and 1989.

1.4 Marilyn had experienced trauma as a child, and she indicated to professionals throughout the scoping period for this review that her husband had been violent during their short marriage. Following separation from her husband, he subjected Marilyn to financial abuse, and she was forced to raise her children without a secure income or stable housing.

1.5 In February 2023, the South London Coroner Court found that Marilyn had died from suspension, and that her death was the result of an accident.

1.6 This DHR examines the involvement that organisations had with Marilyn, a white British woman who was in her early sixties when she died. The scoping period for the review was set as 1st January 2016 to end of July 2020, for contextual information regarding mental health, domestic abuse, and alcohol misuse – this was to provide an understanding of the complexities that Marilyn was living with. The period of detailed analysis was set as 1st August 2020 to April 2022, as August 2020 was the point where Marilyn's mental health issues appeared to be escalating.

1.7 The key reasons for conducting a DHR are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.8. A DHR is undertaken when someone has died due to abuse or neglect, this definition includes sexual violence. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Bexley Community Safety Partnership (BCSP) Board met on 9th June 2022, where it was agreed that the criteria for a DHR had been met and this review would be conducted using the DHR methodology. That agreement has been ratified by the Chair of the Bexley CSP and the Home Office were informed on 21st June 2022.

1.9. Marilyn was not the victim of a homicide (where a person is killed by another). However, this review is framed by the 2016 Home Office Domestic Homicide Review Statutory Guidance which states:

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

## 2. DHR Methodology

2.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Marilyn between 1st January 2016 – April 2022.

2.2 An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

2.3 The IMR authors were also asked to provide pertinent information regarding domestic abuse, mental health or alcohol misuse prior to 2016.

2.4 The initial "summary of involvement" information, spanning the year prior Marilyn's death did not provide any obvious dates from which to begin the scoping period for the IMRs. Therefore, the panel agreed to request IMRs covering the five-year period prior to Marilyn's death in order to provide an insight into Marilyn's life ahead of her death.

2.5 Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a senior manager of that organisation before being submitted to the DHR Panel. Neither the IMR authors nor the senior managers had any involvement with Marilyn or her ex-husband during the period covered by the review.

2.6 In addition to the full IMRs, Kent Police provided a summary report as this was proportionate to the level of involvement that they had with Marilyn.

## 3. Contributors to the Review

3.1. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation before being submitted to the DHR

Panel. None of the IMR authors or the senior managers had any involvement with Marilyn during the period covered by the review.

3.2. Each of the following organisations contributed to the review.

| **Agency / Contributor** | **Information provided** | **Panel Member** | **Job title** |
|---|---|---|---|
| - | - | Dr Liza Thompson | Independent Chair |
| LB Bexley Community Safety Services | - | Deborah Simpson | Domestic Abuse & Sexual Violence Strategy Manager & Commissioner |
| LB Bexley Community Safety Services | - | Leslee Williams | Domestic Abuse & Community Safety Support Officer & minute taker |
| Bexley Safeguarding Adults Board | - | Anita Eader<br><br>Alexandra Bennett | Practice Review and Learning Manager<br><br>Partnership Officer |
| NHS Southeast London Integrated Care Board | - | Phillipa Uren | Designate Nurse for Adult Safeguarding (Bexley) |
| Adult Social Care | Chronology | Susan Chandler | Head of Safeguarding Adults |
| Solace Women's Aid | - | Donna Clayden-Sibley | Head of Quality and Service Excellence |
| NHS Southeast London Integrated Care Board- Bromley | Primary care IMR | Dr Tessa Leake | Named GP Adult Safeguarding |
| Hospital Trust A | Chronology | Ranjana Sharma | Safeguarding Lead |
| Hospital Trust B | Chronology | - | - |
| Hospital Trust C | IMR | Sarah Connelly | Deputy Medical Director for Unscheduled Care |
| Metropolitan Police | IMR | Justin Armstrong | Independent Review Officer |
| Kent Police | IMR | - | - |
| London Ambulance Service | IMR | Jade Speed | South East Sector Safeguarding Specialist |
| Oxleas Foundation NHS Trust | IMR | Karen Laffar | Domestic Abuse Lead |
| Victim Support | IMR | Rachel Nicholas | Head of Service |
| London Survivors Gateway | Summary of engagement | - | - |

## 4. Independent Chair and Author

4.1. The Independent Chair, who is also the author of this overview report, is Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

4.3. Dr Thompson has no connection with BCSP and agencies involved in this review, other than currently being commissioned to undertake this DHR.

