Nottingham Community Safety Partnership

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Domestic Homicide Review (DHR)

Executive Summary

'Daniel'

February 2022

Julia Greig

Version: 6

Date: May 2024

CONTENTS

THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Nottingham Crime and Drugs Partnership (now the Nottingham Community Safety Partnership) domestic homicide review panel in reviewing the death of Daniel who was a resident in their area. Pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family.

1.2 Daniel was 23 years of age when he died by suicide. Daniel was of dual British and Asian heritage and the perpetrator of his abuse was a white British 64 year old man.

1.3 Following Daniel's death police identified a strong suggestion of controlling and coercive behaviour from Michael on Daniel. Michael was arrested. Police searched the property, spoke to household members, and examined relevant financial matters. The police were unable to gather sufficient evidence to bring a charge of coercive controlling behaviour.

1.4 An inquest into Daniel death was opened in August 2022 and a hearing took place in March 2023. The coroner determined death as suicide as a result of pentobarbital toxicity.

1.5 The review process following Nottingham Crime and Drugs Partnership being notified of Daniel's death by suicide on the 24th March 2022. Following notification, the agencies involved were identified and provided an initial trawl of information known. Thirteen of the agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files. On the 7th December 2022 the decision was made to undertake a Domestic Homicide Review.

CONTRIBUTORS TO THE REVIEW

2.1 The agencies that contributed to the review are as follows:

- Adult Social Care, Nottingham City Council – Agency Report
- Nottinghamshire Police – Agency Report
- NHS Nottingham and Nottinghamshire Integrated Care Board – Agency Report
- Nottinghamshire Healthcare Foundation Trust (NHFT) – Agency Report
- East Midlands Ambulance Service – Agency Report
- Nottingham University Hospital – Agency Report
- Equation – Agency Report
- Department for Work and Pensions – Agency Report
- Tomorrow Project – Agency Report
- Housing Aid, Nottingham City Council – Agency Report
- Nottingham Sexual Violence Support Service – Agency Report

- Human Flourishing Project[1] – Agency Report
- Nottingham College – Summary Report

2.2 Agency Report authors were independent with no direct involvement in the case, or line management responsibility for any of those involved.

THE REVIEW PANEL MEMBERS

3.1 The DHR panel members were as follows:

Name	Role	Agency
Julia Greig	Independent Chair and Author	Review Consulting
Paula Bishop Louise Graham	Domestic Violence & Abuse Policy Lead Sexual Violence and VAWG Lead	Nottingham Community Safety Partnership
Julie Stevens	Service Manager	Adult Social Care, Nottingham City Council
Joanna Elbourn	Detective Chief Inspector	Nottinghamshire Police
Nick Judge	Associated Designated Nurse	NHS Nottingham and Nottinghamshire Integrated Care Board
Amy Calvesbert	Named Nurse for Safeguarding	Nottinghamshire Health Care Foundation Trust
Liz Cudmore	Safeguarding Child and Young Person Lead	East Midlands Ambulance Service
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospital
Marie Bower	Head of Service	Equation
Katy Pearson	Advanced Customer Support Senior Leader	Department for Work and Pensions
Katie Freeman	Clinical Operations Manager	Tomorrow Project
Fiona Ryan	Clinical Lead	Human Flourishing Project
Debbie Richards	Service Manager	Nottingham City Council – Housing Aid
Deborah Hooten	Operations Manager	Nottingham Sexual Violence Support Service
Julie Tomlinson	Lead Nurse - Safeguarding Adults	DHU Health Care CIC (111)
Karen Turton	Domestic & Sexual Violence & Abuse Specialist	City Care

[1] The Human Flourishing Project (the HFP) is a free counselling service providing person-centred counselling with the aim to provide emotional and psychologically supportive therapy.

John Matravers	Head of Safeguarding, Quality and Assurance	Children's Integrated Services, Nottingham City Council
Jenny Mogensen	Autism Specialist for the review	Nottinghamshire Healthcare Foundation Trust
Rebecca Butcher	Head of Student Services	Nottingham College
Geoff Howard	Independent Reviewer (observing)	Review Consulting

3.2 Independence and impartiality are fundamental principles of delivering DHR and the impartiality of the independent chair and report author and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel members, had direct involvement in the case, or had line management responsibility for any of those involved. The panel met on three occasions.

AUTHOR OF THE REVIEW

4.1 Nottingham Crime and Drugs Partnership appointed Julia Greig to chair the review and to author the Overview Report. She works both independently and for a local authority as a registered social worker with extensive social work experience in the statutory sector working with adults. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by AAFDA and is an accredited reviewer using the Serious Incident Learning Process. She maintains her CPD through Review Consulting and the AAFDA Network. She is currently undertaking Safeguarding Adult Reviews and Domestic Homicide Reviews in other local authority areas; this is her first review with Nottinghamshire. Julia Greig is independent of all agencies involved in this case and has never worked in Nottinghamshire or for any of its agencies.

TERMS OF REFERENCE FOR THE REVIEW

The Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- Contribute to a better understanding of the nature of domestic violence and abuse;

- Highlight good practice.

Specific terms of reference set for this review

- Identify examples of good practice, both single and multi-agency.

- Did professionals and agencies respond to disclosures of domestic abuse and coercive and controlling behaviour in accordance with agreed processes and procedures at the time of those disclosures?

- Was the agency's involvement in multi-agency/multi-disciplinary fora (including MARACs) effective?

- Analyse the quality of risk assessments undertaken in respects of both the victim and perpetrator. Were links between Mental Health (including risk of suicide) and Domestic Abuse (including historical domestic abuse) identified when risk was assessed?

- Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing?

- What evidence is there of communication and information sharing between agencies? How could information sharing and communication have been improved during the scoping period both within and between agencies?

- Was consideration given to the victim's protected characteristics? What role if any, did these issues play for the victim in accessing services and support?

- To what extent did Covid-19 Lockdown and potential isolation impact on the victim accessing support, e.g., for domestic abuse or mental health services?

- To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review.

SUMMARY CHRONOLOGY

Background information and history

6.1 East Midlands Ambulance Service received a call from Michael at 19:35 hours reporting that Daniel was not breathing. Michael said that he had just found Daniel in bed and thought he was dead. Michael took Daniel down from the bunk bed and began CPR. It was disclosed that there appeared to be a piece of chocolate in Daniel mouth which Michael removed. Michael continued to administer CPR until the ambulance arrived. A paramedic pronounced death at 20:02hours.

6.2 At 20:28 hours Nottinghamshire Police were contacted by East Midlands Ambulance Service who reported the death of Daniel at his home address. It was reported that it was not suspicious, but the death was unexpected.

6.3 Daniel was described as being very bright academically and had attained 13 grade A GCSE's. He then went on to study A-Levels, including politics and history.

6.4 Daniel and Michael were in a relationship and lived together. Daniel was aged 17 years old, and Michael was 57 when they met and started their relationship. They had been in a relationship for seven years, having met on an internet dating website in 2015.

6.5 Daniel was also not getting along with his parents due to coming out as gay and Michael reported to police at the time that Daniel's parents were not supportive of his sexuality and had allegedly booked Daniel on a one-way ticket to Sri Lanka. Michael stated that he wanted to provide help and support to Daniel and over a two week period, after meeting Michael online, Daniel moved out of his family home and moved in with Michael in January 2016. Daniel's mother contacted police concerned about the relationship and Daniel's vulnerability.

6.6 The home address of Daniel and Michael was a three bedroom house owned by an elderly couple who also lived at the address. Michael had lived at the address for around 40 years. The homeowner's were unaware that Michael and Daniel were in a relationship.

Summary Chronology

6.7 The review considered agency involvement with Daniel and Michael from January 2018, coinciding with a the first disclosures of domestic abuse, to February 2022.

