Executive Summary

Domestic Homicide Review

'Georgia'

Died April 2021

Chair and Author: Dan Bettison
Supported by: Ged McManus and Carol Ellwood-Clarke QPM

Date: March 2024

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1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Sefton Together Domestic Homicide Review panel in reviewing the death of Georgia, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, her mother and her father, in order to protect their identities.

Name	Who	Age	Ethnicity
Georgia	Victim	49	White British
Margaret	Mother	69	White Portuguese
Harold	Father	78	White Portuguese

1.3 Georgia was a single woman, with no children, who lived with her parents in Sefton. She was 49 years old when she took her own life at home.

1.4 An inquest was opened and adjourned immediately following Georgia's death. The Coroner wished to wait for the conclusion of the DHR, prior to progressing their process further.

1.5 Following Georgia's death, a referral for consideration of a DHR was made to Safer Sefton Together by Merseyside Police on 20 April 2021. On 16 September 2021, Sefton Communities agreed the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review (para 18 Statutory Home Office Guidance)[1]. The decision to conduct a review was taken because it was apparent that Georgia had taken her own life, had been affected by Harold's abusive behaviour towards Margaret, and lived at home with them. The Home Office was informed on 3 November 2021.

1.6 Georgia, Margaret, and Harold were made subjects of the review. This approach was taken by the panel in order to ensure that as full a picture as possible of the family dynamics would emerge. The panel was clear that the main focus of the review was Georgia.

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

1.7 The panel agreed that the unique circumstances presented by the UK government response to the Covid-19 pandemic should be considered throughout the review. Rather than consider the impact of Covid-19 as an individual term of reference, it was agreed that the impact of lockdown periods and restrictions to mainstream local service provision would be addressed within each term, where appropriate.

1.8 The first meeting of the DHR panel took place on 22 November 2021. Meetings took place in person and using Microsoft Teams video conferencing. The panel met four times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final panel meeting took place on 9 June 2022, after which, minor amendments were made to the report: these were agreed with the panel by email.

2 Contributors to the review

Agency	Contribution
Mersey Care NHS Foundation Trust	IMR[2]
CCG – on behalf of Primary Care	IMR
Southport and Ormskirk Hospital NHS Trust	IMR
Sefton Adult Social Care	IMR
Talking Matters Sefton	IMR
Sefton Women and Children's Aid (SWACA)	IMR
Sefton IDVA Service	IMR
Sefton MARAC	IMR
Swan Women's Centre	IMR
Merseyside Police	IMR

[2] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Georgia, Margaret, and Harold.

3 The Review Panel Members

3.1	Dan Bettison	Independent Chair and author
	Ged McManus	Support to Chair
	Carol Ellwood-Clarke	Support to Chair
	Janette Maxwell	Locality Team Manager, Communities Sefton Council
	Neil Frackleton	Chief Executive, SWACA
	Paul Grounds	Detective Chief Inspector, Merseyside Police
	Lorraine Rock	Safeguarding Lead for Vulnerable Communities, Mersey Care NHS Foundation Trust
	Natalie Hendry-Torrance	Designated Safeguarding Adults Manager, NHS South Sefton CCG and NHS Southport and Formby CCG
	Mal Williams	Principal Social Worker, Sefton Adult Social Care, Sefton Council
	Amanda Comer	Service Lead, Talking Matters Sefton
	Gemma Kehoe	Interim Named Nurse Safeguarding Adults, Southport and Ormskirk Hospital NHS Trust
	Maria Joao Melo Nogueira	Operations, Partnerships and Client Support Director. Respeito [cultural advisor to the panel]

3.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and author of the overview report

4.1 Dan Bettison was chosen as the Independent Chair and Author of the review. Following a career in policing (not Merseyside), he is now an independent practitioner and consults within mental health services, education, and children's social care. He is an Associate Trainer for the College of Policing and an Associate Inspector for Her Majesty's Inspectorate of Constabulary. He has completed accredited training for DHR chairs, provided by AAFDA, and has supported colleagues on numerous DHRs.

4.2 He was supported by two other independent practitioners.
Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Merseyside or an adjoining authority) and has chaired and written previous DHRs and Safeguarding Adults Reviews. He has completed accredited training for DHR chairs, provided by AAFDA.

4.3 Carol Ellwood-Clarke retired from public service (British policing – not in Merseyside), during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for Safe Lives[3]. Carol has completed accredited training for DHR chairs, provided by AAFDA.

4.4 Both practitioners served for over thirty years in different police services [not Lancashire] in England. Neither of them has previously worked for any agency involved in this review.

5 Terms of Reference

5.1 'The purpose of a DHR 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,

[3] https://safelives.org.uk/

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 co-ordinated 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; and

Highlight good practice'.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

5.2 **Timeframe under Review**

The DHR covers the period 1 January 2020 to 8 April 2021

5.3 **Case Specific Terms**

Subjects of the DHR

Victim: Georgia, aged 49 years
Georgia's mother: Margaret, aged 69 years
Georgia's father: Harold, aged 78 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Georgia?

2. What knowledge did your agency have that indicated Georgia could be at risk of suicide as a result of coercive and controlling behaviour or domestic abuse?

3. How did your agency assess the level of risk faced by Georgia, and which risk assessment model did you use?

4. Did your agency consider that Georgia could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult concern and request or hold a strategy meeting?

5. What consideration did your agency give to any mental health issues when identifying, assessing, and managing risks around domestic abuse?

6. What services did your agency provide for Georgia; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?

7. How did your agency ascertain the wishes and feelings of Georgia, Margaret, and Harold? Were their views considered when providing services or support?

8. How effective was inter-agency information sharing and cooperation on this case? Was information shared with those agencies who needed it?

9. Was there sufficient focus on reducing the impact of Harold's alleged abusive behaviour towards Margaret by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

10. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice, and were any gaps identified?

11. What knowledge did family, friends and employers have that Margaret was in an abusive relationship or of the effect it had on Georgia, and did they know what to do with that knowledge?

