NUNEATON & BEDWORTH COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review
Overview Report
(DHR NB01)

Report into the death of a domestic homicide victim on 2nd January 2012

Report produced by Kathy McAteer
Independent Chair and Author
Publication Date: 14th May 2015

Glossary

CAADA: Co-ordinated Action Against Domestic Abuse – a national charity supporting multi-agency responses to domestic abuse through the provision of practical support, learning and development and best practice guidance

CATS: Case Administration and Tracking System - Police database used to hold domestic abuse incidents and other safeguarding matters

CSA: Child Support Agency – the agency responsible for collection of child maintenance payments

Arden NHS Cluster: The Arden Primary Care Trust Cluster were responsible for commissioning GP services at the time the initial review took place however now GP's are commissioned by the Local Area Team (LAT) (NHS England)

CCG: Warwickshire North Clinical Commissioning Group - Primary Care Trusts were responsible for commissioning local health services across Coventry and Warwickshire until 2013 when statutory responsibilities transferred to the new Clinical Commissioning Group. (NHS England)

CMHT: Community Mental Health Team – multi-disciplinary team providing community based assessments and support to people with serious and enduring mental illness

CWPT: Coventry & Warwickshire NHS Trust – the organisation providing local mental health services

CPS: Crown Prosecution Service

DASH: Domestic Abuse Stalking and Honour-Based Violence Risk Indicator Checklist – national risk assessment tool used by police and other partners to assess risks of abuse from the perspective of the victim

DAU: Domestic Abuse Unit – police department responsible for case management of high risk domestic abuse cases

GEH: George Eliot Hospital

Harmoni: Provider of GP out of hours service, commissioned by the CCG (see above).

IAPT: Improving Access to Psychological Therapies – provision of counselling services

IESD: Department of Health Innovation, Excellence & Strategy Development

IDVA: Independent Domestic Violence Advisor – advocacy support for high risk victims of domestic abuse

IMR: Individual Management Report – reports submitted to review by agencies

IRIS: Identification and Referral to Improve Safety Project – training and support for GP practices

ISP: Initial Sentence Plan (probation service)

MARAC: Multi-Agency Risk Assessment Conference – brings together local partners to provide a co-ordinated response to domestic abuse through the sharing of information about people at the highest level of risk

NABSCOP: Nuneaton and Bedworth Safer Communities Partnership

OASys: Offender Assessment System - used by probation service

OGP: Offender Group Predictor - tool used by probation service

OGRS: Offender Group Reconviction Score – a static actuarial predictor of risk used by probation service

OVP: Offender Violence Predictor – tool used by probation service

Promat: Police computerised system for witnesses to identify offenders – replaced the old style Identity Parade

PSAI: Post Sentence Assessment Interview – tool used by probation service

PSR: Pre-sentence report (probation service)

RCGP: Royal College of General Practitioners

SWFT: South Warwickshire NHS Foundation Trust – provider of local community health services

UHCW: University Hospital Coventry & Warwickshire NHS Trust

WCC: Warwickshire County Council

WDVSS: Warwickshire Domestic Violence Support Services – voluntary organisation providing support to people experiencing domestic abuse (now Families First Warwickshire)

WMAS: West Midlands Ambulance Service

SECTION 1: INTRODUCTION

1.1 Circumstances leading to the review

This report of the Domestic Homicide Review (DHR) examines the circumstances and agency responses leading up to the homicide of the victim, 38 years, by her ex-partner. On 2nd January 2012, police were called to an address where the body of the victim was found in the boot of her car. Her ex-partner has subsequently been found guilty of murder. Forensic and post mortem evidence showed that the victim died at her home address as a result of receiving blunt force trauma to her neck.

The victim lived with the perpetrator and her adult son, and had just ended the relationship, having told the perpetrator that he must move out of her house. Records indicated that there was a history of domestic abuse incidents between the perpetrator and victim and between the perpetrator and his previous partners. The victim and perpetrator were known to MARAC (Multi Agency Risk Assessment Conference) and a long term risk management plan was in place.

The Domestic Homicide Panel extends their condolences to the family and friends of the victim. The Panel would also like to thank all who have contributed to this review for their time and patience.

1.2 Purpose of a Domestic Homicide Review

Domestic Homicide Reviews were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The review was conducted to fulfil the requirements bought in under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and was delivered in accordance with the Home Office guidance - 'Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews' and followed the key processes that are outlined within

the 'Warwickshire Domestic Homicide Review - Multi Agency Policy and Procedures'. Real names have not been used in public documents including the terms of reference, the overview report and executive summary.

1.3 The Review Process

The homicide happened on 2nd January 2012 and Nuneaton & Bedworth Community Safety Partnership (NABSCOP) was notified by Warwickshire Police on 5th January 2012. The review was commissioned jointly by Nuneaton and Bedworth Borough Council and Warwickshire County Council on behalf of NABSCOP and the Home Office were notified of the decision to undertake the review on 2nd February 2012. An independent chair and author was selected from a pool of chairs/authors through a selection process. The Panel was selected by the respective agencies on the basis that they had no direct operational responsibility for the case. This included representation from a voluntary sector specialist domestic violence organisation. There were no conflicts of interests. A Terms of Reference was agreed at the first meeting of the Panel on 5th March 2012. Panel Membership:

Agency	**Position**
Independent Chair & Author	Independent social care consultant
Warwickshire Probation Trust	Assistant Chief Officer
Warwickshire Police	Detective Chief Inspector, Protecting Vulnerable People Department
Warwickshire County Council Children's Services	Operations Manager
Coventry & Warwickshire Partnership NHS Trust	Lead Nurse for Safeguarding Children and Vulnerable Adults
Warwickshire County Council Community Safety and Substance Misuse Team	Domestic Abuse Manager Domestic Abuse Admin Officer
Nuneaton & Bedworth Borough Council – Housing & Communities	Housing and Communities Manager Communities Manager Communities Officer
NABSCOP (Nuneaton & Bedworth Safer Communities Partnership)	Chair
Refuge	Senior Operations Manager
North Warwickshire Borough Council	Policy Support Manager (Observer)
Warwickshire North Clinical Commissioning Group (CCG) (NHS England)	Lead Nurse Safeguarding Adults Warwickshire

The process began by identifying agencies that had contact with the victim and/or the perpetrator and/or his previous partners and children. This included 17 agencies, all of which were potential support agencies for the victim or had knowledge of or contact with the perpetrators, or his ex-partners and children. Information on the deceased and perpetrator and their key relationships was collected from 2008, with agencies asked to include the date of their first contact with any of the parties, and to highlight any relevant information prior to 2008 that the Panel should consider. The following 7 agencies reported that they had no recorded contact with the victim and/or perpetrator, or any contact was out of scope and not of relevance to the review:

- North Warwickshire Borough Council
- Nuneaton & Bedworth Borough Council Housing and Communities
- Swanswell
- The Recovery Partnership
- Warwickshire County Council Adults Services
- University Hospital Coventry & Warwickshire NHS Trust
- Harmoni (GP out of hours service)

The following 10 agencies had recorded contact with one or more of the parties identified within the review timescale and held information relevant to the review:

- Coventry & Warwickshire Partnership NHS Trust
- George Eliot Hospital
- GP Practice
- Refuge (including IDVA)
- South Warwickshire NHS Foundation Trust
- Warwickshire County Council Children's Services
- Warwickshire Domestic Violence Support Services
- Warwickshire Police
- Warwickshire Probation Trust
- West Midlands Ambulance Service

Of these, only 5 agencies had any contact with, or knowledge of, the victim prior to her death. They are:

- Coventry & Warwickshire Partnership NHS Trust
- GP Practice
- Refuge and IDVA
- Warwickshire Police
- Warwickshire Domestic Violence Support Services

Coventry & Warwickshire Partnership NHS Trust (CWPT) had been requested by the CPS to defer their internal serious incident investigation until after conclusion of the criminal trial. This significantly impacted on their ability to complete an IMR, which could only be based on an analysis of records rather than interviews with relevant professionals. A revised IMR based on the findings of the serious incident report was therefore submitted to the Panel after the trial.

The Review Panel has obtained all family and perpetrator confidential documentation on the basis of their consent, or in the absence of their consent, in the public interest. There were delays in obtaining some information due to concerns from some agencies on whether they could release the information without explicit consent from the named individual. There is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs30 and that these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic Violence Crime and Victims Act 2004). Although certain bodies can be directed to participate in a review, reviews, including Domestic Homicide Reviews, cannot issue a witness summons. This means there is no legal sanction or power to enforce a request made by the Review Panel Chair or Overview Report Writer that an individual attend for an interview. The review process was delayed by some NHS bodies questioning whether they could share information and delaying their response whilst they took additional advice. The evidence suggests that the organisations were unclear about who within their agency could approve the release of IMRs. This raises issues about adequate awareness training for agencies who may be asked to contribute to a DHR and the Home Office guidance would also benefit from being strengthened to include more information regarding the Data Protection Act and disclosure of information in the public interest.

Each agency and/or service that has had contact with victim and/or perpetrator, their previous partners or children, was asked to submit 2 key documents as follows:

- A chronology of events detailing in date order all contacts with the named individuals
- An individual management report (IMR) detailing key information, based on the key lines of enquiry, including:
    - An analysis of the involvement of all services within the agency including contact and actions taken, outcome of any assessments undertaken, support and services delivered and offered, decision points and reasons for decisions taken
    - the effectiveness or otherwise of inter-agency working, the triggers for information sharing and any missed opportunities to share information
    - learning points and proposed actions for the agency/service
    - learning points and proposed actions for improving inter-agency working

A standard format for both the chronology and the IMRs was used for consistency and ease of analysis. CWPT completed an internal Serious Incident Report in conjunction with the IMR.

The Panel also considered the following additional information:

- MARAC processes, using the IMR format
- MARAC minutes
- a presentation by a CAADA accredited independent consultant on the DASH risk assessment process and what constitutes best practice
- Warwickshire Police Standard Operating Procedure

- Preliminary report of the MARAC Quality Assurance programme for Warwickshire North MARAC
- A copy of the court transcript relating to psychiatric evidence, the Judge's summary and sentencing.

In addition, contact was made with family, friends and employer and they were invited to contribute following conclusion of the criminal trial. This included contacting the victim's and the perpetrator's parents and other family members, the perpetrator via the prison governor, the victim's employer, and 8 other friends and acquaintances identified during the police investigation. Of these, 4 people responded, including two friends of the victim, one close relative and her employer. One friend was unable to contribute due to illness. Contributions were through a mixture of face to face meetings, telephone calls and written submission. The perpetrator responded to decline to be involved.

1.4 Terms of Reference of the Review:

The Terms of Reference were agreed by the Panel and NABSCOP as follows:

- To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to the victim or other partners, and whether any action could have been taken to prevent the homicide. To establish whether the homicide was predictable or preventable.

- To establish how effective agencies were in identifying the victim's vulnerability to domestic abuse and the level of risk to which she was exposed, and whether the single agency and inter-agency responses were appropriate and proportionate in supporting the victim and her family.

- To establish how easily the families of both victims and perpetrators of domestic abuse are able to access appropriate and timely support.