6.8 In 2018 Daniel made his first disclosures of coercive and controlling in his relationship and requested supported accommodation. His family also raised concerns about the relationship with police and Adult Social Care which resulted in both agencies completing DASH risk assessments and adult social care initiating a safeguarding enquiry.

6.9 Further concerns were raised about firearms in the property and the police were notified of these concerns. The police conducted a review of the fire arms license, and removed the firearms license from the male homeowner.

6.10 Adult social care worked jointly with Equation to support Daniel and during this time Daniel disclosed physical abuse, including Michael putting his hands round Daniel's his throat, the use of trackers and CCTV, and shared that Michael had been to prison for attempted murder, a matter which police later confirmed with professionals was not true.

6.11 A DASH was completed as medium risk and was referred to MARAC on the basis of professional judgment. The MARAC took place on the 19th July 2018.

6.12 Daniel began to withdraw from the support offered by Adult Social Care and Equation in August 2018. He stated he wished to remain in the relationship and felt he was unable to cope living independently.

6.13 During 2018 Daniel was also expressing suicidal ideation and began to contact the Crisis Resolution Home Treatment Team when he again disclosed a coercive relationship. Daniel was signposted to his GP, on one occasion to A&E and on another occasion was conveyed to A&E where another DASH was completed and referred to MARAC, although the referral was never received.

6.14 In October 2018 Daniel withdrew from college. The college felt the decision was heavily influenced by Michael, and shared the information with Adult Social Care.

6.15 Throughout 2018 Daniel engaged with the Tomorrow Project support sessions until November 2018. Michael said that 'listening support offers Daniel a chance to reinforce he should kill himself.'

6.16 Daniel's first contact with the Department for Work and Pensions was in November 2018. Daniel disclosed his depression and suicidal intent, and that he was in a coercive relationship.

6.17 Daniel had regular consultations with his GP throughout 2018 where he discussed his mental health and controlling relationship. The GP referred for mental health support and Daniel had an assessment with a Community Psychiatric Nurse (CPN) in December 2018, accompanied by Michael.

6.18 In January 2019 Daniel asked the CPN if he could apply for supported housing. He said he had stopped taking some of his prescribed medication and that the homeowners forced him to drink alcohol when he did not want to, and was made to take the female homeowner's medication. Daniel was advised to seek support from Framework[2] for accommodation. A further CPN appointment was arranged however Daniel did not attend, and was therefore discharged from the service.

[2] Framework provide support and housing to people who are homeless Our services - Framework Housing Association (frameworkha.org)

6.19 Following involvement with Housing Aid and Adult Social Care Daniel decided he did not want to move and was minimising his experience of domestic abuse.

6.20 Daniel continued to experience suicidal ideation throughout 2019 and in October 2019 he attended Maytree[3] for four days for respite.

6.21 The Local Mental Health Team received a referral in November 2019 which identified self-harm risks, suicidal thoughts and a private admission due to trying to hang himself. A CPN completed an assessment with Daniel, Michael was also present. No were risks identified and records reported that Daniel's presentation was in keeping with his diagnosis of Autistic Spectrum Disorder (ASD). Daniel and Michael were given contact details for the Crisis Resolution Home Treatment team if further support was required. Daniel was also referred to Nottingham City Autism service. The service reviewed the referral and agreed that a Cognitive Behavioural Therapy (CBT) therapist would offer a telephone consultation to Daniel. The CBT therapist attempted to call Daniel on the 25th March 2020 but he did not answer.

6.22 Daniel saw his GP throughout 2019. His medication was reviewed and talking therapies was discussed as an alternative to medication. Daniel requested a referral to a psychiatrist for diagnosis and better understanding of his condition which the GP agreed to.

6.23 Daniel's first session with the Sexual Violence Support Service took place online on the 1st June 2020, Michael was present in the background. The second session took place on the 8th June. The therapist explained that Michael's presence was not appropriate and this would not work moving forwards, Daniel assured the therapist that he was safe and did not want to be anywhere else. Daniel had three further sessions in June 2020 and no concerns were identified. Daniel's sixth session took place on the 6th July 2020. The session had to end early as Michael joined the session and displayed worrying behaviours towards Daniel (arm around neck/chest in controlling manner and speaking on behalf of Daniel). The therapist shared their concerns with the GP and stated that they could no longer work with Daniel due to the risks. Daniel was moved to the 'covid pause list', with view to seeing him face to face restrictions were lifted.

6.24 Daniel continued to express suicidal ideation throughout 2020, contacting NHS111 and police for support. On the 24th November the Crisis Resolution Home Treatment Team noted that they have been trying to see Daniel alone due to concerns that he is being monitored closely by partner Michael and that when the service tried to video call, his partner could be seen in background.

6.25 On the 26th November Daniel was assessed by a CPN. Daniel was not accepted into the team however, it was recorded that he had 'ongoing suicidal ideation and risk to self by misadventure'. Daniel was provided with the contact details for Equation and was advised to contact Adult Social Care, Turning Point for

[3] The Maytree Suicide Respite Centre offer a free 4-night/5-day stay for people experiencing suicidal thoughts. Maytree | We're open to suicidal feelings

emotional support and to self-refer to Crisis Resolution Home Treatment Team if he was struggling.

6.26 On the 3rd December Daniel was referred to the Tomorrow Project. The Tomorrow Project completed their assessment session with Daniel via zoom; Michael was also present. Following a discussion with a safeguarding lead, it was agreed to bring Daniel in for a face to face session in January and for a safety plan to be completed prior to the Christmas break, however contact could not be made with Daniel. The GP was informed of the their concerns around suicidal ideation.

6.27 In early 2021 the DWP referred Daniel to Futures Positive[4] and during his appointment with them Daniel disclosed feeling suicidal. Daniel was advised to contact the Crisis Resolution Home Treatment Team if his mental health declined and information was shared with the CPN to request extra support for Daniel. The Crisis Resolution Home Treatment Team continued to provide employment support over the phone until February 2021, although the DWP reported that Futures Positive was withdrawn by 6th January 2021 as Daniel was no longer in receipt of secondary mental health services.

6.28 Michael attempted to cancel Daniel's appointment with the Tomorrow Project by writing an email pretending to be Daniel. The Tomorrow Project raised a safeguarding concern with adult social care citing concerns of control and coercion from Daniel's partner. Daniel was offered face-to-face support and whilst he accepted, Michael refused. Daniel continued his sessions with the Tomorrow Project through to May 2021.

6.29 Adult Social Care initiated safeguarding enquiries and Equation referred to MARAC on the 4th February 2021 based on professional judgement.

6.30 On the 25th February 2021 Daniel was reviewed by the CPN and assessed as not requiring CPN support. No suicidal plans or psychosis were identified. Daniel was signposted back to the GP and to continue with employment support.

6.31 On the 11th March Daniel was discussed at MARAC. Information was shared and an action plan created to increase safety, reduce risk and hold the perpetrator to account. Actions taken from the MARAC were for all services to confirm the identity of Daniel when making telephone contact with him as Michael was known to pose as him. It was recommended that Daniel was seen in person where possible. Equation agreed to meet with Daniel, however, Daniel cancelled all appointments with Equation and Adult Social Care.

[4] Futures Positive is an NHS team providing a holistic person centred approach to provide Employment support for people who are receiving Secondary Mental Health services

6.32 Daniel commenced employment in May 2021, working 40 hours a week. He advised the Tomorrow Project that he could not attend further sessions due to work commitments.

6.33 Daniel continued to consult with his GP regularly and in August 2021 he reported that he tried to kill himself with one on Michael's braces, triggered by criticism from Michael. Daniel told his GP that he would only move out if the homeowners died, he felt he would have a worse lifestyle if he moved out but there were many barriers to doing this.

