London Borough of Bexley Community Safety Partnership

Domestic Homicide Review
Overview report into the death of Marilyn - April 2022

Independent chair and author of the report: Dr Liza Thompson

Report completed: May 2024

TABLE OF CONTENTS

1. Introduction

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 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.

1.5 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.

1.6 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.

1.7. 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.

1.8. 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. Confidentiality

2.1 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2 Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Marilyn's niece.

2.3 Details of the deceased and perpetrator:

Name (Pseudonym)	**Gender**	**Age at time of death**	**Relationship to deceased**	**Ethnicity**
Marilyn	F	62	*Deceased*	White British
Ex-Husband	M	63	*Ex-husband*	White British

2.4 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	**Relation to deceased:**	**Relation to perpetrator:**
Gary	Son	Son
David	Son	Son
Stephanie	Niece	None

3. Involvement of family members and friends

3.1 Bexley CSP, the Independent Chair and all members of the DHR panel express their deepest sympathy to Marilyn's family and friends.

3.2 The Independent Chair obtained contact details of Marilyn's niece from police at the initial panel meeting in October 2022. Stephanie had been first at the scene and therefore police had her as the family contact.

3.3 Stephanie had indicated to the police panel rep that she would be happy for the Chair to contact her – and on 27th October 2022 the Chair sent Stephanie an introductory email.

3.4 Stephanie and the Chair met virtually on 4th November and again on 14th December 2022. Following the initial meeting the Chair sent a referral for Stephanie to Advocacy After Fatal Domestic Abuse (AAFDA), and the allocated advocate was able to join the meeting on 14th December 2022.

3.5 Following the second meeting, Stephanie reached out to Marilyn's son David, he agreed to speak to the Chair, and a meeting was set up for 20th December 2022. Although the Chair reached out to Marilyn's other son Gary, no contact was made with him throughout the review process.

3.6 Between Stephanie and David's information the Chair was able to gain an insight into Marilyn's life, and her struggles and challenges.

3.7 Without the input from Marilyn's closest family members the review would not have been able to reflect Marilyn's experiences. The Chair and panel are extremely grateful for the family's time, and for entrusting them with their precious memories of Marilyn.

Name of Advocacy Service	When was offer made and by whom?	Who was the offer made to?	Was the offer repeated/ advocacy taken up?
AAFDA	Offer made on 4th November 2022 by Independent Chair	Stephanie	Yes – advocate allocated in December 2022.
AAFDA	Offer made on 20th December 2022 by Independent Chair	Son	Not taken up at this time.

3.8. Following a slight delay due to a change in AAFDA advocate, the final draft report was shared with Stephanie in December 2023, and she met with the Independent Chair in February 2024. Feedback from Stephanie was included in the final version of the report.

3.9. Stephanie and her husband met with the panel on 22nd May 2024. The findings of the report were discussed, and following this meeting an additional recommendation was made. The panel were very grateful for Stephanie and her husband's candid and open approach to the review, and particularly towards the learning flowing from the review.

4. Methodology

4.1 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.

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

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

4.4 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.

4.5 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.

4.6 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.

5. Timescales

5.1 The DHR referral was received by Bexley CSP on 31st May 2022. As described above, the decision to hold a DHR was made on 9th June 2022.

5.2 The Independent Chair was commissioned in September 2022, and on 20th October 2022 the DHR panel met to agree terms of reference.

5.3 On 8th November 2022, the Independent Chair met with the IMR authors to brief them on the circumstances of the case, to share information with them from the family and a deadline of 23rd January 2023 was set for completion of the IMRs.

5.4 The panel met on 1st February 2023 to review the IMRs and to identify any further information required. A deadline for this further information was set as 3rd March 2023.

5.5 The panel met on 2nd May 2023 to review the second draft of the report – the first draft having been reviewed offline to expediate the process.

5.6 The final draft report was agreed in November 2023 and shared with Marilyn's niece in December/January 2024.

5.7 The Chair worked with Marilyn's niece to address additional queries which Stephanie raised and the final report was signed off in June 2024.

6. Specific issues to be addressed

6.1. 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.

6.2. 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.

6.3. 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.

7. Contributing organisations

7.1 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.

7.2 Each of the following organisations contributed to the review.

Agency/Contributor	Service Marilyn received	Information	Source of information
Hospital Trust A	Hospital D Emergency Department	Chronology	Review of paper files and electronic records on I-Care.
Hospital Trust B	Hospital B Emergency Department Neurosurgery Colorectal Care	Chronology	Review of paper files and electronic records
Hospital Trust C	Hospital C	IMR	Review of clinical notes from each of the 9 attendances during the scoping period.

	Urgent Treatment Centre		
Primary Care	GP Practice A Registered since January 2000.	IMR	Author spoke to Adult Safeguarding Lead at the GP Practice and reviewed Marilyn's full medical record stored electronically on the EMIS computer system
Metropolitan Police	Police officers were called for welfare purposes. Marilyn was a suspect and reported incidents throughout the scoping period.	IMR	All police contacts from the scoping period were reviewed and research conducted on the MPS and PND
Kent Police	Marilyn was a suspect and reported incidents throughout the scoping period.	IMR	STORM records – call recording system Athena – police information/intelligence recording system Internal police policy documents
London Ambulance Service	Responding to 999 calls, provide medical care to patients across the capital 24 hours per day, 365 days per year. 24-hour 111 integrated urgent care services	IMR	Search of records including 999 calls and electronic patient records
Oxleas Foundation NHS Trust Provides NHS treatment to people living in Bexley, Bromley and Greenwich	Mental Health Liaison Team (MHLT) – based in Emergency Departments (ED) – short term, initial assessment and recommendations for onward treatment. Mental Health Hub[1] – Single Point of Access for GP referring patients with secondary mental health needs. Brief intervention. Community Mental Health Team – longer term multi-disciplinary care. The Anxiety, Depression,	IMR	Clinical notes for Marilyn from June 2007 accessed. Serious Incident Review accessed.

[1] Previously called Primary Care Plus

	Personality and Trauma Disorders team (ADAPT). Regular but not intensive – time limited. Home Treatment Team – short term crisis assessment and intervention. Multi-Disciplinary team. Memory Team – referrals from GP.		
Victim Support National independent charity	Supporting victims and witnesses of crime. London Victims and Witness Service (LVWS) 24 hours support line and LVWS Inbound Caller Service. Victim Support Kent and Medway – core service to victims of crime.	IMR	Full and detailed search of all IT systems was conducted. The IMR Author also spoke with the staff member who had spoken with Marilyn – however she did not recall the conversation.
London Survivors Gateway	LSG provides aftercare for anyone over the age of 13 who lives in London and who has experienced sexual violence.	Summary of engagement	

8. Review panel members

8.1 The review panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Marilyn and/or her ex-husband.

8.2 The members of the panel were:

Agency	**Name**	**Job Title**
	Liza Thompson	Independent Chair
LB Bexley Community Safety Services	Deborah Simpson	Domestic Abuse & Sexual Violence Strategy Manager & Commissioner
LB Bexley Community Safety Service	Leslee Williams	Domestic Abuse & Community Safety Support Officer & minute taker
NHS Southeast London Integrated Care Board- Bromley	Dr Tessa Leake	Named GP Adult Safeguarding

London Ambulance Service NHS Trust	Jade Speed	South East Sector Safeguarding Specialist
Metropolitan Police Service	Justin Armstrong	Independent Review Officer
Lewisham and Greenwich NHS Hospital Trust	Ranjana Sharma	Safeguarding Lead
Solace	Donna Clayden-Sibley	Head of quality and Service Excellence
Hospital Trust C	Sarah Connelly	Deputy Medical Director for Unscheduled Care
Oxleas NHS Foundation Trust	Karen Laffar	Domestic Abuse Lead
NHS Southeast London Integrated Care Board	Philippa Uren	Designate Nurse for Adult Safeguarding (Bexley)
Bexley Safeguarding Adults Board	Anita Eader	Practice Review and Learning Manager
Victim Support	Rachel Nicholas	Head of Service
Adult Social Care	Susan Chandler	Head of Safeguarding Adults
Bexley Adult Safeguarding Board	Alexandra Bennett	Partnership Officer

8.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Marilyn and/or her ex-husband. The panel met on five occasions during the DHR.

9. Independent chair and author

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

9.2 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.

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

10. Other reviews/investigations

10.1. Coroner Inquest

10.1.1. Inquest hearing was held in February 2023, and Marilyn's cause of death was found as suspension. The coroner returned a finding of accidental death.

10.2. Metropolitan Police Service (MPS)

10.2.1. The duty officer supervising investigation into Marilyn's death identified that these circumstances fell within the MPS "death following police contact" definition, and as such a referral was made to the MPS Directorate of Professional Standards (DPS). Following a DPS review and fact-finding, the matter was referred to the Independent Office for Police Conduct (IOPC) as a mandatory referral on 21st April 2022. On 27th April 2022 the IOPC instructed that a local investigation be undertaken by the MPS.

10.2.2. Following Marilyn's death, the investigation into the allegation of rape was completed and reviewed by a police evidential review officer (ERO) who decided that no further action would be taken as the full code test for a successful prosecution was not met.

10.3. Oxleas NHS Foundation Trust

10.3.1. Following Marilyn's death, Oxleas Mental Health Service completed a Serious Incident Review as Marilyn had been under the care of the Home Treatment Team (HTT) between January and March 2022 and was referred onto ADAPT following this episode of care with home treatment team.

10.3.2. The findings of the investigation are included in the Oxleas' analysis below.

11. Publication

11.1 This overview report will be published on the website of the London Borough of Bexley Community Safety Partnership.

11.2. Family members will be provided with the website addresses and also offered hard copies of the report.

11.3 Further dissemination will include:

a. The Mayor's Office for Policing and Crime
b. The Domestic Abuse Commissioner for England and Wales
c. Local MARAC members
d. Bexley Safeguarding Adult Board
e. Bexley Safeguarding Partnership for Children and Young People
f. Bexley Community Safety Partnership
g. DHR Panel members and respective agencies

12. Background information

12.1. The information in this section was provided by David and Stephanie; and was also taken from the background information provided by agencies involved in the review.

12.2. Marilyn's niece described her aunt as beautiful and glamourous. Photos shared with the Independent Chair and the panel, show a well-presented woman, the anguish and trauma which is evident throughout agency case files is masked by her smiles. She said that Marilyn was intelligent, funny, and vivacious. When she was in a good place mentally, she was the best company. She had friends who she

had more recently met, and who did not know about her mental ill health; plus a few lifelong friends who did know about her mental ill health, and with whom she enjoyed meals, trips to the theatre and holidays and who supported her as best they could throughout her life.

12.3. Marilyn shared with agencies that her childhood had been difficult. Her mother had left the family home when Marilyn was seven and she described her father as being cruel to her. Stephanie told the Chair that Marilyn had spent some time in care as a child and it is also recorded in case notes that Marilyn told professionals the same thing, although this is not described in her health records. Marilyn reunited with her mother in her late teens and the relationship remained difficult.

12.4. Marilyn reported that she was asked to leave the family home when she was seventeen and this is when she met her ex-husband. They married aged twenty-one, Marilyn disclosed to professionals that there was violence throughout the relationship.

12.5. Marilyn was married to her ex-husband until 1991. The divorce was acrimonious, and the MPS had multiple contacts, with both parties at various times listed as victims, suspects or witnesses in multiple investigations. More recent contacts with MPS centre on family disputes in the wider sense, rather than any direct contact between Marilyn and her ex-partner.

12.6. David reflected that when his parents separated, his father withheld maintenance, stopped paying for the family home and as a result the family were homeless.

12.7. Despite being homeless and living in a variety of temporary and insecure tenancies, Marilyn ensured her children attended private schools. These were through scholarships, and David recalled doing his homework on bare wooden floors of a derelict house they were living in, whilst attending one of the most exclusive private schools in the country.

12.8. Stephanie told the Chair that Marilyn was very concerned about money, especially since she was dependent on spousal maintenance and Disability Living Allowance for her only income. In the last year of her life, she revealed to mental health services that she found the idea of losing the impending court battle to her ex-husband very difficult.

12.9. Marilyn acknowledged the impact of this relationship and that the on-going court cases were a cause of her significant mental health issues and she felt that the abuse continued via the court proceedings. In the last few months of her life Marilyn felt she was running out of options in terms of receiving the justice she felt she needed and was becoming increasingly frightened and panicked at this thought.

12.10. Stephanie described her aunt as being friendly and bubbly towards people until something would invariably happen which would lead to an argument and then often, she would push them away and the relationship would end.

12.11. Marilyn was a highly intelligent woman – described as sassy and bright. Stephanie described her aunt as being capable of manipulating language and David explained that she was able to talk herself out of many situations, including convincing professionals she was mentally well when she was not.

12.12. Marilyn's suicide attempts and self-harm episodes played a significant part in her life and are documented in the chronology below. It is probable that the trauma Marilyn experienced as a child, in the form of neglect due to parental mental ill health, with subsequent cruelty and abandonment - continued

into her adult relationship with her ex-husband - and contributed to her diagnosis of Emotionally Unstable Personality Disorder (EUPD), and Post Traumatic Stress Disorder (PTSD).