- To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency practice, policies and procedures to improve the identification of, and safeguarding of, people subject to domestic abuse in Nuneaton and Bedworth, Warwickshire, and perhaps more widely, in the future.

- To identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office

1.5 Key Lines of Enquiry

Records suggested that there have been known incidents of domestic abuse since 2008. The review requested information focussed on the period from 2008 to the date of homicide, but with the proviso that any relevant information preceding this date is also brought to the attention of the panel.

a) **History of Events and Relationships:** What was the history of the relationship between the victim and perpetrator, between the victim and previous partners and between the perpetrator and his previous partners, and, in each relationship, their children? How were these linked? What was the sequence of events up to the date of the homicide?

b) **Information:** How was information about the victim and perpetrator received and addressed by each agency and how was this information shared between agencies? What were the trigger points for sharing information, and were there missed opportunities when sharing information may have made a difference? What were the thresholds for decision making?

c) **Risk Assessments:** What assessments were completed to assess the risks to the victim? What risk assessments were completed on the perpetrator and how did these impact on the risk assessment? What were the outcomes of assessments and what actions were taken? Which of these were completed by a single agency and which were multi-agency?

d) **Contact with and Support from agencies:** What contact did each agency have with the victim and perpetrator, wider family members and children from their respective relationships? What support did each receive and from whom? What processes were followed and what were the key decision points, and why? Was there any additional action that could have been taken, and would it have made a difference (missed opportunities)?

1.6 Timescale of the review

This review began on 5th March 2012 and was concluded 29th January 2014. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. However, there was significant information that was not available prior to the criminal trial for the following reasons:

- Coventry & Warwickshire NHS Partnership Trust were asked by the Police/CPS to defer completion of their Serious Incident Review until after the trial. This prevented them from interviewing key staff for the IMR and valuable information was not therefore available to the Panel until following the trial.
- Family and friends were to be called as witnesses in the trial and therefore could not be offered interviews until after the trial

The trial was originally scheduled for November 2012. However, due to a mistrial was further delayed until May 2013. The review was therefore completed in 2 phases due to the timing of the criminal trial. The first phase was completed between March and August 2012 and included analysis of agency information as set out in the chronology and Individual Management Reports (IMRs) This phase of the review was concluded by 9th August 2012 and identified learning that was taken on board by the agencies, and specifically the MARAC. The Panel then reconvened on 17th June 2013 following completion of the trial. The review was completed on 29th January 2014. It should be noted that agency recommendations identified in IMRs were actioned immediately and timescales for completion prior to the finalisation of the DHR can be identified within the Action Plan.

SECTION 2: THE FACTS

2.1 Summary of events*:*

On Monday 2nd January 2012, police were called to the home of the perpetrator's parents by his father. The perpetrator was present at the address having arrived there in a car belonging to the victim. On police attendance the victim's body was found in the boot of the car. The perpetrator was arrested on suspicion of murder. Police enquiries indicated that the victim died at her home address and that her death was caused by a neck injury. The perpetrator was charged with murder and found guilty in June 2013. Forensic and post mortem evidence found that the victim died at her home address as a result of receiving blunt force trauma to her neck.

The victim and perpetrator had been living together at the victim's house, along with her adult son. Though they spent Christmas together, they were splitting up after the New Year holiday, and the perpetrator was due to move out on 3rd January. On the night of the homicide, the perpetrator was working as doorman at a local pub, and the victim was at the same pub as a customer, enjoying the celebrations. They returned home together and were arguing prior to the victim getting undressed and getting into bed. The perpetrator strangled the victim and hit her with some force. Despite the risk of being disturbed by the victim's son and his girlfriend, the perpetrator showered, subsequently concealed the victim's body in the boot of her car, and told plausible lies to explain her absence. The body remained in the car boot for 30 hours, during which time the perpetrator was driving the car and had his young children present.

2.2 Subjects of the review:

The victim

The victim was a 38 year old woman who at the time of her death was living in Nuneaton with the perpetrator and with her 20 year old son from a previous relationship. Friends and family describe the victim as being confident, strong and independent, having a good job and owning her own house. She was attractive, popular and fun to be with, vivacious and kind, described as someone who knew her own mind, and not seen as the stereotype of a woman subject to abuse – indeed, she did not see herself as a victim of domestic violence and abuse and thought she could handle the perpetrator. The victim met the perpetrator in March/April 2010. She was described as being vulnerable and lonely following the break-up of her previous relationship – a person who needed people around her, and wanted to be in a relationship. Having separated from the perpetrator in March 2011, the relationship had resumed a few months prior to the homicide. However, at the time of the homicide the victim had tried to end the relationship and asked the perpetrator to leave.

The victim herself had no cautions or convictions, other than one arrest for an alleged assault on the perpetrator which was finalised with no further action. There were 3 previous domestic abuse incidents reported to the police concerning the

victim and the perpetrator, and one incident recorded that related to her previous partner.

The victim's relationship with the perpetrator was known to be difficult and she had separated from him around March 2011, at which time he was on bail with conditions not to contact her. The most serious incident of domestic violence happened on 23rd April 2011, being reported to police on 7th May 2011 and evidence suggests that from then until September 2011, she considered the perpetrator to be her ex-partner, though she appeared to have regular contact with him (in breach of his bail conditions). It is unclear who instigated ongoing contact - evidence suggests that this was probably instigated by the perpetrator though she also told police on occasions that he was there with her consent. There were a number of incidents during this period with a pattern of the victim reporting incidents to the police and then being unwilling to support police action, assuring police that "all is fine". The perpetrator was released from bail conditions in September 2011 and the evidence suggests that he was living with the victim in her home until her death in January 2012.

The victim had been referred by her GP for counselling in 2009, following the break-up of a previous relationship and prior to her relationship with the perpetrator. She disclosed to her GP in June 2011 that she was being "terrorised by her ex-boyfriend" She was treated for an overdose in December 2011, the week before her death, when she disclosed domestic abuse and discussed her difficult relationship, stating that she "wanted everything to stop".

The perpetrator:

The perpetrator was 31 at the time of the homicide and had been in a relationship with the victim since March/April 2010, having separated from his wife. Evidence from friends of the victim suggests that the perpetrator was manipulative and charming, moving in with her within a few days of meeting her. On one hand, he could be kind and loving, but would quickly turn nasty. He often lied, but was very plausible. He frequently stole from the victim – having had a good job and her own house, this was repossessed after her death as he "had left her with nothing". The perpetrator was a strongly built man whose behaviour was driven by jealousy and wanting to control the victim, often by making threats or damaging her property, than through actual physical violence.

The perpetrator was known to Mental Health services during May/June 2009 and then from August 2011 until the homicide. There was no specific diagnosis and the episodes were initiated by overdoses/suicide attempts, usually while under the influence of drugs or alcohol. The indications are that mental health difficulties were usually triggered by relationship breakdowns and/or bereavement, exacerbated by the use of drugs and alcohol. Though the perpetrator was advised to seek help to reduce his alcohol intake, and was given appropriate signposting to support services, records suggest he did not take this up and he was not known to specialist substance misuse services. There was no evidence of, or diagnosis of, a psychotic illness. Psychiatric evidence presented during the trial suggested that the perpetrator may have a personality disorder characterised by jealousy, being impulsive, frequent aggression and being a habitual liar, but did not have a truly psychotic illness.

Though the perpetrator claimed to have been hearing voices, there was no evidence of delusion and the psychiatric evidence suggested that the "voices" were his own insistent thoughts rather than hallucinations.

The perpetrator has 2 known previous partners, with whom he has a total of 4 children, and there is a history of domestic abuse against partners along with ongoing disputes over access to his children:

Perpetrator's Domestic Abuse history:			
Date	**Complainant**	**Incident/Conversation**	**Source**
July 2003	Ms Z [1]	Electronic record only - further details not known	Police
December 2008	Ms Z	Dispute re perpetrator's alleged affair; Ms Z and perpetrator arrested for assaulting each other; medium risk; Ms Z and her mother cautioned; Perpetrator – NFA Children's services involved as allegedly the perpetrator threatened child Y not to tell his mother that he had kissed neighbour; Perpetrator moved out of family home;	Police Children's Services
April 2010	Ms Z	Ms Z alleges perpetrator has stolen a laptop during a domestic dispute; medium risk;	Police
Oct/Nov 2011	*To note victim's complaints that Ms Z and her new partner are threatening perpetrator re child access and allege perpetrator texting Ms Z; standard risk*		*Children's Services*
March 2011	Victim	Perpetrator damaged phones – bailed with conditions not to contact victim – medium risk. Bail cancelled in April when victim withdraws complaint	Police
24th April 2011	Victim	Perpetrator had entered her house and stolen purse; mentions he attacked her "last Saturday night". Refused to give more information. Standard risk.	Police
7th May 2011	Victim	Perpetrator damaged car and house and threats to kill; Reports incident mentioned above (now 2 weeks previously) of dragging her into house and attempting to strangle her. Perpetrator bailed with conditions not to contact victim. High Risk and referred to MARAC.	Police

[1] Ms Z and Ms V are previous partners of the perpetrator

29th May 2011	Victim	Perpetrator turned up at house while victim on phone to friend. Police arrived – told that victim had gone out for a drink with him. No action taken. Medium risk.	Police
July 2011	Ms V[1]	Told Children's Services that perpetrator said he would kill her, when she challenged him about giving their daughter alcohol (Neither Ms V nor Children's Services contacted police)	Children's Services
July 2011	Ms Z	Told Children's Services that perpetrator had been violent towards her throughout their relationship, and had been violent towards his previous partner, Ms V;	Children's Services
August 2011	Victim	Assaulted by perpetrator at her friend's house where he was lodging. Bailed with conditions; Medium risk	Police
September 2011	*Perpetrator taken to hospital with police support following overdose – argument with victim referred to*		*WMAS Police*
November 2011	Ms V	Made report to police of threatening texts from perpetrator after spending a night with him. He threatened to commit suicide; Police referred to Children's Services. Told Children's Services she was very frightened of him, he had been violent in their relationship.	Police Children's Services

Evidence going back to 1999 shows that the perpetrator lived a fairly nomadic lifestyle with a total of 14 addresses in the Nuneaton area over 12 years**:**

Time period	**Addresses**	**Relationship**
Feb 1999 to April 2010	10 known addresses	Appears to be in a relationship with ex-wife (Ms Z, mother of 3 children) during this period, and some addresses tie back to her known address at times
March/April 2010 to March 2011	Victim's address	Known to be living with victim
April 2011	Not known	Known to be at victim's address whilst bailed not to contact victim
May 2011 to Sept 2011	3 known addresses	Victim describes him as ex-partner during this period

End Sept to Jan 2012	Victim's address	Known to be living with victim

Interpretation of the information suggests that his relationships tended to be volatile, with a pattern of separations and reconciliations. There are indications that previous partners were afraid of him, and in some instances the perpetrator was the alleged victim of threats from his ex-wife's new partner. Evidence from the trial suggests that jealousy contributed to the break-up of his relationships with women – he was controlling and cross questioning of partners, disliked them speaking to other men, being late, or attracting attention from other men. The judge, in his summing up, describes the perpetrator as a threat to any woman with whom he has an intimate relationship.