## 5. Terms of reference for the review

5.1 In May 2021, Marilyn had reported her husband to police for numerous rapes against her in 1988 and 1989, however from the commencement of the DHR, it was not known whether domestic abuse had featured in Marilyn's life since separating with her husband in 1989.

5.2 The initial summary of information forms completed by agencies had not highlighted any recent incidents or agency interventions for domestic abuse or coercive control. However, it was clear that Marilyn had been struggling with mental ill health and problematic alcohol consumption which had led to many self-harming episodes and suicide attempts.

5.3 The panel therefore adapted the specific issues provided in the Home Office guidance, in order to critically analyse Marilyn's experiences of services leading up to her death.

a) An analysis of the communication, procedures and discussions, which took place within and between agencies.

b) How well did agencies work together when supporting Marilyn?

c) Did agencies identify risk of harm, from domestic abuse or mental health and how were this risk assessed?

d) An analysis of agency responses to any identification of domestic abuse issues, including suitable and timely referrals into specialist services.

e) An exploration of the policies, procedures and training available to agencies involved in responding to domestic abuse issues.

f) Understanding of how the report of rape, and responses to this report, may have impacted on Marilyn's mental health, including an understanding of how she came to the point of reporting the crime 33 years after the event.

g) Understanding of the wider family dynamic and how this may have exacerbated Marilyn's mental health challenges.

h) Identifying suicide risks linked to Marilyn's experiences - opportunity for learning about risk factors connected to suicide.

## 6. Summary Chronology

6.1. Marilyn was diagnosed with borderline personality disorder, and acute depression. The records gathered to inform this review evidence many suicide attempts, and self-harming episodes. In 2016, Marilyn was diagnosed with Interstitial Lung Disease, suffered from back spasms and ongoing chest infections. Marilyn also self-medicated with alcohol.

6.2. Marilyn's niece Stephanie supported the DHR by providing background and context to the records gathered for the review. Stephanie explained that Marilyn loved her family very much, and lived for her grandchildren, however she did not see them very much as she had a difficult relationship with her sons and also the grandchildren's mothers. These relationships were affected by the symptoms of Marilyn's borderline personality disorder, which would cause her to push people away, sometimes in very extreme ways.

6.3. Marilyn was a proactive woman, and had tried to access Dialectical Behaviour Therapy (DBT) which she had researched was the best therapy for her condition. This was not available through the NHS locally. Marilyn was also pursuing a civil court case against her ex-husband, for her share of inheritance he had received after their divorce. This was causing her a great deal of stress.

6.4. Four months before her death, Marilyn made a historic rape allegation against her ex-husband. Marilyn's ex-husband was interviewed under caution on 12th April 2022, and it is thought that Marilyn took her life sometime soon after this date.

6.5. Stephanie attended Marilyn's home, following a missed phone call from her, and found her deceased in her garden. She had died by suspension.

## 7. Conclusions

### 7.1 Supporting people with complex needs

7.1.1. The term “complex needs” is used to describe someone who has two or more needs affecting their physical, mental, social or financial wellbeing.[1] These needs are often long term and severe and may be difficult to diagnose or treat. Someone with complex needs may require specialised care because of complex medical needs and other personal factors that impact their life.

7.1.2. The equality and diversity section above details the various challenges which Marilyn was living with and the diagnosis of EUPD, co-existing alongside her use of alcohol, were particularly problematic. As detailed above, EUPD is characterised by instability of mood, and impulsive behaviours. Those with EUPD experience rapid fluctuations from confidence to despair and have strong tendencies towards suicidal thinking and self-harm – people with EUPD are particularly at risk of death by suicide. Additionally, alcohol use has been associated with a 94% increase in risk of death by suicide.[2]

7.1.3. It is important to acknowledge that many of Marilyn’s difficulties with her ability to manage her emotions and the impact this had on her ability to form and manage relationships required long term support which does not always fall under the remit of secondary care mental health services.

7.1.4. Marilyn required clinical interventions following each social crisis to help her manage the risk of the situation and her response to each situation, however this would quickly be resolved, and she would be discharged back to her GP. However, this did not always address the underlying issues of her childhood and abuse which contributed and triggered her responses. It was felt that more unstructured therapy would benefit Marilyn, but this is not readily available on the NHS due to demand, resources, and the need to provide evidence-based outcomes.

7.1.5. There were occasions throughout the scoping period where Marilyn would be taken to hospital by ambulance, would be seen in ED, and would quickly be deemed ready to return home, often without seeing the Mental Health Liaison Team. This led to a revolving door scenario, with no interventions to prevent future emergency calls, and being conveyed back again to the ED.