12.13. Stephanie described Marilyn as very creative and incredibly talented. Together, Stephanie and Marilyn were working on a business selling candles made in vintage teacups online.

12.14. The domestic abuse described by Marilyn continued in the form of financial abuse after she separated from her ex-husband – this led to homelessness for Marilyn and her children. When her sons were old enough, they purchased a home for Marilyn – it was this property where she lived until she passed away.

12.15. The details of Marilyn's sons are difficult to follow on the health records – however it is recorded that in June 2009 Marilyn told professionals that David was living with her, whilst Gary was living with her ex-husband. Marilyn described her relationship with David as supportive. David told the Chair that his relationship with Marilyn was difficult, although he made it clear that he loved her very much, he said she made it hard to love her at times due to behaviours which alienated him and other family members from her.

12.16. In 2011, Marilyn became a grandmother when her son Gary had his first child. However, she had very limited contact with her grandchild. Stephanie explained that this caused Marilyn great upset and turmoil and that Marilyn tried her best to stabilise her life in order to be a grandmother but that behaviours caused by the EUPD always ruined her efforts.

"*She was so full of love, and so desperately wanted to be loved in return."*

12.17. Health notes evidence that Marilyn had some contact with various friends, her sons and her mother prior to her death and Stephanie described a close relationship with Marilyn. It is thought that in later life Marilyn had less contact with friends and she acknowledged to professionals that the impact of her emotional health and her personality was a factor in this.

12.18. Stephanie stated that those closest to Marilyn would sometimes avoid calling her in the afternoon or evening as she would be intoxicated and be prone to angry outbursts.

12.19. Stephanie explained that Marilyn would pull people close and then push them away. She described Marilyn as very lonely – she had five granddaughters who she did not see regularly. Stephanie said she desperately wanted a happy family but would never have been able to maintain this. Stephanie believed that Marilyn had spoken about accessing Dignitas[2] as she wanted an assisted suicide – Marilyn would state that she really did not want to be alive anymore.

12.20. Following review of the completed report, Stephanie recollected "Marilyn was let down by her parents, by her ex-husband, and then by various health services. She was left feeling like there was no-one who could help her anymore"

[2] Home (dignitas.ch)

13. Equality and diversity

13.1 The IMR authors and the review panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, maternity, race, religion and belief, sex and sexual orientation[3] – and which of these characteristics may have shaped Marilyn's life experiences.

13.2 The panel agreed that the characteristics of sex would have shaped Marilyn's experiences – as she was a woman affected by male violence. The fact of Marilyn being a female and a mother would shape her experiences of domestic abuse and engagement with services, particularly when her sons were young.

13.3 Gender is the term used to refer to the socially constructed cluster of characteristics,[4] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[5]

13.4 Attributed masculine characteristics include toughness and the expectation that men will be violent.[6] Germaine Greer states that women are expected to be submissive in order to fulfil male fantasies of what is female "normality."[7] This includes an expectation of the inevitability of male violence[8] and the belief that women need to be protected by other men from this violence.[9]

13.5 The fear of male violence in society and in the home therefore puts men in the position of either predator or protector of women. Jennifer Nedelsky states that this culture of male violence is a constitutive force which shapes women's and men's lives.[10] Women take the fear of male violence for granted; they structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[11] Yet many in society continue to deny the gendered nature of violence against women.[12]

13.6 The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation and shame, exists on a deeper level. Elizabeth Stanko states that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should behave.[13] This gendered view about women's involvement in male violence which dictates that "good women avoid sexual and physical abuse; bad women don't"[14] is prevalent throughout institutional, societal and individual relationships.

13.7 There is also a societal expectation upon women to be caregivers and Martha Fineman states that "women's historic roles in the family anchor them to that institution in ways that men's historic roles do not."[15]

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[3] Equality Act 2010
[4] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56
[5] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265
[6] Hearn, J *The Violence of Men* (1998) p.36
[7] Greer, G *The Female Eunuch* (1993) p.11
[8] Stanko, E *Intimate Intrusions: Women's Experience of Male Violence* (1985) p.9
[9] Nedelsky, J *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2011) p.210
[10] *Ibid* p.204
[11] Stanko, above n 7 p.70
[12] Monckton, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender* (2014) p.19
[13] Stanko, above n 7 p.72
[14] *ibid*
[15] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56

13.8 The role of a "mother" is a universally possessed symbol[16] and has a value attached to it. Motherhood itself is affected by gendered norms to a greater extent than fatherhood.[17] As Alison Diduck asserts, there is an assumption in the relationship between a mother and her child of "never-ending love…timeless and universal duty… (a) romantic ideal…"[18] This gendered expectation of motherhood structures the mothers' lives inside and outside of the home – and more acutely when the mother is also a victim of domestic abuse.

13.9 Mothers are expected to protect children even if the family's difficulties are caused by other people.[19] A failure to measure up to this expectation can easily be construed as "pathological",[20] potentially leading to the removal of the children from the mother's care.[21]

13.10 Following the separation with her ex-husband, Marilyn raised the children alone, without the financial support of their father. This appears to have continued to affect her, in the sense that she pursued him through court, up until her death.

13.11 Despite the lack of financial and emotional support from other sources, Marilyn put her sons through private school. This appeared to have been an aim of hers as a mother. Her sons subsequently found good jobs and were able to provide her with a home in her later years.

13.12 The protected characteristics of sex and marriage intersect at the point of post-separation financial abuse. Upon marriage both parties are extended rights to one another's finances and income, unless an agreement to override these rights is reached before the marriage in the form of a pre-nuptial agreement.[22]

13.13 The Domestic Abuse Act 2021 recognises economic and financial abuse as specific forms of abuse. Financial abuse involves the misuse of money in order to limit and control another person's current or future actions or freedom of choice.[23] Financial abuse as a form of control was not recognised or understood in the 1990s when Marilyn and her ex-husband separated, but it is not difficult to recognise how the withholding of finances, leading to homelessness for Marilyn and her sons, would have shaped her experiences for many years to come.

13.14 Set against the backdrop of being subjected to cruelty and abandonment as a child, it is also not difficult to recognise how the relationship with her ex-husband during, and after, their marriage would have exacerbated Marilyn's mental health challenges.

13.15 Although the challenges Marilyn faced with mental ill health, and subsequently with alcohol misuse are not included in the Equality Act's protected characteristics, it could be argued that Marilyn's struggles with these issues made her particularly vulnerable and would have shaped her life experiences.

13.16. The Government recognise that there are often associations between complex needs and domestic abuse.[24] The 2016 National Crime Survey revealed adults who had taken illicit drugs in the last

[16] Fineman, M "The Neutered Mother" *University of Miami Law Review* 46 (1992) pp.653-54
[17] Boyd, S "Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility" *Windsor Yearbook of Access to Justice* 25 (1) (2007) p.65
[18] Diduck, A *Law's Families* (2003) p.83
[19] Scourfield, J "Constructing Women in Child Protection Work" Child and Family Social Work 6 (2001) p.82
[20] Clarke, K "Childhood, Parenting and Early Intervention: A Critical Examination of the Sure Start National Programme" Critical Social Policy 26 (2006) p.701
[21] Scourfield above n8 p.78
[22] Uniform Premarital Agreement Act 1983
[23] Financial and economic abuse - Women's Aid (womensaid.org.uk)
[24] Home Office *Transforming the Response to Domestic Abuse* (2018) p.10

year are more likely to report being a victim of partner abuse.[25] And substance use features in around half of intimate partner homicides.[26]

13.17. However, the relationship between problematic alcohol use, mental health and domestic abuse is not straight forward.[27] Mental health issues resulting from the psychological distress of domestic abuse may lead to the use of alcohol as a coping mechanism. [28]

13.18. Marilyn's alcohol use would lead to impulsive acts of self-harm and attempts of suicide which she later stated that she regretted. Her alcohol misuse was also a barrier to receiving psychological treatment at times and Marilyn was reluctant to address this apart from three weeks' abstinence in 2020 following online support from an addiction charity.

13.19. In 2006, Marilyn was diagnosed with Emotionally Unstable Personality Disorder (EUPD).

13.21. EUPD is characterised by pervasive instability of interpersonal relationships, self-image, mood, and impulsive behaviour. Sufferers experience rapid fluctuations from confidence through to despair, fear of abandonment and rejection. They have particularly strong tendencies towards suicidal thinking and self-harm, with transient psychotic symptoms, brief delusions, and hallucinations.[29] People with EUPD are particularly at risk of death by suicide.[30]

13.22. Marilyn was diagnosed with Post Traumatic Stress Disorder (PTSD) in 2022, however throughout the review of case files it is clear that symptoms of PTSD were evident throughout her involvement with services. PTSD is a mental condition that develops following a traumatic event – it is characterised by intrusive thoughts about the incident(s), recurrent distress and anxiety, flashbacks, and avoidance of similar situations.

13.23. As is detailed throughout this review, Marilyn struggled to manage her emotions, and struggled to maintain secure and trusting relationships, these issues are linked to both EUPD and PTSD.

13.24. Marilyn was also registered disabled. She was extremely clinically vulnerable during the COVID-19 pandemic due to a respiratory illness - Interstitial Lung Disease[31] – which she was diagnosed with in 2016. She also experienced pain from Cervical Spondylosis.[32]

13.25. Marilyn had made many suicide attempts and had also self-harmed over many years – however her niece Stephanie did not believe that she intended to complete suicide. No one will know for certain what motivated Marilyn to take her own life. As mental health professionals had identified, she may have felt despair at losing the civil case against her husband. However, throughout the review the panel remained mindful of the complexities of Marilyn's personal characteristics, her environment and the relationships

[25] Gadd, D et al "The Dynamics pf Domestic Abuse and Drug and Alcohol Dependency" *The British Journal of Criminology* (59) (2019) p1037
[26] Robinson, A et al "Findings from a Thematic Review into Adult Deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews" *Cardiff University* (2018)
[27] Gadd et al above n 25
[28] Iverson K et al "Predictors of Intimate Partner Violence Revictimisation: The Relative Impact of Distinct PTSD Symptoms, Disassociation and Coping Strategies" *Journal of Traumatic Stress* (2013)
[29] See borderline personality disorder information at Patient | Patient Accessed 28th April 2021
[30] Leichsenring F, Leibing E, Kruse J, et al; "borderline personality disorder" *Lancet* 1377(9759) (January 2011) 74-84
[31] Respiratory - interstitial lung disease - University Hospital Southampton (uhs.nhs.uk)
[32] Cervical spondylosis - NHS (www.nhs.uk)

which were interwoven in her life. This review will apply a sensitive analysis of all these factors when examining agency responses to Marilyn's specific needs.

13.26. The review will also consider discriminatory abuse. This is the unequal or unfair treatment of somebody on the basis of a protected characteristic. Discriminatory abuse can manifest itself as another form of abuse, such as harassment, derogatory remarks or similar treatment.

14. Chronology

14.1. The following section is a combined chronology of contact points and engagement between Marilyn and agencies, services and professionals.

14.2. Hospital D records show two self-harm episodes in 2009, and another in 2010.

14.3. Marilyn's GP Practice holds information about an incident where Marilyn attempted suicide by hanging in 2010 – she was admitted as a psychiatric inpatient at that time.

14.4. In February 2011, Marilyn attended the Hospital D Emergency Department (ED) following a deliberate overdose of diazepam and alcohol. She denied suicidal ideation, was seen by the Psychiatric Liaison Team and to be transferred to Oxleas Mental Health Services. Marilyn declined a transfer to Oxleas, stating she wanted to go home – and left the hospital without being discharged. Marilyn had declined to provide next of kin details so family were not informed. Police were alerted they located Marilyn and took her to an in-patient unit.

14.5. In January 2012, Marilyn attended Hospital D stating she had taken co-codamol with alcohol and had cut herself following an argument with her mother. It is recorded that she had a background of borderline personality disorder and acute depression, her mother had disowned her over the phone, and she had harmed herself. It is recorded that she had been receiving psychotherapy until December 2011. She was booked in for a psych review but self-discharged against medical advice.

14.6. During 2012 and 2013, there were reported incidents of harassment with Marilyn named as the suspect. The victims of the harassment were, on three occasions, David and his girlfriend, and on one occasion Marilyn's ex-husband and his wife. Marilyn received a caution for harassment for the above incidents linked to David in 2013.

14.7. In January 2016, Marilyn was diagnosed with Interstitial Lung Disease.

14.8. In June 2016, Marilyn called her GP with acute muscle spasm, she had taken co-codamol and diazepam to ease the pain. She stated she was still in pain; her cat had gone missing she was very stressed and had been drinking wine. She was advised to call an ambulance if her pain did not ease.

14.9. The next day she called an ambulance as her back had gone into spasm, it is recorded that she had taken medication and was drinking alcohol. On arrival it is documented that Marilyn was crawling on the floor and hyperventilating, she said she just wanted a shot of morphine and to go to bed. On examination the ambulance staff noticed old scars on Marilyn's wrist, and she reported previous suicide attempts, she also reported that she drank a bottle of wine each day. Following the assessment, she was conveyed to Hospital B where she reported depression and alcohol dependency – she was discharged with pain medication.