12. Were there any examples of outstanding or innovative practice?

13. What training did your agency provide to staff around domestic abuse, coercive and controlling behaviour and mental health, specifically dementia? Had staff who interacted with the family, completed the training and when?

14. What learning did your agency identify in this case?

15. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Georgia, Margaret, or Harold?

16. Does the learning on this case feature in any previous DHRs commissioned by Sefton Safer Community Safety Partnership?

6 Summary chronology

6.1 Georgia

6.1.1 Georgia was a single woman of Portuguese/Madeiran heritage who was born in Merseyside. She was 49 years old at the time of her death and lived with her parents, as she had done all her life. She had recovered from anxiety and low mood in 2018, through high intensity cognitive behavioural therapy (CBT) and medication. Georgia suffered from anxiety and depression again during the timeframe of the review and was prescribed appropriate medication by her GP. She did not misuse alcohol or any other drug.

6.1.2 Georgia left school with one GCSE qualification. As an adult, she began working for a national department store and continued to do so for 25 years. Following Georgia's death, her colleagues arranged a number of events to remember her. They scattered flowers in a river in one of her favourite places, planted shrubs, and dedicated a room to her within the workplace named 'The Peony Room' (her favourite flower).

6.1.3 Georgia was described by family and friends as a caring individual who 'always put others before herself.' She was always the one who would offer help, go the extra mile, and remember birthdays and anniversaries. She wanted to make everyone happy. They also acknowledged that this sometimes caused her unnecessary stress as she would not think twice about

working longer hours, doing more work than required, or 'running around to help people'.

6.1.4 Georgia never formed an intimate relationship with anyone and said that she enjoyed her own space. Some family and friends believe that part of the reason, however, was her fear of how Harold would react to her bringing someone home. Harold was always very protective and controlling of his children.

6.1.5 Georgia had been registered with the same local GP surgery for over 20 years. She had longstanding anxiety symptoms dating back to at least 2016. Some of her family described Georgia as a worrier, who had always been anxious of what others would think of her and how she looked. She lacked self-confidence and hated confrontation.

6.1.6 The family believe that Covid-19 restrictions were a significant factor in Georgia's death. Harold's mental health deteriorated at a time when he, Margaret and Georgia were unable to socialise outside of their household. Family feel that the restrictions concentrated the abuse within Harold and Margaret's relationship and made it more difficult for Georgia to cope. Some of the family feel that Georgia, Margaret, and Harold did not receive an acceptable service from healthcare professionals, as a result of Covid-19 restrictions.

6.2 Margaret

6.2.1 Margaret was born in Madeira and moved to live in Merseyside as a married woman in her twenties. All four of her children were born in Merseyside. Margaret lived with her husband of more than fifty years, Harold, and their daughter Georgia. During the timeframe of the review, Margaret suffered from anxiety and was prescribed appropriate medication. She worked part-time in a supermarket.

6.2.2 Margaret told the Chair of the review that both she and Harold quickly learned to speak English on coming to the UK, and that Madeiran culture was, and is, very similar to British.

6.2.3 Margaret did not work for a long time after having children, although by the mid- 1980s, Harold had bought a restaurant and she helped out with various roles such as cleaning and administration. Harold didn't allow her to be 'front-facing' in the restaurant.

6.3 Harold

6.3.1 Prior to moving to the UK, Harold had served in the army and always retained a very military-like, controlling manner with Margaret and all the children. He was the boss. He always seemed to live in fear that something would happen to his family and wanted to keep them close, not allowing the children to go to parties or college.

6.3.2 The panel was told that at the time of the events under review, Harold was considered to have the capacity to make his own decisions. During this period, he began exhibiting signs of dementia.

6.3.3 Harold's medical condition has progressed and it is now assessed by health professionals that he does not have capacity to take part in the review, or consent to access to his medical records. The review has been unable to gain access to Harold's medical records and therefore only brief information relating to his diagnosis is contained within the review.

6.3.4 Despite this, the panel considered asking specific questions of Harold, supported by appropriate healthcare professionals. However, when balanced against the impact this may have on his health and the challenges it would present for his children and Margaret, it was not considered proportionate.

6.3.5 Harold was also born in Madeira and moved to Merseyside after he and Margaret were married. At the time of his daughter Georgia's death, he was 79 years old and had been diagnosed with dementia. He was prescribed appropriate medication and was visited regularly by a Community Psychiatric Nurse. The panel was unable to come to a conclusion as to whether Harold's medical condition would have affected his ability to carry out day-to-day activities to the extent that he was disabled within the meaning of the Equality Act. It is known that he continued some activities. For example, he regularly drove Margaret to medical and other appointments.

6.3.6 Margaret and Harold were Portuguese citizens – they applied for, and were granted, settled status when the United Kingdom left the European Union.

6.3.7 All three subjects of the review were fluent in English, both orally and in writing. They were able to access services freely and had many medical appointments. The family were well integrated into the local community.

6.3.8 Harold is described by his family as always controlling Margaret and all their children. He always wanted to know where they were, keep them away from

other people, and seemed fearful of losing them. They believe this was due to his own mother dying when he was four years old and his father being unable to look after him due to alcoholism. He was brought up by his uncle.

6.3.9 The children were all expected to help out with the family business. The restaurant was successful for a number of years, but by the early 1990s, Harold had also bought a pub attached to the restaurant and this did not work out financially. He sold the restaurant and the family moved to mainland Portugal for a few years. By this point, two siblings were both adults and returned to the UK and began their own lives. A couple of years later, Margaret and Harold also returned to the UK with Georgia and the youngest sibling, settling in Southport. They initially rented a property, but Harold quickly bought a large, terraced house, which he also had extended.

6.3.10 When they returned from Portugal, Georgia initially lived with her sibling in a flat. She considered renting her own property but decided against it and moved in with her parents. She was very close to both and worried about her mum. She wanted to be around Margaret to make sure she was ok. Georgia had a small section of the house to herself, consisting of a bedroom, bathroom, and spare room. By this stage, Harold had passed his HGV driving test and was working as a driver for a supermarket. He did this until around 2018, when he retired following a number of workplace road traffic collisions and accidents within the warehouse. Although not diagnosed by that stage, the family believe these were due to the onset of dementia.