7.1.6. Frontline police officers are trained to deal with extreme crisis cases and apply S.136 of the Mental Health Act to detain if appropriate. There are a wide range of protections and tactical options available to victims with vulnerabilities within the criminal justice system. The MPS main referral mechanism is through the identification of vulnerabilities, with the completion of a Merlin report that is shared with statutory partners via the MASH. There is no evidence police reports that suggests that alcohol misuse created a barrier to service provision or that Marilyn was identified as lacking capacity.

7.1.7. In January 2020 following a report of a theft, when Marilyn identified herself as vulnerable and an alcoholic, there was not a Merlin completed for this. When Marilyn reported malicious communications, she was noted as a “functioning alcoholic”. There were no further

[1] All Party Parliamentary Group on Complex Needs and Dual Diagnosis | Emerald Insight
[2] Alcohol use and death by suicide: A meta-analysis of 33 studies - PubMed (nih.gov)

vulnerabilities identified and the issue was dealt with over the phone, so officer did not see Marilyn.

7.1.8. A Merlin was completed in April 2021 when Marilyn threatened suicide and told officers in attendance to her home that she suffered from PTSD and a personality disorder. However, it has been noted by an internal MPS review that when Marilyn reported the non-recent sexual abuse on 14th May 2021, a Merlin should have been completed for a referral to partner agencies during the investigation.

7.1.9. Oxleas Mental Health services are moving away from using the terminology of EUPD, and instead are using the term "complex emotional needs" (CEN). Terminology has also developed from "dual diagnosis" to Co-occuring Mental Health, Alcohol and Drugs (COMHAD). All Mental Health Hubs have a lead COMHAD role recruited in 2023. This would have not been in place during the scope of this review.

7.1.10. Principles of COMHAD are as follows:

(a) Everyone who requires mental health services will receive this irrespective of their drug and/or alcohol use and irrespective of any opinion about cause and effect of their substance use on their mental health.

(b) Individuals have equal access to all strands of treatment available to those who are not using substances or alcohol.

(c) The Trust will adopt an integrated treatment approach, whereby service users have both their mental health and substance misuse needs addressed at the same time.

(d) The Trust will work in partnership with local substance partners wherever possible, actively challenging ideas that substance use must be addressed or fixed before they can engage in mental health interventions.

7.1.11. Marilyn was seen by a dual diagnosis worker on 23rd February 2018 for assessment. She was angry and initially hard to engage, refused to give details of alcohol intake or any support from alcohol services. This pattern of behaviour, as may be seen by someone with a diagnosis of EUPD and history of trauma, continued. Working with the GP was essential in this case to jointly consider best options for her. This communication is clearly recorded.

7.1.12. Contact notes of the HTT noted that Marilyn was often hostile, irritable and abusive towards staff at beginning of contact, accusing staff of lying/not helping, this may have been a way of Marilyn keeping herself safe by avoiding feeling vulnerable. There was a recorded dissonance between wanting and seeking help and putting barriers up.

7.1.13. Trauma informed practice by Oxleas was minimal, as when Marilyn did not attend appointments or refused engagement, services were closed. Should services be commissioned differently, with more resources for support services, longer term relationships

with agencies may have enabled Marilyn to form more trusting relationships to meet her needs.

7.1.14. Since 2022, the Mental Health Hub has been available. This is a multidisciplinary service where different professionals are available to provide a holistic view of someone's needs and work together to make decisions about how to care for people with mental health conditions. Interventions include assessment of needs, including safeguarding concerns and assessment of risk due to drug and alcohol use co-occurring with mental health issues. It is considered that Marilyn's intervention with the current Primary Care Hub would have considered wider service provisions to meet her needs.

7.1.15. Victim Support were not aware of Marilyn's alcohol misuse, she informed them of her mental health issues. Victim Support staff all receive mental health training, including how to respond to someone struggling with mental health, who self-harms, are in distress or may be expressing suicidal feelings.

7.1.16. Marilyn appeared to be very open about her alcohol issues when engaging with LAS and hospital staff. This would have been during period of crisis when she was always intoxicated. She was also asked about her alcohol intake when she re-attended Hospital C three days after being brought in by ambulance in an intoxicated state. This was good practice however the notes do not indicate why she was asked about alcohol use as on this occasion she was not intoxicated – her response was that she had "cut down a lot". There is no further exploration during this consultation which is a missed opportunity to speak with Marilyn whilst sober.

