THE EXECUTIVE SUMMARY

‘Leonard’

March 2022

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INDEPENDENT CHAIR AND AUTHOR

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The review process

1. The Doncaster Safer Stronger Partnership[1] and those who were involved in the review offer their sincerest condolences to Leonard's family.

2. Leonard was 58 years old and estranged from Lilly his 25 years old wife. They had no children although Leonard had children with previous partners. All of the family are white British and English is their language of communication. Leonard was born and brought up in the Midlands.

3. HM Coroner's inquest had not been concluded when the report was submitted to the Home Office. Leonard died from an overdose.

4. The first meeting of the DHR panel was in September 2022 followed by seven further meetings. The panel met for the final time in July 2023.

1.1 Contributors to the review

5. Twelve of the more than 40 agencies contacted as part of the initial scoping for the review confirmed that they had varying levels of contact with Leonard or Lilly and provided information. All were asked to provide chronological information. Eleven of the organisations completed an individual management review with an analysis of their contact whilst other organisations that had less significant involvement provided a shorter summary of information.

    a) Crown Prosecution Service (CPS);
    b) Creative Support;
    c) Department for Work and Pensions;
    d) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBHT)
    e) Doncaster Domestic Abuse Service (DDAS);
    f) Pheonix WoMens Aid;
    g) Riverside Domestic Abuse Service
    h) Rotherham and Doncaster and South Humber NHS Foundation Trust (RDaSH)
    i) South Yorkshire Integrated Care System
    j) South Yorkshire Police (SYP)
    k) Yorkshire Ambulance Service (YAS).

6. The Railway Housing Association (RHA) was the landlord for Leonard after he moved out of the marital home as a condition of police bail and provided a summary of information.

[1] The community safety partnership set up under the Crime and Disorder Act 1998.

1.2 The review panel members

7. All of the panel members were independent of any involvement or decision-making about the events and people concerned with the circumstances examined by the review.

Organisation and name of the panel member	**Job title or role**
Adult Social Care Services, Doncaster Council Jackie Cooke	Team Leader, Quality and Safeguarding.
Creative Support Nickie Christie	Senior support worker
CPS Chris Hartley	Deputy Chief Crown Prosecutor Crown Court Unit Yorkshire & Humberside Area Crown Prosecution Service
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBHT) Amanda Timms	Lead Nurse Safeguarding Adults
Doncaster Domestic Abuse Service Tim Staniforth Saffiyah Khan	Domestic Abuse and Sexual Abuse Theme Manager Domestic Abuse Caseworker and Hub-Team Manager
Phoenix Women's Aid Vesta Ryng	CEO
Riverside Domestic Abuse Service Andrea Parkinson	Project Manager
Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) Kim Goddard Rebecca Sansom	Lead Professional Safeguarding Adults
South Yorkshire and Bassetlaw Integrated Care System (ICS) Dr Rao Kolusu	GP Clinical Lead, Doncaster Place
South Yorkshire Police DI Roberta Beasley Gary Thompson D Sgt Laura Jones Abigail Acres	Detective Inspector

	Case Review and Policy Officer[2] Detective Sergeant Intelligence Research Officer
Yorkshire Ambulance Service (YAS) Catherine Holliday	Named Professional for Safeguarding
Doncaster Council Sarah Smith	Public Health Improvement Co-Ordinator (Public Mental Health & Suicide Prevention),
Doncaster Council Laura Bunting	Senior Survivor Liaison Worker

1.3 Author of the overview report

8. Peter Maddocks is the independent author of this report and chaired the panel. He has worked in local authority, voluntary and national services in senior and practitioner roles. These have included working with families and children harmed by domestic abuse including work on policy and service development as well as direct work. He is a qualified and registered social worker who continues to participate in regular professional training and development that includes domestic abuse. He has completed domestic homicide reviews with other community safety partnerships in England. He never worked for any of the organisations that contributed to this review and has not held any elected position in Doncaster or South Yorkshire. He is not related to any individual who either works or holds an elected office in Doncaster or South Yorkshire. This was his first DHR in Doncaster.