14.10. GP records indicate that on 13th June 2016 Marilyn's back pain was eased from medication and stretching exercises.

14.11. Throughout July and August 2016, Marilyn had ongoing chest infections, she had antibiotics prescribed. During July 2016 one of Marilyn's grandchildren were born and on 5th August 2016 she was very upset that the ongoing chest infection had stopped her from seeing her new-born grandchild.

14.12. On 23rd August 2016, the London Ambulance Service (LAS) was called to Marilyn's home where she was found bleeding from cutting her wrists. She was intoxicated and upset as she had recently had her cat put down. She had left a note saying sorry. She was deemed to have capacity for treatment, although no capacity form was completed to support this decision. She was taken to Hospital D, where she was treated and referred to the Mental Health Liaison Team – who assessed that Marilyn was not experiencing ongoing thoughts of suicide or self-harm, therefore no further action was taken. A Merlin[33] was sent through to the Multi Agency Safeguarding Hub (MASH),[34] and was considered at triage, with a decision for no further action. Marilyn's GP was provided with a copy of the Merlin and the decision.

14.13. On 5th July 2017 LAS were called for an ambulance to transfer Marilyn from Hospital C to the nearest ED, she was persistently vomiting and not able to hold down fluids. Marilyn had self-presented to Hospital C as she had been retching all afternoon. She reported being stressed as she had received a court bundle that morning, had not been able to eat at all and that she had consumed a bottle of wine that day – she also described herself as an alcoholic. When the ambulance arrived, she was crawling around the cubicle floor and was in distress, she was conveyed to Hospital D's ED. Marilyn was deemed by LAS to have full capacity at this time, although a capacity form was not completed to support this decision, because she was intoxicated. Medical notes from Hospital D indicate that the vomiting was likely to be on a background of excessive alcohol consumption – Marilyn was discharged with no follow up.

14.14. Three days later, Marilyn called NHS 111[35] and reported that she had been stung by a bee three days before, and her ankle was now swollen to double the size. She was advised to attend the local Urgent Care Centre[36] which was situated at Hospital C. Here she received a prescription for antibiotics and antihistamines – she was also asked about her alcohol consumption, and she stated she had "cut down a lot". There are no notes to indicate the rationale behind the questions about alcohol, although the staff may have remembered her from three days before – this is not noted.

14.15. On 11th August 2017, Marilyn contacted NHS 111 to request advice on medication, she had Moviprep sachets[37] and reported increasing severe pain in her upper stomach since starting to take the medication. She was advised not to take the second sachets and to contact an out of hours GP within two hours. Marilyn was spoken to by an OOH clinician and advised no further action needed following this.

[33] The Merlin System was created as a vehicle for police officer to deal with vulnerability. It allows the recording and sharing of concerns with partners in order to effectively safeguard members of the public.
[34] csc-mash.pdf
[35] Get help for your symptoms - NHS 111
[36] Urgent treatment centres provide medical help with it is not a life-threatening emergency. Other types of urgent care services are called minor injuries units or walk in centres. They can deal with many of the common problems people go to Emergency Departments for – there are GPs working at the centres and can also provide prescriptions.
[37] These are used to treat constipation.

14.16. On 21st August 2017, Marilyn contacted the MPS to report Gary's ex-partner for sending abusive emails. Officer recorded this as a civil dispute linked to contact with Marilyn's grandchildren and no further action taken.

14.17. Late night on 23rd January 2018, David contacted police stating that his mother had sent him a photo of a knife and blood. Upon arrival at Marilyn's property, she was seen through the window to be lying at the bottom of the stairs with a large amount of blood next to her and a knife could be seen. The property was locked but police knocked, and Marilyn eventually got up off the floor and let them in. She smelt heavily of alcohol and a bottle of wine was on the stairs – she was very emotional and unsteady and had a laceration to her forearm. She was agitated that David had called police and indicated suicidal ideation. Marilyn reported that she had a "bad hearing" at court, had drunk three bottles of wine, and had cut her forearm with a small kitchen knife. LAS were called, and staff assessed her and conveyed her to Hospital D – she was deemed by LAS to have full capacity, but a capacity form was not completed to support this as she was intoxicated. Hospital D treated the wound, and she was seen by Mental Health Liaison Team, but declined support from the Home Treatment Team. She complained that she had not received suitable help due to lack of funding and that when she was given help it wasn't for long enough. She said she had lost a court case that day and felt she had let herself down, would now have to pay a considerable amount of money – and this was why she had self-harmed. She was medically cleared and dropped home by officers. Marilyn returned to Hospital D the following day as the wound was swollen; this was treated with antibiotics.

14.18. GP practice had contacted Mental Health Liaison Team for information regarding Marilyn's ED attendance – GP was provided with details of the assessment and on 29th January 2018 they referred Marilyn to Primary Care Plus (PCP)[38] stating daily alcohol and stressors, including debt. She was telephone-triaged on 8th February 2018, and the initial plan was to discharge back to the GP, to make a referral to drug and alcohol and debt support. However, Marilyn reported that she did not drink every day, she was therefore offered a face-to-face appointment to further review, which she was ambivalent about and it was agreed that the team would give her time to think about it. She was recontacted on 12th February 2018 and offered an appointment with the dual diagnosis worker.

14.19. On 23rd February 2018, Marilyn saw the dual diagnosis worker. She requested Dialectical Behaviour Therapy (DBT) and stated she needed a social worker. She presented as angry and hard to engage. She refused to give details of alcohol intake or accept any support from alcohol services. She agreed some harm reduction techniques and referred back to her GP.

14.20. On 4th March 2018, an ambulance was called to Marilyn's property as she was experiencing chest pains, she reported a sharp pain in her left side, she believed this was anxiety following stress over family issues. She reported having drunk a bottle of wine and was conveyed by ambulance to Hospital B, although Hospital B have no record of this attendance. This lack of record of attendance may have been due to Marilyn leaving the hospital before being checked in by ambulance crew, but there is no way of confirming this.

14.21. On 18th May 2018, Marilyn requested weekly payments of her Employment Support Allowance (ESA)[39] as she could not manage on fortnightly payments.

[38] Primary Care Plus Pathway is a direct link between primary and secondary care services and focuses on tele-triage, providing direct advice and support to GPs and directing service users to the pathway that will specifically meet their needs.

[39] You can apply for ESA if you have a disability or health condition that affects how much you can work. It gives you, money to help with living costs if you are unable to work, and support to get back to work if you are able to.

14.22. On 5th July 2018, Marilyn attended Hospital C with a cut on her wrist from self-harming. Mental health support was explored with Marilyn, she stated "they are not interested and do not want to know" – she was discharged home with antibiotics and wound care advice.

14.23. On 3rd October 2018, Marilyn's GP referred her to Oxleas PCP service – the referral requested antipsychotics to help manage Marilyn's emotions. She had a telephone triage on 12th October, where Marilyn explained that she was dependent on diazepam and alcohol and had a diagnosis of EUPD. Her history of self-harm and suicide attempts was also noted. Marilyn was then discussed at a Multi-Disciplinary Team meeting on 15th October and a plan to offer an Outpatient's Appointment (OPA) [40] with a psychiatrist.

14.24. On 27th October 2018, Marilyn attended Hospital C with self-harm cuts to her elbow, however she did not wait to be seen.

14.25. On 20th November 2018, Marilyn's request for weekly payments was agreed and put in place for 6 months.

14.26. On 28th November 2018, Marilyn attended an OPA with a psychiatrist – where she underwent a detailed assessment. Following this assessment, the plan was to increase her pregabalin, she was advised regarding reduction of alcohol intake, and signposted to Citizens Advice Bureau and Mind for her social issues. She was also offered a follow up with the psychiatrist on 18th January 2019.

14.27. Upon receipt of the letter from the psychiatrist detailing the above information, Marilyn contacted her GP. She was very angry and complained that the assessment did not include complex trauma and felt she had been failed.

14.28. On 4th December 2018, Marilyn was placed on Limited Capability and Work-Related Activity (LWCRA)[41] for 12 months. An ESA113[42] was completed and indicated that there would be a substantial mental or physical risk if Marilyn were found capable of work due to a recent urgent mental health referral and a diagnosis that year of Emotionally Unstable Personality Disorder. The decision was for review in the "medium term."[43]

14.29. On 20th December 2018, an ambulance was called to Marilyn's property by a mental health nurse, concerned that Marilyn had been drinking and had taken an overdose. They called Marilyn, who was adamant that she didn't want an ambulance, she said she was in bed watching television and did not sound drunk. Ambulance was cancelled.

14.30. The next day, Marilyn called Oxleas' crisis line, she was distressed and reported that her ex-husbands family had reported her for benefit fraud. She was currently open to PCP, so they were informed.

[40] An outpatient appointment is a consultation with a healthcare practitioner, this could be a doctor or a nurse.
[41] The Limited Capability for Work Related Activity Group of Universal Credit is for claimants who the Department for Work and Pensions consider to have such severe health problems that there is no current prospect of their being able to undertake work or work related activities.
[42] This is a form for health care professionals to complete to advise the DWP of their patient's severe mental health issues.
[43] A medium term award means that review of the award will be undertaken within 18-24 months.

14.31. On 18th January 2019 – Marilyn did not attend her review OPA meeting. Her case was discussed between the Consultant and her GP, and she was discharged from PCP on 23rd January 2018.

14.32. On 6th March 2019, a significant weekly deduction was taken from Marilyn benefits due to water arears.

14.33. On 17th May 2019, Marilyn called NHS 111 reporting that she was stressed and feeling low. The call handler tried to triage the call, but Marilyn then reported she was fine and had to go, she declined a clinician call back. The call handler recorded that suicide and/or self-harm was not a concern, and the case was closed.

14.34. On 29th July 2019 Marilyn was sent an invitation to claim Personal Independence Payment (PIP)[44] and on 2nd August 2019 Marilyn called to make this claim – a claim pack was issued on 13thAugust 2019. On 5th September 2019 Marilyn contacted the DWP to request a paper-based assessment due to mental health difficulties, and the caller completed the form with her. Further medical evidence was received by DWP on 16th September 2019. On 25th September 2019 she called DWP to advise that the assessment process was causing her distress which was affecting her mental health.

14.35. On 2nd October 2019, a referral was sent to Marilyn for a Work Capability Assessment (WCA)[1], this led Marilyn to call DWP very distressed, asking why she had another assessment when it was not twelve months since the last review. She completed the ESA50 and returned it on 7th October 2019. She is recorded as being vulnerable due to numerous suicide attempts. The GP provided a letter on 7th October 2019, stating that her mental health had not improved since the last assessment – she has frequent suicidal ideation and feelings of despair. Her assessment was delayed for a further 12 months.

14.36. On 13th November 2019, Kent Police attended the home of Gary's ex-partner, in response to calls from Marilyn expressing concerns about her grandchildren. On attendance the ex-partner provided attending officers with years of abusive messages from Marilyn – as a result Marilyn was identified as a suspect for harassment.

14.37. Marilyn recontacted police attempting to retract her statement, she was extremely upset and said that she wished she were dead. As a result of this call Kent Police requested MPS conduct a welfare check on Marilyn. This led to LAS being called to Marilyn's property. Marilyn refused to open the door to LAS staff, she came to side window and stated that she hadn't requested an ambulance and asked them to leave. She appeared well and deemed to have capacity; LAS staff left the scene.

14.38. On 22nd November 2019, weekly ESA payments were agreed for the life of the claim.

14.39. Contact with Marilyn as a suspect for harassment against Gary's ex-partner was attempted on several occasions with this being achieved in January 2020. Marilyn stated she could not be interviewed by Police at that time as she was undergoing treatment for her mental health. Contact was made again later in January 2020 when Marilyn stated that she was home from her treatment but was on an alcohol withdrawal programme. She stated her physical and mental health was too poor for her to be interviewed at that time.

14.40. Conversations with both Gary's ex-partner and Marilyn highlighted that there were a number of allegations and counter allegations on both sides. It was decided that due to Marilyn's health issues it would

[44] Personal Independence Payment (PIP): What PIP is for - GOV.UK (www.gov.uk)

not be in the public interest to pursue any criminal prosecutions and words of advice were given to both parties. Gary's ex-partner had also disengaged with police; therefore, no further action was taken,

14.41. On 6th January 2020, Marilyn reported to police that she had received abusive emails linked to a dispute with her sons. When police attended the following day, she stated she wished to cancel police attendance. The issue was believed to be linked to Marilyn wishing to see her grandchild. No further action taken.

14.42. On 27th January 2020, Marilyn called police alleging that Gary's ex-partner had taken money from her account on 13th January 2020 without permission, this was via a food delivery app. It is recorded that she was distressed, felt that her family were against her, and she referred to herself as an alcoholic. The officers reported that Marilyn was very sporadic with information and would often go on a tangent – the food delivery service was contacted, and she was reimbursed.

