Liv SAR-DARDR

Executive Summary Report into the death of Liv in 2022

Report Completed in September 2024

Author: Parminder Sahota

Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Liv's tragic death and thank them for their involvement and support in this process.

Only the review panel has been identified, all other names and potentially identifying information has been changed or removed.

The primary objective of a Domestic Abuse Related Death Review (DARDR) is to learn lessons from the deaths of people aged 16 or over from domestic abuse related deaths to improve how practitioners and organisations work together to prevent future harm and deaths.

She was a fantastic mother who cared and loved her child, who adored her.
John, Liv's husband.

She was lovely, with a heart of gold. She was an amazing mum and had all the time for her child. She was very bright, good at her job, and a perfectionist, and everything had to be done right at work.
Jo, Liv's friend.

Contents

Section One: The Review Process

This summary outlines the process undertaken by the Safer Cornwall Partnership in reviewing the domestic abuse related death of Liv, a young woman, who was a resident in their area.

The Cornwall and Isles of Scilly and Safer Cornwall Community Safety Partnership agreed to undertake a joint Safeguarding Adults Review (SAR) and Domestic Abuse Related Death Homicide Review (DARDR), into Liv's death, which was initially suspected to be by suicide. All agencies that may have had contact with Liv or Liv's recent intimate partner, Matthew prior to her death were contacted and asked to confirm any involvement.

The following pseudonyms have been used to protect identifies:

- The victim: Liv
- Husband: John
- Intimate partner: Matthew

Liv's inquest was held after the review had been commissioned and recorded her cause of death as a drug-related death.

The chronologies and reports provided by involved agencies were authored by practitioners independent of any case management or service delivery.

Section Two: The Review Panel Members

The independent panel members for the review were:

Role	Organisation
Review and Quality Manager	Cornwall Housing Options, Cornwall Council
Head of Nursing	NHS Cornwall and Isles of Scilly Integrated Care Board
Named Nurse Safeguarding Children	Best Start, Community Health and Wellbeing, Cornwall Council
Domestic Abuse Implementation Lead	Domestic Abuse and Sexual Violence Team, Cornwall Council
Domestic Abuse Strategy Coordinator and MARAC Chair	Domestic Abuse and Sexual Violence Team, Cornwall Council
Safeguarding Adults Review and Development Manager	Adult Care and Support Cornwall Council
Director of Domestic Abuse Services	Safer Futures
Education and Safeguarding Lead	Education and Community Health, Cornwall Council
Adult Care and Support Operations	Cornwall Council
Detective Sergeant Criminal Case Review Unit	Devon and Cornwall Police

Operations Manager with the Adult Service	We Are With You Drug & Alcohol Service, now called With You.
Detective Chief Inspector CID & Moonstone (Domestic Abuse Investigations) – CIOS	Devon and Cornwall Police
Consultant Nurse for Integrated Safeguarding Services	Royal Cornwall Hospitals Trust and Cornwall Foundation Trust (RCH/CFT)

The panel met a total of seven times.

Section Three: Author and Chair of the Review

Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Domestic Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over 20 years. She is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

Parminder Sahota is independent of all agencies involved and had no prior contact with family members or Safer Cornwall Partnership.

Section Four: Purpose of a Domestic Abuse Related Death Review

Statutory guidance sets out the purpose of a domestic abuse related death review is to:

- Establish the facts that led to Liv's death in 2022, and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Liv.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-organisation approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

Liv's family were involved with and agreed to the terms of reference; family questions were also included for the agencies represented in the review.

Section Five: Liv

Liv met her husband John in her late teens; they married and had one child. Following school, Liv built a career and was well regarded professionally. During the COVID-19 pandemic, significant workplace pressures in her job adversely affected her mental health, leading to anxiety, depression, and work-related trauma. She sought help for increasing alcohol and substance use but engaged intermittently with support services.