7.1.17. There are little to no records of discussions about alcohol from any of the three hospitals which Marilyn utilised. Marilyn's alcohol use presented a barrier to accessing services and the lack of exploration with her about this presented a further barrier. Hospital staff should be encouraged to signpost people who are presenting with alcohol issues to one of the many community drug and alcohol services available in Bexley[3] and this should be recorded within their hospital notes.

7.1.18. It is clear from Marilyn's records that she had a greater than average attendance record at the local UTCs and EDs. She may have been utilising these unscheduled care services in place of engagement with her GP, indicating that medical care was not always sought in a co-ordinated manner. She also accessed the mental health hub on occasions which is a drop-in service. This did not allow for a coordinated, and possibly multi-agency approach to her ongoing care – instead provided a reactive "sticking plaster" response to Marilyn's ongoing complex needs.

### 7.2 Long term impacts of abuse

7.2.1 The perceived historical nature of the domestic abuse Marilyn experienced meant that practitioners did not always consider the impact on her day-to-day life. She was not referred for specific domestic abuse interventions, staff did not feel that she required safeguarding

[3] Drug & Alcohol Misuse | Bexley Safeguarding Partnership

procedures as it was believed that she had limited contact with her ex-husband. However, Marilyn did acknowledge that the consistent battle to get justice and going back to court felt like abuse and was traumatic in itself.

7.2.2 Although Marilyn indicated to professionals that she initiated the ongoing court process herself, the effects of the process on Marilyn, including the impact of this on her wider family relationships, could have been identified as requiring support from a specialist service.

7.2.3 In Bexley, Solace Women's Aid[4] runs the Solace Advocacy and Support Service (SASS),[5] which offers one to one advocacy, support and safety planning for victim/survivors who are assed as medium and high risk of harm. They also run a women's refuge in Bexley, and deliver the Bexley Domestic Abuse One Stop Shop, offering a range of advice under one roof, to help all victim/survivors of domestic abuse – this launched in November 2021.[6]

7.2.4 Rights of Women provide advice and support to women engaged with family, criminal and immigration law.[7]

7.2.5 Surviving Economic Abuse provide advice and support to anyone effected by financial or economic abuse.[8]

7.2.6 It should also be noted that at times Marilyn did resist ongoing referrals, for example she threatened to stop engaging with the SOIT Officer if he referred her to specialist services and indicated that she had disengaged with Survivors Gateway when they referred her to mental health services – albeit it the notes do not indicate this to be accurate as she continued to accept their calls following the referral to CMHT.

7.2.7 Since the period of this review, Oxleas has introduced a domestic abuse lead who is responsible for the implementation of the Trust's domestic abuse strategy, data collection and the coordination and delivery of domestic abuse training; within includes a section on economic abuse. Training is delivered to all mental health teams in person. The domestic abuse strategy includes a commitment for clients to be routinely asked about domestic abuse during assessments. If Marilyn had been asked about her experiences of abuse, this may have allowed further exploration of the impact of her experiences on her current mental health.

7.2.8 It has also been identified that there was some reliance on Marilyn to self-refer to debt services and alcohol support services. Considering Marilyn's fluctuating mood and life outlooks – both linked to, and exacerbated by her complex needs, support and follow up of referrals to agencies would have been more appropriate. This level of support is now available through the Mental Health Hub.

7.2.9 Hospital Trust C have enhanced their domestic abuse and routine enquiry training to include economic abuse. The awareness around financial and economic abuse is much

[4] Solace in Bexley (SASS) | Solace (solacewomensaid.org)
[5] bexley-poster_final.pdf (solacewomensaid.org)
[6] bexley_one_stop_shop.pdf (solacewomensaid.org)
[7] Who are we - Rights of WomenRights of Women
[8] Surviving Economic Abuse: Transforming responses to economic abuse

greater amongst clinicians since the period of this review. Although Marilyn did not disclose her experiences of domestic abuse she was also not asked about it.

7.2.10 All Victim Support (VS) staff have completed the homicide timeline[9] training, and also suicide training.[10] All VS IDVAs are trained by Surviving Economic Abuse, however during the call with Marilyn economic abuse was not identified as a factor. Marilyn was referred to the Survivors Gateway following her call with VS, due to her disclosures of non-recent rape.

7.2.11 There is also a charity local to Bexley which supports survivors of sexual abuse and rape[11] which Marilyn could have been referred into.