6.34 On the 28th September 2021 adult social care received a safeguarding concern from Daniel's friend. Daniel had disclosed that Michael controlled him and he sometimes he felt like ending it all. The social worker called Daniel who said he had recently left his job due to feeling stressed and suicidal. Daniel said he did not feel his relationship was controlling and coercive but other people do although he was willing to speak to adult services further.

6.35 Daniel told his GP in September that continued to think about suicide daily and the GP agreed to refer to Local Mental Health Team. The Local Mental Health Team advised that Daniel was not suitable for their service and that referrals should be made to the Attention Deficit Hyperactivity Disorder (ADHD) service. The GP promptly made a re-referral to Local Mental Health Team which agreed to put Daniel on the CPN waiting list for an assessment. The referral to the ADHD service was not accepted due to there not being enough information relating to ADHD symptoms in the referral.

6.36 The social worker maintained contact with Daniel by phone. Daniel said he was not too concerned about Michael's controlling behaviour. Daniel felt Michael was supportive and that he would not cope living without support, and may end his life by hanging if this was the case. Daniel stated he was waiting for mental health support and never felt he had the type of support that he needed. Daniel recognised that his relationship was more restrictive than others but was better than living on the streets and being homeless. Daniel felt he could not afford supported living. Daniel was provided safety advice and Daniel confirmed that he did not want to leave Michael.

6.37 The Local Mental Health Team assessed Daniel on the 2nd November 2021 by phone. Daniel disclosed he was still made to take other people's prescribed medication and drink alcohol. The assessment identified thoughts of suicide but no plan to carry through with actions. Daniel stated that he rarely left house. Daniel was not accepted into the service. The Local Mental Health Team documented that the most appropriate service to support the Daniel was the Human Flourishing Project. Daniel was advised that the GP refer to Step 4 Psychology.

6.38 Adult social care made a welfare call to Daniel on the 17th December 2021. Daniel advised that he was using a suicide forum, but he had no plans to end his life.

6.39 Daniel had a phone appointment with the GP on the 20th December 2021. Daniel said he was having severe thoughts yesterday, thoughts of hurting other people and killing them In the shower. It made him feel like a bad person and he just wanted to kill himself because he did not want to have thoughts about killing. Daniel said he thought about killing Michael by blows to his head and could picture and hear those images.

6.40 Following liaison with Daniel's GP, the Crisis Resolution Home Treatment Team completed an assessment with Daniel on the 21st December 2021. The assessment identified that Daniel was experiencing a decline in his mood with sleep and diet affected. Michael stated that this was a result of stressors related to Daniel's parents. Risks were identified as self-harm, thoughts to harm others and feeling hopeless.

6.41 Daniel contacted NHS111 on the 9th January 2022 with regards his mental health and was provided talking support. Daniel had a telephone appointment with his GP the following day and said he was having some thoughts of rage. The GP agreed to refer for Step 4 Psychology.

6.42 Adult social care considered the use of the inherent jurisdiction of the High Court but their legal services advised that the threshold would not be met and was therefore not an option.

6.43 On the 26th January the GP was notified that the referral for Step 4 Psychology had been rejected as Daniel's mental health was too unstable and would therefore not be able to engage.

6.44 The social worker attempted to contact Daniel on the 27th January, 3rd, 15th, 18th and 21st February, he did not answer the phone and messages were left.

6.45 Daniel told his GP that he had made some online friends but had issues with the suicide forum, and that he had had thoughts about getting barbiturates Nembutal from Mexico.

6.46 On the 31st January the Local Mental Health Team agreed to consider re-referral due the Step-4 Psychology referral being declined. Review of the referral identified instability, impulsivity and Daniel being unsettled. The referral also mentioned 'relationship difficulties'. The Local Mental Health Team referred to Turning Point.

6.47 The GP wrote to the Local Mental Health Team on the 4th February requesting further input for Daniel. The Local Mental Health Team planned to discuss Daniel

at their team meeting but the referral was rejected due to no changes in Daniel's presentation and a decision to continue with a referral to Turning Point.

6.48 Daniel has his first session with Human Flourishing on the 18th February and this reportedly went well. Daniel also had two consultations with his GP in February with nothing of significance noted.

6.49 On the 25th February Daniel cancelled his counselling session with Human Flourishing and requested future sessions by phone. Human Flourishing decided that it was preferable to continue with in-person sessions due to an understanding that Daniel had limited space to have privacy at home.

6.50 On the 28th February Michael phoned 999 and requested an ambulance as Daniel was not breathing. Crew attended and confirmed Daniel was deceased.

KEY ISSUES ARISING FROM THE REVIEW

Response to disclosures of domestic abuse and risk assessment

7.1 There were a number of disclosures of domestic abuse throughout the period subject to review. In 2018 Daniel made the first disclosure to his GP in January and to the police in February, whereby he explicitly cited controlling behaviour. Further concerns were raised by his mother, his father, his uncle, his GP and the Include service just in that year. Daniel further disclosed behaviour, which amounted to domestic abuse and coercive controlling behaviour, to Adult Social Care and Equation. Daniel continued to disclose behaviour which indicated coercion and control throughout the scoping period and a number of agencies raised concerns about the same.

7.2 In response to disclosures, DASH risk assessments were completed by police, Adult Social Care, Equation and Nottingham University Hospital. There were a number of instances where DASH risk assessments would have been appropriate to undertake but were not, and opportunities for other services to assess the risk of domestic abuse, and to refer to adult safeguarding services. However, some of the agencies did seek further advice from their safeguarding leads, including the DWP and GP.

7.3 NHFT recognised that routine enquiry was not completed at numerous contacts with Daniel. If routine enquiry had been conducted this may have provided Daniel with opportunities to access specialist domestic abuse services. DASH risk assessments should have been completed after each disclosure of domestic abuse made by Daniel in line with the NHFT Domestic Violence and Abuse policy, these were not undertaken based on the assumption that other agencies were taking responsibility for safeguarding and had already assessed the risk. The fact that Daniel repeated the disclosures on several occasions to different professionals with no positive outcome may have left him feeling despondent.

7.4 Good practice was demonstrated by Adult Social Care in their liaison with specialist services and application of professional judgement to affect referrals to MARAC. The service also initiated safeguarding enquiries in accordance with the Care Act 2014 and the enquiries took account of the further concerns raised and disclosures made during the process. Adult Social Care also identified the presence of firearms which might have been used to exert control, and alerted police on two occasions, who responded in accordance with their own policies and procedures.

7.5 Adult Social Care and Equation undertook safe enquiry with Daniel, utilising the college for joint meetings. Unfortunately, after Daniel withdrew from college in October 2018 it became difficult to undertake safe enquiry with Daniel and it was suspected that he disclosed appointments to Michael who then made Daniel cancel them. Safe enquiry was further compromised by the covid-19 lockdown whereby most consultation with Daniel was undertaken remotely.

7.6 Daniel was deemed to have mental capacity, and so Adult Social Care considered the impact of coercive control on his ability to make decisions and explored the use of the Inherent Jurisdiction of the High Court. The Inherent Jurisdiction of the High Court is an option of last resort but provides a safety net to those whose decision making ability is impaired because of undue influence or duress but are not considered to lack capacity under the Mental Capacity Act 2005. The High Court's primary function is to facilitate the time and space for someone to make a decision free from duress or undue influence. There are cases where the High Court have directed someone on where to live, albeit for temporary duration, and have passed orders to allow professionals to access the adult in their home. Adult Social Care sought legal advice on making an application to the High Court but were advised that there was not sufficient evidence upon which to make such an application.

7.7 The police were contacted by Daniel on six occasions between February 2018 and April 2020 following reported arguments with Michael. A DASH was only completed following the first report. Nottinghamshire police reflected that in 2020 there was a lack of understanding of coercive and controlling behaviour in the Criminal Prosecution Service, and that understanding is better today. A prosecution was not pursued due to Daniel's lack of engagement in supporting a prosecution, the lack of independent evidence, and therefore no prospect of a prosecution. In 2023 all officers wear body worn cameras which are used in response to all domestic abuse incidents, whereby evidence from body worn cameras can help support cases leading to evidence led prosecutions.