14.43. On 29th January 2020, Oxleas PCP service received a referral from Marilyn's GP, which stated low self-esteem, anxiety and mood swings – along with a request for therapy. The referral was telephone triaged on 12th February 2019, where Marilyn disclosed anxiety, alcohol dependence and reduced impact of Diazepam on her sleep. Marilyn stated that she had a PIP review upcoming, and that her mother had recently passed away. She was also not happy with her experiences of mental health services. The outcome of the assessment was a referral to ADAPT psychological therapies, which was rejected due to her alcohol use. Marilyn was subsequently discharged back to the GP on 20th February 2020.

14.44. Between 29th January 2020 and 20th February 2020, Marilyn was supported by Oxleas' PCP, following a GP referral. She reported anxiety, alcohol dependence, using diazepam to sleep, she said she had a PIP review upcoming and that her mother had passed away. She is recorded as having low self-esteem, mood swings, and requesting therapy. She was referred to ADAPT psychological therapies, but this was declined as her alcohol use did not meet the service criteria. She was not happy with the mental health services provided to her. She was recommended to attend Bromley Drug and Alcohol Service (BDAS)[45] prior to any therapy. There is no indication that Marilyn accessed BDAS.

14.45. On 17th February 2020, DWP sent Marilyn a PIP review form – she called them unhappy about this and was advised that the assessment providers would look at a home assessment. Marilyn was very upset about this as she was given an indefinite award of Disability Living Allowance (DLA)[46] – she was provided with an explanation for the change to PIP and the assessment process – Marilyn remained upset. The PIP assessment was completed two days later, the report was sent to the DWP, and an award of standard rate for daily living and standard rate for mobility was awarded, and a letter sent detailing this on 8th March 2020.

14.46. Marilyn called DWP on 10th March 2020, as she was unhappy about this award, as she had previously been in receipt of higher rate DLA care and lower rate mobility before she was transferred to PIP. She provided medical evidence on 11th and 27th March 2020, with a request to reconsider the award.

14.47. On 11th June 2020, the award was increased to enhanced rate for daily living and for mobility – Marilyn was informed the same day.

[45] This service is now provided by Change Grow Live drug and alcohol services following recommissioning of the services London Road - Drug & Alcohol Service - Bromley (changegrowlive.org)

[46] Disability Living Allowance is a monthly payment to help with care and mobility needs if you are living with a disability. This is being replaced by Personal Independence Payment.

14.48. On 13th August 2020, Marilyn attended Hospital C urgent treatment centre with a cough and a sore throat, she had a chest examination and was discharged home. Two days later she called NHS 111 requesting advice on blood pressure increase, she was given home management advice.

14.49. On 16th August 2020, Marilyn called police to report her neighbour's behaviour and damage to her car.

14.50. On 2nd September 2020, police called LAS with concerns about Marilyn. She had called police about her neighbour and had stated she felt low. Marilyn spoke with call handler and stated she did not need an ambulance; her issue was with the neighbour.

14.51. Police attended Marilyn's property on 10th September 2020 following the report about her neighbour to police on 26th August 2020. Marilyn had footage of her neighbour on that day, he was swearing and shouting and throwing rubbish around. She stated that the incident had upset her which had led to her self-harming. She did not want any referrals to outside agencies and did not want to disclose what had happened. Police spoke with the neighbours who apologised and stated that Marilyn's behaviour was not acceptable, she had been constantly making degrading comments and shouting verbal abuse at his family. Bexley Council were aware of the issues caused by Marilyn – however there is no record of an ASB case against Marilyn, at this time or any other, as Bexley Council have no record of her.

14.52. On 10th October 2020, Marilyn contacted NHS 111 reporting an eye infection – she was given home management advice.

14.53. On 15th November 2020, Marilyn alleged to have been receiving malicious communication from her ex-husband's family. It is recorded that there had been ongoing issues between them for 30 years. A crime report was created for sending letters with intent to cause distress and the case was closed with no further action (NFA) as it did not reach the threshold for a successful prosecution.

14.54. On 12th January 2021, Marilyn contacted NHS 111 and reported that she was experiencing stress, anxiety and had a rash on her face. She was advised to attend Hospital C.

14.55. The next day, Marilyn reported to police that Gary's ex-partner had sent false information to "Track and Trace"[47] to cause her to isolate, this was to stop her seeing her grandchildren. The issue was NFA'd.

14.56. On 16th January 2021, LAS were called to the property following a report that she had taken over 60 tramadol[48] tablets the previous night. They found her in bed, family were also on the scene and reported a long history of depression, self-harm and countless overdoses. The family further reported they were exhausted by Marilyn's behaviour. She was nauseous and shaky. She was conveyed to Hospital D. It is documented that at Hospital D, a discussion was held with a senior manager regarding a safeguarding referral – however there is no documentation around safeguarding.

14.57. Marilyn was admitted as an inpatient at Hospital D. The next day, on 17th January 2021, the consultant discussed Marilyn with the Liaison Psychiatry Team's (LPT) Clinical Nurse Specialist (CNS) at around 5pm. They explained the reason for Marilyn's hospital admission, stated she was clearly a high

[47] The locate and trace app was introduced in May 2020 to assist with reducing the spread of COVID-19. Those who tested positive for COVID-19 would register this on the app, and anyone who had been near to them (via the GPS on the app) would receive an alert and would have to self-isolate for ten days.
[48] This is a strong opioid painkiller

risk of further overdose and did not want to risk sending her home to re-present with a further overdose. The consultant asked for an urgent review to see whether Marilyn could be discharged from a psychiatric perspective. There was no one available that evening to complete the assessment – this put the medical team in a challenging position as they would have to assess whether a DoLS[49] was required, and they felt that she had capacity. It was agreed that LPT would attend in the next hour unless an urgent ED case came up. In the meantime, they advised if she tried to leave to put her under Section 5(2).[50]

14.58. At 1am on 18th January 2021 the patient was assessed by the on-call doctor advised the nursing team that Marilyn could leave and would be seen by the Home Treatment Team – she was assessed as well – LPT also confirmed that Marilyn could go home but advised her to wait for her "summary of care" - Marilyn left without this, stating she didn't need the summary.

14.59. Psychiatry notes from that evening included that Marilyn was well kept and appropriately dressed in winter coat. She had engaged well, maintained eye contact, and had a good rapport – she described her mood as "okay". She described her mood at the time of the overdose as minus 25 out of 10, and this had now improved to an 8 out of 10. Her speech was spontaneous, normal tone and volume, coherent and relevant – her thoughts were recorded as free-flowing, no active thoughts of self-harm or suicide, no delusional beliefs – no perceptual abnormalities – well orientated to time and place. She acknowledged her background diagnosis, her feelings of low mood, her self-harming behaviours and current need for treatment. She declined an informal admission but was happy to engage with home treatment team support. She was able to weigh all information and use them to make her decisions – she communicated that she wanted to engage with Home Treatment Team and continue with Prozac, she stated she didn't have any plans for future suicidal attempts and felt she had upset her friends and family due to her actions. She was discharged to Home Treatment Team.

14.60. From 18th January 2021 to 30th January 2021, Home Treatment Team had input with Marilyn – she had a psychological and medical review. She had emotional support via a Telephone Wellness and Recovery Plan. She stated her relationship with her sons were not good, she had a few friends, and problems with neighbours and her physical health was poor. She was engaging with online addictions work. She was often hostile, irritable, and abusive towards staff, accusing them of lying and not helping. There was a dissonance between wanting and seeking help and putting barriers up. Her medication remained the same.

14.61. On 4th April 2021, a vulnerable adult report was created by police. Marilyn had contacted a friend saying he was the only person she could trust and that she wanted to die. On arrival at the property Marilyn was intoxicated and said she had taken tablets – she stated that she had a personality disorder and post-traumatic stress disorder and depression. A full mental capacity assessment was completed, and Marilyn was assessed as medically fine with capacity, she said she just wanted to sleep. She said her friend's message was misread and had no intention of hurting herself. She did not want to go to hospital and was left at home in the care of her friend. A referral was sent to Adult Social Care (ASC).

14.62. Late on 16th April 2021, Marilyn contacted NHS 111 and reported that she had a chest infection and was experiencing pain in her lung below her shoulder blade. NHS 111 requested an ambulance and

[49] The Deprivation of Liberty Safeguards – this is a procedure prescribed in law when it is necessary to deprive a resident of patient of their liberty because they lack capacity to consent to their care and treatment in order to keep them safe from harm.

[50] Mental Health Act 2007 s.5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time the patient should receive an assessment that decides if further dentition under the Mental Health Act is necessary.

Marilyn was conveyed to Hospital D at 2am on 17th April 2021. She is recorded by LAS as being disoriented and hectic. Once assessed at hospital she is recorded as being alert and explained that she was concerned about pneumonia as she had been taking prescribed medication and it had not improved. She was discharged home after a full examination.

14.63. On 14th May 2021, Marilyn called police to report historic domestic abuse by her ex-husband between 1988 and 1989. She provided details of incidents including suffocation and rape. She provided a visually recorded interview and the investigation was closed without any interaction with the suspect.

14.64. On 30th June 2021, Marilyn called Oxleas' crisis line requesting medication. She called them again on 16th July 2021 with no clear reason for the call.

14.65. On 11th September 2021, Marilyn called NHS 111 as she had been stung by a bee and was in pain with a swollen foot. She was advised to attend Hospital C for a face-to-face assessment – which she did the same day and was discharged home.

14.66. On 20th September 2021, Marilyn called Oxleas' crisis line, initially she was talking about a GDPR[51] breach and expressing concern for her grandchildren's welfare – she was also chasing up the Bromley Anxiety, Depression, Personality and Trauma (ADAPT) referral which had been made in February 2021. The crisis line team chased up this referral. The ADAPT team acknowledged that the initial referral had been overlooked and scheduled a discussion about the referral at the Multi-Disciplinary Team (MDT) referrals meeting on 24th September 2021.

14.67. On 24th September 2021, Marilyn contacted Oxleas' crisis line expressing concerns about her grandchildren and chasing ADAPT referral.

14.68. Also on 24th September 2021, the ADAPT referral from February 2021 was discussed at the MDT referrals meeting. This referral had been overlooked until Marilyn had chased it up when she called crisis line. It was decided that Marilyn did not meet the threshold because the severity of her symptoms and the impact on her function was not great enough to require secondary care. Marilyn and her GP were advised to contact Mind in Bromley however she was reluctant to do this and did not acknowledge her alcohol misuse as an issue.

14.69. On 4th October 2021 Oxleas received GP referral to PCP, stating that Marilyn was experiencing anxiety and depression and wanted input from a psychologist. Her main concerns were regarding Gary's ex-partner, and her grandchildren being neglected. It is recorded that social services were involved. This referral was declined.

14.70. On 7th October the GP received the outcome of the ADAPT referral decision which had been made on 24th September, which stated that the multiple contacts highlight Marilyn's primary issue is regarding managing emotions, for example anger and there was no indication for secondary mental health.

14.71. On 7th October 2021, Marilyn had a telephone consultation with her GP. It is recorded that she had stopped drinking in January 2020, and she enquired again about the ADAPT referral made in

[51] This is a security incident leading to the accidental or unlawful destruction, loss, alteration, or unauthorised disclosure of, or access to, personal data transmitted, stored, or otherwise processed by an organisation.

February 2021. Marilyn stated she was eager to try DBT and was stressed about a court hearing the following Monday.

14.72. On 15th October 2021 was seen at the Oxleas Mental Health Hub.

14.73. On 21st October 2021 Marilyn had a telephone consultation, she was swearing and ranting about Oxleas who had stated she should attend Mind in Bromley as she had anger management issues. Marilyn had called Mind in Bromley and was told she was out of area for their services. She was worried about hair loss and one of her toes was peeling and painful. She thought she needed DBT but the psychology and ADAPT team did not think so. She was worried about her memory, her mother had dementia. She was given advice about attending ED if she had self-harming thoughts but did not want to attend hospital through fear of being sectioned. The GP summarised the issue as EUPD.

14.74. On 29th October 2021 Marilyn called her GP practice very upset, and stated she was having flash backs about bestiality – she was crying and requesting to speak to her GP. The GP called her back and she explained that she was having flashbacks about the abuse, as she was preparing for her court hearing the following Tuesday. She called Mind in Bromley; they had not called her back. She stated she had not been drinking, GP unable to judge this, due the level of emotions Marilyn was displaying. She was stressed about the court case on the following Tuesday, she had run out of diazepam despite having been prescribed enough for the week. The GP agreed to prescribe an additional six diazepam the following week.

14.75. On 16th November 2021, LAS were called to Marilyn property following a report that she was feeling suicidal. On arrival it was documented that Marilyn was not expecting an ambulance, she invited them in. She was alert and orientated but tearful and old scars were evident from previous self-harm. She reported being under stress due to an ongoing legal case involving her ex-husband, she also reported feeling let down by her local mental health services. Marilyn had consumed half a bottle of wine but was not intoxicated. Marilyn was left at home and referred to mental health team.

14.76. On 19th November 2021 Marilyn attended a smoking cessation session. She told the GP that she has a high court warrant to pay £2000, she had not been called back by Citizens Advice Bureau for help, or Mind in Bromley. She requested a Do Not Resuscitate to be added to her files. She spoke about her memory loss, and believed she had dementia as she used to have a photographic memory.