The perpetrator was well known to the police with 12 previous convictions for 24 offences including driving offences, burglary, theft, common assault, criminal damage, breach of community orders, and a caution for handling stolen goods. He was also arrested but not charged for 4 domestic abuse incidents including assault occasioning actual bodily harm and criminal damage, threats to kill and theft, in relation to the victim, and common assault with a previous partner. He was also involved in several other incidents involving previous partners. In addition there were warrants issued in relation to civil matters – that is, by the Child Support Agency (CSA) in relation to unpaid child support.

Perpetrator's convictions:

Offence Date	**Court Date**	**Offence/Conviction**	**Sentence**
1.1.12	5.1.12	Murder	Life sentence
23.6.11	29.9.11	Theft – Shoplifting	Fine £100 costs £50, victim surcharge £15
11.8.11	29.9.11	Theft – Shoplifting	Compensation £99.87
20.8.11	29.9.11	Theft – Shoplifting	Compensation £109.52
27.2.11	22.8.11	Failing to give name/address after accident	Community Order 22.8.12, unpaid work 150 hours, costs £85, driving license endorsed
27.2.11	22.8.11	Driving otherwise than in accordance with a licence	Driving license endorsed
27.2.11	22.8.11	Driving without due care and attention	Driving license endorsed
25.5.01	7.11.08	Theft	Community rehab Order 12 months, community punishment order 90hours, costs £60
10.5.05	17.5.05	Destroy or damage property	Conditional discharge 12 months, costs £70 and compensation £175
5.12.04	4.4.05	Breach of community punishment order	Fine £50, order to continue
16.1.05	4.4.05	Breach of community punishment order	Costs £35 to Warwickshire Probation serve, order to continue

6.2.05	4.4.05	Breach of community punishment order	order to continue
20.2.05	4.4.05	Breach of community punishment order	order to continue
27.2.05	4.4.05	Breach of community punishment order	order to continue
14.7.04	1.12.04	Breach of community punishment order	order to continue, costs £35 payable to Warwickshire Probation
12.8.04	1.12.04	Breach of community punishment order	order to continue
9.2.04	5.3.04	Theft - Shoplifting	Community Rehabilitation Order 12 months, costs £70
15.7.01	15.1.02	Common Assault	Fine £350, compensation £150
15.11.01	15.01.02	Failing to surrender to custody at app time	Fine £25, costs £60
5.3.01	11.04.01	Burglary and theft	Community punishment order 200hrs, costs £203, subs varied 15.2.02 imp 6 months
29.7.01	5.9.01	Breach of community punishment order	Community punishment order 10hours consequence, cost £35
1.3.99	12.4.99	Driving whilst disqualified	Community Service order 100hrs, DL endorsed, varied community service order 200 hours
1.3.99	12.4.99	Using vehicle while uninsured	Driving license endorsed, costs £45
12.2.99	22.2.99	driving a motor vehicle with excess alcohol	Disqualification from driving 12 months and licence endorsed. Costs £40
5.7.99	17.7.99	Handling stolen goods	Caution
Non Conviction Offences:			
22.8.11	22.9.11	Assault occasioning actual bodily harm	NFA – there was liaison with CPS whilst perpetrator was in custody, and further work requested, so he was bailed. During this time the victim withdrew the allegation. She stated that the offence did occur but that she would not proceed with prosecution or assist with the investigation. A victimless prosecution was considered but recorded as not in the public interest. The victim withdrew the complaint stating that they were no longer within a relationship and she believed he wold change as he was attending an anger management course and was doing really well.
22.8.11	22.9.11	Destroy or damage property	NFA as above
7.5.11	14.9.11	Threats to kill	NFA – Offender was not identified by witness on Promat (computerised ID system).

			Examination of the phone did not provide adequate evidence to progress investigation. No further lines of enquiry were available.
25.3.11	30.4.11	Theft	NFA – initial call was made by the victim but she then refused to provide further details to substantiate any offence, therefore no investigation could commence.
28.6.10	14.8.10	Use threat, abusive, insult words or behaviour	NFA – independent witness refused to provide a statement so no evidence to progress investigation
14.12.08	15.12.08	Common Assault	NFA – no injuries or witness accounts to corroborate allegation. Offender denied allegation. Unable to substantiate allegation.
28.9.07	6.12.07	Burglary and theft - non dwelling	Insufficient evidence to proceed

Civil Cases/Warrants/other contacts:

Date	**Issue**	**Comments**
11.04.11	Failure to Appear warrant	CSA – non-payment of child support £13,042.70
20.04.11	Warrant Office	Perpetrator called warrants office stating going on holiday 20/4/11 and arranged to call on his return on 4/5/11
05.05.11	Warrant Office	Perpetrator left message on answer phone to call after 3.30pm to arrange surrender – was spoken to and will finish at 10am next Friday 13.5.11 and will surrender straight from work to NJC.
07.05.11	Arrest	Arrested on Failure to Appear warrant
26.5.11	Summons	Appeared Warwickshire Magistrates re driving offences; adjourned to 30.06.11
13.06.11 15.06.11	Bail	Failed to appear Bail varied to 12.07.11
30.06.11	Failure to Appear adjourned	Warwickshire Magistrates adjourned to 15.07.11
15.07.11	Failure to Appear warrant	Motoring offences from 27.02.11
25.07.11	Failure to Appear warrant	Re CSA - £13,042.70
28.07.11	Warrant office	Police enquiries at relatives - perpetrator rings and states he will hand himself in next week
22.08.11	Arrest	06.00hrs: surrendered and taken into custody

The relationship:

Friends and family confirmed that the victim and perpetrator met around March or April 2010, with the perpetrator moving in to the victim's home within a few days of their relationship starting. The first confirmed record by agencies of the victim and perpetrator living together was in June 2010 (this was not due to any domestic abuse incident). It is also recorded that the perpetrator's ex-wife said he had "gone to live with another woman" in April 2010. There were incidents during October and November 2010 involving the perpetrator's ex-wife and her new partner, related to child access.

A friend of the victim witnessed what she believes to have been the first incident of domestic abuse around August bank holiday 2010, when the perpetrator hit/pushed the victim in the street causing her to fall. This was not reported to police or any known agency. The first incident of domestic abuse to be reported to the police was in March 2011, when he damaged a phone, resulting in the perpetrator being bailed with conditions not to contact the victim. The victim withdrew her complaint in early April 2011, when it was also known that the perpetrator was in breach of the bail conditions. However, at this point the victim was stating that they were not in a relationship.

The second and most serious incident of domestic abuse happened later in April 2011 in front of the perpetrator's children, when he allegedly attempted to throttle the victim. Initially, the victim refused to give more information about this, until there was a further incident in May 2011, when the perpetrator damaged her car. At this point the April incident was assessed as high risk and referred to MARAC.

Friends described the perpetrator as being extremely controlling, using threats and fear more than actual physical violence – for example, he would break into her house while she was out, taking one thing so that she knew he had been there, would threaten to harm pets, would damage her car and property, and send threatening texts.

Records across agencies with contact with the victim consistently evidence that they were not living together between March and September 2011, and this was corroborated by friends of the victim. During this period she consistently describes him as her ex-partner. Though the perpetrator was bailed with conditions during this period there were 2 further incidents reported, in May 2011 and in August 2011.

Bail conditions were lifted in September 2011 when all charges against the perpetrator were dropped due to lack of supporting evidence. Records suggest, and friends confirmed, that he and the victim had recommenced their relationship and were living together, and continued to do so until her murder in January 2012. During this latter period, the victim was reported by friends as becoming more secretive – the victim had also started a new job and told work colleagues that she was single. Prior to Christmas, the victim told the perpetrator, friends and family that she was ending the relationship and that the perpetrator was moving out on 3rd January 2012.

During this period, the perpetrator was receiving support from Mental Health services for depression and suicide attempts, resulting in a short admission for treatment.

Discharge was planned for 23rd December though he subsequently discharged himself against medical advice one day early, on 22rd December 2011. The day after this – 23rd December – the victim was admitted to A & E following an overdose. She disclosed that the relationship was troublesome and she "wanted it all to stop". The homicide happened one week later, on 2nd January 2012.

2.3 Equality and Diversity:

Due consideration was given to all protected characteristics under the Equality Act and none were found to be relevant. Though the perpetrator was known to mental health services there was no diagnosis of serious and enduring mental illness.

2.4 Summary of key events:

A full chronology is available. The table below summarises the key events:

Date	Event
March/April 2010	Victim and perpetrator start relationship and he moves into her home very soon afterwards.
28th June 2010	First police record of perpetrator living with victim (unrelated crime report)
August 2010	Victim assaulted by perpetrator in company of friend, not reported to police.
26th March 2011	Victim reports to Police that perpetrator has stolen and damaged her phone. Perpetrator bailed with conditions to protect victim pending CPS advice. **DASH risk assessment: medium** Referred to WDVSS – telephone contact made with victim on 29th March 2011 to offer support, declined.
12th April 2012	Police attend victim's address to take a further statement - perpetrator present in breach of police bail conditions. Victim was seen separately and stated that he was there with her consent and "was fine".
19th April 2011	Victim withdraws complaint of theft of phone. Bail cancelled.
23rd April 2011	*Perpetrator attempts to throttle victim in front of his children*
24th April 2011	Victim reports to Police that perpetrator has broken into house, stolen purse and had attacked her the previous Saturday night. Initially reported on phone that he had attempted to throttle her but when she attended police station, refused to confirm or disclose any information **DASH risk assessment: standard**

7th May 2011	Victim reports to police that perpetrator damaged her car and house and threatened to kill her. Gave details of the incident 2 weeks ago (23rd April) stating he dragged her into house, throttled her until she turned blue, and she escaped. Witnessed by children and visitors. Perpetrator arrested and bailed on conditions not to contact victim. **DASH risk assessment: High** Referred to IDVA on 9th May 2011 – 2 attempts made to contact victim on 11th and 17th May, no response. Referred to MARAC.
29th May 2011	Friend of victim reports to police that whilst on phone to victim, she said that the perpetrator had turned up. Police attend and are told that victim and perpetrator have gone for a drink at an unknown location. Police track down victim and subsequently speak to her alone, who is reluctant to talk to them saying he "had been fine recently". Note that perpetrator is in breach of police bail conditions. **DASH risk assessment: Medium**. Assessment noted that risk from perpetrator may be high. Referred to WVDSS on 1st June 2011 who attempted to make contact by telephone, no response. Relationship ended – resumed in August or September 2011.
1st June 2011	Victim tells GP she is "being terrorised by ex-boyfriend" and that police are involved.
16th June 2011	MARAC MEETING – discussion of attempted throttling incident of 23rd April. MARAC not aware of subsequent incident of 29th May 2011.
22nd August 2011	Perpetrator appears at Nuneaton magistrates court for motoring offences, and Unpaid Work proposed. Full information regarding domestic abuse history and bail conditions not identified.
22nd August 2011	Victim reports to police that she was at a friend's house, where perpetrator was lodging, and that he assaulted her. Perpetrator arrested, with bail conditions. **DASH assessment: Medium** Referred to WDVSS. Not re-referred to MARAC.
14th September 2011	Bail conditions from arrest on 7th May cancelled as no further action being taken regarding threats to kill and assault. Custody record states that victim withdrew the complaint. IDVA made telephone contact with victim, who refused support.