7.8 The learning event discussed how and what evidence of coercive controlling behaviour could be gathered. The police said that it would be overwhelming for agencies to report every piece of evidence as and when it arose and suggested that MARAC would be the forum for initiating a request for evidence.

7.9 Responses from police and out of hours mental health crisis services were further compromised through the identification of Michael as a friend, carer, and

housemate. It is not known if Michael or Daniel confirmed this was the relationship or whether it had been assumed, particularly due to the age difference, nevertheless there was historical information available to confirm that they were in a relationship. Further exploration of the relationship may have triggered a response involving an assessment of domestic abuse risk and onward referrals.

7.10 In relation to the police response in January 2020, the two other adults in the home were, mistakenly, considered a protective factor. A DASH in January and April 2020 would have been beneficial to assess the level of risk and would have been expected. Police reflected that this occurred three years ago, and since 2020 practice has changed and positive action would be taken now. Following significant work in this area the volume of completed DASHs in the past 18 months has increased significantly.

Assessment of risk

7.11 Specifically in relation to the quality of risk assessments and whether links between mental health (including risk of suicide) and domestic abuse (including historical domestic abuse) were identified when risk was assessed, it is evident that in the main the links were not made.

7.12 There was recognition by some agencies that the domestic abuse Daniel was experiencing was having an adverse effect on his mental health and onward referrals were made to mental health services and information shared with Adult Social Care and the GP as a result. However, the mental health service response focussed on the presenting mental health issue, neglecting the context of domestic abuse. In October 2018, despite a direct disclosure by Daniel and the service being aware of the recent MARAC, mental health services determined that Daniel's presentation was 'in keeping with Aspergers syndrome' and that he was hypomanic due to medication.

7.13 Coercive control was not identified by NHFT as a contributory risk factor to Daniel's mental health, despite the known history. Their agency report identified a gap in learning in respect of professionals' understanding of the impact that continued and sustained coercive control can have on mental health. Following the NHFT internal serious incident review, the Local Mental Health Team invited Equation to attend their team leaders meeting in November 2022 to provide a presentation around coercive control.

7.14 Research undertaken by Refuge and the University of Warwick into the links between domestic abuse and suicide identified that domestic abuse has a long term adverse impact on psychological wellbeing[5]. The fact that Daniel was experiencing suicidal ideation should have been considered in conjunction with the domestic abuse and coercion and control and should have raised the risk for agencies. Mental health of both the victim and the perpetrator are included in the DASH risk assessment, however, this case indicates that there needs to be a

[5] WRAP-Domestic-abuse-and-suicide-Munro-2018.pdf (warwick.ac.uk)

greater understanding amongst professionals about the impact of domestic abuse upon mental health and the prevalence of domestic abuse related suicides.

7.15 Although occurring outside of the timeframe subject to review, it is important to reference the allegation of Honour Based Abuse which was made by Michael early in the relationship. Although Daniel subsequently moved to live with Michael, Honour Based Abuse may have been an ongoing risk for Daniel. It is also possible that Michael used this allegation as a means of isolating Daniel further from his family. Either way there was a missed opportunity for agencies to explore the risk of Honour Based Abuse for Daniel and to secure specialist support for him in this respect.

The Suicide Timeline

7.16 The Suicide Timeline[6] provides an eight-stage timeline for domestic abuse related suicide. It is a practical tool, for use by professionals, developed through research and analysis of case studies to understand the interactions between perpetrators of coercive control and their victims, and how these interactions may be linked to escalating and de-escalating risk of serious harm or homicide.

7.17 The stages represent potential escalating risk. The further along the stages, the higher the risk of serious harm, with opportunities at every stage to cease the progression. Each stage provides indicators of perpetrator and victim characteristics. Although the stages are arranged sequentially they are not necessarily mutually exclusive, they can and do overlap, and may not occur in order with 'circling' through the stages occurring in some cases.

7.18 Stage one draws on previous research which identified that perpetrators are both repeat and serial offenders and that those who employ coercive control are likely to do so in all their intimate relationships. Criminal behaviour does not just relate to a criminal record and previous convictions, but may also be identified through testimony from professionals, the victim, family or the perpetrator themselves. History may also be identified through behavioural characteristics.

7.19 In relation to the victim, the research identified vulnerabilities from past domestic abuse, sexual abuse, child neglect, bereavement, or eating disorder.

7.20 Little is known about the Michael's history and past relationships. The only recorded offences relate to an attempted burglary in 1983 and possession of firearms without a licence. It was also reported that he was actively looking for 'young troubled boys/men' on the internet in order to 'save' them. Daniel believed that Michael had been to prison for attempted murder. Daniel had also alleged past sexual abuse as a child from a family member.

[6] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide - Research Repository (glos.ac.uk)

7.21 Stage two represents the early relationship. It is marked by relationships that develop quickly with early cohabitation, or early declarations of love. Families report the strong influence exerted by the perpetrator at an early stage and often express concerns about the speed of which the relationship developed.

7.22 The early relationship was marked in this case by early cohabitation, within two months of meeting. Daniel's family expressed concerns about grooming, and contacted police concerned about the relationship and Daniel's vulnerability.

7.23 Stage three relates to the relationship. In all cases reviewed relationships were dominated by intimate partner abuse with just over half evidencing serious repeated violence. Control and violence started at an early stage within the relationship.

7.24 The first concern of coercive and controlling behaviour was raised in 2017 and was followed by numerous reports of emotional and physical abuse, and coercion and control throughout the period of Daniel and Michael's relationship. Daniel reported controlling behaviour which included: the use of CCTV cameras and phone trackers; having to take photos to prove his whereabouts; physical abuse such as slapping, grabbing his throat, and inflicting burns; administration of medication he was not prescribed and withholding prescribed medication; forced consumption of alcohol; isolation from friends, family and professionals; control of social media and email; threats of violence; financial abuse; psychological abuse and gaslighting. There was also evidence that Michael controlled the household and that he used the female homeowner to exert control over Daniel.

7.25 During stage four the victim identifies the behaviour of the perpetrator as abusive and may start to disclose, usually to friends and family first. Disclosure may be incremental and may come before explicit help-seeking. Disclosure in health settings is common as the environment may feel more confidential and supportive, although research suggests that victims are more likely to disclose to their GPs than in an A&E setting, with victims returning to surgeries 30 or 40 times before managing to disclose domestic abuse.

7.26 Perceived escalation of the seriousness of the abuse is a key factor in the victim deciding to disclose. Equally shame, perpetrator threats, fear over increased violence, and how disclosure will affect social interactions, were reasons for hesitating to reveal abuse. It was found that early disclosure appeared to be more common in cases of domestic abuse suicide, than homicide cases. It is important for professionals to recognise that a disclosure will not represent the beginning of the risk but will likely be an indication of escalation. Disclosure is distinct from help-seeking as it is more likely to be linked to exploration and validation for the victim.

7.27 The first recorded disclosure by Daniel was in January 2018 when Daniel disclosed to the GP surgery, and soon after to the police. Daniel continued to disclose throughout the timeline to various agencies. Although Daniel's family reported their concerns to police and Adult Social Care it is unknown whether this was following a disclosure by Daniel to his family. It appears unlikely that this was the

case as the family did not mention this in their reports and it is known that by this stage Daniel was significantly isolated from his family.

7.28 Help-seeking can occur at stage five, usually after disclosure, and often in response to the victim's perception that the abuse has escalated, and things have become more serious. Active help-seeking can be seen as a threat to the control exerted by perpetrators, as a result there may be consequences, and the perpetrator may also increase their control in response. Perpetrators are seldom deterred as a result of help-seeking, even if the help sought includes police involvement and results in arrest, prosecutions, civil orders and so on, with perpetrators continuing to exert control despite any sanctions.