14.77. On 23rd November 2021 LAS attended Marilyn's property following a call from a member of the public to police. On arrival Marilyn reported that she had a call from police with regards a court case and she had become distressed, police believed she was having a mental health breakdown. Social stressors were shared regarding the ongoing court case and information sharing at court about her mental health. She expressed anger at police, the court system and mental health services. Advice was provided to Marilyn, to contact Oxleas Crisis Line when in distress or crisis, and Marilyn was left at home on this occasion.

14.78. Between 19th November 2021 and 20th December 2021, Marilyn was assessed by the Bromley Memory Service following a referral by her GP. Marilyn had complained of her memory getting worse, that she was experiencing stress from her daughter-in-law and was no longer drinking. She stated a history of dementia in the family. A thorough assessment with nurse, psychologist and psychiatrist, an MRI scan and her bloods were taken. Her history of EUPD, anxiety, depression, suicide attempts, and self-harm was articulated. She stated stressors were her relationship with her sons, an ongoing court case and feeling like her mental health had been shared incorrectly as part of the court judgement. Brain

scans were returned as normal, and no dementia was identified. The GP was informed, and Marilyn was closed to the service.

14.79. Marilyn sent an email to the GP practice on 5th January 2022 asking for an increase in diazepam due to:

> "Extreme anxiety. I cannot stop shaking. My heart keeps pounding, I cannot sleep. The tears keep falling and as I am trying to keep myself together, I can't. I am having severe headaches. I have a court hearing on 14th and I have to concentrate and conduct myself coherently which I can't. The psychiatrist confirmed I am dealing with insurmountable anxiety and stress, and he said he was writing to you. Please can somebody call me."

14.81. The GP Practice called Marilyn back and she stated she had contacted her local MP to help her get money back from the legal case against her ex-husband. She stated that her ex-husband had breached confidentiality.

14.82. A medication review was conducted by Marilyn's GP on 10th January 2022, with her medication remaining the same. On 13th January 2022, Marilyn had an urgent care review at Hospital C.

14.83. On 15th January 2022, Marilyn called Victim Support's "Support Line" regarding historic abuse. She told them that she had spoken to "Women's Rights" on 14th July 2021 – although when contacted Rights of Women[52] confirmed that they had no record of speaking to Marilyn, so it is unclear who this organisation was. She told Victim Support that on 28th June she had a video interview with police. She recalled that she'd asked the police "please don't make me go through this if they are not going to follow it through". She further recalled that after a month the sergeant had said it was going to remain live, but they were not taking it any further. She had contacted the CPS, was feeling suicidal with no means to carry this out. She was asked what area she lived in and stated "Kent" so was directed to the Kent team for ongoing support, which she was happy with and said she would ring them the following morning.

14.84. On 17th January 2022, Victim Support's Kent Line received a self-referral by telephone – she left a voicemail regarding historic and ongoing harassment for ex-husband and requested a call back. She stated that she was a victim of historic abuse and the "national line" had told her that she "badly needed support". She said that "the police won't do anything because he'll give a no comment interview…the CPS have said they absolutely would have done had the case gone forward to them." She stated "I've complained to the police three times…please can somebody call me, I'm desperate. My ex-husband is now inciting me to commit suicide and that exactly what he is doing and I just don't know how to stay alive."

14.85. The Victim Support Kent Line called Marilyn back, following her voicemail, Marilyn explained that her ex-husband had come into inheritance, and she had contacted the courts to increase her maintenance payments. She spoke about years of abuse from the ex-husband. She stated there was a court case ongoing regarding her daughter in law applying for an injunction against Marilyn to stop her seeing her grandchild. She expressed suicidal thoughts and was awaiting the finalisation of her will before she does anything. She stated she needed support for ongoing and historic intimidation from her ex-partner and that this was being allowed through the courts. Marilyn felt that the police had not dealt with the situation adequately and her complaints to the IOPC had not been actioned. She had received an email stating they wouldn't be taking any action. She said she had spoken to her GP the same day and

[52] Rights of Women - Helping Women Through The Law Rights of Women | helping women through the law

said, “I cannot die today”. She was advised that because she lived in the London area, she would be supported by London Victim Support and she was provided with the contact details and advised to call them. The Victim Support worker explained that the completion of a DASH was required to ascertain the risk level and Marilyn ended the call as someone had entered the room.

14.86. Also on 17th January 2022, Marilyn called Victim Support’s London inbound line stating she was a victim of historic sexual violence. She stated that she was struggling to cope with the aftermath of the crime. She was signposted to the London Survivors Gateway (LSG) Line for further support.

14.87. Marilyn called LSG the same day. She spoke with a support worker at around 11am, about feeling suicidal and her struggles with navigating the criminal justice system following the report of rape. The LSG support worker contacted Marilyn’s GP and explained their concerns for Marilyn’s suicide risk. The LSG also obtained consent from Marilyn to make a referral to PCP – which they completed at around 3pm. By 4.45pm the GP had returned the support worker’s call and agreed to speak with Marilyn.

14.88. The GP called and spoke with Marilyn via telephone. Marilyn stated that the family court hearing had not gone well, she required more diazepam and was told that the GP could not prescribe anymore as the last time was a one off due to the court case looming. She stated that since the last court hearing she had to produce lots of figures which she cannot do. The GP recommended a referral to a social prescriber who could help with preparing the court case. She stated that she could not get a counsellor on NHS and couldn’t afford one privately.

14.89. On 19th January 2022, LSG support worker contacted Marilyn and completed an assessment of risk. They also contacted Family Matters to discuss a referral.

14.90. On 20th January 2022 the LSG referral was received by PCP. The referral stated that Marilyn was having panic attacks and thoughts to end her life. It is stated that her ex-husband came into inheritance, and she had contacted the courts to increase her maintenance payments. She disclosed years of abuse from him. She also stated there was a court case pending which was pertaining to an injunction against her seeing her grandchild. She stated she would finalise her will then take her own life. This referral led to an urgent referral to HTT.

14.91. LSG followed up with the GP on 20th January 2022 and was told that the referral had been expediated. They spoke to Marilyn again on 21st January 2022 to check on her welfare. LSG were advised that HTT would be working with Marilyn.

14.92. On 21st January 2022 the HTT called Marilyn, who said the caller, “thank god you speak English” – when invited to a medical review she stated, “I’m not coming there to see somebody who can’t speak English, I don’t speak or understand Pidgeon English and I am not coming to the hospital to be sectioned”. She then terminated the call. Staff tried to call her back after some time to cool off.

14.93. The LSG support worker called Marilyn again on 25th January 2022 and was told that the HTT psychiatrists was calling Marilyn daily. Marilyn stated she felt much better and was happy with the support that LSG had given her.

14.94. Marilyn was open to the Bexley HTT from 21st January 2022 to 4th March 2022. During this time, she had thirteen face-to-face appointments, twenty phone calls and two medication reviews. The visits and phone calls supported Marilyn on a range of presenting issues and psychosocial support was offered,

around physical health, monitoring symptoms of risk, medication management and offering practical support.

14.95. During this time, she also had a psychological assessment and review which formulated Marilyn as having EUPD and PTSD from rape and emotional and physical abuse from her ex-husband 30 years before. She felt she needed justice for this, hence her need to pursue him through civil court. However, the themes throughout the contacts was she was running out of options, and this frightened her – leaving her feeling there was "no point."

14.96. Marilyn reported as feeling let down by most services and continued to show defensive and agitated behaviour and was untrusting. However, she was able to be more vulnerable with some staff.

14.97. On 1st February 2022, Marilyn contacted her GP Practice, concerned about the Zolpidem medication she had been prescribed for sleep – she stated she only trusted GPs at her practice, had not been sleeping and could not stop shaking. GP called her back, she stated she was booked to see the psychologist the next day, she stated she hadn't slept for 8 months, was due back in court, had tried multiple solicitors, was under the crisis team and stated she was scared and tearful and panicky. The GP assured her that short term use of the Zolpidem, whilst the court case was proceeding would not be problematic.

14.98. Following Marilyn's request, the rape investigation was reopened on 8th February 2022, under the Victims Right to Review Protocol.[53]

14.99. On 9th February 2022 it is recorded in the HTT notes that Marilyn had been advised that the rape allegation was being reopened by police, she was relieved about this but stated she knew it would be difficult. The psychologist felt that private therapy that was unstructured would benefit given the reopening of the court case. A report was sent to Marilyn and her GP.

14.100. On 23rd February 2022, DWP commenced a £16.34 weekly deduction from Marilyn's benefits.

14.101. On 11th March 2022, Marilyn had a phone consultation and stated she had an adverse reaction to Quetiapine, making her feel unwell and drowsy. She requested to return to Fluoxetine, GP agreed to try this again and to gradually increase. Advised to call 999 if any plans to self-harm or suicidal thoughts.

14.102. GP called again on 14th March 2022, Marilyn sounded calmer and more reasonable, she had taken the diazepam over the weekend and would have a further five days prescribed. She was due for an ADAPT follow up and stated she felt very drowsy when she took Quetiapine and had disposed of it, she stated Mirtazapine made her feel sick. It was suggested that she retry Prozac, she was also given medication for her breathing and cough. Sleep was still posing a problem, ADAPT had prescribed Promethazine and it had helped.

14.103. On 20th March 2022, Marilyn called police to ask why officers were not dealing with her investigation. She stated that she was contacted last weekend and was told that investigating officers would be back in touch the following Tuesday, but she had not heard anything. She said she had not heard anything from police since February 2022. She spoke about a breach of penal order and was advised this was dealt with by civil courts. The report was forwarded to the line manager of the Officer in Charge (IOC).

[53] Victims' Right to Review Scheme | The Crown Prosecution Service (cps.gov.uk)

14.104. On 21st March 2022, Marilyn had a further GP phone consultation, stating there was lots of stress with the police and court cases. She stated she was eager to go up on Fluoxetine due to depression feelings, she was denying self-harm, suicidal thoughts and plans. She was remaining on weekly scripts only for safety.

14.105. On 22nd March 2022, Marilyn called police to follow up on the report of rape. She stated it was not acceptable and wished for a Detective to call her. Records indicate that a Detective Sergeant had attempted to call her on 20th March 2022.

14.106. On 27th March 2021, an ambulance was requested to Marilyn's address following a local MP receiving an email from Marilyn stating she had self-harmed. Upon arrival, Marilyn asked the crew to leave. The Crew checked her injury which was no longer bleeding and following a brief assessment the crew left Marilyn at home.

14.107. On 29th March 2022, Marilyn had a GP phone consultation, she requested historic papers about being hit in the back by her ex-husband while she was pregnant in 1983. She stated that her previous GP in Town X had the notes about this. She was very anxious as she was taking her husband to court for historic abuse and rape, she was advised to contact the medical reports team, but it was likely that the police would contact the GP to request a report. She stated that she had cut her wrists last week due to stress.

14.108. Around this time a referral was made by LSG to the South London Rape Crisis Team. At that time, they held a 22-month waiting list

14.109. On 4th April 2022, Marilyn had a phone consultation with her GP, she stated she had not been self-cutting anymore, her wrist was not healing and was advised to see the nurse. Her mood was still low. She saw the nurse the following day and had her wound checked.

14.110. On 11th April 2022, Marilyn called police stating that she had sent an abusive message to her ex-husband who the police would be interviewing the following day.

14.111. Marilyn's ex-husband was interviewed under caution on 12th April 2022, where he denied the offence, stating that Marilyn was making up the allegation to support her claim for his inheritance. Marilyn was updated via email as the officer was unable to make contact by phone.

14.112. On a day in mid-April 2022, Stephanie arrived at her home and found her hanging in the garden. She was pronounced deceased at the scene. It is thought that she had been deceased for a few days, her niece had received a missed call from Marilyn a few days before – she was attending Marilyn's home to check on her welfare and found her deceased.

15. Overview

15.1. Marilyn was distrusting of services and became difficult particularly after someone had shown kindness or care towards her.

15.2. Her presentations and re referrals to services almost always came in response to difficult social situations – being charged with benefit fraud, financial difficulties, court cases with her ex-husband or criminal proceedings, her cat dying or her mother dying.

15.3. The crisis would be dealt with, and Marilyn would no longer require the support until the next issue within her life arose.

15.4. Marilyn also self-harmed and indicated suicidal ideation whilst under the influence of alcohol. When sober she would state that she was no longer suicidal and was always assessed as having the mental capacity to make decisions around keeping herself safe.

15.5. Services were predominantly reactive to Marilyn's needs and very little preventative work was carried out with her; largely this was because she would seek help whilst in crisis and then decline ongoing support.

15.6. It is not clear whether any individual agencies identified or responded to Marilyn as a suicide risk, beyond the Consultant at Hospital D raising a concern in January 2021. There was also a lack of multi-agency, partnership working to establish Marilyn's risk of suicide or accidental death through self-harm.