Liv self-referred to drug and alcohol support services reporting heavy alcohol use and weekend drug use. She engaged intermittently with support services and was also assessed by mental health services and diagnosed with experiencing anxiety and depression linked to work-related trauma and interpersonal stressors. At the time when Liv was working, agencies who knew about her employment missed opportunities to consider the potential for transferrable safeguarding risks to the workplace.

Loss of employment marked a major turning point for Liz, after which her mental health deteriorated further and substance use escalated. She moved out from her family home and experienced housing instability, including homelessness, which affected her ability to engage with services. It was at this time Liv formed an intimate relationship with Matthew in which she experienced sexual violence and domestic abuse characterized by coercive and controlling behaviour.

Ongoing domestic abuse significantly worsened her mental health, contributing to symptoms consistent with depression, anxiety, emotional dysregulation, and post-traumatic stress. Liv used alcohol, illegal substances, and prescription medications as coping mechanisms in response to trauma, and this further compounded her risks. Despite periods of sobriety, Liv cycled into relapse.

In the weeks before Liv died, her mental health and wellbeing deteriorated markedly, she experienced suicide ideation, heavy drinking, eviction from temporary accommodation and further housing instability.

Section Six: Key Issues arising from the review / lessons learned

This section includes a summary of the themes identified in the review and considers the key challenges Liv faced, and also those experienced by her family when trying to support her.

Liv's substance addiction as a response to trauma

It is recognised that childhood trauma has wide-ranging and long-lasting effects, and that trauma as an adult (such as domestic abuse and sexual violence) often re-activates, intensifies, and compounds earlier trauma.

Research identifies that childhood sexual abuse can have lifelong impacts on emotional wellbeing, relationships, self-worth and vulnerability to further victimisation. Adult sexual violence may compound earlier trauma and contribute to worsening mental health, substance use, self-harm and suicidal thoughts. Liv's experiences demonstrate the importance of ensuring that services recognise both historical and current trauma when assessing risk and planning support.

Liv described Matthew's behaviour as controlling and coercive, including monitoring her movements, making repeated demands that she proved who she was with, and making threats towards her, her husband and her child. This behaviour reflected recognised patterns of coercive and controlling behaviour within intimate partner relationships. Liv also reported feeling controlled by her family at certain points, although these actions were attempts to protect her from substance use and safeguard her child. The panel considered it important that Liv's perception and lived experience of these relationships was recognised and recorded by agencies.

Liv spoke about using alcohol, illegal substances, and prescription medications as a response to trauma to drug and alcohol services, the acute hospital, mental health services and her GP practice.

Liv experienced multiple relapses despite periods of sobriety (including a 6-month period drug-free). Liv's addiction was compounded by her experience of trauma, and this significantly affected her mental health, physical health, relationships, finances, and parenting.

Liv was prescribed medications by her GP practice. She reported addiction to these medications, and her family shared that she also obtained them illegally via the Internet or on the street. It was noted in the review at Liv's inquest that opioid deprescribing, dispensing and regular review were undertaken by the GP practice. There is learning for the wider healthcare system about embedding safe prescribing for this cohort of people into clinical practice.

The panel also determined that With You (drug and alcohol support services) are the correct service to assist people who require prescriptions for support with substance use, and Liv's GP practice agreed.

Safer Cornwall Domestic Abuse, Sexual Violence and Drugs and Alcohol Team has developed a Joint Working Protocol with the following objectives:

- To ensure seamless joint working between services and collaborative recovery care planning where appropriate
- To validate the experience of those who have or are continuing to experience domestic abuse and sexual violence and to create a safe environment, which will encourage disclosure by service users and staff members to be better supported and informed.
- To ensure that there are clear referral pathways between drug and alcohol services and domestic abuse and sexual violence services when either issue is identified.

- To ensure that there are comprehensive screening tools to identify drug and alcohol issues within domestic abuse and sexual violence services and to identify domestic abuse and sexual violence within drug and alcohol services.
- To ensure an agreed information sharing protocol, including service user consent between the drug and alcohol and domestic abuse and sexual violence services to facilitate joint working to meet the needs of people requiring these services more effectively.
- To ensure that those currently or historically experiencing domestic abuse and sexual violence do not face an increased risk as a result of interventions by the drug and alcohol services.
- To encourage service users and staff members who are engaging in abusive behaviours to acknowledge and address their abusive behaviour.