6.3.11 The panel was informed by the cultural advisor that Portuguese-speaking culture is very family orientated. It is commonplace for any conflict or friction to radiate through a whole family network. It is often the case that if an individual does not marry, they remain within the family home and care for their parents.

As with many Western European countries, domestic abuse is common within Portuguese-speaking culture. However, coercive and controlling behaviour is not generally recognised as a form of domestic abuse.

6.3.12 Georgia's sibling told the Chair of the review that throughout their childhood, the children heard arguments and verbal abuse, which they suspected escalated to physical violence. Harold would, on occasions, hit the children if they had misbehaved or had not done as he told them, although this was not a regular occurrence. The exception was Georgia, as she never did anything wrong.

6.3.13 Prior to the time frame of the review, there were no reports to any agency of domestic abuse in the family and Harold has no criminal record.

6.4 Relevant Events

6.4.1 In March 2020, Georgia saw her GP with increased anxiety attributed to issues at work.

6.4.2 On 1 April 2020, Georgia had a GP appointment for anxiety, which now also related to her father's behaviour. She was worried that he was not adhering to social distancing guidance. She was referred to psychology services and signed off work for the next two months.

6.4.3 Access Sefton was the local Improving Access to Psychological Therapy (IAPT service) and provided Georgia with nine sessions of cognitive behaviour therapy, resulting in some improvement in her symptoms. She was discharged in December 2020.

6.4.4 On 8 June 2020, Harold had an in-person GP appointment. He was not in the surgery when his turn came, and the GP went into the car park to look for him. The GP found Margaret and Georgia waiting in their car. Margaret was distressed and told the GP that Harold had assaulted her earlier that day, hitting her multiple times with a belt. She showed the GP the injuries, which were belt mark bruising to her trunk and legs. She had not contacted the police following the assault and she was advised to contact the police if there was any further violence. Margaret did not want anything further to be done that day for herself but agreed to a follow-up telephone call.

6.4.5 On 10 June 2020, the GP phoned Margaret, however it was apparent she didn't feel safe to speak over the phone as she said that Harold had been screening her phone calls. She agreed to a safeguarding adult referral and arranged a face-to-face appointment at the surgery for the next day. The GP raised a safeguarding concern with Adult Social Care.

Margaret attended the appointment on 11 June, where she discussed the difficulties at home with Harold and how best to ensure her safety. She did not want any police involvement.

6.4.6 On 12 June 2020, Adult Social Care called Georgia as her number had been given in order to make contact with Margaret. Georgia agreed to speak to Margaret regarding her desired outcomes for the safeguarding and the potential for a lifeline pendant (alarm) to be allocated to Margaret.

The case was not progressed to a safeguarding enquiry under section 42 of the Care Act 2014 as Margaret did not have any care and support needs – she was mobile, self-caring, and was employed.

6.4.7 On 15 June 2020, the duty social worker spoke to Georgia who said that Margaret did not want a lifeline pendant or SWACA referral; therefore, the case was closed. Margaret's GP was informed.

6.4.8 On 15 June 2020, Harold attended a face-to-face appointment with a Consultant Psychiatrist and Community Mental Health Nurse. He was diagnosed with mixed dementia. Margaret was seen separately and discussed the incident of assault that had previously been reported to her GP. Margaret said that there had been no further incidents of aggression towards her or other family members and Harold did not remember the incident. Margaret told of a history of physical, emotional, sexual and psychological abuse from Harold, including regular non-consensual intercourse throughout their marriage (the panel considered the wording used within medical records, but were clear that non-consensual intercourse is rape).

6.4.9 On 22 June 2020, Mersey Care made a referral to SWACA for Margaret.

6.4.10 On 29 June 2020, after obtaining consent from Margaret, Mersey Care made a referral to MARAC. A DASH[4] risk assessment was completed that showed the risk as high. The referral was shared with the Independent Domestic Violence Advocate (IDVA)[5] team.

6.4.11 On 2 July 2020, after previous unsuccessful attempts, an IDVA called Georgia as her number had been given in order to make contact with Margaret. Georgia asked for the IDVA phone number and stated that she would get Margaret to call the IDVA when it was safe. Margaret returned the call later

[4] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

[5] Independent Domestic Violence Advocates (IDVAs) are specialists who are Safe Lives accredited. IDVAs provide high-risk victims of domestic abuse with a tailored and person-centered safety and support plan so that victims and their families are protected from abusive behaviour.

the same day. Safety planning was completed and access to a refuge was discussed. Margaret said that she was not ready to do anything immediately. Margaret asked for no further contact from the IDVA at that time and stated that she would contact the team when safe to do so.

6.4.12 On 7 July 2020, Margaret had her first appointment with SWACA. Georgia was the 'go between' for arranging appointments and updates with her mother.

Margaret said that Harold had been controlling throughout their marriage but until the assault in June, she had always been able to predict when he would be physically confrontational with her. On that occasion, the assault was without warning. She explained that Harold's behaviour had deteriorated over the previous 12 months and that it coincided with his memory loss.

6.4.13 On 23 July 2020, Margaret and Harold were discussed at MARAC. At the meeting, actions were set to provide support to Margaret.

6.4.14 On 5 August 2020, Margaret had a face-to-face GP appointment. She said that Harold had become angry and told her that she couldn't attend today's appointment, but there had been no further physical violence. She stated that she would not leave the family home as she didn't want to leave Georgia alone at home with Harold. The GP recommended that she leave the family home, with Georgia, and go to a women's refuge, but she declined this advice.

6.4.15 On 16 September 2020, Margaret attended a routine appointment at Southport and Ormskirk Hospital. Margaret stated that Harold had hit her three weeks earlier and that she had not reported this incident. She told the nurse that she was a victim of domestic abuse and that she was working with agencies following a MARAC in July. Margaret left the hospital prior to review from the Trust Safeguarding Team; therefore, SWACA was contacted, and information was shared with Margaret's case worker.