	Referred to WDVSS as no further criminal proceedings.
26th September 2011	Perpetrator taken to hospital following overdose. Living with victim having resumed their relationship. During the period between September and November, perpetrator is absent from Unpaid Work on several occasions, all with acceptable reasons for absence .
November 2011	Whilst living with victim, there is known to be contact between perpetrator and an ex-partner (Ms V) who tells Children's Services about threatening texts and discloses history of violence and that she is very frightened of him. .
December 2011	Though still living together there is evidence that victim was ending the relationship and had told perpetrator to leave after Christmas.
9th December 2011	Perpetrator taken to hospital intoxicated and suicidal – admitted for psychiatric assessment/treatment.
22nd December 2011	Perpetrator discharges himself from psychiatric unit one day earlier than planned discharge.
22nd December 2011	Victim taken to hospital following an overdose; discharged following day as medically fit and referred to GP for follow up in one week. Discloses abusive relationship with ex-partner and that he had tried to strangle her when she previously tried to finish the relationship – did not want to kill herself but wanted it all to stop.
2nd January 2012	Victim found deceased in boot of car, perpetrator arrested and charged with murder.

SECTION 3: ANALYSIS

3.1 Agency involvement

3.1.1 Warwickshire Police

Summary of involvement:

Warwickshire Police recorded 29 contacts with the victim or perpetrator, of which 28 were from 2008 until the date of the homicide. These included all contacts, not just those related to domestic abuse incidents. These included:

- Four recorded incidents of domestic abuse involving the perpetrator and 3 previous partners in 2003, 2008, 2010 and 2011 respectively.
- One recorded contact related to an incident that involved the victim and her previous partner.
- Three contacts were with the victim in relation to motoring offences
- Eight contacts were with the perpetrator linked to motoring offences or where he was a victim of crimes such as theft or assault.
- Two contacts were with the perpetrator when he had taken an overdose
- Five contacts were related to disputes relating to access to the perpetrator's children or unpaid CSA
- Between March and August 2011 there were five contacts due to domestic abuse incidents involving the victim and the perpetrator. In addition, there was an earlier incident of criminal damage to the victim's house and car in June 2010 that is recorded as related to a dispute between the perpetrator and a third party.

It is noted that there were several contacts with the perpetrator and victim in late 2010 that were related to child contact disputes between the perpetrator and his ex-wife, and incidents regarding unpaid CSA that were concurrent to the documented domestic abuse incidents involving the victim.

Incidents relating to domestic abuse involving the victim and perpetrator began in March 2011 and escalated quickly to the serious high risk incident that led to their referral to MARAC:

On **26th March 2011** the victim contacted the police to report that the perpetrator had damaged her phone in a bid to prevent her from reporting that he had stolen from her. On police attending the incident the victim was initially arrested for assault on suspicion of hitting the perpetrator with a phone handset. When questioned, the victim denied the offence stating it was self-defence as the perpetrator was trying to get the phone from her and she was released without charge. The perpetrator was arrested for theft, which he admitted, and the stolen property was recovered. He was bailed with conditions to protect the victim whilst CPS charging advice was sought. CPS stated that, as the initial statement from the victim was poor, a further statement was needed. Having read the statement, the IMR author concurs with this

judgement. The incident was assessed using the DASH risk assessment as being medium risk, and a referral made to WDVSS.

On **12th April 2011** Police attended the victim's home address to take a further statement from the investigation arising out of the incident reported on 26th March 2011. The perpetrator was at the address decorating. His presence there contravened his police bail conditions. He explained that he and the victim had reconciled their differences and he was decorating by way of apology. The victim was seen alone and confirmed this, and whilst she stated that she would not be re-commencing her relationship with the perpetrator, she wished to withdraw her complaint. The victim provided a statement later that day stating she hadn't been coerced into doing so, but had done so because she had made her peace with him. Further advice was sought from CPS, who advised in the absence of the further statement of evidence requested earlier, and with the retraction statement, the evidential test had not been met, and the crime was subsequently filed un-detected. The perpetrator was not arrested for breach of police bail as the victim had stated that he was present with her agreement and no offence had been committed.

On **24th April 2011** the victim rang the police at 2352hrs to report that her ex, the perpetrator, had let himself in to her house and had stolen her purse, and that he had also tried to throttle her the previous Saturday night (this being the day before). She stated that she couldn't report it then because his children were at the house at the time. The victim stated that she "just wanted to report it", but she was advised that because of the allegations she would need to be seen by police. An appointment was booked for her to be seen at her home address on 26th April 2011 and she was advised to have the locks change promptly and to ring on '999' if anything further happened. On the day of the appointment the victim rang police in an attempt to cancel, but was advised she would still need to be seen, and thus the appointment was moved from her home to Nuneaton Police Station as she didn't want police attending the house.

At the subsequent appointment, the victim declined to disclose any further information regarding her original report and thus an investigation was not commenced. The incident was assessed using the DASH risk assessment and the risk was assessed as standard. The incident notes that the victim and perpetrator live apart. A children's service referral was made, albeit the specific CATs record does not provide details of the perpetrators children that were allegedly present because these were not recorded on the referral. CATs is the database used to hold details of domestic abuse incidents as well as other safeguarding matters. Inputting of incidents on to CATs is prioritised according to the assessed risk level, to ensure risk is managed appropriately.

At the time of this incident there was a backlog of inputting, and as a standard risk incident, this was not inputted on to CATs, or any referrals made, or letters sent to the victim and perpetrator signposting them to support services, until 12th May 2011, some 16 days after the assessment was completed. A further incident was reported on 7th May 2011 which was assessed as high, but because the incident of 24th April 2011 had yet to be input, it wasn't available to be found on CATs when conducting lateral checks.

On **7th May 2011** the victim reported to police that her car and house windows had been damaged, and that she believed that her ex-partner (the perpetrator) was responsible, as he had been threatening her via text messages. The victim further stated that 2 weeks previously the perpetrator had tried to kill her in front of his children by throttling her. This is the event that occurred on Saturday 23rd April 2011 and is likely to be that which she referred to in the contact on 24th April set out above. A crime investigation commenced, and the risk was assessed as 'high' using the DASH risk assessment tool. The account was that the couple had separated in March 2011 as indicated above, but that the perpetrator and his children had stayed at the victim's home on Saturday 23rd April 2011 with the idea of them resuming their relationship. The perpetrator had attempted to strangle her in front of the children, and after leaving the house, made threatening texts to her over the next few days. The victim states that on Friday 6th May, whilst drunk, she responded to the texts to 'wind him up'. The following day she found the damage.

The perpetrator was arrested for threats to kill. In interview he denied all offences but admitted sending the texts to infer that their relationship was over and she should move on, rather than to put her in fear for her life. He was bailed with appropriate bail conditions, to return to the police station on 13th June 2011 regarding this investigation, but kept in custody for court on an unrelated warrant. In the victim's statement she states that she believes that the perpetrator is capable of killing her and that she is fearful for her life. The perpetrator was arrested for a Failure to Appear warrant issued on 11th April 2011.

An attempt was made to fit a police alarm in the victim's house, but it was defective and thus she stayed with a friend. Risk management was allocated to an officer in the Domestic Abuse Unit (DAU) as it had been assessed as 'high risk'. A referral was made to the Independent Domestic Violence Advocacy (IDVA) service, which provides support for high-risk victims involved in the judicial process. A referral was also made to children's services. The DAU officer arranged for the Sanctuary Scheme to attend the address and improve security as needed. The victim was visited on Thursday 12th May 2011, and it was confirmed that the Sanctuary Scheme had been, and that she had the support of friends and neighbours. The DAU officer remained linked in with the investigation Officer in the Case (OIC). A referral was also made to the Multi-Agency Risk Assessment Conference (MARAC).

The perpetrator's bail was varied to 12th July 2011 for an identification process to be run with witnesses that saw someone leaving the scene of the damage on 7th May 2011. Unfortunately he was not identified, and examination of the victim's phone only showed texts of an amicable nature. On 14th September 2011 the crime was submitted for filing as undetected and he was released from his bail.

On **29th May 2011** a friend of the victim reported to police that she was on the phone to victim when she heard her shouting that the perpetrator had 'turned up' and snatched the phone from her hand. At this point police bail conditions were in place preventing him from having contact with the victim. Police attended promptly, and spoke to the victim's son, who stated that she and the perpetrator had 'gone out for a drink to talk'. It was not known where, and the victim had left her mobile at home. Police made efforts to trace the victim and were eventually able to speak to her at 0330hrs some 5 ½ hours later, after she had returned home. The victim was

reluctant to talk, but allowed police to check the house. The perpetrator was not there. The victim would only confirm that she had 'bumped into him in a pub earlier'. She was confirmed as being safe and well with no injuries. This incident was assessed as medium given that the victim told police that she was happy to go with the perpetrator for a drink and that he had been 'fine' recently. (This contradicts the friend who contacted the police because she shouted that he had turned up at the house). She did further disclose that she had been meeting up and talking with him and that had been her own decision. The attending police advised her about her own safety. No action was taken regarding the breach of police bail.

Risk management remained with the DAU as part of a long-term risk management plan. During a contact following the latest incident, the victim disclosed to the DAU officer that she had felt pressured into going for a drink after the police were called, this was the first time, and she wouldn't again. The victim was advised about not having any contact, to ring '999' and that having contact with him gave the perpetrator mixed messages.

On **22nd August 2011** the victim reported to police that the perpetrator, her ex-partner, had assaulted her at a mutual friend's house where he was lodging. The victim stated that she went to the address and sat on his bed with him to discuss their relationship. She felt he was in a mood (this was the date he had appeared in court and received fines and so increased the risks to the victim) so decided to leave, and at that point he assaulted her pushing her down the stairs and the altercation continued outside. The victim received bruising, cuts and swelling but declined medical treatment. The perpetrator was arrested for assault, and in interview said that the victim had lived with him at the friend's address for the past 2 weeks as they tried to reconcile their relationship. Given the account, he was bailed to allow a further statement to be taken from the victim. The mutual friend describes in her statement hearing raised voices and banging, and described the victim as the perpetrator's girlfriend. There is reference in the file to the perpetrator accusing her of being in a relationship with a someone else. When approached for a further statement, the victim provided a statement of retraction stating the incident had occurred as she described, but she believed the perpetrator would change as he was attending an anger management course and doing well. This wasn't checked out and no photographs had been taken of injuries. She also stated that she was not under any pressure to retract, and wasn't in a relationship with him. Bail was subsequently cancelled and the crime filed undetected on 4th September 2011.

The risk was assessed as 'medium' risk, but management remained with the DAU as part of the long-term risk management plan. A referral was made to the WDVSS for support for the victim. The long-term risk management plan was kept open following the bail cancellation to monitor any further developments. This incident was not referred to the MARAC. CAADA best practice is that incidents fitting the definition of a 'CAADA repeat' should be referred back to the MARAC. The CAADA repeat definition is held within their guidance, and is where a high risk incident has taken place, and within another 12 months a further incident occurs that if police were involved, would be recorded as a crime. CPS advice was that the evidential for charges was not met due to discrepancies in the victim's statement.