The impact of domestic abuse on Liv's mental health

Liv reported ongoing domestic abuse from Matthew in the form of threats, harassment, intimidation, and coercive behaviours. Liv experienced mental health difficulties which presented with recurrent depression, anxiety, and emotional dysregulation, which was compounded by symptoms of post-traumatic stress disorder. These experiences collectively triggered further substance use and made her more vulnerable.

The panel noted that previous Domestic Homicide Reviews and ongoing work through Safer Cornwall's Domestic Abuse Strategy have already resulted in significant activity regarding practitioner awareness of coercive control and stalking, therefore no additional recommendation was considered necessary.

Liv had a history of self-harm and suicidal ideation, which included multiple presentations to healthcare services expressing intent or attempts. Despite frequent contact, she was often triaged out of secondary mental health services because her "primary issue was addiction."

Domestic abuse victims frequently come into contact with healthcare services and may disclose abuse in settings other than specialist domestic abuse services. Liv disclosed abuse to a number of agencies including healthcare, housing and police services. The review identified the importance of routine enquiry, trauma-informed responses, validation of disclosures, and appropriate onward referral to support services when domestic abuse or sexual violence is identified.

Learning was identified for GP practices about making appropriate enquiries into the impact of reported domestic abuse and offering referrals to support services. Since Liv's death, GP practices in Cornwall and the Isles of Scilly have had access to the GP domestic abuse service (support for domestic abuse and training) for a further 2 years.

Self-Harm, Suicide Risk and Domestic Abuse

Liv had a long history of self-harm and suicidal ideation and repeatedly disclosed distress to professionals. Research demonstrates a strong association between domestic abuse, self-harm and suicide risk, particularly where abuse is persistent and coercive in nature.

The review found that many of the factors identified in national research concerning domestic abuse-related suicide were present in Liv's circumstances, including escalating abuse, help-seeking behaviour, feelings of entrapment and increasing hopelessness. This reinforces the importance of considering domestic abuse as a significant risk factor when assessing presentations involving self-harm, suicidal ideation or emotional crisis.

Impact of housing instability and homelessness on Liv's recovery from substance and alcohol use

In the months before she died, Liv reported being homeless and had multiple moves between friends' homes, temporary accommodation, hostels and hotels. Before this, she lived with family and friends, and she had been able to abstain from alcohol and work with support services.

Liv resided in temporary housing, at two different locations. The family and panel agreed that these were not suitable placements for Liv because of her vulnerabilities. An example is that Liv was placed in accommodation above a pub, despite known alcohol addiction.

Housing instability was closely linked to other vulnerabilities identified within the review. Temporary accommodation placements did not always appear to take full account of Liv's substance use, recovery needs, domestic abuse experiences, and the importance she attached to maintaining relationships with her child and support network.

Delays experienced by Liv in accessing detox and rehabilitation

Liv was told to expect a 3-month wait for detox and rehabilitation; in reality she waited over 9 months without a placement. This prolonged delay intensified her risk, distress, and sense of hopelessness. Only two detox beds existed in Cornwall, this severely limited access to timely intervention.

Liv's loss of parental role and increased isolation

Liv loved her child deeply; motherhood was recorded as a major protective factor for her. The repeated periods of separation due to her addiction and mental health deeply affected her self-worth.

The services working with Liv did not fully assess or address the emotional impact of this loss or consider whether independent advocacy may have assisted her in navigating multiple services and expressing her wishes. The review identified the importance of recognising the profound impact that separation from children can have on parents experiencing addiction, mental ill-health and domestic abuse.

Family Engagement and Listening to Family Concerns

Family members consistently expressed concerns about Liv's wellbeing and reported feeling excluded from aspects of her care. Practitioners discussed the challenges of information sharing where an adult has capacity and does not consent to disclosure. However, the review found that this should not prevent agencies from listening to, recording and risk-assessing information provided by family members.