1.4 Terms of reference

9. The timeline for the review is from August 2021 when Leonard was taken to the hospital following an overdose until the date of Leonard's death in March 2022 taking account of relevant history where it is known. Agencies contributing reports or information to the domestic homicide review used the following terms of reference to provide information and analysis for the domestic homicide review.

    a) Opportunities for the disclosure or detection of domestic abuse before November 2021; this included whether for example there was any disability or other difficulty as well as whether control and/or coercion and/or economic or social dependency were factors;

[2] Following the death of Gary Thompson, representation at the panel was covered by other members of the SYP team. Sincere condolences are offered to Gary's family and friends.

b) What prompted or assisted the disclosure of domestic abuse in November 2021?

c) Was there information about Leonard's history with a previous partner that should have caused any different action before November 2021;

d) What mental health history including evidence of self-harm was known? Did psycho-social assessments and inquiries explore the potential for domestic abuse and or self-harm?

e) What follow-up was provided to Leonard and/or Lilly after Leonard's overdose in August 2021?

f) What were the concerns and risks identified at MARAC and did they result in effective planning and action that addressed the risk and safety?

g) Are there appropriate local services for men who are perpetrators of domestic abuse and were they used in this case?

h) Are there appropriate services for men who report being victims of domestic abuse and were they used in this case?

1.5 Summary chronology

10. Leonard and Lilly met in 2014 and began living together in August or September 2014 and married in June 2016.

11. Domestic abuse was first disclosed in November 2021 when Lilly became very frightened due to escalating threats from Leonard. The DASH recorded a high-risk history of coercive and controlling domestic abuse throughout the relationship and was referred to the MARAC which discussed it at a scheduled meeting in early December 2021.

12. Lilly was given information about Leonard's history under the domestic violence disclosure scheme (DVDS). Leonard was already known by the police to have an extensive history of violence against an ex-partner and the ex-partner's father and had also breached court orders and used weapons. The information was sufficient to cause the police significant concern for Lilly's safety.

13. An IDVA contacted Lilly on the day of the police referral. Lilly reported being constantly monitored by Leonard via her telephone whenever out of his company and she was not allowed to work. Lilly reported being

assaulted several times during the marriage. Lilly said that she had attempted to leave the relationship. Lilly described Leonard as having mental health problems and had taken an overdose although believed this had been more "to mess with Lilly's head"[3]. Lilly was referred the same day to the NCDV[4] for help with applying for a non-molestation order and gave details of local solicitors. A safety plan included the IDVA delivering four stick-on window alarms, a door chain and a personal alarm. CCTV was already fitted.

14. The IDVA had leave scheduled and advised Lilly to contact the DA Hub if she needed help while the IDVA was away but no arrangement for a named cover (this has now changed).

15. When Lily contacted the DA hub requesting help with acquiring a court order, she stated that she was the victim of coercive control and threats to kill. The duty hub worker passed the referral on to Riverside apparently without checking their system and identifying that Lilly was already open to an IDVA and that she was at high risk of domestic abuse. Riverside processed the referral unaware that an IDVA was already allocated to Lilly until a phone conversation with the IDVA service in January 2022. Riverside involved Lilly in a therapeutic programme which was completed over eight weeks. As part of their contact with Lilly, Riverside completed a DASH at a lower medium level with Lilly.

16. Leonard denied the allegations made by Lilly. The police had requested a charging decision from CPS on the day they had taken Lilly's statement. The CPS noted that the police investigation had not yet been completed but based on the information provided by the police agreed that it was appropriate to charge and produce Leonard at the next available court. CPS also agreed for bail to be opposed. CPS provided an action plan for the police concerning outstanding information that was needed. In the event, the police did not charge Leonard until mid-December 2021 and he was released on police bail with conditions that included not contacting Lilly or going to the marital home where Lilly remained.

17. Lilly consulted her GP in early December 2021 for depression and mentioned that her husband had left her two weeks before and that he

[3] Research has shown a link between gender, violence, and suicide. This relationship is complex, and few empirical studies have explored suicide and family and interpersonal violence perpetrated by men. Fitzpatrick, S. J., Brew, B. K., Handley, T., & Perkins, D. (2022). Men, suicide, and family and interpersonal violence: A mixed methods exploratory study. Sociology of Health & Illness, 44(6), 991– 1008. https://doi.org/10.1111/1467-9566.13476

[4] National centre for domestic violence.

was currently on bail. There is no recorded evidence of exploring the circumstances of either the separation or why Leonard was on bail. Lilly said that she was struggling to sleep but was not having thoughts about suicide. She was prescribed a one-off sleeping tablet (zopiclone) and said that she was in contact with a counselling service and would contact them if necessary.

18. Leonard was released under investigation (RUI) in mid-December 2021 and from this stage was not subject to bail or any restrictions beyond voluntarily agreeing to not contact Lilly or attempt to visit the marital home. The police had informed Lilly (but not the IDVA) that Leonard had been released from bail conditions. Lilly subsequently told the CPS lawyer in March 2022 that Leonard had continued to contact her although none of the services was told about this at the time.