15.7. Although there is no record of such, it would be likely that Marilyn was viewed with some frustration by practitioners. This may have been due to their cognitive[54] or unconscious[55] biased, from what they knew about Marilyn's historic dissonance,[56] between her numerous situations of help seeking and then the subsequent refusals of help. Considering the high number of calls and contacts with services, set against the backdrop of Marilyn's behaviours towards professionals – it would be unlikely that practitioners did not get frustrated by Marilyn's presentations, and this could be the reason for the lack of safeguarding referrals and coordinated response to her needs.

16. Analysis

16.1. Metropolitan Police Service

16.1.1. At an early stage within this DHR, it was clear that there were issues with the early closure of the investigation into the allegation of rape made by Marilyn against her ex-husband. The rationale for this closure appeared to be the passage of time and a lack of corroboration. However, the decision not to interview the suspect at this stage, based on these factors alone, was flawed and against policy and approved professional practice.

16.1.2. This issue has been addressed by a debrief, bringing attention to the approved practice in the management of major investigations and suspect risk management which was completed in October 2022.

16.1.3. On 27th January 2020, Marilyn called 999 to report ongoing issues with Gary's ex-partner – who was also the mother of her grandchildren. She stated that the ex-partner had used her bank account for three transactions totalling £68. Marilyn stated that the ex-partner reported her to Kent Police due to harassment and there was a history of malicious communication from the ex-partner towards Marilyn.

[54] Cognitive biases are common across humankind and relate to the wiring of our brains. They are a heavily theorised and researched concept. Cognitive biases may inform some of our unconscious biases.

[55] Unconscious biases relate to perceptions between different groups and are specific for the society in which we live, Unconscious biases are a description rather than a clearly defined term. We are not aware of our unconscious biases whereas we may be aware of our cognitive biases.

[56] Dissonance means a lack of agreement between two elements – in Marilyn's case she would ask for help, and then push the help away – there was therefore a dissonance between her help seeking behaviours and her rejection of help.

16.1.4. The call operator offered an appointment for an officer to attend the home in the next three days as the call did not require an immediate response. When police arrived, Marilyn explained that her account had been used for a food delivery service, without her permission. She had no proof of it being Gary's ex-partner but was certain it was her. Marilyn was very erratic and distressed and thought officers were there about a complaint of harassment made by Gary's ex-partner against her. She explained to the officer that she'd had problems with her family for 30 years, she asked about a crime she had reported against her husband thirty years before and suggested that her ex-husband may have given her bank details to Gary's ex-partner.

16.1.5. Officers contacted the food delivery service, and the money was refunded. The matter was closed with NFA due to lack of identifiable suspects and the low value of the theft.

16.1.6. On 16th August 2020, Marilyn reported that her neighbours were damaging her car and were outside swearing and banging at her door. When officers attended and spoke with both Marilyn and her neighbours, they decided no criminal offences had taken place, and deemed the matter to be an Anti-Social Behaviour (ASB) incident – to be passed to the Safer Neighbourhood Team (SNT). The officer involved with the report recalled that Marilyn had placed bags of her rubbish in the neighbour's parking space and at their back gate area. She had been using the space while the neighbouring house was vacant. Once the house was rented Marilyn continued to do this – and the neighbours placed the rubbish back into her front garden with a note asking not to use their space. Marilyn argued this and stated that she would get the space back, she had been intoxicated at the time. The officer stated they had not identified any vulnerabilities in Marilyn and if they had, there would have been a MERLIN[57] created in line with safeguarding policy.

16.1.7. An SNT officer subsequently attended along with a Local Council Official on 10th September 2020, as the neighbour had poured rubbish around Marilyn's car whilst shouting and swearing. Marilyn stated that this incident had upset her so much that she had self-harmed – she showed the officers the wounds. She was erratic during this interaction and refused referrals to partner agencies for her assistance. At this point the SNT Officer completed a MERLIN report highlighting Marilyn's vulnerabilities which was assessed within the MASH as amber and shared with ASC.

16.1.8. On 15th November 2020, Marilyn contacted police to report an abusive Facebook message from her ex-husband's family member. This was deemed as not urgent and passed to the MPS Telephone and Digital Investigation Unit (TDIU). She informed the reporting officer that she had issues with her ex-husband's family member several times over the past 30 years – Marilyn had posted a message on Facebook to this person accusing her of tax evasion, and the response had been abusive. The case was closed as did not reach evidential thresholds for a crime.

16.1.9. On 14th January 2021, Marilyn contacted MPS to report that she had been falsely contacted by "Track and Trace" which she believed was Gary's ex-partner forcing her to self-isolate in order to stop her from seeing her grandchildren. She requested no further action but wanted the incident logged for future reference.

16.1.10. On 4th April 2021, officers were called to Marilyn home by a friend, who stated that Marilyn had texted to say she was taking an overdose. On arrival Marilyn was intoxicated and state she had taken diazepam, although not a high quantity. Officers checked her prescribed medication and searched the bins to ensure she had not taken more than reported – this was good practice. She was described as very up

[57] This system was created for police to record vulnerabilities – it allows the recording and sharing of concerns with partners in order to effectively safeguard members of the public.

and down – and was talking about a family court matter from 30 years ago. She became angry with officers and spoke about her hostile relationship with her ex-husband.

16.1.11. The LAS were called, and she was found medically fit with capacity to make her own decisions. A MERLIN report was created, noting personality disorder, post-traumatic stress disorder and depression. This was graded as amber and sent to ASC.

16.1.12. When the Independent Chair spoke with Stephanie, she spoke about a charity CEO who had been supporting Marilyn with her alcohol issues. Stephanie stated that he had moved into the house at one point and gave this as an example of how Marilyn got into situations after befriending people – Stephanie believed that this friendship had ended acrimoniously, and Marilyn therefore no longer had support from that charity.

16.1.13. On 14th May 2021, Marilyn called 999 to report abuse by her ex-partner. The call handler had difficulty understanding what she was saying but established it was a historic allegation and despatched officers to carry out an initial investigation. Officers established that Marilyn was making an allegation of rape and suffocation against her ex-husband dating back over 30 years. She also mentioned that he owed her money for unpaid child maintenance and other sums she believed she was entitled to.

16.1.14. The officer completed research over the past five years and a DASH[58] risk assessment in line with MPS domestic abuse guidance. Marilyn answered yes to four questions on the risk assessment, including that she believed he would pay someone to kill her, she feared one of his family members and she believed that he used illegal drugs.

16.1.15. Marilyn indicated to the officer that she had accessed advice from a local domestic abuse charity and the officer suggested support from the MPS Sexual Offences Investigation Team (SOIT) which Marilyn declined. The officer dealing with this report recalled Marilyn threatening never to speak to him again if he referred her to any other services.

16.1.16. The initial report was assessed as “medium” and passed to the specialist rape investigation department. A SOIT was not assigned to the case as there were a shortage of officers and cases which were forensically “live” had taken priority. It is noted that best practice would have been for the Officer In Charge (OIC) to make initial contact from the team in order to reassure Marilyn that they had received the allegation and to explain the delay.

16.1.17. A video recorded interview was booked for 23rd June 2021 and Marilyn reported she was in a civil case against her ex-husband which was started on 9th April 2021 and that she had disclosed domestic abuse to the judge.

16.1.18. On 22nd July 2021, a Detective Sergeant reviewed the case and decided that it did not meet the full code test[59] for prosecution and the police would take no further action. A SOIT was requested to inform Marilyn of his decision. The closing rationale appears to be due to the passage of time between the incident and the reporting and a lack of corroboration. However, the decision not to interview the suspect was flawed and against policy and approved professional practice.

[58] Dash Risk Checklist | Saving lives through early risk identification, intervention and prevention
[59] The Code for Crown Prosecutors | The Crown Prosecution Service (cps.gov.uk)

16.1.19. The SOIT recalled that his role was to carry out the initial contact and investigation. He described Marilyn as a demanding client who was often difficult to deal with, she lived in a lovely house that was always well presented, but she was clearly a traumatised victim of domestic abuse, who would often focus on the civil court case she was pursuing against her ex-husband. He stated that supporting Marilyn was challenging as she would often say that she didn't need support. She had told him that she would not work with the local domestic abuse charity because they had referred her to mental health services.

16.1.20. Marilyn had been rude to the SOIT and another officer during a further meeting, where she stated that she did not want to speak to him but only speak to the OIC whom she referred to with a disparaging name. The SOIT did not see any signs of suicide risk at this stage.

16.1.21. Following the interview with Marilyn's ex-husband, the SOIT tried to call Marilyn. When there was no answer, he sent Marilyn an email to advise that the investigation was ongoing.

16.1.22. In June 2021, the Government published a report entitled the "End to End Rape Review Report", which identified numerous shortcomings within the criminal justice system in relation to rape. The report boldly concluded that "too many rape victims do not receive the justice they deserve."[60] This led to an improvement plan within public protection, therefore no further recommendation regarding serious sexual offences policy is necessary from this review.

16.2 Oxleas Mental Health Services

16.2.1. Marilyn's experiences of mental health services were difficult, she often felt let down and untrusting of them. This could have been due to her trauma experiences, EUPD and PTSD – and may have been exacerbated by the changing thresholds and criteria for access to services.

16.2.2. During the first eight years of Marilyn's contact with mental health services she was offered support and therapy which meant she could form longer term relationships with MH staff – she found this helpful and was able to reach out for help. During this time, MH staff were mindful of her experiences but did not address the domestic abuse in a way which would be expected under current guidance.

16.2.3. From 2006 when she received her EUPD diagnosis, until 2015, Marilyn received a continuous support and therapy, which included therapy with David. Her reliance on MH teams reduced until she was discharged and remained out of MH services for over a year.

16.2.4. Between 2007 and 2012 Marilyn was under the care of Bexley Community Mental Health Team (CMHT) and received care coordination supporting her to manage her finances and debt as well as improve her mental wellbeing. She was diagnosed with EUPD in 2007 and received two years of psychotherapy which enabled her to manage her emotions in a better way and acknowledged the impact previous trauma had on her.

16.2.5. Between 2012 and 2016 there was very minimal contact between Marilyn and mental health services. From 2016, there were thirteen contacts with Oxleas Crisis Services, these were in response to social stressors, including civil court cases. There were six referrals to Primary Care Plus, and one referral to Memory Services. Marilyn received Home Treatment Team case in 2021, and in 2022.

[60] Operation Soteria – Transforming the Investigation of Rape (npcc.police.uk)

16.2.6. Marilyn's experience of MH service in the last four years of her life were often short episodic interventions to manage the current risk and crisis as a result of a social stressor. They did not offer the same level of care and support as her first contact between 2007 to 2015 and Marilyn may have found this difficult.

16.2.7. Mental Health Services have changed and adapted to support growing demand, they provide evidence-based care that is time limited and focus on diagnostic criteria and impact on function. Although there was a growing awareness of the Marilyn's trauma in the more resent interactions with mental health services, there are fewer services available within the NHS to support this long-term trauma response need.

16.2.8. Oxleas have a documented history of Marilyn having a difficult and abusive relationship with her parents and ex-husband. In 2007 clinicians did not always address these historic issues in the way that would be expected in 2023, however, the therapy helped Marilyn to manage her emotions, and taught her how to work with triggers to enable her to get help in a more constructive way. Marilyn was diagnosed with Post Traumatic Stress Disorder (PTSD) in 2022 but throughout the review of the notes it is clear to the IMR author that symptoms of PTSD are evident, alongside Marilyn's difficulties in managing her responses to life stressors.

16.2.9. Marilyn had a difficult relationship with services, it is documented that she found the idea of trusting people and people showing her kindness and care difficult. Marilyn would relax and open up to people and quite quickly felt she had 'showed' too much of herself and responded with aggression and abuse in order to shut down the relationship. This is common in people living with EUPD.

16.2.10. The short-term episodes of care offered by services in recent years made it more difficult for Marilyn to form trusting and meaningful relationships which may have been helpful to her recovery.

16.2.11. Marilyn was able to ask for help, although at times however not in a helpful or constructive way. Calls for help often came at a time of crisis, when she would become intoxicated, harm herself and then reach out to a friend, her sons, or a service. She would be assessed by mental health services and would generally be honest in her request for support. The assessment or review were often enough for Marilyn to feel validated but sometimes she required more input.

16.2.12. Marilyn had multiple assessments and re referrals and there was often a reliance of historical information carried through. Due to Marilyn's involvement in services prior to the introduction of information gathering around family and support networks, some of this information is limited.

16.2.13. Therapy is usually structured around goals or outcomes. Due to her specific needs Marilyn would have benefitted from unstructured therapy to help her to make sense of her emotions and her relationships. This type of therapy is led by the client, tends to last over a longer period of time than structured therapy, and goes deeper into issues. Unstructured therapy is not readily available on the NHS due to limited resources and it is not thought that Marilyn would have been able to fund the therapy herself.

16.2.14. At times services were resistant to offering psychological interventions due to Marilyn's alcohol misuse and this is an area that often causes tensions. People with substance misuse should not be denied therapy but there is an acceptance that therapy will have limited impact.