Families often hold important contextual information about escalating risks, changes in behaviour and emerging vulnerabilities. The review highlights the importance of documenting third-party concerns, offering advice and support to families, and incorporating relevant family information into professional risk assessments.

Liv told her family, a close friend, and drug and alcohol support services that she was proud to be a mother and adored her child, who was also a protective factor in preventing her from harming herself.

Agencies identified a need to consider the impact of mothers being unable to care for their children. This impact could have been factored into assessments for Liv's accommodation and access to support services.

There were also missed opportunities for agencies to consider their adult safeguarding and Care Act Advocacy duties for Liv.

Section Seven: Individual Agency Recommendations

Devon and Cornwall Police

Some incidental learning relating to information that comes into our organisation via the Force National Computer Bureau (FNCB) has been identified. This learning has been overcome with the new NICHE computer system.

First Light Safer Futures (domestic abuse service)

First Light acknowledges that there are areas where their practice can be improved regarding family involvement in assessments and support plans. We are currently reviewing these practices

and looking at ways to improve how we approach consent and employ curiosity about our service users' more comprehensive support network.

GP Practice

When Liv's family were involved in her care, it positively impacted her care. It is recommended that there is learning about applying and communicating with families for people with complex needs. This, of course, needs to be balanced with ensuring that consent is obtained to share such information and carefully reviewing whether this remains appropriate when there is a suspicion of controlling or coercive behaviour. This involves consideration of the communication formats, which may vary depending on the person's presentation.

Cornwall Housing

Review and re-circulate the Domestic Abuse Housing Pathway and ensure relevant staff have appropriate training.

Royal Cornwall Hospitals Trust and Cornwall Partnership NHS Foundation Trust

The Trusts have several pertinent recommendations from prior reviews and will continue working on them to help enhance their response to circumstances like Liv's.

In addition to the following:

Recommendation 1
RCHT/CFT An ongoing audit regarding MARAC documentation and flags (10 cases per month) will be established. The integrated safeguarding team will commence in July 2023.

Recommendation 2
RCHT Continue to ensure all health practitioners are educated in the screening and identification of alcohol misuse and the alcohol withdrawal guidelines.

With You (drug and alcohol support services)

Recommendation 1
There was insufficient joint working between services. Information was effectively shared via the MARAC process, and the initiated safeguarding processes could have led to further robust collaborative working; however, at times, important information was only available to some professionals. There needed to be more communication between Drug and Alcohol Support Services and Mental Health Support Services.

Recommendation 2
The provision of the Mental Health Connect line has made communication more straightforward, and ongoing work is being undertaken to revise and improve the Dual Diagnosis Strategy within Cornwall. It is essential that this work concludes and facilitates closer working arrangements between Mental Health Support Services and Drug and Alcohol Support Services.

Recommendation 3
Appropriate accommodation is standard for many With You service users. This review has highlighted the importance and need for appropriate emergency supported housing for vulnerable individuals within Cornwall and the potentially tragic consequences when this is unavailable. When this is unavailable, vulnerable people are isolated and struggle to cope with significant life events.

Recommendation 4
Possible areas for training across agencies to be considered include compassionate support for those experiencing extreme life events and recognition that responses may be complicated for professionals to understand fully.

Section Eight: Multi-Agency Recommendations

This section relates to the multiagency recommendations and includes the rationale for these recommendations agreed by the panel in response to the learning from Liv's review.

Intersectionality, Loss and Trauma

Liv was a mother, wife, daughter, sister and professional. Due to her addiction, she was unable to provide for her child and sought to enter rehabilitation to be free of addiction. Consequently, her role as a mother was suspended. She also left the family home and was estranged from her husband, whom she reported had discarded her house keys. The panel agreed that her sense of identity as her mother and wife had been removed.