6.4.16 On 29 September 2020, Georgia told her SWACA case worker that Harold had become increasingly verbally abusive towards Margaret. Georgia said that she did not believe he would act on the abusive statements made – safety arrangements were made, should the abuse escalate further.

6.4.17 On 29 September 2020, Harold's Community Psychiatric Nurse contacted Adult Social Care requesting a Care Act Assessment for him, due to concerns of breakdown of care and support.

6.4.18 On 7 October 2020, Adult Social Care called Georgia. It was established that following a recent change in Harold's medication, his health and mobility had improved. During the contact, the social worker was also informed that Georgia did not believe a Care Act Assessment was required at the time, as the family were coping and were able to support Harold. Discussions took place regarding community activities that may benefit Harold and also provide some respite for Georgia and Margaret, as opposed to formalised respite within a care setting. It was agreed, however, that more formal support may be required in the future and Georgia was informed that a further referral could be made. The case was closed.

6.4.19 On 15 October 2020, Harold's Community Psychiatric Nurse contacted Adult Social Care. The CPN said that Margaret was experiencing domestic abuse: taking the form of emotional intimidation and threatening violence. The Community Psychiatric Nurse or Georgia were to be points of contact. Adult Social Care called Georgia who said that a lifeline referral (alarm) had been made and confirmed that Margaret was engaging with SWACA. The social worker recorded that there was no further role for them and closed the case.

From 15 October 2020 to 20 October 2020, a series of discussions took place between Harold's Community Psychiatric Nurse and Adult Social Care about obtaining a day centre place for him.

6.4.20 On 29 October 2020, Adult Social Care contacted Georgia to discuss arranging a care and support assessment for Harold. Georgia said that Harold was now attending the day centre. She did not believe that a Care Act Assessment would be beneficial and could potentially make things worse at home. Georgia said that she had Power of Attorney (POA) for Harold over his finances, health and welfare.

On the same day, Sefton Carers Centre contacted Georgia to discuss a carer's assessment for Margaret. Georgia said that Margaret did not want to go ahead with the assessment. Information and advice were given, and the case was closed.

6.4.21 On 25 November 2020, Margaret had a GP telephone appointment. She disclosed that Harold had grabbed her against the wall at home following an

argument about Margaret continuing to work after the new year, as Harold did not want her to continue. The information was given to the Community Mental Health Team treating Harold.

6.4.22 On 19 January 2021, Georgia informed SWACA that Margaret had become close to using her lifeline over the previous weekend. She explained that Harold's behaviour was becoming worse, and he was asking Margaret for sex on almost a daily basis. She explained that in an attempt to reduce his libido, his Community Psychiatric Nurse had increased his medication.

Georgia also explained that on 17 January 2021, Harold had pulled Margaret's hair and threatened that if she ever left him, "she would be in trouble." Georgia did not witness this but was told by Margaret. SWACA acknowledged that Georgia had a limited support network and made a referral to SWAN Women's Centre for counselling.

6.4.23 On 20 January 2021, Margaret informed SWACA that on Christmas Day, Harold had woken at 6 am and asked if she had cooked the turkey for that day. When she stated not, he pushed her out of bed, on to the floor. Margaret stated that she offered to make him breakfast, but he said that he did not want anything from her. She explained that when Georgia woke around 8 am, she was able to persuade Harold to have some breakfast and open presents with them.

Margaret also told SWACA that in mid-January, there had been another incident when Harold had pulled her hair and been verbally abusive towards her. She said it was following an appointment Harold had with his Community Psychiatric Nurse and her colleague. Harold accused Margaret of telling them that she was not having sex with him. She tried to leave the room to get away from him, but he restrained her by pulling her hair. She managed to text one of her children, who rang Harold and tried to diffuse the situation. Harold did, however, continue to be 'in a bad mood.'

SWACA discussed safety plans with Margaret, including the use of her lifeline. She stated that although she had considered using this option, she had decided not to as she was fearful of repercussions from Harold.

6.4.24 On 22 January 2021, Georgia had her first counselling session with SWAN Women's Centre. She said that she had had a breakdown two years ago. Georgia discussed what felt most important to her at the moment: her mum and dad's health. She was worried about her dad's dementia. She did not

mention domestic abuse although it was known that the referral was via SWACA. Georgia thought that she was doing ok as she worked full time so felt like she was managing that.

Georgia had weekly online counselling sessions via Zoom; her last appointment was on 2 April 2021. She discussed feeling anxious and depressed.

6.4.25 On 2 February 2021, Georgia called SWACA. She was feeling very low with the current situation with her dad. Georgia said that on Wednesday 27th January, she was at rock bottom as she had received a letter from the hospital asking her to come for a bladder scan following a referral from her GP. Georgia was Googling bladder cancer from this and was becoming increasingly anxious. Georgia stated that her dad was in a very paranoid mood and her mum was unable to leave his side and was very anxious as a result.

6.4.26 On 5 February 2021, Georgia had a GP telephone appointment with symptoms of insomnia due to the volatile situation at home. She was noted to be in contact with SWACA. Georgia was issued a short course of zopiclone sleeping tablets and diazepam tablets for anxiety.

6.4.27 On 8 February 2021, Georgia had a face-to-face GP appointment. Her anxiety had increased. She was concerned that urinary symptoms that she had, could be an underlying cancer, but also admitted that she was living in fear that something terrible would happen at home. She said that she had been looking up her symptoms, and also her father's behaviour, on YouTube, and the sites she had accessed had left her distressed and traumatised. She agreed to trial an antidepressant medication citalopram. The GP made an urgent referral to the Community Mental Health Team and agreed to follow up later that week.

6.4.28 On 11 February 2021, Georgia had a telephone appointment with a GP and then went on to see the GP in person. She was very worried that the police would investigate her for viewing the websites she had accessed. During this consultation, she admitted that she had thought about taking an overdose of tablets the previous night. She then produced a small handful of unidentifiable tablets from her pocket, which the GP took from her. The GP recommended an immediate mental health team assessment by way of an admission to the local designated place of safety at Southport Hospital A & E. However, having discussed it, Georgia calmed down considerably and

declined this. The GP assessed that she had capacity to do so. The GP agreed to contact the Community Mental Health Team (CMHT) to ask for them to assess Georgia as soon as possible, as an alternative approach.