16.2.15. Marilyn did engage and acknowledge the impact of her alcohol use and in 2020 reduced this via online support from a charity. She was subsequently referred for secondary care[61] psychological therapies but did not, at that time, meet the thresholds. She was unable to access therapy via Improving Access to Psychological Therapies (IAPT)[62] as her diagnosis of EUPD does not fit the criteria and these therapies are all structured which would not have been suited to her needs.

16.2.16. Marilyn had requested Dialectical Behaviour Therapy (DBT) – this is an empirically supported treatment for personality disorders.[63] It focuses on the tendency of emotional vulnerability and the idea that emotions may have been dismissed in the past. DBT teaches people to accept their feelings as being valid, allowing them to challenge the emotions and substitute negative thought patterns for positive ones. Experiencing intense emotions of EUPD is more distressing if you have been taught that you are wrong for having the emotions. Patients are taught how conflicting emotions are a natural part of being human and this helps them to break the cycle of extreme emotions which reduces the risk of distress leading to self-destructive behaviours.

16.2.17. There is limited access to structured psychological intervention available on the NHS nationally, and DBT is not available on the NHS in Bexley.

16.2.18. Mentalisation-Based Therapy (MBT) is a psychotherapy which helps patients to identify and challenge their thoughts and beliefs. This is effective for treating EUPD because it offers a greater understanding of why they may carry out impulsive behaviours – including self-harming – allowing them to think through what is driving their actions before they act on their impulses. This would be valuable for the long-term management of their EUPD symptoms – it is not currently widely available on the NHS.

16.2.18. Marilyn felt it was important that she got justice through the civil court, and she was become increasingly panicked that she was running out of options via the legal system to get this justice. She acknowledged that this was having an impact on her mental health but wanted to see it through. Marilyn had previously self-harmed and attempted suicide usually in the context of alcohol and acute social stressors, but she had reached out for help and support which helped manage her risk. HTT discharged her as she was no longer in crisis, there were not offering any further treatment and could not continue to support her throughout the court process. They referred her onto longer term CMHT to look at support. There were some delays in Marilyn receiving follow up care which the Serious Incident Review made recommendations to prevent happening again.

16.2.20. Serious Incident Review

16.2.20.1. Oxleas undertook a serious incident review following Marilyn's death. The investigation concluded the following.

16.2.20.2. The ADAPT operational policy did not stipulate a timeframe for referrals to be screened. Referral processes need to be standardised across the borough.

[61] Secondary care is when your primary care transfer your care to someone who has more specific expertise in whatever health issue you are experiencing.
[62] IAPT is a programme which began in 2008 with the direct objective of improving access for people with anxiety and depression into evidenced based psychological therapies, such as Cognitive Behavioural Therapy (CBT).
[63] May, J et al "Dialectical Behaviour Therapy as Treatment for Borderline Personality Disorder" *The Mental Health Clinician* 6(2) (2016)

16.2.20.3. The referral form from Home Treatment Team to ADAPT was not comprehensive and inclusive of all current risks and maintaining factors. The Home Treatment Team operational policy is being reviewed to include a standardised process for all referrals.

16.2.20.4. The serious incident review panel also found that it would have been appropriate to acknowledge the referral had been missed and offered an apology to Marilyn. It would also have been helpful to include the details of the organisation ADAPT were advising Marilyn to self-refer to in her case files.

16.2.20.5. Multi-Disciplinary Team discussions were not recorded in the clinical records.

16.2.20.6. Marilyn's use of alcohol was not fully assessed. She was not seen for the first three days of the ADAPT support and this was not documented as a plan.

16.2.20.7. There were missed opportunities to review Marilyn's support network and re-check whether she would like them to be involved in her care and treatment. There is no indication in the clinical record that any attempts were made to contact Marilyn's family and/or support network.

16.3. London Ambulance Service NHS Trust

16.3.1. LAS Trust has a safeguarding adult's policy and practice guidance, and ambulance staff are trained to identify adults at risk and signs of abuse and neglect as per the Trust's domestic abuse policy and procedures. It is the ambulance staff's duty to identify concerns on scene and dynamically risk assess if a safeguarding referral is required or if immediate action needs to be taken such as seeking the assistance of agencies such as police.

16.3.2. The Trust has in place a capacity test/tool to assess a person's capacity and aid decision making should the person lack capacity. If a person lacked capacity ambulance staff would act in their best interest.

16.3.3. There was a general theme of awareness by the ambulance staff of Marilyn's history which included alcohol, self-harm, suicidal thoughts and attempts. However, on some occasions there was no evidence to suggest that ambulance staff explored whether Marilyn was receiving any support or what support she may have needed to manage her social needs.

16.3.4. On each of the occasions during the scoping period where LAS conveyed Marilyn to hospital, the crew identified that she had menta capacity to agree to being conveyed to hospital. However, on each of these occasions there is no evidence of the Mental Capacity Act Assessment tool being completed to evidence the rationale for this assessment. The reasoning for the lack of form being completed on each occasion was Marilyn's intoxication. On each of these occasions, further exploration and use of the tool would have supported the decision making and evidenced the rationale for each decision.

16.3.5. The LAS does acknowledge potential issues around unconscious bias in relation to alcohol misuse having an impact, although this is an issue that is not exclusive to the LAS.

16.3.6. The LAS has ongoing training that covers responding to people with personality disorders and PTSD and covers how to respond to their risk-taking behaviours which can be extreme and spontaneous. New starters have a mental health session included in their training and the apprentice paramedics have training that covers these issues. All emergency medical technicians undertake a comprehensive mental

health component within their skills refresher training which covers the categories of mental health illness. All LAS staff follow national clinical guidelines to aid their decision making.

16.4. Victim Support

16.4.1. Victim Support (VS) Kent and Medway had a single contact with Marilyn. The Initial Response Officer (IRO) had some information about Marilyn from the voicemail she left – and she made appropriate first contact with Marilyn from this. The referral to VS Kent and Medway was incorrect as although she had a "Kent" address, she was a resident of Bexley and therefore should have been directed to the London service.

16.4.2. The IRO was aware that the Marilyn was subject to historic and ongoing intimidation and abuse from her partner and at the time of the call was upset. During the call Marilyn acknowledged her suicidal thoughts and the IRO explored whether she had any immediate suicide plans and was told she did not. Marilyn also said she had spoken to her doctor that day and stated, "I cannot die today".

16.4.3. The IRO then confirmed her home address and realised that VS Kent and Medway would not be able to support her. Marilyn was given the contact details of the London service.

16.4.4. The Kent and Medway IRO followed policies and protocols. She had explained confidentiality and was able to assess if Marilyn had any immediate or imminent plans for suicide. At the time of the call, the IRO was not aware how Marilyn had been referred to Kent and Medway, and in referring Marilyn to the London Service she was following the process and information that was current at the time.

16.4.5. As the IRO had no reason to believe that the Marilyn was at immediate risk and had signposted her to access support, a follow up welfare call does not appear to have been considered or felt necessary.

16.4.6. The national contact centre process has been reviewed following this DHR and improvements have been implemented to ensure clients are given accurate local contact details. For example, staff now ask callers the town they live in, rather than the County, as this will ensure they are directed to the correct area.

16.5. Hospital Trust C

16.5.1. There is no indication that Marilyn was asked about domestic abuse when attending Hospital C Urgent Treatment Centre. On her closure form it states "no disclosures" however there is no evidence what she was specifically asked.

16.5.2. The clinical system used within the service, called *Adastra,* includes a specific question relating to adult safeguarding and domestic abuse concerns. This is to be answered before the clinical notes can be closed. Neither safeguarding nor domestic abuse were flagged as a concern by any of the professionals who saw Marilyn on any attendance at Hospital C.

16.5.3. There was also the opportunity for all clinicians to ask questions directly about the nature of injuries and how these were sustained. There is no statement in any of the clinical notes to confirm whether this question was asked of Marilyn, however an inference from the non-flagging of the mandatory question within the clinical system that this risk was not identified by any clinicians following their assessments.

16.5.4. On Marilyn's 7th attendance, the nature of her finger injury was discussed directly with Marilyn as she has stated her finger was shut in a car door, although there is no specific documentation around domestic abuse.

16.5.5. Following learning from other DHRs in the area, inquiry about domestic abuse is now in place across Hospital Trust C services. This inquiry includes asking about the cause of injuries when patients attend with injuries. However, Hospital Trust C are working on a process for inquiry with a wider range of patients, ensuring that inquiry becomes routine rather than targeted inquiry.

16.5.6. In Marilyn's 1st, 3rd and 7th attendance she was referred to ED. On one occasion she was conveyed via ambulance, on the other two occasions she drove herself to ED. Communication would have been made with ED about the reason for attendance and on the first occasion, communications would have been with LAS. There were no other inter-agency communications or discussions from the review of the clinical notes.

16.5.7. Marilyn's attendance in January 2021 highlighted a gap where communication could have been improved between the UTC and mental health services. The notes imply that Marilyn is known to mental health services, and she attended with an episode of self-harm. Direct communication should have been made between the UTC clinician and mental health team.

16.5.8. Hospital Trust C have policies in place for responding to the needs of people with mental health issues. However, the clinicians are GPs or associates who bring their own specialisms and undertake their own training. Hospital Trust C safeguarding team are available to provide advice and training around issues such as mental capacity and domestic abuse.

16.5.9. During this January 2021 attendance Marilyn was asked about alcohol consumption and it was noted that she was reluctant to answer this question. She stated that she had "cut down a lot." Alcohol consumption should be asked as part of a thorough history for all patients as part of the social history. The clinician on this attendance appeared to have been asking routinely – which is good practice, however Marilyn's response that she had "cut down a lot" indicated an issue, even if was a prior issue, which could have elicited more questions – this is a missed opportunity.

16.5.10. It was known that Marilyn had ongoing mental health problems with a documented history of self-harm, depression and anxiety. From a comment recorded during one of her attendances, it appeared that she had a distrust of mental health services.

16.5.11. Marilyn appears to have used the UTC as a place of treatment rather than the GP, although this is inference rather than fact. Marilyn had a greater than average number of attendances to the UTC for various medical complaints - it is possible to speculate that medical care was not always sought in a co-ordinated manner if there was a reliance on unscheduled care services for routine medical problems – for example bee stings and wound care.

16.5.12. Marilyn's sixth attendance highlighted a gap where an opportunity for communication with Marilyn's GP could have been made. Marilyn attended with an episode of self-harm and was triaged but did not wait to be seen. For completeness and to ensure there were no further concerns around Marilyn's mental health, the GP should have been directly contacted with a copy of the clinical notes. An attempt to contact Marilyn herself, if made, was not documented. The Trust's normal practice for a patient presenting with a self-harm/mental health concern, who then leaves the department before assessment would be to contact the patient/GP to ensure patient safety.

16.5.13. There were no concerns identified in terms of co-operation between different agencies although there were gaps identified where communications should have been made to mental health services and Marilyn's GP.

16.5.14. Post 2018, Marilyn would have booked into the UTC using an eTriage tool which captures clinical information and demographics from patients before assigning them a clinical priority. This tool asks the patient to input answers to questions around domestic abuse if they present with an injury. The eTriage tool is the first stage in the process of accessing ED and is followed up by triage with a practitioner.

16.5.15. In 2018 domestic abuse processes and a safeguarding policy was introduced and is widely available to all clinicians. Multi-Agency Risk Assessment Conference[64] (MARAC) assessment tools have been introduced and there are clear pathways into domestic abuse agencies.

16.5.16. Within the service there is a domestic abuse and adult safeguarding lead who send out regular updates on domestic abuse and links in with local services. This was particularly important during the COVID_19 restrictions.

16.5.17. All Hospital Trust C staff are up to date with mandatory training in domestic abuse and adult safeguarding. Clinicians have access to face-to-face level three adult safeguarding training every three years.

16.5.18. Prior to the internal reviews of domestic abuse processes which took place in 2018, which led to the above changed and mandatory checklists being included in practice, domestic abuse enquiry would not have been carried out routinely as part of expected practice.

16.5.19. During clinical assessment and history taking there were further opportunities to explore and document the nature and circumstances of the injuries as well as communications around alcohol support services and mental health services/primary care. There was no disclosure of domestic abuse however no direct statement or questioning around this was documented in the history taking.

16.5.20. When Marilyn chose not to wait after presenting with a self-harm wound in October 2018, this should have been followed up. The Did Not Attend Standard Operating Procedure specifies that if a vulnerable patient who is in attendance with mental health concerns does not wait to be seen it is the clinician's responsibility to attempt contact with the patient if they feel that is appropriate. There is no record in Marilyn's notes to indicate whether the clinician considered a follow up with Marilyn.

16.6. Primary Care

16.6.1. Marilyn had regular contact with her GP surgery to review mental and physical health. She attended the surgery for regular medication reviews and routine blood tests.

16.6.2. Marilyn had a "Do Not Attempt Resuscitation" order in place.[65]

[64] Domestic abuse MARAC | London Borough of Bexley

[65] This is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient stop breathing or if their heart stops beating.

16.6.3. There were occasions where Marilyn reported verbal and physical abuse against her and also an episode of harassment by people known to her. During these episodes, a referral to IRIS[66] or a referral to Solace[67] may have been beneficial.