7.29 Help is most commonly sought from mental health services and the police. When help is sought from mental health services the help sought is for mental health linked to the domestic abuse being experienced. However, services do not always make those links explicitly; prescription medication is a more common response than specific help with the abuse.

7.30 The victim's mental health help-seeking appears to dominate assessments of them and the victim's assessment of themselves leading to self-blame. The victim being perceived as 'mentally unstable' creates perceptions that they are culpable in the abuse. This can become worse, and attention further diverted when the victim self-harms, talks about suicide, or makes attempts to end their lives. In some cases, it was felt by victims that if they received mental health support they would become 'strong enough' to leave the abuser.

7.31 Daniel was likely starting to seek help in 2018 when he started to request supported accommodation. As time passed Daniel began to deny that Michael was controlling and Daniel's help seeking became focussed on his mental health and suicidal ideation. Daniel talked about ending his life and made two attempts to do so. There are numerous contacts throughout the chronology of Daniel making contact with mental health services and seeking help for his mental health. As has already been mentioned, Daniel's mental health was responded to in isolation from the domestic abuse he was experiencing, links were not explicitly made and the impact of the abuse upon is mental health not fully explored or appreciated. As time progressed and Daniel began to receive more support from agencies there was evidence of Michael's control increasing, including Daniel's withdrawal from college, various appointments cancelled and withdrawal from agency support.

7.32 Furthermore, there was significant evidence of technology facilitated abuse, including the use of phone trackers and CCTV, alleged instances of Michale pretending to be Daniel in email correspondence, and prohibiting a safe and confidential space for online meetings. Such abuse would have limited Daniel's ability to seek help and attend the necessary meetings to receive the support he needed.

7.33 Although suicidal ideation is placed at stage six, this is considered the latest, but most common stage that suicidal ideation was noted in the cases analysed,

although in some cases, it appeared in earlier stages, sometimes as early as stage one. Self-harm, suicidal ideation and suicide attempts are sometimes seen as confirmation of mental instability, re-focusing attention on the victim's mental health rather than the abuse.

7.34 Suicidal ideation can occur in parallel with homicidal ideation in perpetrators of high-risk abuse, and all suicidality should be taken seriously. There were also cases in the sample where the perpetrator had actively encouraged suicide of the victim.

7.35 Daniel was expressing suicidal ideation from as early as February 2018, and he regularly reported this throughout the following three years. It certainly appears that in this case Daniel's suicidal ideation and suicide attempts were confirmation of his mental instability, which re-focused attention on his mental health rather than the abuse he was experiencing, including by Michael.

7.36 At stage seven the victim feels and sometimes vocalises that they feel trapped in a situation from which there is no escape and feel that nothing will get better.

7.37 Interestingly, there is evidence of entrapment very early on in the relationship. In late 2018 despite taking steps to pursue alternative accommodation Daniel resolved that he could not live independently, regularly referring to Michael telling him he had the mind of a twelve year old, and wished to remain in a relationship with Michael. Daniel made statements which indicated feelings of feeling trapped, such as 'I would have a worse lifestyle if I moved out but there are so many barriers to do this', that he could not cope living without Michael, that living with Michael was better than living on the streets, and that he would only leave once the homeowners died. These statements became more prominent from September 2020 and continued into late 2021. Furthermore, there were many indicators of financial abuse, including Daniel leaving his job, the writing of a Will, and the purchase of a car, that would have further fuelled feelings of entrapment for Daniel and was clearly a barrier to him leaving the relationship.

7.38 Suicide occurs at stage eight. The most common method of suicide was ligature and in at least 16 cases the perpetrator was the last person to see the victim and, in many cases, discovered the victim's body. In some cases it seemed clear that the victim had taken their own life and intended to do so, in some cases there was evidence that the perpetrator had encouraged suicide, and some families expressed concerns that suicide had been staged. It is common for the suicide to be accepted based on the mental health history of the victim, especially if there was a history of suicidal ideation.

7.39 Daniel died by suicide as a result of pentobarbital toxicity. Michael was the last person to see Daniel and discovered his body.

7.40 Application of the suicide timeline shines a light on Daniel's experiences of the coercive controlling behaviour perpetrated and the escalation of risk which ultimately culminated in his suicide. Each stage of the Suicide Timeline can be directly applied to Daniel's case and demonstrates how information can be

gathered as an aid to assess risk, identify escalations in risk, and consider prevention strategies and interventions. The timeline also highlights the importance of greater professional curiosity to minimise the risk of misinterpretation of presentations of mental and physical ill health, which may in fact be attempts of disclosure and help-seeking.

Multi agency response

7.41 Daniel was referred to, and heard at, MARAC on two occasions. The first MARAC was held on the 2nd July 2018 following a medium risk DASH which had been escalated to high risk based upon professional judgement, at the time Daniel was 19 years of age. Multiple agencies raised concerns regarding control and coercion and Adult Social Care, Nottinghamshire Police, Equation, NHFT and Childrens Integrated Services shared information. All agencies were instructed to add a domestic abuse marker to their files in relation to Daniel and to note that Michael was not to chaperone Daniel to or during appointments. The police were asked to review the DASH, link in with the Equation IDVA and liaise with the Serious Collision Investigation Unit for further information. Equation was tasked with meeting Daniel to explore risks and Adult Social Care were to review Daniel's history. Other actions were agreed in relation to the homeowners such as sharing MARAC minutes with their GPs. MARAC were unable to report if all agencies completed actions within the agreed timescale and action outcomes were not updated.

7.42 There was no evidence that MARAC considered how ASD could impact Daniel's understanding of what was being explained to him, or his understanding of coercion and control. However, a referral to an appropriate service, Include, was made.

7.43 Although it was noted that Daniel had to undertake chores as he did not pay rent, there was no evidence of discussions around Daniel being exploited for domestic servitude, although this may have been considered as part of the control Michael used over Daniel.

7.44 However, the MARAC allowed agencies to link together to share information and updates. Risk to the homeowners from Michael was considered. Checks for more information and requests for safety measures to be put in place were made. Agencies were made aware that Michael often presented as Daniel's chaperone, and of the potential risks to Daniel from Michael being treated as a chaperone. Daniel's mental health as a result of the domestic abuse he was experiencing was considered and shared. There were plans to review this alongside other risks posed by Michael when the IDVA and social worker next met with Daniel and joint meetings were arranged to enable the IDVA and other agencies to engage with Daniel when he met with the social worker. It was agreed that all contact with Daniel would be through his social worker as a means of managing risks.

7.45 The second MARAC was held on the 11th March 2021. Again, the referral was made based upon professional judgement following discussion with other

agencies. Information was provided by Adult Social Care, police, Equation, NHFT, and Housing Aid. All agencies were asked to flag domestic abuse on their systems. Police were asked to review the DASH, Equation were asked to link with Adult Social Care for planned support for Daniel, NHFT were asked to share MARAC minutes with the Local Mental Health Team, to log on their systems that Michael sends emails on behalf of Daniel, and to link with Equation to provide support to Daniel. All actions were reportedly completed.

7.46 All agencies were made aware of Daniel's ASD although there was little evidence of agencies acknowledging this as something they must consider when working with Daniel. Historic information was shared that raised concerns of Honour Based Violence from Daniel's family which does not appear to have been explored further following a referral to the police's Honour Based Abuse team, there was a concern that Michael was seen by some of the agencies as a protective factor for Daniel in this respect.

7.47 Not all the agencies who were supporting Daniel attended the MARACs as they were not part of the core membership. This included third sector providers such as the Tomorrow Project, and the DWP.