19. Two days after Leonard was RUI, the IDVA phoned Lilly and was told by Lilly that she was being supported by family and friends though no other detail was recorded. Lilly told the IDVA that Leonard had been charged with coercive and controlling behaviour; the IDVA had not been given this information by the police. Lilly had acquired a job. She had set up a separate bank account. Lilly said that the solicitors had been unable to help with the non-molestation order due to a conflict of interest given they had been instructed by Leonard. Lilly was given details of a firm in Sheffield.

20. The police DASH risk assessment of Leonard was discussed at the SPA (the mental health *single point of access*) multi-disciplinary team (MDT) meeting which resulted in a letter being sent to Leonard advising him to contact the SPA if he needed help with his mental health. Leonard responded by phoning the Crisis Team and in the absence of acute mental health needs, was signposted to local services. Although Leonard discussed “the relationship problems with his wife” there is no further recorded inquiry about this or of a DASH being considered or completed. The GP did not have a record of this SPA contact in their patient records.

21. The IDVA service was notified by the police in late December 2021 that Leonard had reported being the victim of domestic abuse from Lilly. The IDVA service did not allocate an IDVA given they were already supporting Lilly. Regarding the significance of the counter-allegations, the police DASH risk assessment was assessed as standard risk. Consent is required to contact standard and medium-risk victims to offer support and to share information with other agencies but was not given by Leonard. This would not have in itself prevented discussion between

relevant professionals about how counter-allegations are a strategy along with obstructing victim access to legal advice used by some perpetrators of coercive control and this should have happened.

22. Leonard contacted Safe Space in late December 2021 describing that he had moved out of the marital home and the police were involved. Leonard described having thoughts about suicide but had no plan to act on those thoughts. Leonard said that he was the subject of a non-molestation order (although an order had not been made at this stage). Leonard described having debt problems.

23. Leonard self-referred to the DA hub in late December 2021. The referral was sent on the following day to the Riverside domestic abuse service to respond. It was re-directed to Phoenix as Riverside was already working with Lilly (as a result of the misdirected telephone contact from Lilly).

24. During Safe Space telephone contacts in January 2022, Leonard talked a lot about his ex-partner and “what she had done to him” as well as practical arrangements such as moving to his new tenancy. He fluctuated in his mood between feeling “really bad and feeling very low” to being more upbeat feeling “very good and positive”.

25. The first face-to-face appointment was not until the end of January 2022 when Leonard reported that he had been made homeless when his wife made allegations against him of perpetrating domestic abuse which he denied. He described struggling with his mental health since an attempt to die by suicide in August 2021. He discussed the options of counselling, a support group, food parcels and having access to the 24/7 helpline. A food parcel was delivered the following day. Leonard attended the first counselling session at the start of February 2022 where he discussed concern about his wife’s actions and was described as making valuable contributions. He attended a drop-in a week later and a further counselling session two days after that. He attended a men's domestic abuse peer support group four days later.

26. Leonard registered with a new GP practice after being given a tenancy in a different part of Doncaster. During a consultation with the GP in early February 2022 Leonard mentioned that he had recently separated from his wife who he reported had caused “significant domestic abuse and taken possession of his house”. No further information is recorded and no indication of any action to explore his mood and state of mind or to consider potential support needs. Information about Leonard’s low mood

and overdose the previous year would have been on the electronic patient record system.

27. During a counselling session in mid-February 2022, Leonard disclosed suicidal ideation. Contact was arranged with the SPA and Crisis Team. Leonard did not want to discuss the charges he was facing in court.

28. The SPA was phoned by Phoenix where Leonard had been attending support groups and had disclosed he was facing charges of controlling and coercive behaviour which he denied and said it was his wife who was controlling and was a factor in his thoughts about suicide. The Crisis Team contacted Leonard who spoke about his situation and talked about being the victim of financial abuse by Lilly. He was advised to work with the services and legal system to “resolve the situation with his wife”. A letter was sent to his GP regarding the “self-medication” and reviewing his antidepressants; there is nothing recorded in the GP patient record about this letter. Leonard was advised to contact SPA if he needed support with his mental health.

29. At the end of February 2022, Leonard asked Phoenix's counsellor for a letter of support to use in court to say he was a victim of abuse. This was the first time that Phoenix became aware of domestic abuse allegations against Leonard or court proceedings.