7.2.12 Marilyn spoke about the civil case against her ex-husband on numerous occasions, to LAS staff, hospital staff, VS Support, London Survivor Gateway, Home Treatment Team, and also during many consultations with her GP. None of these conversations triggered signposting or a referral to specialist services to support with the complexities of a family court case. This review has highlighted a knowledge gap regarding these services and awareness of such services will form a recommendation from this review.

7.2.13 Bexley has a dedicated domestic abuse website, which has been in place since 2018 – there is no evidence from case files that Marilyn was referred to this website, or that professionals referred to the website in their conversations with her. Awareness of the Bexley Domestic Abuse website will form a recommendation from this review,

### 7.3 Alcohol misuse and legal powers

7.3.1. As discussed above at 17.2, Marilyn's alcohol misuse impacted on her capacity to make decisions to keep herself safe. A recent publication[12] providing advice and support to practitioners faced with dependent[13] and chronic[14] drinkers who are also highly vulnerable[15], highlights the need to use existing legal powers wherever possible and not to allow the person's denial and refusal to stop intervening if they are at risk.[16]

7.3.2. The Care Act 2014 states that a person does not need to lack capacity to be vulnerable or self-neglecting. There is no evidence of any safeguarding referrals being made for Marilyn despite her ongoing and frequent presentations. The only alert received by Adult Social Care would have been into the MASH, via the Merlin in 2016 – there is no record that this led to any further action.

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[9] Home (dreams-lms.com)
[10] Free online training from Zero Suicide Alliance ASIST - Grassroots Suicide Prevention (prevent-suicide.org.uk)
[11] Family Matters - Care and support for those afraid to talk (familymattersuk.org)
[12] Safeguarding-guide-final-August-2021.pdf
[13] Alcohol addicted drinking at levels that make them physically dependent.
[14] Alcohol dependent for a long time – usually decades.
[15] People who present a high level of risk to themsel3ves, and suffer long term negative effects. One indicator is a high use of emergency services.
[16] Safeguarding-guide-final-August-2021.pdf p.8

7.3.3. It is also problematic to assume that if a person can care for themselves when they are sober, that they do not require intervention. Alcoholism is a "chronic relapsing condition"[17] and the fact that they have been at risk during intoxication previously, indicates that this could happen again. Relying on assessments which are made during periods of sobriety is unlikely to help the person in the long run – the whole trajectory of their condition must be considered. In Marilyn's case, she presented as well kempt and articulate, yet when intoxicated self-harmed with the intention of suicide – it is the risk of this behaviour which should have been assessed rather than her sober presentation of reasonableness. Preston-Shoot states that long term, evidence-based views are required when responding to people with chronic and complex alcohol use – such as Marilyn's.[18]

7.3.4. The view that people are entitled to make unwise decisions can be taken out of context. The Mental Capacity Act Code of Practice states that "People have the right to make decisions that others might think are unwise."[19] The Mental Capacity Act has a more measured statement: "The following principles apply for the purposes of this Act… A person is not to be treated as unable to make a decision merely because he makes an unwise decision."[20] However, "For the purposes of this Act" is a critical caveat. This is not a general statement about the right to make unwise decisions in all contexts. Also, the word "merely" is relevant, the fact that the decision is unwise is not sufficient to conclude that the person lacks capacity, however it may be a relevant consideration to consider in determining whether a person is unable to make a capacitous decision,[21] for example if there are many repeated unwise decisions, taking in specific circumstances, a consideration of executive capacity[22] may be appropriate.

7.3.5. A Plymouth Safeguarding Adult Board SAR stated the following:

> "Whilst capacitated adults are considered self-determining, and in law have the right to make unwise decisions, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what can be done to support them in caring for themselves… In order to be able to work with a person who is self-neglecting and very reluctant to engage with support, it is necessary to create a relationship with them."[23]

7.3.6. The Blue Light Project have developed a Guidance manual[24] for professionals who may encounter people with problematic alcohol issues, who also have complex needs and who are not currently engaged with specialist alcohol services. The manual provides guidance on how to provide assertive outreach[25], along with details of the legal powers available to intervene when it is clear that a person's chronic alcohol issues may be putting them at high risk.