7.48 Although there was effective information sharing and planning at both MARACs, there was little discussion noted about what could be done to hold Michael to account. However, it is of note, that where there is no charge for any offences, and no agencies actively involved with the perpetrator, and as such it is more difficult to hold that person to account. This would have been further compounded by Covid 19 and lockdown restrictions.

7.49 The two MARACs were the only multi-agency meetings held in respect of Daniel. The convening of a MARAC relies on any future disclosures triggering the completion of a DASH and a referral to MARAC if the threshold is met. This was an area of learning identified in DHR Chapeau which made the recommendation that 'All MARAC agencies to be reminded that repeat referrals of any risk level within a 12-month period should be referred back to the MARAC. This point to be emphasised in on-going MARAC training.'[7] Repeat MARACs can assist in reviewing the risk, actions and safety plans, and securing evidence. It is then significant that despite ongoing disclosure by Daniel, and concerns raised by agencies, there were only two MARACs held, almost three years apart.

7.50 It was further noted that a referral was made to MARAC in October 2018 but not received by the MARAC, highlighting the need for agencies to follow up on any referrals made and to ensure there are systems in place to acknowledge with the referrer any referrals received.

7.51 Given the number of agencies involved and supporting Daniel, identification of a lead agency would have been beneficial. Agencies reflected that due to the complexity of the presenting risks it would have been of benefit for agencies to have a separate multi-agency meeting outside of the MARAC to allow for a more

[7] ncc_dhr-operation-chapeau-exec-summary-26-nov-2020.pdf (nottinghamcity.gov.uk)

detailed discussion around the risks and to develop a multi-agency action plan. Adult Social Care considered themselves to be the lead agency in this case, in terms of safeguarding, who could have coordinated a multi-agency response. However, once safeguarding enquiries were concluded there was no requirement for ongoing social worker involvement, and therefore no lead agency. It is recognised that there is no capacity in the workforce to allocate social workers on a permanent long term basis and therefore other actively involved agencies would have needed to take on the lead role in terms of ongoing support for Daniel.

7.52 Previous DHRs in the Nottingham area have identified a lack of any co-ordinated multi-agency approach with a danger that, if a case does not meet the threshold for MARAC, professionals do not feel empowered to call a meeting to discuss a case. The learning event considered other multi-agency forums available that could have been utilised in this case, and identified the monthly complex persons panel which provides a wraparound multi-disciplinary team coordinated by Adult Social Care. However, agencies felt that MARAC was the most appropriate forum and noted the availability of the MARAC plus meeting for repeat cases which allows additional time for discussion of these complex cases. It is acknowledged that the MARAC forum for repeat cases would not have been triggered for Daniel as there were only two referrals in three years, thus highlighting once again the need for agencies to complete the DASH and referrals to MARAC.

Information sharing

7.53 There were many examples of inter-agency information sharing and communication. There was excellent information sharing and communication between Nottingham College, Adult Social Care, the Tomorrow Project, Housing Aid, and Equation who also shared information with, and made requests for information from, Nottinghamshire Police.

7.54 Information was shared between agencies about the risk of domestic abuse and suicidal ideation. This was achieved not only via the MARACs held but also through referrals made to other agencies, such as Housing Aid.

7.55 There was evidence of good dialogue and information sharing between the GP and Adult Social Care. The GP and social worker also communicated and shared information with multiple partner agencies to ensure that Daniel was in receipt of supportive services. There was evidence that requests for information and onward referrals were acted upon swiftly.

7.56 The Human Flourishing Project were not aware that Daniel had and was experiencing domestic abuse and coercive control. This was not communicated to them by any other agency because Daniel self-referred to the service and the service was not aware of the other agencies that were involved. It is acknowledged that their involvement was brief and so may not have made a difference in this case, but having this knowledge may have led to them alerting

other agencies to the presence of Michael during a meeting, issues of confidentiality and privacy, and non-attendance.

7.57 Throughout NHFT's involvement there were several contacts where risks identified reached the threshold for information sharing between agencies and onward referral to external agencies such as Adult Social Care, in line with NHFT policies and procedures. However, this did not occur as there was an assumption that other agencies were taking responsibility for safeguarding and were already in possession of the information.

Protected characteristics

7.58 Daniel was diagnosed with ASD[8] in 2017. Daniel reported on many occasions that Michael would tell him that he had the mind of a 11/12 year old. Daniel was offered the ASD post diagnostic group. This group is described as an empowering group but is provided as a one-off session; one session would not have been enough to counter the perception perpetrated by Michael.

7.59 With regards to Michael's attendance at appointments, the autism specialist commented that it is common for autistic people to bring others to appointments to manage communication, this would be seen as a reasonable adjustment which conflicts with the notion of safe enquiry in domestic abuse. However, autism assessment requires information from another person (in addition to direct assessment of the client). It is preferable to speak to a parent about the client, but partners are often also included in the absence of parents. Daniel did not give consent to speak to his parents. While Daniel may well have communicated very effectively in sessions, the purpose of the informant is not to communicate on the client's behalf, it is to provide information about their communication, social interactions and evidence of any restricted/repetitive behaviours. People with ASD are not always able to see themselves through other people's eyes, so this third party information is considered an important part of the assessment. During his assessment for ASD the Neurodevelopmental Specialist Service were able to gather a lot of information from Michael reflecting the need for people with autism to have a supporter to manage communication. However, whilst there are some assessments where it is appropriate to have a supporter, there are other appointments where safe enquiry does not support this approach and professionals need to consider with the person how best to support their communication, including independent advocacy.

7.60 The DWP identified Daniel as a vulnerable customer and a number of steps were taken to provide Daniel with appropriate additional support, such as the involvement of the Disability Employment Advisor, creating six-point plans[9], referral to the DWP Psychologist, Intensive Personalised Employment Support and

[8] Asperger syndrome (autism.org.uk)

[9] Six-point plans are completed when a claimant declares an intention to take their own life or self-harm. The process is triggered by the declaration, at which point DWP staff consider whether there is an immediate need to contact the emergency services. DWP staff will also consider signposting to appropriate external organisations who may be able to assist.

Employment Individual Placement Scheme, as well as external sources of support, including contact with his GP.

7.61 The GP evidenced making reasonable adjustments in response to Daniel's mental health and ASD, these included facilitating consultations when Daniel was late, providing extended consultations to allow Daniel to express his thoughts and feelings, and making rooms available for Daniel to meet with social workers and the IDVA.

7.62 Daniel presented to mental health services on multiple occasions with suicidal ideation, yet the level of risk associated with this appeared to be minimised and attributed to his diagnosis of ASD and therefore not responded to appropriately. Daniel had a number of comorbidities, which is more common with people with ASD. He suffered with depressive symptoms, anxiety and intrusive and obsessional thoughts, low self-esteem and poor confidence. Daniel's presentation appeared to have been linked to features of his ASD and not attributed to poor mental health. Therefore, treatment identification appeared to be problematic, and he was moved around mental health services without adequate support or a clear treatment pathway.

7.63 Research has shown that people with ASD are at higher risk of suicide than the general population, with up to 35% having planned or attempted suicide. People with ASD are believed to be at greater risk for a number of reasons. Actively masking their ASD can negatively affect their mental health; some experience difficulty in identifying and describing their emotions; they can get stuck and continuously mull over particular thoughts or behaviours, and this persistent thinking can lead to feeling trapped in an unbearable situation. People with ASD also experience a lack of appropriate support and services for their mental health and suicidality compared to the general population.[10]

7.64 It is evident that agencies did not fully consider or understand the impact of ASD upon Daniel's mental health and his understanding of healthy relationships, and would have benefitted from seeking specialist advice. It was clear that there was no agency route/pathway provided by NHFT to specialist advice. Agencies were dependent upon the success (or not) of Daniel accessing mental health and ASD services via the GP.