30. A welfare check by Phoenix in the first week of March 2022 followed the magistrate's court hearing. Leonard said that he was not coping and felt in need of more emotional support. Phoenix called the Crisis Team who in the absence of a mental health emergency referred them back to the police who in turn referred them back to The Crisis Team. Leonard cancelled the counselling session needing “to rest and collect” himself. In a follow-up call, Leonard said he felt tired and emotionally drained but did not want additional support at that time. He was offered a counselling appointment the following week which he did not keep.

31. Three days later, the SPA was phoned by Leonard and the police who were concerned for his safety due to Leonard’s thoughts about suicide. During the discussion with the Crisis Team, Leonard said that he felt safe and that he could contact the Crisis Team at any time. There was nothing in the GP records about this contact with SPA.

32. Four days later, Lilly phoned the IDVA to say that she doing fine and that the non-molestation and occupancy order had been granted. She also said that Leonard was due in court in the first week of April 2021.

33. Leonard did not attend a scheduled counselling session with Phoenix. An attempted welfare check got no answer. The Creative Support worker phoned Phoenix to say Leonard had not kept a scheduled appointment with them and subsequently checked with Leonard's solicitor who said they had not heard from him to take instruction for the court appearance.

34. Leonard was subsequently found deceased at his flat.

Key issues arising from the review

35. Lilly described the abuse beginning early in the relationship with Leonard seeking to control Lilly. She said he prohibited her from working and therefore she had no independent source of income. The Domestic Abuse Act 2021 implemented a legal definition of economic abuse from June 2022 which is discussed in the overview report.

36. Lilly was frightened of what Leonard might do after she had made her disclosures. Lilly did not know the details of Leonard's history with his previous wife until after she contacted the police in November 2021. She was worried that he would not keep to his bail conditions given he had a history of ignoring previous court orders with his earlier partner. She was shocked when she was phoned by the police in December 2021 to be told that the bail had been lifted and that Leonard was not under any conditions or controls. Recording in DAS in February 2022 indicates there was a misunderstanding about the bail status of Leonard who the IDVA thought was still under conditions of bail. This is discussed in the overview report.

37. The CPS authorised the police to charge Leonard with two crimes engaging in controlling/coercive behaviour and making threats to kill. The circumstances under which Leonard was released under investigation (RUI) are discussed in the overview report.

38. Lilly was offered contact with an IDVA when the referral from the police was received. Practical safety measures such as window locks were discussed and delivered quickly. Advice to seek a protective court order was not followed up by effective enough legal advocacy and a court order was not made for several weeks. Lilly tried several legal firms but had all been contacted by Leonard who had made counter-allegations to the police. Lilly was eventually put in contact with solicitors based in Sheffield.

39. When the IDVA went off on leave Lilly was required to access support through the hub which proved ineffective in dealing with practical issues such as Lilly's problems in getting legal representation after Leonard had

contacted the same firms. The decision to refer Lilly to Riverside was inappropriate given Lilly was already open to an IDVA.

40. Leonard's claims that Lilly's allegations of domestic abuse and that he was the victim of her controlling behaviour were processed as unrelated behaviour rather than considering whether it could be perpetrator behaviour intended to control and divert the investigatory processes. This is an important area of learning in the review. The fact that coercion and control had been identified at the point of the initial disclosure should have been factored into subsequent plans and strategies including when Leonard made his counter-allegations.

41. Coercion and control along with economic abuse is a continuing pattern of behaviour that requires vigilance and the ability to adapt plans and responses by the respective agencies such as police and domestic abuse services.

42. The counter-allegations were not referred to a MARAC or discussed by any of the services that processed information about them. The MARAC should be in a position to address the safety needs of a victim of domestic abuse and consider how the behaviour and welfare of the perpetrator are also to be addressed. The psychological impact of a perpetrator losing control represents a heightened risk for the victim and the perpetrator. The significance of this is discussed in the overview report.

43. There were opportunities for services to have inquired about domestic abuse before November 2021. The clearest example is when Leonard presented at hospital emergency services following an overdose and the subsequent contact with the mental health Crisis Team. Neither of these services demonstrated sufficient informed curiosity about domestic abuse. Lilly also consulted the GP about depression and was on medication until late 2020. When Lilly spoke to the GP about depression it was after she had been told that Leonard had been RUI and she had been prevented from securing effective legal advocacy to get a court order.

44. The GP practice had extensive contact with Leonard and he was on repeat prescriptions. There is no evidence of information sent from services such as the hospital being recorded and followed up. The GP and SPA share a common patient record system.