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[17] *ibid*
[18] *Ibid*
[19] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London, 2007) p.19
[20] Mental Capacity Act 2005 in Practice (publishing.service.gov.uk)
[21] Jenkinson, A. and Chamberlain, J., 'How misinterpretation of 'unwise decisions' principle illustrates value of legal literacy for social workers' Community Care, (28 June 2019)
[22] Executive capacity is the ability to carry out a decision.
[23] SAR Ruth Mitchell - safeguarding_adult_review_ruth_mitchell.pdf (plymouth.gov.uk) p.30
[24] The-Blue-Light-Manual.pdf
[25] This is a proactive approach to delivering support and interventions. It is used with people who have difficulties engaging with services. It is a way of organising services to provide an intensive,

7.3.7. Through the application of hindsight, this review has highlighted the difficulties practitioners faced when responding to Marilyn. However the narrow interpretation of the Mental Capacity Act made interventions impossible, as she was always assessed as having the capacity to make choices, even if they were unwise choices and even if they were choices made whilst having an impairment of the mind due to alcohol.

7.3.8. Marilyn was also not identified as an adult who required safeguarding, which is identified as a missed opportunity on many occasions. It could be argued that Marilyn had many care and support needs, around her alcohol misuse and her complex mental health issues – and particularly where these intersected and led to self-harm and suicidal attempts. From analysing the information available, Marilyn's vulnerabilities were generally assessed during sobriety and when she presented as articulate – her family described her being able to manipulate professionals and situations – and this appears to have happened throughout the period of this review.

## 8. Lessons to be learnt

### 8.1. Metropolitan Police Service

8.1.1. The initial closure of the rape allegation was premature and, as such, a recommendation for personal learning has been made and actioned by a member of the local senior leadership team. In addition there was an unacceptable delay in initially contacting Marilyn which would have resulted in personal learning for the original officer in the case if they had not already left the MPS.

8.1.2. The main strategic issues identified within this report are already being dealt with at a management board level and have appropriate plans in place along with senior officers leading their development and delivery.

### 8.2. Oxleas Mental Health Services

8.2.1. Recognition of the impact of historic domestic abuse and associated trauma to people's mental wellbeing needs to be better acknowledged through a domestic abuse and trauma informed practice training within Oxleas.

8.2.2. There is also a need to acknowledge that whilst recognition of domestic abuse is now a requirement in practice, clinical staff should also be supported to look at the options for support for that individual. A domestic abuse programme for all Oxleas clinical staff is currently in progress. This will support staff curiosity to enquire about historical and current abuse and ensure staff have some tools to support when a person discloses. It is important to acknowledge that support after abuse often does not require a clinical intervention, as peer support and counselling may also be beneficial. Marilyn was not signposted to these types of

assertive and comprehensive service, and challenges the idea that a client is always responsible for engaging with services and showing that they want support.

services in the past and she may have benefited from this type of support throughout the course of her life.

8.2.3. The Risk Assessment and Management Policy was updated in July 2022. Clinical risk assessment and management should always be an ongoing process and a review of the individual's history, risks and needs should be considered at key points in the persons care, this can include care plan reviews, serious incidents, changes in presentations and upon transfers to other teams. The clinical practitioners should always update the risk assessment and management plan accordingly.

8.2.4. Upon reviewing the report, Stephanie confirmed that she had attended a mental health appointment with Marilyn once, and she thought this would have been an ideal opportunity for the practitioner to take her contact details, and to request Marilyn's permission to use Stephanie as a contact on the occasions when Marilyn withdrew her engagement.

### 8.3 London Ambulance Service

8.3.1. There was a lack of exploration and professional curiosity when responding to Marilyn. This is also evident through the absence of formal mental capacity assessments during attendances where she was documented to be under the influence of alcohol – which was in the vast majority of attendance.

8.3.2. Since 2019, the Trust has implemented level 3 safeguarding training which encompasses in depth learning around domestic abuse, including how to recognise signs of abuse and how to discuss concerns with victims safely. Level 3 training is in line with the NHS Intercollegiate Adult Safeguarding: Role and Competencies for Health and Social Care Staff.

8.3.3. Domestic abuse stickers, which include the Refuge National Domestic Abuse Helpline number,[26] were introduced throughout LAS in 2020. These can be placed on the ambulance staff uniforms or on their service issued iPad, and it has the National helpline number for people to see. This may enable those who don't feel safe enough to disclose abuse to identify what support is available.

8.3.4. Since mid-2019 the LAS safeguarding team has expanded, now having six dedicated safeguarding specialists covering the five London operational sectors as well as the addition of a IUEC (Integrated Urgent and Emergency Care) safeguarding specialist. The role of the specialist is to provide training to staff, provide expert advice and support to the sector, to build relationships with key stakeholders both internal and external and to provide assurance of safeguarding in their areas.

8.3.5. Since July 2020, a governance and training support role has been in post which supports the training agenda and a learning database has been introduced, which logs and tracks all learning identified, and ensuring that recommendations from reviews have been implemented.