7.65 One in six to seven men will experience domestic abuse during their lifetime, however, the percentage of gay men (6%) who suffered domestic abuse in 2019/20 is more than for heterosexual men (3.5%).[11] LGBT victims of domestic abuse are twice as likely to have self-harmed and attempt suicide,[12] with one in eight LGBT people having attempted to end their life in the year 2017.[13]

[10] Autistic people and suicidality (autism.org.uk)
[11] Male Victims - Domestic and Partner Abuse Statistics (mankind.org.uk)
[12] Free to be safe web.pdf (safelives.org.uk)
[13] LGBT in Britain - Health (stonewall.org.uk)

7.66 LGBT victims often find it difficult to seek help for fear of being outed or having to disclose their sexuality. This does not appear to have been a significant factor for Daniel as he reached out and disclosed domestic abuse and his sexuality to a number of agencies. However, just because he disclosed his sexuality it did not necessarily mean he disclosed everything or felt comfortable about sharing his experience of abuse within the relationship. If there was sexual abuse he may have felt uncomfortable talking about it. Furthermore, Daniel had a complex relationship with his family, related to his sexuality and his family's negative response to this. This may have compounded his reliance on Michael for emotional and financial support as he relied on him for his accommodation and sense of belonging. The lack of a multi-agency joint approach, including the fragmented mental health support, and the ongoing feelings of inadequacy reinforced by Michael, may have prevented him from feeling able to function independently.

7.67 Whilst Daniel was able to access support from Equation Men's Domestic Abuse Service, at the time the service did not have a LGBT+ worker. Therefore, it would have been beneficial to secure the services of GALOP as an LGBT+ specialist.[14] Whilst agencies utilised the DASH to assess the domestic abuse risk, the LGBT Special Considerations Checklist (Appendix One) was not utilised. This checklist highlights the specific risk indicators for LGBT victims and would have enabled a greater appreciation of the risks, timelier multi-agency support and MARAC actions that were directly targeted at Daniel's experiences as a gay man.

7.68 Specifically in relation to housing, it is reported that there are concerns about male hostels in the City and fears around homophobia. Daniel may have therefore been concerned once he was told about the accommodation options. Daniel would have benefited from the Safe Accommodation support that is now in available. Whilst the Safe Accommodation statutory duty did not come into force until October 2021, Housing had a discretionary duty to rehouse the vulnerable; experience of domestic abuse supports a person being more vulnerable than the average homeless person.

7.69 Both the age difference and sexuality may have led to the failure of professionals to recognise that Daniel was Michael's partner because of assumptions about relationships. In addition, the age difference between Daniel and Michael would likely have created a power indifference, particularly in the context of Daniel's culture.

Mental capacity

7.70 Adult social care confirmed that for every safeguarding concern and enquiry a social worker will assess the person's capacity to engage with the process. In this case the social worker also assessed Daniel's capacity to understand his relationship, and to consider alternative accommodation. Despite there being a number of social workers assigned to work with Daniel over the years, each one

[14] Galop - the LGBT+ anti-abuse charity

was experienced and competent, and all concluded that Daniel had capacity to make decisions in relation to safeguarding, his relationship and accommodation.

7.71 What was recognised is that it is difficult to assess how controlling and coercive behaviour can impact upon capacity. Although the Mental Capacity Act 2005 does not explicitly mention what to do when a person's relationships and interpersonal influence might affect their capacity, research shows that relational issues frequently arise during capacity assessments and in the Court of Protection, although it appears to be an area in which the court are still finding their way[15].

7.72 It is recommended that professionals assessing capacity should be mindful of interpersonal influence, and if it is suspected all practical steps should be taken to support independent decision making. It is also proposed that relational factors could be considered in the test for mental capacity and there is case law[16] to support the proposition that the assessment of capacity can take into account the interaction between the pressure that the person is under, and the impairment in the functioning of their mind or brain which makes it more difficult for them to understand, retain, use or weigh relevant information. Any argument made on this basis should spell out how the impairment and the interpersonal influence interact to cause the functional inability.[17]

7.73 Furthermore, the autism specialist commented that to understand relationships one needs to understand the perspective of others, seeing the world through someone else's eyes, which can be very difficult for people on the autistic spectrum, and it is quite possible that Daniel lacked this ability.

7.74 An added complication was that it was difficult to engage Daniel in terms of meeting with him. People with ASD can have very concrete understanding which can make assessing their capacity complicated, particularly in the areas of assessing someone's ability to weigh-up and use information relevant to the decision, and therefore any determination would require lengthy assessments to assess capacity. The social workers had limited time and opportunity to explore Daniel's understanding thoroughly and on reflection felt that specialist involvement during adult social care interventions with Daniel may have resulted in better outcomes for him.

Impact of covid-19 lockdown

7.75 In March 2020 the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

[15] The person seems to be under the influence of someone else - Capacity guide
[16] NCC v PB & TB | 39 Essex Chambers
[17] The person seems to be under the influence of someone else - Capacity guide

7.76 There was a further national lockdown introduced for four weeks on the 2nd November 2020 and from the 21st December 2020 London and the Southeast entered its third lockdown, this was extended nationwide on the 6th January 2021. The 'stay at home' order was finally lifted on the 29th March 2021 with most legal limits on social contact being removed on 19th July 2021 . Therefore, throughout most of the period in scope for this review, the country was in lockdown.

7.77 In some cases, victims' access to ongoing support or help with mental or physical health conditions was reduced during the lockdown, anecdotally people chose not to access services so as not to burden overwhelmed services. Although this does not appear to be the case for Daniel who continued to initiate contact with services. The pandemic also affected waiting lists for some agencies meaning that Daniel had to wait longer for support to be provided to him.

7.78 Adult Social Care reflected on the perception of health and social care services being overwhelmed during the pandemic and wondered whether this prevented others from making safeguarding referrals, although the other agencies participating in this review did not think this occurred in this case.

7.79 Daniel was reportedly spending a significant amount of time in bed during the pandemic and Michael reported that he was encouraging him to get up, which was the reason given in relation to an argument that led to police involvement. Police reflected that incidents occurring during the covid pandemic period and associated lockdown could have been interpreted in the context of people suffering anxiety and isolation during the pandemic.

7.80 During the pandemic a number of agencies moved to remote working, meeting with their clients/patients online or via telephone. In a number of online sessions with Daniel, agencies noted that Michael was present, and some observed his coercive and controlling behaviour during these interactions. This also meant that confidentiality was compromised and led to a withdrawal of services, it also increased the opportunity for technology facilitated abuse. For mental health the default was telephone contact with patients, although a follow up meeting was undertaken face to face, Michael was also present.

7.81 All agencies recognised that remote contact meant they missed communication that would have been conveyed visually. The autism specialist commented that people with ASD found the pandemic and lockdown particularly difficult and said that face to face contact with people with ASD must be the default unless there is good reason for it to be remote.

7.82 The Tomorrow Project continued to see their clients face to face recognising that remote consultation was a barrier to their work. Face to face appointments were offered to Daniel, he initially accepted these then declined by email, believed to be Michael, citing covid as a reason not to travel. The Tomorrow Project confirmed that they would have been able to provide evidence of essential travel to support his attendance.

7.83 Commentary on the impact of the covid-19 pandemic upon people with ASD has highlighted that individuals with ASD may be more during the pandemic due to the communication, socialisation, and executive functioning differences, finding it more difficult to adapt to and absorb the substantial and rapidly changing public health information. As a result, many individuals with ASD may have become increasingly reliant on their families and caregivers. Individuals with ASD may have also had difficulty with some core components of resilience such as making future predictions, envisioning multiple outcomes to a given situation, adapting and being flexible to abrupt changes.[18]

7.84 The covid-19 lockdown undoubtably had an impact upon Daniel. It likely affected his mental wellbeing leading him to feel further trapped in his relationship. It compromised the opportunity to meet with Daniel in a confidential space and to undertake safe enquiry. It also gave Michael the means to exert further control, and there is evidence that he utilised the restrictions to prevent Daniel attending an in-person meetings and to facilitate technological abuse.