45. Leonard told the GP in February 2022 about domestic abuse and having left the marital home although presented himself as the victim. The GP had no information about the MARAC but did have information about Leonard's history of overdoses and self-harm. There was little inquiry about the circumstances of the domestic abuse and no self-harm assessment.

Conclusions

46. Leonard suffered trauma that began early in his life. At the time of his death, he was under significant levels of stress associated with the loss of a relationship and his marital home. His history of domestic abuse and breaching orders in a previous relationship and the allegations about his behaviour toward Lilly were indicative of coercive control. The loss of control would have exacerbated his stress. Leonard should have been offered clearer support to address his behaviour and there should have been a more informed appreciation of the anxiety and stress that he was suffering over a long period which no doubt was exacerbated by the prospect of going to court.

47. Leonard's move to a new GP practice in February 2022 occurred as the UK was gradually relaxing Covid-related restrictions although primary health services were still providing a significant proportion of their consultation by remote contact such as telephone.

48. Although there was an effective initial police response and risk assessment when Lilly made her initial disclosures of domestic abuse the subsequent follow-up did not provide effective support to Lilly. She struggled to find legal representation to secure protective orders and the decision to release Leonard under investigation without bail conditions left her vulnerable.

49. The decision to release Leonard under investigation (RUI) was not adequately explained given the previously identified high risk he presented to Lilly. There may have been an assumption that Lilly was being helped to find legal advice and advocacy to seek protective court orders. It is inappropriate to place responsibility on a victim to protect themselves particularly when the perpetrator has a high-risk history and there is current evidence of coercion and/or control. Without bail conditions or a court order, it can be difficult to control the behaviour of the perpetrator. An RUI decision can also undermine the legal argument in court for some form of a protective order.

50. Two parallel investigations were opened in response to the separate allegations of domestic abuse but no account has been given about how

the counter-allegations were considered over and above ensuring the relevant OIC was made aware. The allegation made by Lilly against Leonard in November 2021 was assessed as high risk from the DASH and therefore was allocated to the DA Team for investigation. The counter allegation by Leonard against Lilly in December 2021 was assessed as medium risk and therefore remained with the local policing team (LPT) to investigate.

51. The failure to resolve the issue of Leonard's counter-allegations is a significant area of learning along with how evidence of self-harm was dealt with. Controlling and coercive behaviour is a pattern of behaviour that precedes the detection or disclosure and is likely to continue and possibly escalate as a result of a victim disclosing information and leaving the relationship and control of the perpetrator. Risk assessment and mitigation strategies need to take this into account alongside the criminal investigation.

52. Security equipment was delivered to Lilly's home; she had to arrange the fitting of all the equipment which was common practice at the time and some of which did not require any tools or DIY skill.

53. Funding has been released to pay for the equipment and fitting costs for any person living in Doncaster who is threatened with homelessness as a result of domestic abuse and/or is at risk of further harm from the perpetrator.

54. The workload associated with domestic abuse has increased in Doncaster and nationally. The police did not comment specifically on whether there were resource issues in terms of the availability of investigatory capacity or specialist knowledge and expertise that had an impact on any aspect of this particular case. There are resourcing issues within DA teams which are monitored through the monthly PVP performance meetings. There is a national shortage of detectives and SYP is also impacted by this. All officers within the domestic abuse teams carry high workloads; this is monitored to ensure officers are not pushed beyond capacity.

55. The MARAC has introduced gatekeeping processes to help manage an ever-increasing workload that involves consistent agencies. Some of the implications are seen in how for example the issue of counter-allegations was not referred to despite being potentially symptomatic of an escalating pattern of behaviour and how they should be addressed through the lens of perpetrator behaviour rather than a victim. The quality of discussion in terms of identifying risk as a result of domestic needs to

take account of potential welfare risks for the victim and perpetrator. A fundamental part of that is ensuring GP practices are alerted to information.