[26] Home | Refuge National Domestic Abuse Helpline (nationaldahelpline.org.uk)

### 8.4 Victim Support

8.4.1. Since the period of this review VS have introduced a new resource, called *Navigator* which allows all staff to access information on all VS areas including their referral/signposting destinations.

8.4.2. Across the country VS services are commissioned locally, by police and crime commissioners – which had led to different services operating differently, dependent on the local contract requirements. However, the National contact centre is funded, and utilised by all VS services. London Victim and Witness Service have a closer working relationship with the National contact centre, as they utilise them more – and there are currently in the process of renegotiating the relationship between the two internal services. A number of workshops have been held to improve the training offer, the communication between the services and the use of approved risk assessments in domestic abuse cases.

8.4.3. As a result of learning from this and other DHRs, the London Victim and Witness Service are currently working with the VS National contact centre to adopt best practice in relation to domestic abuse risk assessment – across both VS departments. This will result in a service level agreement (SLA), which will closely align the practice and key performance indicators of both departments.

8.4.4. There is currently an action plan in place to develop areas required for the SLA to function. Current actions include:

a. An update of internal referral forms, to include full needs assessment fields.
b. Piloting of asking five critical questions, to replace full DASH risk assessment.
c. Development of safety planning – including training for National Contact Centre staff.

8.4.5. Nationally, VS is in the process of building and introducing a new case management system, it is currently in the testing phase with transition to be implemented towards the end of 2023/2024. The objective of the new system is for all VS services – including the National contact centre – to have access to the same information across the UK. This will help facilitate cross referencing and avoid clients being signposted to other services within VS.

8.4.6. All VS Kent and Medway staff have been sent the briefing paper “Highlighting the link between Domestic Abuse and Suicide” completed by Kent & Medway Suicide Prevention Team.

### 8.5. Hospital Trust C

8.5.1. This review has highlighted the need for routine enquiry in the hospital setting.

8.5.2. The case has highlighted a need for review around actions to take when a patient chooses not to wait to be seen, and mental health concerns have been identified.

8.5.3. Hospital Trust C has introduced a question around domestic abuse concerns for all patients attending which must be completed before the notes are closed.

8.5.4. A domestic abuse update took place at an educational event in March 2023. Mandatory training continues annually, and clinicians are expected to achieve this in a timely way. Clinicians are followed up if this has not been done.

8.5.5. In December 2021 an educational session on routine enquiry for all staff with representatives was held – this involved Solace Women's Aid. There are plans to repeat this session.

8.5.6. Staff at Hospital C are also able to access Bexley Borough Council's domestic abuse training,[27] and can engage with the Bexley Domestic Abuse Health Subgroup, and local Domestic Abuse Operational Board.

8.5.7. A future protected learning time[28] session will include links to community-based services supporting people with EUPD.

8.5.8. This review has highlighted the needs for specific CPD modules for doctors and nurses around EUPD and other complex mental health issues.

### 8.6. Primary Care

8.6.1. Primary Care practitioners should refer patients to local domestic abuse services when domestic abuse is disclosed.

8.6.2. Primary Care practitioners in Bexley have access to Domestic Abuse Champions, and Primary Care Practitioners in Bromley have access to the IRIS[29] programme in their practices.

8.7. This review highlights learning around the identification of adults with safeguarding needs. Marilyn could have had an Adult Social Care referral considered. The GP was well placed to recognise the ongoing complexities of Marilyn's issues. Hospital letters and CMHT/HTT updates would have been sent to the GP, and when pieced together – as has been done for this review – it would have been clear that Marilyn was a high suicide risk and that her risk was increasing due to ongoing alcohol and mental health issues and the stressors of the court hearing and latterly criminal justice process.

### 8.8. Multi-Agency Responses

[27] Training for professionals - Bexley Domestic Abuse Services
[28] This is designated time for clinicians and practitioners to access and carry out essential training to support their work. Participation of the entire primary care workforce is encouraged at the training events.
[29] About the IRIS programme - IRISi

8.8.1. This review highlights a gap in multi-agency working when responding to a person with complex needs, who is resistant to engaging with services, and is facing multiple social stressors.

8.8.2. Marilyn told services that she was alcohol dependent, she was very open about self-harming and her wish to die. Marilyn told professionals about her debt issues, about the ongoing civil case, the rape allegation and about her non-recent experiences of domestic abuse. Marilyn also told practitioners about her increasing isolation from her family, the animosity with many family members and her deteriorating social networks.