On **25th September 2011** the ambulance service called police for assistance at the victim's address in Nuneaton. The perpetrator had argued with her, and then taken numerous tablets. Police assisted in ensuring that he attended hospital peacefully. On arrival, the perpetrator was upstairs, emotional and unwilling to go to hospital. There was no mention or suggestion of a domestic abuse incident and the victim was happy to accompany the perpetrator to hospital.

On **24th November 2011** a previous partner, Ms V, reports that the perpetrator had been sending threatening texts, and threatening to commit suicide. They had been a couple up to 8 years previously and had a child. Two weeks previously they had spent the night together, and Ms V was considering re-commencing the relationship, but following the threats has decided not to. Ms V decided not to proceed with a complaint. The incident was assessed as medium risk. Referral made to North Warwickshire Children's Team.

On **9th December 2011** the ambulance service called police for assistance at the victim's address. The perpetrator had cut his wrists and taken 50 paracetamol tablets and alcohol, and needed to be persuaded to attend hospital. He was conveyed to hospital.

Analysis:

Warwickshire Police have a robust policy of identification and risk assessment of domestic abuse, along with taking positive action to manage it. In the incidents detailed, the IMR author considers that those policies have been complied with, but with the following observations.

- It is rare that police get more than one chance to obtain evidence for a specific incident from a victim of domestic abuse. On 26th March 2011, CPS identified the statement of evidence obtained from the victim as being poor, and the IMR author's review of the information supports this. Efforts were subsequently made to take a further statement, but the nature of the relationship between victim and perpetrator had changed by that point, and she had changed her mind about both pursuing the complaint, and providing information about the incident. It isn't known whether a victimless prosecution could have taken place if the statement had been more detailed, given the subsequent withdrawal of complaint.

- At the time of contact on 24th April, there was a backlog of inputting data onto CATs. This meant that the standard risk incident was not inputted until 12th May 2011, some 18 days later. This delayed the referral to children's services by the same interval. This was 5 days after a subsequent high-risk incident was identified. Whilst not ideal, it is unlikely that this delay would have affected the risk management in this case.

- Regarding the contact on 24th April, the IMR author has spoken to the assessing officer, who recalled completing the assessment. He stated that the victim had answered all questions and had given a negative answer to DASH question 18 regarding strangulation. He does not recall the comment on the associated STORM incident print out in which it is recorded that the victim

stated that the perpetrator had tried to strangle her. The DASH was completed on 26th April 2011. The officer recorded the justification for the assessment level as;

(i) Parties now live separately with no previous history of violence or immediate threat of violence.

(ii) Victim refuses to disclose any matter and does not wish for police assistance.

However, with regard to point (i), there was a previous incident in March 2011 and an incident involving a previous partner of the perpetrator in 2008. It is also noted that point (ii) is often used as a reason for not taking action in domestic abuse cases and shouldn't be used as a reason for making a decision about low risk. Had the officer checked the history on STORM, then the risk assessment may have been medium.

- The incident on 7th May 2011 was assessed as high risk. However an officer with less than 2 years' service, and thus still a student officer, investigated it. Having reviewed the file, there isn't any written supervisory guidance/advice/instruction, or any indication that a supervisor had viewed the file until the date that the investigation was discontinued on 28th September 2011. Had the investigation commenced 2 days later, on Monday 9th May 2011, then the re-organisation in Warwickshire Police would have meant that this would have been investigated by Local Investigations, and thus supervised by a Detective Sergeant. Notwithstanding the change of process following 9th May 2011, it was not appropriate for a criminal investigation into a high risk domestic abuse incident to be conducted by a student officer alone, and definitively not appropriate to do so without robust supervision. Prior to 9th May 2011, the investigation should have been assessed and allocated to the appropriate resource, be it a CID officer, or by a non-CID officer with appropriate support, and all crime should be supervised with appropriate advice, and further report dates set for review of progress.

- The bail management in this case is poor. The perpetrator is first bailed to 13th June 2011, does not attend, but on 15th June 2011, his bail is amended to 12th July 2011. He does not attend, nothing appears to have happened as a consequence, and his bail is ultimately cancelled on 14th September 2011 despite it not being extended to that date.

- The police, whilst aware of the principle of referring repeat victims, as per the CAADA definition, to the MARAC, had not yet implemented a robust process for identification and referral of such repeats. This is evidenced in that a medium risk case involving a crime that occurred within 12 months of a previous high-risk case, hadn't been referred to the MARAC. The case in was assessed in isolation was a medium risk case and thus didn't get referred as its status as a repeat was not recognised.

The Panel requested additional information as follows:

- *Clarification regarding the process for reporting repeat incidents to MARAC:* It was noted that high risk repeat incidents are reported back to MARAC, but the

system was at the time less robust if repeat incidents were assessed at a lower level of risk.

- *Why was there no medical examination following the throttling attempt:* It was clarified that the victim had no visible injuries or marks following the report of strangulation, and thus a medical examination was not sought. (It should be noted that a friend of the victim subsequently said that she did have marks on her neck after the incident, but there was a time delay before she reported it to the police, by which time injuries may have faded).

- *Why did the risk assessments vary over time – what risk assessments were used and during which periods:* Prior to April 2008, Warwickshire Police used a risk assessment that was in place in the West Midlands Police area. This was based on the South Wales model, and was chosen for use in Warwickshire because there was a possibility that Warwickshire Police would be merged with West Midlands Police. The West Midlands model was similar to the South Wales model and 'counted ticks' i.e. positive answers to set questions to determine whether the risk was judged to be standard, medium, high or very high. This risk assessment presented significant problems for Warwickshire because it was heavily weighted to high or very high risk assessment, and made it difficult to determine which incidents were the most serious.

  The decision was then taken to change to SPECCS+, which was one of the then two ACPO approved risk assessments, along with the South Wales model. There was a phased introduction which commenced in Spring 2008. The phased aspect meant that officers dealing with domestic incidents applied the West Midlands model already in use, and then SPECCS+ was applied within the DAU to all incidents assessed as high and very high. The SPECCS+ model identified risk as standard, medium and high. The intention was to ultimately roll out SPECCS+ to all staff, but before that could be done, the decision was taken nationally to create one national risk assessment. This is DASH.

  DASH was implemented in Warwickshire on 4th May 2010, and is still in use today. Officers dealing with domestic abuse incidents apply DASH at the time, to determine whether the risk is standard, medium, or high.

  The DASH risk assessment is based on professional judgement. The history of a case is clearly a significant part of the information collation that informs the risk assessment. To that end, intelligence research is conducted on all reported incidents of domestic abuse prior to officers attending. The level of risk can increase and reduce over time based on the prevailing factors at the time of application. A simplistic example would be the potential reduction in risk that may occur when a perpetrator is sent to prison but continues perpetrating Domestic Abuse from the prison cell.

- *Clarification as to police involvement and actions when the perpetrator was taken to hospital handcuffed on 25th Sept 2011 (as identified in the WMAS chronology)*: The attending Inspector confirmed that the incident was one of

welfare for the perpetrator who it was suspected had taken an overdose. He had to be persuaded to go to hospital. There is no reference to the use of handcuffs detailed on the STORM incident. The sergeant detailed on the STORM incident that the perpetrator and victim had had an argument. On interview the sergeant states that they attended to assist the ambulance service. On arrival they were met downstairs by the victim who appeared very blasé about the whole incident. The perpetrator was upstairs, sick, emotional and un-willing to go to hospital. After a short period of time, he agreed to go. The sergeant cannot recall who mentioned an argument, or indeed if anyone did, but does recall being told that the perpetrator had 'gone back on drugs recently' and that this had caused problems in their relationship. The sergeant went on to say that there had been no mention of a domestic related incident by either party to Police whilst dealing with the incident, and there had been nothing to suggest that there had been any domestic incident prior to Police arrival or earlier in the night, the victim was happy to accompany The perpetrator to the hospital.

- *Was there consideration of pursuing victimless prosecutions arising from crimes reported by the victim involving the perpetrator*: The panel were provided with a detail report relating to each incident and it was clear from the evidence that victimless prosecutions were considered. The IMR author did not consider that in any of these investigations, there was an opportunity to run a victimless prosecution and supports the decisions made at the time.

- *There were a number of incidents when it was clear that the perpetrator was in breach of bail conditions to not contact the victim*, *but no action was taken to arrest him*. The conditions that were breached had been issued by the police when they had previously granted bail to the perpetrator after an earlier arrest. However, Police bail conditions do not have the same status and powers as bail conditions issued by a criminal court. An arrest can be made when Police bail conditions are breached in order to mitigate any immediate threat, but it is not an offence in its own right to breach conditions of Police Bail. If there have been no other changes in circumstances since the Police Bail was initially granted, and no additional criminal offences have been committed, then the only possible outcome (other than to cite the event at any future trial) is to release the perpetrator on Police Bail again. In this case, on each occasion a breach occurred, officers interviewed the victim alone and were assured by the victim that all was well. However, it is recognised that victims of domestic abuse are often too frightened to say otherwise and rely on the police to enforce the conditions put in place to protect them from the perpetrator.

Lessons Learnt

a) Good practice

- When the victim rang to say that she wanted to withdraw her complaint, officers insisted on a face to face meeting, and made every attempt to ensure that she was not doing so under duress from the perpetrator

- When police attended the house following a report from a friend of the victim, the victim was not at home – officers persisted in tracking her down to ensure that she was safe

- There is evidence that victimless prosecutions were considered

- On the occasions that the perpetrator had breached bail conditions, police took action to speak to the victim on her own.

b) Areas for improvement

- The statement taken on 26th March 2011 suggests that the officer involved may not have had the right level of expertise. The investigation of domestic abuse requires the right level of investigative ability and resources including custody bail and associated bail conditions. This incident took place immediately before a large internal change programme on 9th May 2011, which fundamentally changed the structure of the force and how investigations would be managed. Since that date, domestic abuse incidents have been subject to review at the following daily tasking meeting on the respective policing area and all live investigations have been undertaken by trained investigators within the Local Investigations Dept. On 30th September 2013, a new large change programme will be implemented as part of the alliance between Warwickshire Police and West Mercia Police. This change programme will result in a dedicated investigative capability being created within the current Domestic Abuse Unit that will deal with investigations associated with 'high risk' cases, such as those connected to the relationship between the victim and perpetrator. Other domestic abuse related investigations will continue to be undertaken by the appropriate resource with oversight by the relevant policing area daily tasking meeting.

- The time span between the incident and the inputting of contact of 24th April was too long. Daily within the police 'Harm Assessment Unit', a process is undertaken to identify reported Domestic Abuse incidents that are 'high', 'medium' and 'standard' based on the DASH risk assessment. As a consequence of the Police IMR, additional daily prioritisation processes have been put in place to ascertain whether any of the incidents assessed as 'medium' or 'standard' risk are connected to any current or previously open 'high risk' cases. If any are so identified, they are then prioritised alongside those incidents assessed as 'high' risk. As part of the current change programme, it has been agreed that a new tier of supervision will be introduced into the Harm Assessment Unit. One responsibility of this incoming tier of supervision will be to manage the prioritisation processes.