6.4.29 On 12 February 2021, following a referral from her GP, the Mersey Care Single Point of Access (SPA) telephoned Georgia to assess the risk to her. She had no suicidal thoughts or plans identified. She was offered an SPA appointment for further assessment of her mental health.

6.4.30 On 17 February 2021, Georgia had a telephone appointment with a GP and then went on to see the GP in person. Georgia reported heightened anxiety and that she was feeling constantly on edge. She said that she was having counselling with SWACA and that she was not suicidal, as she was too scared to harm herself. The GP discussed the possibility of leaving the family home to escape the situation there, but Georgia declined this. She was prescribed propranolol for anxiety, and promethazine to help her sleep.

6.4.31 On 22 February 2021, Georgia had a face-to-face appointment with a GP and was noted to be brighter in person. She admitted that she was worried she may 'do something stupid' but again reiterated that she was too scared to undertake an act of self-harm.

6.4.32 On 28 February 2021, Georgia had a telephone assessment with the Mersey Care SPA team. No plans or intent to harm herself were identified during the assessment. She was referred to the Mersey Care Community Mental Health Team and additional support was requested from the Mersey Care Complex Care Team in relation to Harold's diagnosis and psychoeducation for the family.

6.4.33 On 1 March 2021, Georgia had a telephone appointment with a GP. She remained anxious and paranoid. She also raised concerns about a letter from the Community Mental Health Team about an assessment on 28 February 2021, and what effect this might have on her in the future.

6.4.34 On 3 March 2021, at a psychology session, Margaret disclosed that she was struggling with the impact that Harold's behaviour was having on her and Georgia. She said that if Harold assaulted her again, she "would kill him" and could do this by giving him all his medication.

6.4.35 On 5 March 2021, as a result of Margaret's disclosure at the psychology session, a safeguarding concern was raised to Adult Social Care by Mersey Care.

6.4.36 On 5 March 2021, Georgia saw a GP in person. She said that she felt close to harming herself but that she had no active plans for this. There was again a discussion about attending the local designated place of safety at Southport Hospital A & E but Georgia declined and had the capacity to do so. The GP spoke to the Community Mental Health Team to ensure that they were aware of the situation.

6.4.37 On 8 March 2021, Georgia saw a GP in person and again had fears that she would come to harm in the future because of her contact with the Community Mental Health Team. She said that she still had suicidal thoughts but reiterated that she would not do anything and wouldn't go through with it.

6.4.38 On 11 March 2021, Margaret saw a GP in person. She said that she was upset about the impact the situation at home was having on Georgia. She was having to cuddle and console Georgia, and that if Harold ever did anything to harm Georgia, this could drive her to take matters into her own hands. She admitted that she had been thinking if those events occurred, she would intentionally overdose her husband to kill him.

She had already disclosed similar thoughts to her psychologist: this had triggered further safeguarding input and a planned MDT meeting, the next day, with Community Mental Health Team, social worker, psychology, and the safeguarding team, to discuss the whole family.

6.4.39 On 11 March 2021, Georgia attended a face-to-face appointment with a Community Mental Health Nurse. Georgia said that she had fleeting suicidal thoughts, she denied any current plan or intent to act on these thoughts, and stated that she would never harm herself as she knew what this would do to her family, particularly her mother.

6.4.40 On 12 March 2021, Georgia saw a GP in person. She was noted to be significantly better. Although she had ongoing anxiety, she had no thoughts of self-harm or suicide.

6.4.41 On 12 March 2021, arising from the safeguarding concern, a virtual MDT meeting took place to discuss the whole family: the outcome of which, was a strategy meeting was to be arranged involving the police, as well as to plan

the safest intervention. The police were requested to place a 'treat as urgent' marker on the home address. [Present were Mersey Care, GP, SWACA, and Adult Social Care].

6.4.42 On 17 March 2021, Georgia had a telephone appointment with a GP. She sounded much calmer. She was still anxious but did not have suicidal ideation. She said that she had self-referred to psychology services.

6.4.43 On 19 March 2021, a second virtual MDT meeting took place. The outcome was that the GP was to reduce the family's repeat medications to weekly prescriptions to minimise the risks of an intentional overdose of Harold by Margaret. The meeting heard that Margaret was due to return to work in a week's time, which was thought to be positive. [Present were Mersey Care, GP, and Adult Social Care].

6.4.44 On 21 March 2021, during a telephone call with the Community Mental Health Team about Harold, Margaret asked that they speak to Georgia as she was struggling with anxiety. Georgia denied any thoughts, plans or intent to harm herself. She was advised to contact her GP and was signposted to anxiety apps. An appointment was arranged with a Consultant Psychiatrist for 15 April 2021.

6.4.45 On 22 March 2021, a strategy meeting took place arising from Margaret's disclosure to her psychologist on 11 March 2021.
[Present were Merseyside Police, Mersey Care and Adult Social Care].

Actions:

- Police to add a flag to their records indicating that there was a safeguarding enquiry under S42 of the Care Act ongoing.
- A referral to be made for an urgent Care Act assessment for Harold.

6.4.46 On 26 March 2021 at a counselling session with SWAN Women's Centre, Georgia said that she was feeling fearful and anxious still, especially in the morning. She was still experiencing trauma associated with family issues.

6.4.47 On 29 March 2021, Georgia saw a GP in person. She appeared much calmer than on a previous assessment. She had much greater insight into her anxiety and discussed the imminent easing of Covid-19 lockdown restrictions that might improve the situation at home, by allowing her father to resume swimming regularly. She also discussed her hopes to return to work in a

month's time. Georgia said that she was mortified that she had even considered harming herself and had no current thoughts of self-harm.