16.6.4. Marilyn was also identified for further support with a Practice Social Prescriber due to debt concerns. She saw the Social Prescriber on 31st January 2022, and within the entry it is also documented that she had been to see the Citizen's Advice Bureaux.

16.7. Mental capacity assessments

16.7.1. Mental capacity is the ability to make a decision or decisions for oneself. Someone could lack capacity to make some decisions, for example managing their personal finances, but at the same time, retain the capacity make other decisions, for example going to the shops to purchase some items.

16.7.2. Capacity can also fluctuate. This can be due to internal or external factors. A person may be able to make a decision about a matter, under specific conditions, however, lose their capacity to make the same decision about the same matter under other conditions.

16.7.3. The Mental Capacity Act[68] says that a person is unable to make their own decision if they cannot do one of more of the following four things:

(a) Understand the information relevant to the decision.

(b) Retain that information long enough to make the decision.

(c) Weigh up that information as part of the process of making the decision.

(d) Communicate their decision – this could be by talking, using sign language, or even simple muscle movements such as blinking an eye or squeezing a hand.

16.7.4. Marilyn had various mental capacity assessments by ambulance staff upon their attendance at her home. LAS staff utilise a capacity test/tool to assess whether a person can consent to treatment. Ambulance staff were aware of Marilyn's alcohol, self-harm and suicidal thoughts, and some of the capacity assessments could have benefited from exploration and consideration of the Mental Capacity Act assessment tool, due to her intoxication and alcohol dependency.

16.7.5. Under the Mental Capacity Act, professionals are required to assess capacity before carrying out any care or treatment, if there is a reasonable belief that the person lacks capacity.

16.7.6. In order to decide whether an individual has the capacity to make a particular decision, there are two questions to answer;

a) Stage one – is the person unable to make a particular decision – *this is the functional test.*

b) Stage two – Is the inability to make a decision caused by an impairment or, or disturbance in the functioning of the person's mind or brain? This could be due to long-term conditions such as mental

[66] IRIS is a specialist domestic violence and abuse training, support and referral programme for General Practices.
[67] Solace Womens Aid – For safe lives and strong futures
[68] (2005) Mental Capacity Act 2005 (legislation.gov.uk)

illness, dementia, learning disability; or more temporary states such as confusion, unconsciousness or the effects of substances – *this is the diagnostic test.*

16.7.7. It could be argued that whilst under the influence of alcohol Marilyn lacked capacity to make decisions around suicide attempts, and self-harm – as due to the alcohol she may not have been able to weigh up her risk of death or serious injury.

16.7.8. It would appear that Marilyn was not suicidal when she was no longer intoxicated. For example, on 17th January 2021, after admission to Hospital D following an overdose, she stated that the day before, when intoxicated, she felt "minus 25 out of 10" and was now feeling "8 out of 10". This was less than 24 hours after an overdose, with presumably the only changing factor being lack of intoxication.

16.7.9. This is supported by Stephanie and David's description of Marilyn being engaging and fun unless she had been drinking – and then she would take a different turn. Her life outlook changed – and it would appear that she would then be more susceptible to self-harm and apparent suicide attempts.

16.7.10. The coroner's finding of "accidental death" also supports the link between Marilyn's suicidal behaviours and alcohol. The inquest did not find an intention of suicide and it could be argued that when under the influence of alcohol Marilyn had an impairment of the mind which mean she was unable to make decisions about keeping herself safe.

16.7.11. This poses a problem for practitioners as an assessment of capacity is not intended as a "future capacity" test, instead assessment is made of the presenting factors. LAS staff may have therefore been in a unique position to assess Marilyn's capacity to keep herself safe, as they were often responding whilst she was intoxicated. However aside from two occasions in November 2019 and April 2021, where Marilyn was left at home by LAS upon her request, most of the LAS capacity assessments followed her consenting to conveyance to hospital where it is presumed that a further capacity assessment would take place regarding consent to treatment only.

16.7.12. The January 2021 admission to Hospital D is the only one within the scoping period which included some consideration of Marilyn's future risk of self-harm or suicide. The consultant raised a concern with the Liaison Psychiatry Team (LPT) that Marilyn was "clearly a high risk of further overdose" and they asked for an urgent review to assess if she should be discharged home from a psychiatric perspective. At the point of this discussion, at around 5pm, it was agreed that in the absence of suitable staff to make the MCA assessment, Marilyn should remain on the ward, and if she attempted to leave the nursing team should put her under a S.5(2).[69] However, by 1am the following morning the on call doctor advised the nursing team that Marilyn could leave the ward and would be supported at home by the Home Treatment Team (HTT), this was also supported by the PLT staff.

16.7.13. At this point, the hospital notes described Marilyn as "well kept, engaged well, good eye contact, good rapport, coherent with no delusions, and happy to engage with HTT." It is recorded that she was able to weigh all information and use them to make her own decisions. Her grandchildren and her cat are recorded as being her protective factors.

[69] Mental Capacity Act 2005 – this section gives doctors the ability to detain someone in hospital for up to 72 hours, during which time they should receive an assessment that decides if further dentition under the Mental Health Act is necessary.

16.7.14. Marilyn's family told the Chair that she was very good at talking herself out of situations, she knew how to use appropriate language to her advantage and understood the legal and technical elements of the services she was engaging with. The ability to present as stable and reasonable, alongside the possibility that the use of alcohol led to Marilyn's inability to make decisions to keep herself safe, would have made it virtually impossible for practitioners to gauge an understanding of future impairment of capacity due to alcohol.

16.7.15. However, an understanding of the effects of alcohol on Marilyn's capacity may have supported responses to her following episodes of self-harm. Questions asked in order to assess mental capacity could have been tailored to Marilyn's situation, to gauge whether she was able to weigh up the risk of successfully taking her own life when she either self-harmed or took steps to end her life. Stephanie told the Chair that Marilyn would usually be found following such acts, and on the last occasion, she believed that she was not found in time and the act that she took as a "cry for help" unintentionally became her final act.

16.7.16. Lessons can be learnt regarding how to approach discussions of suicidality linked to alcohol consumption in a way which can help those who may lack capacity whilst under the influence of alcohol to make safer choices whilst they are not intoxicated which may reduce the risk of them taking their own life whilst lacking capacity to make safe choices.

17. Conclusions

17.1. Supporting people with complex needs

17.1.1. The term "complex needs" is used to describe someone who has two or more needs affecting their physical, mental, social or financial wellbeing.[70] 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.

17.1.2. 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.[71]

17.1.3. 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.

17.1.4. 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 the abuse which contributed to and triggered her responses. It was felt that more unstructured therapy

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

would benefit Marilyn, but this is not readily available on the NHS due to demand, resources, and the need to provide evidence-based outcomes.

17.1.5. 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.

17.1.6. 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.

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

17.1.8. 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.

17.1.9. 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.

17.1.10. 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.

17.1.11. 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.

17.1.12. 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.

17.1.13. 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.

17.1.14. 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.

17.1.15. 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.

17.1.16. 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.

17.1.17. 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[72] and this should be recorded within their hospital notes.

17.1.18. 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.

[72] Drug & Alcohol Misuse | Bexley Safeguarding Partnership

17.2. Long term impacts of abuse

17.2.1. 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 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.

17.2.2. 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.

17.2.3. In Bexley, Solace Women's Aid[73] runs the Solace Advocacy and Support Service (SASS),[74] 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.[75]

17.2.4. Rights of Women provide advice and support to women engaged with family, criminal and immigration law.[76]

17.2.5. Surviving economic abuse provide advice and support to anyone effected by financial or economic abuse.[77]

17.2.6. 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.

17.2.7. 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.

17.2.8. 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.

17.2.9. 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 greater amongst clinicians

[73] Solace in Bexley (SASS) | Solace (solacewomensaid.org)
[74] bexley-poster_final.pdf (solacewomensaid.org)
[75] bexley_one_stop_shop.pdf (solacewomensaid.org)
[76] Who are we - Rights of WomenRights of Women
[77] Surviving Economic Abuse: Transforming responses to economic abuse

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

17.2.10. All Victim Support (VS) staff have completed the homicide timeline[78] training, and also suicide training.[79] 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.

17.2.11. There is also a charity local to Bexley which supports survivors of sexual abuse and rape[80] which Marilyn could have been referred into.

17.2.12. 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.

17.2.13. 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,

17.3. Alcohol misuse and legal powers

17.3.1. As discussed above at 17.2, Marilyn's alcohol misuse impacted on her capacity to make decisions to keep herself safe. A recent publication[81] providing advice and support to practitioners faced with dependent[82] and chronic[83] drinkers who are also highly vulnerable[84], 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.[85]

17.3.2. 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.

17.3.3. 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"[86] 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

[78] Home (dreams-lms.com)
[79] Free online training from Zero Suicide Alliance ASIST - Grassroots Suicide Prevention (prevent-suicide.org.uk)
[80] Family Matters - Care and support for those afraid to talk (familymattersuk.org)
[81] Safeguarding-guide-final-August-2021.pdf
[82] Alcohol addicted drinking at levels that make them physically dependent.
[83] Alcohol dependent for a long time – usually decades.
[84] People who present a high level of risk to themsel
+3ves, and suffer long term negative effects. One indicator is a high use of emergency services.
[85] Safeguarding-guide-final-August-2021.pdf p.8
[86] *ibid*

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.[87]

17.3.4. 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."[88] 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."[89] 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,[90] for example if there are many repeated unwise decisions, taking in specific circumstances, a consideration of executive capacity[91] may be appropriate.

17.3.5. 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."[92]

17.3.6. The Blue Light Project have developed a Guidance manual[93] 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[94], 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.

17.3.7. 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.

17.3.8. 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,

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[87] *Ibid*
[88] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London, 2007) p.19
[89] Mental Capacity Act 2005 in Practice (publishing.service.gov.uk)
[90] Jenkinson, A. and Chamberlain, J., 'How misinterpretation of 'unwise decisions' principle illustrates value of legal literacy for social workers' Community Care, (28 June 2019)
[91] Executive capacity is the ability to carry out a decision.
[92] SAR Ruth Mitchell - safeguarding_adult_review_ruth_mitchell.pdf (plymouth.gov.uk) p.30
[93] The-Blue-Light-Manual.pdf
[94] 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, assertive and comprehensive service, and challenges the idea that a client is always responsible for engaging with services and showing that they want support.

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.

18. Lessons to be learnt

18.1. Metropolitan Police Service

18.1.1. 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.

18.1.2. 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.

18.2. Oxleas Mental Health Services

18.2.1. 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.

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

18.2.3. 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.

18.2.4. 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.

18.3 London Ambulance Service

18.3.1. 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.

18.3.2. 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.

18.3.3. Domestic abuse stickers, which include the Refuge National Domestic Abuse Helpline number,[95] 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.

18.3.4. 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.

18.3.5. 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.

18.4. Victim Support

18.4.1. 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.

18.4.2. 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.

18.4.3. 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.

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

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

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.

18.4.5. 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.

18.4.6. 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.

18.5. Hospital Trust C

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

18.5.2. 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.

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

18.5.4. 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.

18.5.5. 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.

18.5.6. Staff at Hospital C are also able to access Bexley Borough Council's domestic abuse training,[96] and can engage with the Bexley Domestic Abuse Health Subgroup, and local Domestic Abuse Operational Board.

18.5.7. A future protected learning time[97] session will include links to community-based services supporting people with EUPD.

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

18.6. Primary Care

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

[96] Training for professionals - Bexley Domestic Abuse Services
[97] 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.

18.6.2. Primary Care practitioners in Bexley have access to Domestic Abuse Champions, and Primary Care Practitioners in Bromley have access to the IRIS[98] programme in their practices.

18.6.3. 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.

18.7. Multi-Agency Responses

18.7.1. 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.

18.7.2. 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.

18.7.3. 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.

18.7.4. 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.

18.7.5. 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.

18.7.6. 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.

18.7.7. 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.[99]

[98] About the IRIS programme - IRISi

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

18.7.8. 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.

18.7.9. 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.

19. Recommendations

19.1 Oxleas

19.1.1. Clinical teams within Oxleas, including the Home Treatment Team (HTT) and ADAPT[100], 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.

19.1.2. 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.

19.2 Primary Care

19.2.1. 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[101] and is also a feature of the Bexley Domestic Abuse Strategy.[102]

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

19.3. Hospital Trust C

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

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

19.4. Multi-Agency Recommendations

19.4.1. 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.

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

19.4.2. 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.

19.4.3. 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.

19.4.4. 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.

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

19.4.6. 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[103]

	Paragraph	**Recommendation**	**Organisation**
1.			
2.			
3.			
4.			

[103] Determinants of health (who.int)

5.			
6.			

Bexley Community Safety Partnership

Domestic Homicide Review (DHR) Marilyn

Action Plan

Source of recommendation:
Overarching recommendation: Recommendation 1

Action Number	Action to take	Lead agency	Key milestones in recommendations	Target date	Completion date and outcome	RAG rating
1.1						
1.2						

Source of recommendation:
Overarching recommendation: Recommendation 2

Action Number	Action to take	Lead agency	Key milestones in recommendations	Target date	Completion date and outcome	RAG rating
2.1						
2.2						