- In all cases, but specifically where there is a delay between the time of report, and the actual application of DASH, the assessing officer should review all information available, including that information supplied to police by the initial caller. This would have enabled the answer regarding strangulation to have been challenged and may have affected the risk assessment. This learning has already been promulgated through the daily tasking meetings and also when DASH risk assessments are received into the Harm Assessment Unit to

ensure that all information is considered, and where necessary a re-assessment of risk is undertaken. This will be subject to further direction through the DHR recommendations.

- There needs to be a more robust process for identifying repeat incidents that meet the CAADA criteria for a further referral to MARAC. The MARAC Steering Group should consider the need to develop a robust process for identification of MARAC repeat cases from all agencies along with subsequent MARAC referral, as part of the MARAC Improvement Plan. The Warwickshire MARAC is still considering viable options for identification of MARAC repeats. However, Warwickshire Police (who make the vast majority of referrals to MARAC) now have a process in place to identify repeat cases amongst the DA incidents reported to it.

Agency recommendations:

- To review the investigative decision-making process relating to 'high risk' domestic abuse incidents, to ensure that the appropriate level of skill and type of resources and supervision is allocated to each specific domestic abuse investigation.

- A review of the police Referrals & Assessment Unit (RAU) has taken place, and has identified the need for better levels of supervision and processes to facilitate more efficient management of caseloads of staff:

    - Further work is already underway to develop a policy that identifies acceptable levels of inputting backlogs dependant on risk level, and that includes a mechanism for reporting when the levels are exceeded.

    - A new process has already been introduced to actively manage and triage any backlog to identify any case that relates to either a pre-existing or subsequent 'high risk' incident

    - A business case to introduce a new structure within the RAU with dedicated supervisory roles has been accepted as part of the new joint policing arrangements between Warwickshire Police and West Mercia Police. These posts will be in place by December 2013.

- The learning points from this IMR and the DHR as a whole to be shared with all police officers and staff using DASH to ensure that the risk assessments are applied with consideration of all available information.

- The MARAC Steering Group to be invited to develop a robust process for identification of MARAC repeat cases from other agencies along with subsequent MARAC referral, as part of the MARAC Improvement Plan.

3.1.2 Coventry & Warwickshire Partnership NHS Trust

Coventry & Warwickshire Partnership NHS Trust provides secondary mental health care to the population of Coventry and Warwickshire through a range of in-patient

and community based services. This includes the following services, that all accept referrals from service users, carers, police, social services, GPs, or other mental health teams when someone between the ages of 16 onwards who maybe experiencing a mental health issues:

- *Single Point of Access (SPA), Adult Mental Health Services:* provide multidisciplinary assessment and, if appropriate refer on to other services within CWPT and sign post to services outside of CWPT, offer home treatment as an alternative to hospital admission.
- *Adult Community Mental Health Services*: provide multidisciplinary assessment and on-going support .
- *Crisis Resolution and Home Treatment Team* provide multidisciplinary assessment and, if appropriate, offer home treatment as an alternative to hospital admission

Summary of involvement:

The IMR submitted to the Panel took into account the findings of the Serious Incident Report.

The victim: There were 2 contacts with the victim, the first of which pre-dated her relationship with the perpetrator when she was referred for counselling in June 2009. The second contact was on 23rd December 2011 when the victim was assessed by a Senior House Officer at George Eliot Hospital following an overdose of paracetamol on the previous day. At the point of assessment the victim was assessed as being medically fit and ready for discharge from hospital. She stated that she had been with her current partner, the perpetrator, for about 18 months and described the relationship as having been very troublesome. She reported that she had discovered about three weeks ago that the perpetrator had been engaging in theft and 'antisocial' activities. The victim stated that she had not wanted to die but had wanted everything to stop. She denied any current drug or excessive alcohol use and her mood was recorded as euthymic, with no abnormalities of perception. In respect of her social circumstances she reported that she lived in her own home with her 20 year old son and stated that her partner lived with his parents. She went on to state that her plans for the future included getting away from her partner and getting on with her own life.

A Steve Morgan Risk screening was undertaken, in line with Trust Policy, where it was recorded 'stated abuse by other' as a concern and noted that the victim had been "previously physically abused by ex-boyfriend. Current partner had tried to strangle her when she was going to stop the relationship before"

The following Initial Management Plan was recorded and was agreed by the victim:
1) Fit to be discharged from psychiatric perspective
2) GP to review in one week's time and consider starting anti-depressants if feeling low in mood.
3) Crisis team details given and advised to contact if needed.

Additionally records indicate a referral to a Consultant Psychiatrist for an out patients appointment

The perpetrator was first referred to mental health services prior to his relationship with the victim, in May 2009, by his GP requesting assessment due to concerns about his mental health specifically poor self-esteem and low mood, risk of suicide and substance use. He was subsequently admitted to accident and emergency at George Eliot Hospital complaining of being "down and low". At this point he referred to the loss of employment and the recent break-up of his marriage and stated that he was using alcohol and cocaine daily and recently attempted to hang himself but was stopped by his wife. Records noted that he had 4 children who live with their respective mothers and that he was living at a friend's house Following psychiatric assessment he was offered hospital admission but this was declined in favour of follow up in outpatients and staying with his parents. He was advised to reduce alcohol intake and seek help with this, provided with Crisis Resolution Home Treatment team contact details and details of this episode to be passed to GP.

Following this incident the perpetrator was seen in outpatients on two subsequent occasions and in both appointments he reported that he has stopped drinking alcohol but was experiencing poor sleep and low mood. In the second appointment he referred to fleeting suicidal thoughts but no plans or intent. It is noted in the records that he states that he is living with his grandmother. He was risk assessed as being low in respect of harm to others and self.

In July 2009 the perpetrator was admitted to A & E following an overdose of Citalopram whilst under the influence of alcohol and cocaine. He stated that he was hearing voices telling him to kill himself and was admitted to the mental health unit at his request and remained there until his discharge 4 days later. At the point of discharge the risk of harm to self and others was recorded as low though it was noted this risk may increase with the use of substances. Having failed to attend subsequent outpatients appointments, he was sent an 'opt in' letter asking him to make contact with services. He did not reply to this letter and as such his care was discharged back to his GP on 2nd September 2009.

The perpetrator had no further contact with mental health services until he self-referred to Improving Access to Psychological Therapies (IAPT) services on the 12th August 2011. In the subsequent assessment on the 17th August 2011 he reported that he was back with his girlfriend (the victim) but that about 4 months ago they had split up after an argument that had culminated in him having 'trashed their flat' and "taking a girlfriend on the rebound". *(The timing of this relates to the "throttling incident" of April 2011 and ties in with reports of the victim and perpetrator resuming their relationship around September 2011).* The influence of alcohol in these events was noted but the assessment concluded that alcohol was not a primary problem at the point of assessment. The assessment also concluded that there was no current drug use.

Within the following appointment the perpetrator described "bottling things up" and getting angry occasionally and made reference to an incident in which he 'grabbed his girlfriend'. He referred several times through this appointment to the breakdown of this relationship being the main trigger to many of his current problems. He also said that he doesn't feel like seeing his children and cannot deal with them at the minute and that he is not seeing his children as much as he should be.

On 26th September 2011 the perpetrator was admitted to A & E at George Eliot hospital following an overdose whilst under the influence of alcohol and cocaine. He reported that his partner (the victim) had asked him to leave, that he was worried about an impending court case, and the recent death of his grandfather. He also stated that he was not being allowed contact with his children by his ex-wife as she was concerned about his "unpredictable behaviour". Records show that he reported that social care were involved with his children at this time following an argument with his partner in the presence of his children (*this relates to the throttling incident in April)*. He denied any thought of self-harm/ suicide and stated that he did not know why he had taken the overdose.

The perpetrator was referred to the local Community Mental Health Team (CMHT) on the 29th September 2011 outlining the key issues as self-harm, alcohol dependence, relationship problems, recent bereavement, appearance in court, limited contact with children, and recent depression. Risk assessed as low to self, and others, and low regarding self-neglect. In response to this referral the perpetrator was offered an assessment appointment for the 2nd November 2011.

He had also been offered an appointment with IAPT for the 20th October 2011. He did not attend this appointment and consequently was sent a letter advising that if he did not make contact within two weeks he would be discharged from the service. There is no evidence that he made contact with IAPT services following this letter and as such he was discharged on 8th November 2011 with a copy sent to his GP. The perpetrator also failed to attend to attend an outpatients appointment on the 24th October 2011 as well as the assessment appointment offered for the 2nd November 2011. A further appointment was offered initially for the 30th November 2011 and then re-arranged by CWPT for the 7th December 2011 but he also failed to attend this appointment.

On the 9th December 2011 the perpetrator was admitted to George Eliot Hospital following an overdose and self-harm. He was intoxicated and was taken by police to the hospital in handcuffs due to him being aggressive and violent. At this point he was not medically fit to be assessed by mental health professionals. On the 13th December he was considered to be medically fit and was assessed by mental health services. He reported that he had taken the overdose at his partner's house and also stated that this relationship had been 'on and off' over the past 6 months but that now it was over. He discussed wanting to re-start contact with his children indicating that there had not been any restrictions about this other than caused by his own avoidance. He was assessed as being high risk of self-harm but low risk to others, and low to moderate risk of self-neglect. The outcome of this assessment was that he was admitted to the mental health unit on a voluntary basis on the 16th December. Admission records differ from the previous contact in September in that they indicate that his home address is with his partner, the victim.

The perpetrator remained an inpatient at the Mental Health Unit until the 22nd December 2011 at which point he discharged himself against medical advice, though it was planned that he would be discharged on the following day. During this period of inpatient treatment there was a record of contact with undefined family members who visited him. A ward review was undertaken on the 19th December 2011 and it

was noted that he no longer wishes to die and wants to 'get his life back together', start again, get a job, and re-establish contact with his children. Prior to his discharge he was seen by the Trust link liaison nurse who made arrangements to see him following discharge on the 22nd December 2011. Nursing records indicate that 'family' were informed of his discharge.

The perpetrator attended the appointment on the 22nd December and reported that he had received an appointment for the Community Alcohol Service which he intended to keep. His appetite was described as poor but that he eats when encouraged to do so, and he reported racing thoughts and poor concentration. He described his Mum as supportive though he felt over observed. He reported protective factors of children and mum and states that he was not drinking, denied any thoughts of self-harm, though generally low mood. He was given advice about support available to him and the link liaison nurse records that he will liaise with the Community Mental Health Team regarding their assessment of the perpetrator and at this point he is closed to link liaison service.

CWPT's next and all subsequent contact with the perpetrator is following his arrest and is connected to assessing his mental health and meeting any identified needs during his detention.