8.8.3. None of these issues could have been addressed by one service alone – Marilyn needed to build trust and rapport with people before she engaged – and her personality disorder led her to push people away when they became too close. This information is all documented in her notes and was therefore known to individual services.

8.8.4. It could be argued that an Adult Social Care referral could have provided the opportunity for a coordinated response to Marilyn's needs. An allocated social worker could have identified and introduced suitable services to support with the financial issues, the emotional issues due to non-recent abuse and the fractured family relationships.

8.8.5. The current Primary Care Hub provision, introduced in 2022, could have also been a positive provision for Marilyn had it been in place during the review period.

8.8.6. Some people cannot afford private healthcare and do not meet the criteria for the specific therapy or support that will be helpful for them through the NHS. Wider health and care systems need to acknowledge this and look to the voluntary sector and partner agencies to consider additional support mechanisms for people who have experienced domestic abuse and require unstructured support and or therapy.

8.8.7. Healthcare staff need to be confident that appropriate, reliable and effective domestic abuse and therapeutic services are commissioned locally in order to embed routine enquiry into practice. Without services available to refer people to, staff are reluctant to ask about domestic abuse.[30]

8.8.8. All practitioners should be furnished with the details and scope of local services who can support with these social and environmental issues, and they should all be encouraged to provide information and preferably refer into these services. Practitioners should not assume that someone else will do this.

8.8.9. Practitioners should also be empowered to ask questions about social and environmental issues – being professionally curious about the person in front of them and recognising the whole person not just the small part they are presenting with.

[30] Bexley Domestic Abuse Services are available on the website Bexley Domestic Abuse Services

## 9. Recommendations

### 9.1 Oxleas

9.1.1. Clinical teams within Oxleas, including the Home Treatment Team (HTT) and ADAPT[31], to access learning around intersectional approaches, economic abuse, the impact of historical domestic abuse and trauma informed practice. Following access to domestic abuse training Oxleas clinicians will be required to routinely enquire about domestic abuse at client assessments when safe to do so. All staff will be aware of local domestic abuse services to refer to as needed.

9.1.2. This review will be shared with staff in order to illustrate the key opportunities to enquire about domestic abuse and to raise awareness of the ongoing impact of non-recent domestic abuse.

### 9.2 Primary Care

9.2.1 Bexley GPs to be reminded of the Domestic Abuse Champions Scheme and encouraged to nominate a Champion for their practice. This was a recommendation in a previous DHR[32] and is also a feature of the Bexley Domestic Abuse Strategy.[33]

9.2.2 To publicise the locally available domestic abuse referral services and training provision amongst GPs within Bromley and Bexley.

### 9.3 Hospital Trust C

9.3.1 Educational update on EUPD Services to be shared at educational event in October 2023.

9.3.2 To add mental health/EUPD specific modules to Bluestream mandatory training programme for clinical staff.

### 9.4 Multi-Agency Recommendations

9.4.1. Marilyn's case will be presented at a multi-agency learning forum to raise the issue of responding to people with complex needs, to raise awareness of alcohol misuse and legal powers – and to encourage all agencies, including GP Practices, to begin multi-agency/multi-disciplinary conversations when responding to cases such as Marilyn's.

[31] Our services | Oxleas NHS Foundation Trust
[32] https://www.bexley.gov.uk/sites/default/files/2022-02/bexley-dhr-andrea-overview-report.pdf
[33] Add Title (bexleydomesticabuseservices.org.uk)

9.4.2. The development of a multi-agency/multi-disciplinary response toolkit for working with people with complex needs and alcohol misuse issues. This will be included with the current toolkits available on the Bexley Safeguarding Adult Board website. This toolkit will support the commencement of conversations, and ongoing joint working processes, regarding people with complex needs.

9.4.3. All agencies will be reminded of the resources available on the Bexley Domestic Abuse website, and of the multi-agency domestic abuse training available from Bexley Borough Council.

9.4.4. Learning from this review will be shared with NHS England, to highlight the impact of the gap in availability of NHS provided structured psychological interventions for people with personality disorders.

9.4.5. All health partners to commit to publicising the "right to choose" NHS treatment on their websites.

9.4.6. A learning briefing will be developed to share across all services – this will provide reflective questions, and resources in respect of the following areas of learning:

(a) Alcohol misuse and legal powers

(b) Engaging with family members – including a Think Family approach to identifying the best person/support network for the patient

(c) Routine enquiry – including childhood trauma, or historic abuse

(d) Financial and economic abuse

(e) How social factors affect health – determinants of health[34]

[34] Determinants of health (who.int)