CONCLUSIONS

8.1 Daniel experienced sustained coercive and controlling behaviour for at least four years prior to his death, and in all likelihood the abuse was present from early in the relationship.

8.2 Daniel disclosed controlling behaviour perpetrated by Michael on numerous occasions between 2018 and the date of his death, and agencies identified the risk of domestic abuse and shared concerns. Daniel also experienced depression and suicidal ideation for which he sought help for on many occasions. Unfortunately, Daniel did not always receive the mental health support he required and when support was given, links were not made between mental health and the domestic abuse he was experiencing.

8.3 This review has highlighted a number of interacting complexities arising from Daniel's protected characteristics (gender, sex, age, sexuality, disability) which agencies found challenging to work with and, at times, lacked the expertise to respond to.

8.4 Application of the Suicide Timeline has highlighted the increasing risk for Daniel and has highlighted how application in practice can assist with information gathering as an aid to risk assessment, identification of escalations in risk, and consideration of prevention strategies and interventions.

8.5 It is acknowledged that the scoping period dates back to 2018 and in the last five years there have been significant developments in responses to domestic abuse as well as new legislation[19]. Agencies have demonstrated, through this review, changes in practice which have already been implemented.

[18] COVID-19 Pandemic and Impact on Patients with Autism Spectrum Disorder - PMC (nih.gov)
[19] Domestic Abuse Act 2021

LESSONS TO BE LEARNED

Victims of domestic abuse with ASD

9.1 The review has highlighted the need for specialist training and advice for those working with victims of domestic abuse who have ASD, to assist professionals in understanding how people with ASD view and understand the relationships they are in and receive support appropriate to their needs.

Assessing capacity

9.2 This area of learning links to the above. The review has identified the challenges of assessing mental capacity for people with ASD and the impact of interpersonal influence upon decision making where there is evidence of domestic abuse. The risk of victim blaming is recognised, and that it may not be directly applicable in this case as professionals felt that Daniel understood his relationship and had mental capacity to make decisions relating to it. However, it remains important learning for the future for professionals working with victims of domestic abuse where an assessment of mental capacity is undertaken.

Suicidality and ASD

9.3 Previous DHRs have identified the need for training in self-harm and suicide and have also recommended all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network. People with ASD are at higher risk of suicidality than their non-autistic counterparts. Agency responses need to be mindful of this when responding to people expressing thoughts of self-harm, suicidal ideation and suicide attempts. This may include consideration of developing or adapting assessment for suicide risk for people with ASD.

The impact of domestic abuse on mental health

9.4 Research has shown that mental health is often considered and responded to in isolation from the experience and impact of domestic abuse, and this was demonstrated in this case. Professionals should be aware of the impact of domestic abuse upon a person's mental health and tailor support in response which addressed both and recognises that domestic abuse is often the precursor to a decline in mental health.

Working with LGBT

9.5 LGBT people who experience domestic abuse also experience additional challenges to disclosure and access to support which is tailored to their needs. The research shows there is a higher risk of suicidality for this group. There are also additional indicators of risk which should be considered when assessing domestic abuse risk. Professionals should be confident in supporting members of the LGBT community, with an awareness of the specialist tools and services available. Consideration should be given to availability of specialist LGBT advice or worker

within their services to ensure they are accessible to members of the LGBT community.

Intersectionality

9.6 The review has demonstrated the importance of recognising and understanding the intersectionality of protected characteristics, specifically age, disability, sexuality, gender, and ethnicity in this case. The review has recognised the importance of reviewing and taking into account protected characteristics and intersectionality at the outset of the process, ensuring that all relevant protected groups are represented on the panel.

Multi-agency approaches

9.7 Agencies and professionals need to be aware of the multi-agency forums available in their areas that are designed to support multi-agency working and management of risk in complex cases. Whilst MARACs are the appropriate forum for cases of high risk domestic abuse these are often time pressured meetings, and in some cases, alternative forums should be considered. Such forums will ensure that cases can be considered in more depth, and the ongoing sharing of information, assessment and management of risk. Multi-agency forums, including MARAC, should identify a lead professional lead professional to ensure coordination, that information is shared, risk assessed and managed, and actions completed, and to act as a single point of contact for the other agencies involved.

Routine enquiry and risk assessment

9.8 This review has highlighted the need for routine enquiry, professional curiosity and risk assessment following suspected domestic abuse and disclosures of domestic abuse. Professionals should be confident in asking questions and assessing risk, signposting to appropriate support services for domestic abuse and ensuring appropriate referrals to MARAC. Professional curiosity should also be applied, and assessments of risk utilised, to gather sufficient information about relationships between persons where abuse is alleged.

Evidence/research based practice

9.9 Evidence-based practice is about making better decisions that informs action that has the desired outcome. An evidence-based approach is based on a combination of using critical thinking and the best available evidence. It makes decisions less reliant on anecdotes, received wisdom and personal experience, although professional judgement remains important and should be applied in combination with the evidence and research available. In this case it includes data and research relating to ASD, domestic abuse and suicide.

Gathering evidence of Coercive and Controlling behaviour

9.10 The review has identified the difficulties in gathering evidence of coercive and controlling behaviour to affect a successful prosecution of the offence. Professionals require advice and guidance on 'what' and 'how' to gather such evidence, and consideration should be given to the need to gather and submit evidence at MARAC.

Technology facilitated abuse

9.11 There was evidence of technology facilitated abuse. Michael utilised CCTV and mobile phone trackers, he was present during confidential online meetings and posed as Daniel in emails, and made Daniel send photos of his location when he was away from the home. The use of technology as a means of control is likely to have had a significant impact on Daniel's ability to access help. Agencies therefore need to increase their understanding of technology facilitated abuse and how to respond.

9.12 In response, Equation have commissioned training entitled 'Domestic Abuse and Technology'. The training is available to all agencies and addresses: the increasing ways digital technologies are being used by domestic abuse perpetrators; the use of spyware, creation of fake accounts, use of covert devices, and the Internet of Things; how children are increasingly being used and harmed in technology-facilitated domestic abuse; and policy and practice recommendations to support victim-survivors. In addition, Equation have developed a new resource for practitioners which includes a tech safety plan template. As this work has already been undertaken, a specific recommendation around technology facilitated abuse has not been made by this review.

RECOMMENDATIONS FROM THE REVIEW

- Nottingham Community Safety Partnership to ensure that an intersectionality review is undertaken at the outset of every Domestic Homicide Review, that the principle predominating protected characteristics are considered and the panel are provided with a view about those characteristics.

- Nottingham Community Safety Partnership's partner agencies to develop professionals' awareness of the impact upon decision making for people who have mental capacity and who are, or may be, experiencing coercion and control and interpersonal influence.

- Nottingham Community Safety Partnership to liaise with the Safeguarding Adults Board and Children Safeguarding Partnership Board to identify the multi-agency forums available in the area, their purpose, membership, access criteria and referral routes, and then raise awareness of these across partner agencies to ensure that approaches and responses are coordinated.

- Nottingham Community Safety Partnership and their partner agencies to ensure that current training includes the Suicide Timeline (to include the additional risk indicators based upon protected characteristics for example, ASD and LGBT).

- Nottingham Community Safety Partnership to share information with partner agencies about the support available to people with ASD in the Nottinghamshire area.

- Nottinghamshire Police to advise partners how to gather and document evidence when there is coercive controlling behaviour through forums such as MARAC.

- Equation and Juno Women's Aid to promote the availability of local and national specialist LGBT domestic abuse support services with partner agencies. Including completing the LGBT Special Considerations Checklist alongside the standard DASH RIC

- Nottingham College to review their provision in relation to healthy relationships, men's services and LGBT support.