Learning

56. The learning is summarised;

a) Loss of control and leaving a relationship escalates the risk to a victim and can trigger a major psychological crisis for a perpetrator; the emotional and psychological welfare of both has to be considered alongside any strategies for addressing abusive behaviour;
b) Understanding the lived experiences and stressors contributing to poor mental health and self-harm and not relying on tools and questionnaires that use terms such as low risk or reducing risk is recommended practice by the Royal College of Psychiatrists and applies to other professional disciplines involved in risk assessment. An in-depth conversation and a detailed appreciation of a person's circumstances and background that encourages disclosure of domestic abuse and relationship breakdown is clinically and therapeutically valid and creates an opportunity to address domestic abuse more effectively;
c) MARAC action plans need to include addressing potential mental health and welfare risks and ensuring primary health and mental health services are notified of MARAC referral and discussion;
d) All health providers should be encouraged to routinely inquire about domestic abuse as part of psycho-social assessments with patients presenting with low mood or concerns about self-harm, especially with evidence of relationship breakdown and any additional factors that suggest coercive control has been a factor and therefore implications for psychological crisis and escalation; encouraging GPs to routinely follow up notifications about contact with other services following self-harm and or mental health concerns; attention to the use of non-prescribed medication associated with self-harm/self-poisoning;
e) Resolving counter-allegations as part of criminal investigation and safety strategies is essential to minimise the potential for manipulation and address the needs of a victim and perpetrator; using and manipulating legal processes and institutions/systems to threaten, harm,

impoverish or discredit a victim is a recognised tactic of coercive control occurring before and after separation; manipulation of victims and professionals is another well-recognised symptom;

f) Recognising and responding to coercive control along with economic abuse as a pattern of cumulative behaviours and ensuring that incidents are assessed and dealt with in that context; this includes DASH and criminal investigatory processes and how discussion at MARAC is framed and recorded; it is behaviour that is likely to continue and escalate; manipulation and interfering with legal and investigatory processes can be part of a repertoire of perpetrator behaviours;
g) A high-risk DASH needs to be followed up by concerted action by the police and specialist domestic abuse services that are focussed on securing the immediate and long-term safety of the victim; this includes ensuring the security of premises and being provided with effective legal advice and advocacy;
h) Ensuring the physical safety of victims of high-risk domestic abuse has to include effective measures to provide their physical security that should not be delayed; this means working with private landlords to ensure urgent action is taken to upgrade safety measures for domestic abuse victims; the Domestic Abuse Housing Alliance (DAHA) had developed good practice guidance in consultation with Standing Together;
i) Communication between police and IDVA about charging and bail decisions and use of court orders;
j) The practice of releasing under investigation (RUI) an accused perpetrator of high-risk domestic abuse is inappropriate and does not reflect national guidance that has been subsequently introduced since November 2022;
k) The importance of a named IDVA covering absences of colleagues supporting a victim of high-risk domestic abuse;
l) Quality of recording and supervision by IDVA service;
m) Understanding that domestic abuse is hidden when euphemisms are used such as relationship breakdown and without proper enquiry; the significance of dependency and self-harm (threatened or otherwise) being recognised as risk factors for a perpetrator's safety and potential escalation in abuse.

n) Power imbalances can occur in many different forms including age, finances and authority; not all power imbalances are abusive.

Recommendations

1. The Safer Stronger Doncaster Partnership should develop a clear policy and protocol for the processing of counter-allegations of domestic abuse.
2. The Safer Stronger Doncaster Partnership should consider what further measures can be taken to promote domestic abuse guidance for private rented sector landlords in Doncaster developed by the Domestic Abuse Housing Alliance (DAHA)[5] cross-referenced to local schemes such as Safe at Home.
3. A review of IDVA arrangements for covering high-risk cases in the absence of the allocated IDVA should be completed as a matter of urgency.
4. The workload of IDVA service should be reviewed and include the support, supervision and oversight of case recording and risk assessments,
5. RDaSH should review whether any action is required from this review on the use of medication in self-harm following the recent audit on concordance with Nice Guidance for self-harm assessment and preventing recurrence.
6. MARAC should ensure that action plans include highlighting any potential safeguarding or welfare concerns for the victim and perpetrator and that GP practices and RDaSH (SPA) are routinely advised of MARAC's discussion and plan.
7. The SYP ensure that current arrangements for managing the bail of perpetrators of domestic abuse are compliant with national guidance that discourages the use of RUI in cases of domestic abuse and where there is an ongoing risk to victims.
8. The SYP should confirm an action plan has addressed any learning about the decision-making by the SIO and custody officers following the CPS advice to immediately charge Leonard.

Issues for National Policy

1. The Home Office to determine if further research and collation of information about counter-allegations of domestic are required.
2. The Home Office should consult with the Association of Chief Police Officers as to whether further national guidance for the

[5] http://www.privaterentedservice.co.uk/wp-content/uploads/2019/12/PRS-Landlord-Guidance-around-domestic-abuse.pdf

handling and processing of counter-allegations in domestic abuse cases involving evidence of coercion and/or control is required.