Analysis:

The victim: the initial referral for counselling was prior to the victim's relationship with the perpetrator. IAPT is a primary mental health care service aimed at people with mild to moderate anxiety and depression. The service provides a range of interventions from self-help techniques to Cognitive Behavioural Therapy (CBT)**.** There is so little information recorded that it is not possible to draw any meaningful conclusions. From a Trust perspective, good practice in making clinical records is that they should contain a full account of any planned or provided care or the decision not to provide care and the decision making process that sits behind any outcomes should be explicit.

With regard to the second episode – the Mental Health Assessment following paracetamol overdose: all patients admitted to hospital following a suspected incident of self-harm/suicide are offered a mental health assessment once medically fit. In addition to the mental health concerns and the identified action plan there are recorded concerns that the victim's current partner had attempted to strangle her when she had previously attempted to end the relationship. There is no indication within the records that suggest consideration was given to further specific risk assessment such as DASH / CAADA which may have prompted referral to the multi-agency risk assessment conference (MARAC). There is no indication within the records that the assessor discussed or signposted the victim to the support and choices available to victims of domestic violence and abuse. The noted actions do not provide an appropriate and proportionate response to the concerns raised in the risk screening process. There does not appear to be further investigation around the capacity or choice of the victim, children she may have contact with, or provision of information around support options for victims of domestic violence. CWPT has clear guidance within it's 'Domestic Abuse Policy' that requires staff to assess risk around domestic violence and abuse and to consider referral to MARAC, police,

social care etc, but this policy does not appear to have been followed in this instance and as such does not suggest gaps in the interagency practice, policies or procedures.

A review undertaken by a senior doctor identifies that the assessment overall was of a reasonable standard given that it established causative factors, mental state, commented on capacity and identified a follow up plan. In the opinion of the senior doctor it would have been reasonable in this case, given the concerns that were highlighted, for the junior doctor to have sought further detail around what was meant by a troublesome relationship and establish what plans the victim may have had around leaving her partner. There was no indication that consideration was given to placing these concerns into a multi-agency context by the assessor.

Training around domestic violence and abuse for junior doctors is very limited with 'safeguarding' training delivered within medical school focussing predominantly on children. When junior doctors join the Trust they are required to attend a three day induction session within which, at the time, included a 45 minute session covering safeguarding adults and children. Within this session there was reference to domestic violence and abuse which signposts to relevant policy and where to access further advice and support. The Induction programme is aimed at making all Trust staff aware of their corporate and clinical responsibilities, but it is the responsibility of individual practitioners and their manager to identify if any additional training is required. The Trust now offers domestic violence and abuse awareness training and DASH training. It is the IMR author's opinion that even if further assessment had been completed the homicide could not have been predicted or prevented.

The perpetrator: Referral to mental health services was first initiated by the GP in 2009. The perpetrator had some contact with community services through attendance at outpatients appointments and also a period of involvement with IAPT. In both 2009 and 2011 there were incidents of admission to accident and emergency following overdose with co-existing use of alcohol / drugs, in the context of breakdown of relationships.

There is no indication within the records of assessments that there is any exploration around potential domestic violence and abuse. Steve Morgan Risk screening undertaken at this time indicated that the perpetrator was viewed as presenting a low risk to self and others. In 2011 the records of IAPT assessment reflect a context of alcohol / substance use and relationship problems with the addition of specific reference to the perpetrator 'trashing the flat' following an argument and an incident in which he had 'grabbed' his girlfriend. Additionally there is reference within the assessment following the overdose in September 2011 that he had been involved in an argument with his partner in front of his children and that his ex-wife was not allowing him to have contact with his children. There is liaison between the IAPT worker and the doctor that assessed the perpetrator, but there is no indication within the records that there was any discussion regarding domestic violence or abuse or child safeguarding risks. Assessment following the overdose in December 2011 also notes that he is 'aggressive and violent' having to be brought to A & E by the police in handcuffs, and that the overdose was taken at his partner's home and refers to a 'messy break up'.

Analysis has identified that each incident was considered as isolated and contained events, not recognising the theme of the perpetrator's behaviour as that of a perpetrator of domestic violence. The failure to link these noted events impacted upon the risk assessment process. None of the staff involved had received any specific domestic violence and abuse training at that time other than the brief element that is covered within 'level two' safeguarding adults and safeguarding children training which is the core training requirement for clinical staff. It is the IMR authors' view that there were indicators to instigate further consideration and assessment around the issues of domestic violence, in particular specific consideration of the risks that the perpetrator presented to others which was consistently indicated to be 'low', but that the ability of staff to recognise these indicators was poor due to not having received any specific domestic violence and abuse training.

The IMR author is also of the view that there should have been broader consideration of the perpetrator's circumstances as required by 'Think Family' (Refocused CPA 2008). However, had there been a greater knowledge and understanding of domestic violence it is the view of the IMR author that this would not have directly affected the outcome in this case as clinical staff were reliant on the perpetrator identifying who his partner was. The client was not identified as a perpetrator of domestic abuse, and therefore most interventions available to staff would be around attempts to manage the perpetrator's mental health, substance use and behaviours and the risk management of the client in relation to self-harm, rather than the direct protection of the victim.

It is clear that there were missed opportunities in assessment of the risks that the perpetrator presented to his partner. It is reasonable to expect that had the risks he presented within the context of domestic violence and abuse been recognised and more adequately assessed, that there would have been a more robust response to these risks including signposting to specialist domestic violence support services and consideration of a multi-agency response.

It is of note that there are significant delays incurred in the communication between mental health services and the perpetrator's GP with summary letters being sent as much as four months after the event being referred to. Whilst the communication sent did not relate specifically to concerns about domestic abuse and would not overtly impact upon the outcome in this case, it is essential the information relating to admissions, discharge, non-attendance at appointments, identified risks etc are communicated in a timely manner. By way of example - had this communication included information about risks to others there would have be significant delay in the sharing of this information with other professionals that may potentially have impacted on outcomes.

Lesson Learnt:

a) Good practice

- Action was taken to ensure that a psychiatric assessment was undertaken following the victim's overdose, prior to her discharge from A&E.

- Mental Health referrals were dealt with appropriately and in a timely way.

b) Areas for improvement

- Clinical staff, at a variety of levels, did not recognise indicators of Domestic Violence and Abuse (in respect of either victim and/or perpetrator) with this in turn impacting upon the assessment and management of risk. As risk relating to domestic violence was not identified, the interventions that staff established or undertook did not seek to address issues relating to domestic abuse.

- Staff had not received any specialist Domestic Violence and Abuse awareness training, either prior to the event, or subsequently. As such there is a clear basis for recommending that all 'client facing' staff to be required to attend DVA awareness training.

- In the case of 'transitory' staff such as 'bank' and agency workers, junior doctors in training, medical locums and similar there is a need to ensure that safeguarding training delivered as part of induction explicitly highlights domestic violence and abuse issues and signposts these staff to specialist advice and support both within and external to the Trust.

- Written communication to other agencies suffered significant delay. Although this did not have an impact upon the outcome in this instance it is clearly of concern and in other circumstances could have a direct impact on outcomes.

- The IMR authors are unaware of what screening processes in respect of domestic abuse are currently in place within A & E services at George Eliot Hospital.

Agency recommendations:

- CWPT to establish a clear requirement for 'client facing' staff, particularly those undertaking assessment, to complete training regarding Domestic Violence and Abuse (DVA) awareness that is proportionate and relevant to their role. This needs to include understanding of indicators of domestic abuse from the perspective of perpetrators and / or victims, the impact upon victims, particularly children, knowledge around specific assessment tools such as DASH, support services available and professional responsibilities.

- To review the current safeguarding sessions delivered within induction to all staff, to ensure that it explicitly highlights domestic abuse issues and signposts to specialist advice and support available both within and external to the Trust.

- To review administrative procedures and support within community mental health services to ensure that correspondence to other agencies is completed within an appropriate timescale.

Multi- agency recommendations:

- To consider how information around domestic abuse is communicated between, and responded to, by the different health agencies within the context of deliberate self-harm and other mental health assessments within A & E.

- That all health agencies need to provide leadership at a senior level to develop a culture whereby domestic abuse is recognised and acted upon at all levels in the organisation.

3.1.3 Refuge and IDVA (Independent Domestic Violence Advocacy)

Refuge (the UK's largest provider of specialist support services for victims of domestic violence) delivered an independent domestic violence advocacy (IDVA) service in Warwickshire during the period 1 January 2009 to 31 March 2012. The service was commissioned by Warwickshire County Council.

The role of IDVAs is to help keep victims and their children safe from harm from violent partners or family. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis, to assess the level of risk. They:

- discuss the range of suitable options
- develop plans for immediate safety – including practical steps for victims to protect themselves and their children
- develop plans for longer-term safety
- represent their clients at the Multi-Agency Risk Assessment Conference (MARAC)
- help apply sanctions and remedies available through the criminal and civil courts, including housing options

These plans address immediate safety, including practical steps for victims to protect themselves and their children, as well as longer-term solutions.

In the service specification the small IDVA service was commissioned to support up to 120 victims at 'high risk' per year and represent clients across three county MARACs. However, there were approximately 1200 high risk victims reporting to Warwickshire police alone per year (from estimated police referrals). There was a clear need to prioritise to determine which 120 high risk victims the service would support. As a result, it was decided in October 2009 (with full knowledge, agreement and support from local partner agencies including the police, commissioners, and the county council's domestic violence coordinator) that Refuge's IDVA service would prioritise high risk clients in charged cases alone – i.e. cases that had been classified as 'crimes' and where the victim had been assessed as being at high risk of homicide or serious harm (i.e. either by scoring a minimum of 14 on the CAADA-DASH-ACPO checklist or by professional judgement).

All other cases would be referred to other support agencies in the borough – i.e. Warwickshire Domestic Violence Support Service (WDVSS), this being a generic domestic violence support service with a greater number of staff and hence capacity.

Refuge also runs accommodation-based refuge services in the county. All domestic violence services were re-commissioned in a competitive tendering process in April 2012. Refuge was re-awarded the contract to provide refuge accommodation in Warwickshire but the IDVA service contract was awarded to Stonham Home Group so Refuge no longer provides an advocacy service in Warwickshire and nor does WDVSS.

The Panel noted that the CAADA Quality Assurance Report identified that, based on the statistics, the IDVA service for North Warwickshire requires 3.5 full time IDVAs to adequately support the number of high risk victims being referred. This equates to a total of 8 IDVAs for the whole County compared to the 2 current posts. Government funding is available for one part time (0.5) post for the County, the remaining funding is provided by Warwickshire County Council.

Summary of involvement:

Refuge had no direct involvement with the victim, perpetrator or any of the children of the victim or the perpetrator. However, Refuge had indirect contact with the victim.

On **9th May 2011** the victim was referred by email to Refuge's IDVA service by the police following an incident that had been reported to police on the 7th May. The IDVA service had access to the police CATS system and the IDVA attempted to make contact with the victim on two separate occasions, on 11 and 17 May 2011, by telephone but there was no response on either occasion. No Refuge employee made any further attempts to contact the victim. The IDVA monitored the case – and the updates added by police – on the police CATS system.