6.4.48 On 31 March 2021, following a self-referral, Georgia had a telephone appointment with Talking Matters and an assessment was completed. Georgia disclosed that she had an appointment for a psychiatric assessment on 15 April 2021. This was felt to be unusual, given Georgia's presentation, and caused Talking Matters to follow up about the psychiatric assessment before arranging further appointments with Georgia. This was not resolved before her death.

6.4.49 On 1 April 2021, Georgia spoke with SWACA and described improvements at home. She said that Margaret had started back at work and Harold seemed settled with this. She also said that she felt that counselling had helped her and she had 'turned a corner' in terms of her own mental health: she planned to return to work at the end of April.

Georgia asked SWACA to act as a conduit between Margaret and Harold's Community Psychiatric Nurse as she was sharing information which made her feel uncomfortable. She also asked that Margaret not be informed that she had requested this. SWACA agreed to this.

6.4.50 On 1 April 2021, Georgia had a telephone appointment with a GP. She requested the cancellation of the planned follow-up from the Community Mental Health Team, as she felt she no longer needed their input. She further discussed the plan to gradually reduce citalopram. This was Georgia's last contact with her GPs.

6.4.51 On 7 April 2021, Adult Social Care called Georgia and a conversation took place with Georgia and Margaret. Georgia now thought that a Care Act Assessment for Harold would be beneficial. Arrangements were made to meet with Margaret at SWACA later in April.

Georgia said that she was able to go out and that Harold's behaviour did not impact upon her lifestyle, although she did suffer from anxiety. She also said that the Covid-19 lockdown had exacerbated things between her mother and father.

6.4.52 Georgia was found deceased at home in her bedroom on a day later in April. A police investigation ruled out any third-party involvement and Georgia appeared to have taken her own life.

7 Conclusions

7.1 Harold subjected Margaret to domestic abuse for many years, and prior to him exhibiting signs of dementia. Incidents were not reported to the police and the abuse went unnoticed by friends and family, who may not have identified Harold's behaviour as being coercive and controlling.

7.2 The panel was grateful for the advice provided by Respeito. An awareness of Portuguese and Madeiran culture added context to the dynamic within the household. Georgia remained in the family home and was committed to caring for both parents. She was unreservedly loyal to both and worried about her mum, not wishing to leave her alone with her dad for very long. The support Georgia gave to her mum also presented a moral dilemma for her. The panel felt that hiding things from her dad and acting as a conduit for professionals to speak with Margaret would have made Georgia feel very uncomfortable and increased the significant emotional pressure she was already under.

7.3 When Margaret reported physical abuse to her GP in June 2020, Georgia was already suffering with poor mental health. She was worrying about Harold's behaviour and was finding social distancing difficult. That incident began a chain of events by professionals, all intended to support Margaret as a victim. However, such was Georgia's role as supporter and organiser for both her parents, those same events placed additional pressure on her, which contributed to her becoming unwell. The 'lockdown' restrictions may have increased the frequency and nature of the abuse Margaret received, which in turn exacerbated the impact on Georgia.

7.4 The panel felt that professionals may not have recognised that Georgia was experiencing domestic abuse in the context of emotional or psychological abuse. It was felt that she was a victim of controlling and coercive behaviour by Harold and could have been referred for assessment and support in her own right. The panel felt that because Georgia was an adult without any obvious vulnerabilities, the risks to her were not considered, and as such, neither was the increased risk of suicide.

7.5 Professionals offered and provided support to both Margaret and Georgia, but the panel felt that more could have been done to support the family within the remit of the Care Act. That may have relieved some of the pressure

Georgia placed on herself to fulfil her duties as daughter – caring for her parents in emotionally challenging circumstances.

7.6 After disclosing physical abuse in June 2020, Margaret's GP raised a safeguarding concern with Adult Social Care. Neither the GP nor Adult Social Care conducted a domestic abuse risk assessment or ensured that one was conducted by another agency. The absence of a risk assessment resulted in risks not being fully understood and a lack of action to address Harold's behaviour. The case was eventually referred to MARAC; however, Georgia was not identified as a potential victim. This was a missed opportunity for all agencies involved to better understand the impact on Georgia and take appropriate action.

7.7 In March 2021, two multi-disciplinary meetings and a strategy meeting took place after Margaret stated that she would harm Harold, if anything happened to Georgia. Nothing was done to address Harold's alleged abusive behaviour in terms of enforcement or preventing future harm. Harold's dementia complicated matters, but the panel did not feel that other options had been considered. Those meetings lacked clarity of purpose.

7.8 Agencies were in possession of information that Harold was a perpetrator of domestic abuse and no enforcement action was taken to address this. The panel was told that at the time of the events under review, Harold was considered to have the capacity to make his own decisions. The panel concluded that Harold's age must have been a factor in this.

8 Learning identified

This multi-agency learning arises following debate within the DHR panel.

8.1 Narrative

The possibility of Georgia being affected by emotional abuse and therefore being a victim of domestic abuse in her own right was not recognised by agencies during the timeframe of the review.

Learning

Further work is needed by agencies involved in the review to enable their staff to recognise all aspects of domestic abuse.

Recommendation 1 applies

8.2 **Narrative**

The panel thought that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

Learning

Knowledge of the link between domestic abuse and suicide will enable professionals to formulate appropriate risk assessments and risk management plans.

Recommendation 2 applies

8.3 **Narrative**

Professionals in three agencies did not follow existing domestic abuse pathways.

Learning

Knowledge of and adherence to agreed domestic abuse referral pathways maximises the ability of agencies to understand risk and provide appropriate services to victims.

Recommendation 3 applies

8.4 **Narrative**

Agencies had information which pointed to Harold's continuing abusive behaviour that pre-existed a medical diagnosis of dementia.

Learning

The absence of effective action to address domestic abuse perpetrated by older people means that there is continuing risk for victims. Domestic abuse involving older people needs to be acknowledged as domestic abuse and dealt with according to established policies and processes for domestic abuse.

Recommendation 4 applies

9 Panel Recommendations

9.1 All agencies involved in the review should provide the Domestic Abuse Board with assurance that training has been provided to staff to enable them to recognise and act upon all aspects of domestic abuse within the definition contained in the Domestic Abuse act 2021.