She had stayed with her immediate family and friends, and all placements broke down; the reason cited was the impact of her dual diagnosis. Cornwall Housing initially placed her in Accommodation One, from which she was evicted. Subsequently, after a brief stay with her father, she was relocated to Accommodation Two.

She was reported to have experienced trauma, including adverse childhood experiences, and later in her professional working life during COVID-19. Most recently, she experienced domestic abuse, from someone she had begun an intimate relationship with whilst homeless. The panel emphasised that she had lost her self-worth.

An intersectional approach enables a comprehensive understanding of how society perceives Liv and others in a similar situation. Each person has multiple identities shaped by history and social relations. An awareness of this can assist in understanding the complex traumas, oppressive systems, and barriers to care that affect their lives.

Several agencies missed the opportunity to let Liv know she was entitled to advocacy and could seek advice from the Citizens Advice Bureau or legal advice.

Recommendation 1: Safer Cornwall, Child Removal Design Group

To support parents who are involuntarily separated from their children, it is necessary to provide them with access to advocacy and therapeutic services pre and post removal.

A missed opportunity to confirm that Liv had received support in accessing advocacy regarding her separation from her child was overlooked. It is recommended that this assessment be incorporated into referral processes and multi-agency processes whenever feasible. Some of these include safeguarding referral templates, certain multi-agency processes and meetings, such as MARAC, section 42 enquiries, and early help/child-in-need procedures, but they are not exhaustive.

Recommendation 2: Adult Social Care, Together For Families, Safer Cornwall

The specified multi-agency referral procedures and meetings will be reviewed to check if a prompt to identify support for a parent who is involuntarily separated from their child/ children is included. (The referral procedures included are MARU, MARAC, and adult safeguarding.) Agencies will then be required to direct parents to the right support following removal.

The extent of the impact of loss and trauma on Liv could have been better understood and explored.

Recommendation 3: Health, Adult Social Care and First Light

Agencies that provide ongoing care and support to adults should provide assurance to Safer Cornwall about what they do to ensure that potential carers are identified; that a referral for a carer's assessment is offered; and that families, friends, and carers are informed of the support services they can access.

Impact of housing on ability to recover from addiction

Liv had left the family home to be free of addiction before she could reunite with her child. As per Liv's request, rehabilitation was requested. She was granted emergency housing. There was no identification of her specific needs, including trauma, domestic abuse, alcohol dependency, and substance use, in her personalised housing plan.

The panel identified a dearth of supported housing options for vulnerable individuals. Being in emergency accommodation was a turning point in Liv's life, as she became isolated.

'Cornwall's Housing Strategy to 2030' sets out how we will ensure our homes help our residents thrive. One such outcome is providing accommodation that supports the resident's needs.

Recommendation 4: Cornwall Housing Options

Personalised housing plans must be tailored to the individual's needs and circumstances of the customer and include steps to secure suitable housing alternatives such as refuges. Any risks associated with a temporary accommodation placement must be identified and mitigated.

Recommendation 5: Housing Commissioners

Commissioners should review Supported Housing Options for temporary emergency accommodation for those in crisis. Consideration should be given to the specific needs of individuals, considering intersectionality and how the impact of isolation from support networks can adversely affect their mental well-being. The provision of suitable accommodation that does not place vulnerable people alongside others who may be in a position to exploit any such vulnerability should be considered, and as such, bespoke supported housing options would be preferable.

Recognition of domestic abuse and support through GP practices

The DASA service is currently in a pilot format. There is an identified need for improved recognition of the signs of domestic abuse. The increase in referrals demonstrates that recognition is improving. The service is to continue with the existing measures for sustained recognition, training and advocacy improvement. This will require an agreement for sustained funding to become a permanent service.

Recommendation 6: Integrated Care Board, DASV Strategic Commissioning

The Primary Care DASA service should be funded on a recurrent basis to enable continuous improvement. Resources should match any increase that arises from the rise in demand for the service. It is recommended that the ICB consider this recommendation, decide if the service will be funded on a recurrent basis and communicate this decision to Safer Cornwall.