9.2 All agencies involved in the review should provide the Domestic Abuse Board with evidence that information has been provided to staff on the links between domestic abuse and suicide.

9.3 All agencies involved in the review should provide the Domestic Abuse Board with evidence that staff in their organisation have been provided with information on Sefton domestic abuse referral pathways, including implementation processes.

9.4 The Community Safety Partnership should produce a briefing summarising the learning from this review in relation to domestic abuse in older people.

9.5 All agencies involved in the review should provide the Domestic Abuse Board with evidence of their approach to dealing with domestic abuse affecting older people as victims or perpetrators.

9.6 All single agency recommendations are shown in the action plan at appendix A.

Appendix A
Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	All agencies involved in the review should provide the Domestic Abuse Board with assurance that training has been provided to staff to enable them to recognise and act upon all aspects of domestic abuse within the definition contained in the Domestic Abuse act 2021.	Local	All DAPB agency members are asked to submit information and evidence Outcomes from this are fed into a training and development sub group – linked with Safeguarding Adults Board and Sefton Children's Safeguarding Board sub groups Additional multi agency training developed if gaps identified	Domestic Abuse Partnership Board	Questionnaire devised to enable consistent capturing and analysis of information Questionnaire sent out to all agencies Analysis of information collected shared with DAPB and training and development sub group(s) Additional multi agency training and DA resources in place	January 2024 March 2024	Audit of current agency training completed Feb 2024.Additional multi agency training offer available as part of the new integrated Sefton Domestic Abuse Service offer. Info from audit has fed into this. As part of this, DA awareness e- learning package has been produced to be made available to all agencies across Sefton, launched November 2024 Multi Agency DA Protocol is being updated and refreshed. Resources and information available on new DA website, including 7 minute briefings and DHR Learning briefings

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							www.sefton.gov.uk/domesticabuse which will be added to as and when more info is available. Multi agency DHR Learning event held October 2024 – 160+ people attended. Training offer is regularly reviewed
2	All agencies involved in the review should provide the Domestic Abuse Board with evidence that information has been provided to staff on the links between domestic abuse and suicide.	Local	Linked to the above recommendation and actions Also development of specific DA & Suicide Prevention training	Domestic Abuse Partnership Board	As above DA & suicide training specification agreed DA & Suicide training rolled out Numbers completing training in Sefton	January 2024 for audit work February 2024 To be agreed once specification ready	Links between suicide and DA are being regularly discussed at DAPB. Key priority within Sefton DA Strategy. Ongoing work with Merseyside DA & Suicide Prevention group to develop and roll out DA & Suicide Prevention training to professionals in collaboration with CHAMPS (public health). Procurement exercise underway March 2024

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	All agencies involved in the review should provide the Domestic Abuse Board with evidence that staff in their organisation have been provided with information on Sefton domestic abuse referral pathways, including implementation processes.	Local	Linked to the above recommendation and actions New SDAS service developed and in place and all agencies aware of the offer and pathways	Domestic Abuse Partnership Board	As above SDAS contract Regular report to DAPB on progress and learning outcomes Evidence of information shared across the partnership	January 2024 for audit work November 2023 for SDAS service	New Sefton Domestic Abuse Service (SDAS) contract in place from November 2023, providing 'one front door' approach to offering victim support services. This includes a new Helpline number for victims. Friends and family and professionals. Information has been shared across DAPB and SST partners and within local community based organisations Over the next 6-12 months this will be developed further across a range of wider organisations, including local VCF groups and businesses
4	The Community Safety Partnership should produce a briefing summarising the learning from this review in	Local	Produce and share briefing with DAPB, SST, SSCP (children's safeguarding), and	Safer Sefton Together	Briefing produced	April 2024	Complete. DHR12 Learning Briefing and DA & Older People 7 Minutre Briefing produced. Shared at

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	relation to domestic abuse in older people		SSAB (adult safeguarding)				DHR Learning Event October 2024 and across partnerships. Also available on DA webpage www.sefton.gov.uk/domesticabuse
5.	All agencies involved in the review should provide the Domestic Abuse Board with evidence of their approach to dealing with domestic abuse affecting older people as victims or perpetrator	Local	Linked to actions 1 – 3. Outcomes shared with SSAB	Domestic Abuse Partnership Board	As above in Action 1 -3	April 2024	To be progressed

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
Mersey Care NHS Foundation Trust							
1	Raise awareness of victims of domestic abuse within non intimate relationships.	Local	Discuss the training need within MCFT safeguarding team training assurance group and agree how to include in	Mersey Care		September 2022 Expected outcome: Raise awareness of victims.	Completed Sept 2022.Domestic Abuse training packages reviewed and updated. Mersey Care has a training pool of specialist safeguarding

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			bespoke DA training packages.				leads delivering modular training on key issues with Domestic Abuse
2	Raise awareness of victims of domestic abuse with additional support needs.	Local	Discuss the training need within MCFT safeguarding team training assurance group and agree how to include in bespoke training packages.	Mersey Care	Not provided	September 2022 Expected outcome: Raise awareness of victims with additional support needs.	Domestic Abuse risk screening across the Trust is under review with an expected relaunch of routine questioning and bespoke training packages to assist the different service lines in their engagement with patients.
3	To share the learning from this review with the Trust's Suicide Prevention Leads.	Local	Meet with the Trust's Suicide Prevention Leads to highlight the learning themes from this review.	Mersey Care	Not provided	With immediate effect. Expected outcome: Ensure that the learning from this review is shared and the themes are highlighted as part of the Trust's suicide	Action complete. Safeguarding leads also sit on the Suicide Prevention Group to share learning from reviews and link into the safety plan awareness across the Trust. Themes of the current reviews are reported against on a quarterly basis by the Assistant Director of Safeguarding at the

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
						prevention initiatives.	Trust Strategic Patient Safety Improvement Group. All reviews are also highlighted at the quarterly Safeguarding Assurance Group chaired by the Divisional Deputy Director of Nursing & Governance.
CCG – on behalf of Primary Care							
1	Reinforcing link between suicide and DA.	Local	Share learning from local DHRs and links between suicide and DA at clinical practitioner learning event.	Named GP for safeguarding adults Sefton CCGs	Linked with SDHR13, audit undertaken reviewing self-harm disclosures and holistic review of GP records.	30.06.22	Completed 15.06.22 Presentation at learning event as well as sharing of research 6. 15.10 to 15.25 - Dr Anna Hunter.ppt
2	Highlight knowledge of DA and the new Act to GPs and surgery staff.	National	Create a Rapid Read in collaboration with NHS England.	Named GP for safeguarding adults Sefton CCGs	Written by Named GP in collaboration with Sefton GPs involved in DHRs.	31.05.22	Completed and disseminated nationally 24.05.22 **Rapid Read for GPs and surgery staff on**
Sefton Adult Social Care							

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Reinforce the need to be professionally curious in our interventions with service users, their carers, and wider support systems.	Local	Agenda discussion in professional practice forum with frontline practitioners and devise and distribute a Quality Practice Alert (QPA) across Adult Social Care (ASC), outlining the need for us to practice a degree of professional curiosity, rather than accepting things at face value.	Mal Williams Principal Social Worker (PSW)	Not provided	October 2022 Expected outcome: Increased knowledge of professional curiosity and how this can support practitioners to question and challenge information they receive, identify concerns, and make connections to enable a greater understanding of a given situation. Consequently, it is envisaged that this will lead to Adult Social Care professionals becoming more proactive in their care	

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
						planning and producing comprehensive and holistic Care Act assessments.	
2	For the development of appropriate pathways within the Local Authority.	Local	Sefton MBC (Sefton Adults, communities, and Children's services) to design an agreed appropriate pathway to ensure all contacts made into Sefton Council, are managed effectively, and signposted to appropriate agencies where criteria for access to service is not met.	Joan Coupe, Safeguarding Governance and Board Business Manager, Sefton Adult Social Care.	Not provided	December 2022 Expected outcome: A more integrated pathway is established across all council and partnership services. Thus, ensuring appropriate response where domestic abuse features.	
Talking Matters Sefton							
1	Request NOK/emergency contact details at the point of every referral.	Local	1. Examples, including this case, to be shared with the administration	Administration Managers	Information re. impact of not obtaining emergency contact details	Audit 3 monthly. Emergency contact details	

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			team to demonstrate possible impact from not having this information. 2. To work with Data Lead to carry out audits to monitor compliance.		shared with administrators, using this case as a 'live' example.	are obtained for all clients or alternatively it is clearly documented that client declined to provide.	
2	Additional training to be delivered to the PWP team to develop understanding and confidence of when to appropriately explore possible safeguarding issues.	Local	1. Training package to be developed by Learning & Development Team 2. Live examples to be provided and used, anonymised as part of training. 3. Training delivered to PWP team.	Step Lead	Not provided		November 2021 Training delivered by MHM's Learning & Development team. Evidence in case management/ clinical supervision that practitioners are identifying potential adult/child safeguarding, exploring, gathering key information and discussing appropriately

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	Strengthen links with local dementia care services, with a view to improving knowledge for all staff.	Local	1. Link with local Alzheimer's Society. 2. Share information and/or advice received regularly from the Society with the TMS Team. 3. Consider a nominated practitioner with a special interest in support for carers. 4. Invite AS to present at team meetings.	Service Lead Clinical Lead Step Leads	Establish contact with key individuals in local Alzheimer service provision.	Special interest group practitioner identified – April 2022 Presentation to teams – May 2022	1. Links established, regular emails received from AS. 2. Good examples of working together, e.g., suggestion of a joint piece of work between therapist and 'dementia care expert' to support a specific client.
4	To consider all options available to clients who find it challenging to access the service without adaptations.	Local	1. All staff to be aware of the need to flag challenges for any client in accessing the service. 2. Managers to explore all options, thinking innovatively as necessary.	Service lead	Not provided	Complete	Staff aware and flag as appropriate. Evidence of considerations; arrangements made with specific GP practices to meet an individual client's needs; home visit carried out; increasing out of hours activity; use of interpreters;

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							liaising with support workers.
Sefton IDVA Service							
1	Ensure the risks and needs of any other adult family members living in a household where there is domestic abuse are considered as standard practice for all IDVA referrals, even where the abuse is partner related (rather than family abuse) between other individuals.	Local	IDVA procedures updated to include a specific point about considering the risks and needs of any other adults living in the household where the domestic abuse is being perpetrated, even when the referral is in relation to partner abuse associated with other individuals. Hold a reflective learning session with the IDVA team to discuss the findings from this case and the new procedure going forward.	IDVA Team manager	Procedures updated. Team session held.	March 2022	Complete Discussed as part of a team session held 3 March 2022. Team have actively taken this on board and considered this as part of new cases. IDVA procedures.
Sefton MARAC							

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Ensure the risks and needs of any other adult family members living in a household where there is domestic abuse are considered at MARAC meetings, even where the abuse is partner related between other individuals.	Local	Review of the MARAC Operating Protocol to ensure it includes a specific point about asking agencies to consider the risks and needs of any other adults living in the household where the domestic abuse is being perpetrated, even if they are not classed as a vulnerable adult, and also when the referral is in relation to partner abuse involving other individuals. Highlight this learning to all MARAC partners. Details of any other adults living in a household named	MARAC Coordinator	Updated MARAC Operating Protocol in place. All MARAC partners informed of changes. MARAC papers include the details of any adults living in the household.	September 2022	Action plan and proposed changes discussed and agreed at MARAC Steering Group 29 June 2022. Links to other DHR and child practice review learning re: best use of known information . Additional information about adults in a household added to the MARAC Operating Protocol, wording also changed on MARAC referral form to include all adults in a household. All MARAC members updated and received updated MARAC Protocol

Single Agency Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			on the MARAC referral to be included in all future MARAC case paperwork.				

End of Executive Summary 'Georgia'

Please note: the action plan is a live document and subject to change as outcomes are delivered.