On **16th June 2011** the IDVA attended the Multi-Agency Risk Assessment Conference (MARAC). The case had been referred to the MARAC by the police and was discussed at the conference. The IDVA's role in the MARAC is to represent the views of victims of domestic violence and to advocate on their behalf among the other agencies. The IDVA updated partner agencies at the conference that although the police had referred the victim in relation to the incident reported on 7th May and despite having made two separate attempts, she had been unable to make contact with the victim. The MARAC minutes state the following entry next to the IDVA box of the form: 'no contact – continuing attempts'.

The IDVA saw on the police CATS system that on **1st June 2011** and on **23rd August 2011**, following repeat incidents, the police had referred the victim to Warwickshire Domestic Violence Support Service (WDVSS) – another voluntary agency in the borough also commissioned by Warwickshire County Council as explained in the background section above,

On **16th September 2011**, the day after the police had decided to take no further action against the perpetrator, the IDVA closed the case, recording on the case record that the Refuge's IDVA service would not be offered to the victim because no charges were proceeding and a referral was made to WDVSS on the same day, highlighting the following factors of the case:

- The correct name, address, date of birth and contact details for the victim.

- That children had possibly witnessed the attack [i.e. that there may be child protection concerns]
- The perpetrator's threat to kill [recognised risk indicator of homicide/ serious harm]
- The perpetrator's strangulation attempt [recognised risk indicator of homicide/ serious harm]
- That the perpetrator had not been remanded [i.e. offender may return which presents safeguarding concerns for woman and children]
- The lack of bail conditions restricting movement of perpetrator [i.e. offender may lawfully return which presents safeguarding concerns for woman and children]
- The name of the police officer in charge of case within Domestic Abuse Unit
- Advice to contact the victim by telephone, initially, owing to the risk of the perpetrator being at the property at the time of contact [which could put the victim at increased risk].

No Refuge employee had any further indirect contact with the victim.

Analysis

Following referral to the Refuge's IDVA on 9th May 2011, there were two attempts made to contact the victim by telephone but there was no response. The IDVA reported this to the MARAC on 16th June - though the minutes record that attempts to contact were continuing, this was inaccurate, as no further attempts were made. Following the police decision in September 2011 to take no further action against the perpetrator for the incident reported on 7th May, the IDVA referred the victim to WDVSS for ongoing support.

It is clear from the MARAC minutes that the victim was an appropriate MARAC referral on the basis of information that was disclosed to police on 7 May 2011 and that she was at 'high risk' of homicide or serious harm. Recognised dangerous risk indicators of the perpetrator's behaviour were shared among agencies at the MARAC. It is unclear why, following three separate subsequent incidents she was subsequently assessed as being at 'standard' or 'medium' risk. Domestic abuse is best understood as a pattern of controlling, intimidating, and frequently violent behaviour – usually characterised by a sequence of incidents. The incidents should have been viewed collectively – not in isolation. This is a recommendation that the Independent Police Complaints Commission (IPCC) frequently and publicly makes to police forces across the UK following investigations into domestic homicides that were preceded by police involvement. In this case the escalation in frequency of reports should have been identified as a sign of escalating risk to the victim in that it included:

- A very serious reported incident of threats to kill and strangulation
- The perpetrator was not in custody
- The bail conditions imposed on him were unlikely to protect the victim given his historic disregard for the criminal justice system.
- The victim's address had been 'flagged, so all subsequent incidents should have been treated as urgent.

The fact that police did not refer the victim to Refuge's IDVA service after the 7 May 2011 incident suggests that there may have been an assumption that the further incidents reported to police would not result in charges being laid, or not recognising that the repeat incidents made the case high risk. It would have been too early for the police to have formed that decision (before any investigation had been conducted).

Lessons Learnt:

a) Good practice

- It is clear from the MARAC minutes that the victim was an appropriate MARAC referral on the basis of information that was disclosed to police on 7 May 2011 and that she was at 'high risk' of homicide or serious harm. Recognised dangerous risk indicators of the perpetrator's behaviour were shared among agencies at the MARAC.

b) Areas for improvement

- It was agreed in October 2009 that Refuge's IDVA service would prioritise high risk clients in charged cases only – i.e. cases that had been classified as 'crimes' and where the victim had been assessed as being at high risk of homicide or serious harm. All other cases would be referred to Warwickshire Domestic Violence Support Service (WDVSS) – a generic domestic violence support service with a greater number of staff and hence capacity. This case has highlighted the importance of having clear written contractual agreements in place to make it explicit where responsibility for the case lies.

- Having been correctly referred to MARAC as being at high risk, it is unclear why, following three separate subsequent incidents she was subsequently assessed as being at 'standard' or 'medium' risk. The incidents should have been viewed collectively – not in isolation. This is a recommendation that the Independent Police Complaints Commission (IPCC) frequently and publicly makes to police forces across the UK following investigations into domestic homicides that were preceded by police involvement. In this case the escalation in frequency of reports should have been identified as a sign of escalating risk to the victim.

- The fact that police referred the victim to WDVSS instead of Refuge's IDVA service after the 7 May 2011 incident suggests that there may have been an assumption that the further incidents reported to police would not result in charges being laid, or not recognising that the repeat incidents made the case high risk. It would have been too early for the police to have formed that decision (before any investigation had been conducted).

- There were missed opportunities to arrest the perpetrator on several occasions for domestic violence related incidents reported to police and for breach of bail *(Note: Refuge were asked to provide dates and details of incidents when arrests should have been made but were unable to do so).*

- It was highlighted in the MARAC minutes that the perpetrator had breached community punishment orders on 8 occasions. It is unclear how this was allowed to happen. The police, knowing that the perpetrator had a total disregard for the criminal justice system should not have taken the risk of releasing him on police bail (in May and again, later in August) knowing that he was unlikely to respect the bail conditions given his historic disregard for such conditions, and knowing that a woman (and possibly children) could consequently be at risk of further harm. (*Note: The Panel have identified that the minutes did not reflect the full position – though the perpetrator had not attended on 8 occasions, reasons were given and included supporting medical evidence from the perpetrator's GP. Actions taken were therefore appropriate.)*

- It is unclear from the MARAC minutes relating to the meeting on 16 June whether agencies knew that the police had also made referrals to WDVSS, though WDVSS were present at the MARAC meeting themselves and could have shared this information. This would have clarified whether another domestic violence support service had successfully made contact with the victim

- It is unclear from the MARAC minutes relating to the meeting on 16 June whether Refuge's IDVA had made continuing attempts to contact the victim (i.e. an update on past practice) or whether she was at that time making continuing attempts to contact the victim (i.e. an agreed action point).

***Agency recommendations**:*

- Refuge to ensure that any change of operational practice from the service specification to be documented in writing and is treated as a formal appendix to the contract and to the specification signed by both Refuge and the commissioning body.

Multi-agency recommendations:

- There should be mandatory, comprehensive training in domestic violence including in risk assessment for all police officers and staff of Warwickshire police.

- That Warwickshire police ensure that they take positive action to:

    - arrest perpetrators of all alleged crimes relating to domestic violence when the opportunity arises
    - collect evidence including at initial call-out to increase chance of prosecution
    - detain perpetrators – when possible and at every opportunity – to increase safety of victims

- That Warwickshire Police take action to consistently enforce bail conditions and deny bail conditions to those who have a proven track record of breaching/ disregarding bail/ injunctions/ community punishment orders.

- That the Community Safety Partnership works with the Safer Warwickshire Partnership Board to put in place clear, written policies for all agencies in the county explaining when and how to refer to specialist domestic violence support services e.g. Refuge (for accommodation services) and Stonham Home Group (the organisation now running IDVA and outreach services in the county) to ensure vulnerable victims do not fall through the cracks.

- That clear SMART action points are included in MARAC minutes following all MARAC meetings to prevent ambiguity.

3.1.4 Warwickshire Domestic Violence Support Services

Warwickshire Domestic Violence Support Services is a voluntary organisation which exists to support those experiencing domestic violence by offering a range of help and support services.

Summary of involvement:

On **28th March 2011** an email referral was received from police. Telephone contact was made with the victim to following day when she declined support. A further referral was received from the police on **1st June 2011** but an attempt to make contact received no response.

The final referral was received from IDVA on **16th September 2011**. Three attempts were made to contact the victim on 20th, 26th and 27th September. Contact was made on 27th September 2011 and she responded that no support was required. The worker making contact remembers that the victim was angry at being contacted.

Analysis:

It is usual practice to try to contact a victim 2 or 3 times. It is not known why only one attempt was made to contact the victim following the referral on 1st June 2011. There is no record of a referral received from the police on 23rd August 2011. *(The Panel noted that Warwickshire Police confirmed from their X drive records that the referral was encrypted and password protected in the usual way and that the email and winzipped attachment was sent a 17.01hrs, with a message timed at 17.04hrs stating that the email had been successfully relayed).*

There is no requirement to feedback to referrer on the outcome or failure to make contact.

Lessons learnt:

a) Good practice

- WDVSS have set up a drop in centre since August 2011. The new procedure is that any failure to make contact will be referred to the drop in centre for follow up.

b) Areas for improvement

- Panel discussion identified a learning point regarding the lack of a feedback loop to alert referrers of failure to make contact. A series of referrals within a short timescale combined with lack of contact or refusal of support could potentially be flagged to identify alternative options.

Agency recommendations:

- No recommendations were identified by the agency within the IMR.

- However, the panel identified that a process needs to be put into place to ensure that feedback is requested and given on the outcome of referrals, especially if no contact can be made or support is declined, so that alternative options can be explored.

3.1.5 Primary Care

Primary Care had contact with the victim through the Medical Centre where she was a registered patient. The Arden PCT Cluster was the main commissioner of primary care services at the time the initial review took place and therefore acted as lead contact for this part of the review with the GP practice where the victim was a registered patient. The perpetrator was registered at the same GP practice as the victim but did not consent to medical information being disclosed to the panel and the GP Practice did not consider releasing any information without consent on the grounds of public interest.

Arden Cluster also had contact with other GP practices for the other named persons provided as part of this review. The relevant GP Practices were contacted and information was requested relating to all contacts with named individuals. This process was subsequently queried by the GP practices who had sought advice from their medical defence union as to whether their patients had consented to their information being shared. The Associate Director of Nursing for the Arden Cluster sought advice from the chair of the DHR panel and it was agreed that only information relating to the victim would be initially submitted to the Domestic Homicide Review and the Panel could make a further request for additional information if deemed relevant.

Summary of Involvement:

The electronic records show that the victim had regular contact with the Medical Centre. When she first registered with the practice the victim had indicated that she had no partner and this remained unchanged on the electronic records. On three contacts the victim informed the Medical Centre that she had been or was in a relationship.

The majority of the contacts were in relation to the monitoring and management of medical conditions that were unrelated to domestic abuse. There were some contacts in relation to injuries that are noted on the electronic records. On 2nd March 2008 a hand written letter was received from A&E at George Eliot Hospital informing

the practice that the victim had attended A&E for a "sprain – chest". On 14th September 2009 it is recorded that she had contact with a GP in regards to a scald, it is noted that the injury was accidental, and had occurred 2 days prior to the GP appointment. On 20th March 2011 the electronic records note that the victim attended A&E, George Eliot Hospital for a right foot injury. The clinical letter informing the Medical Centre of the A&E attendance was unreadable. It is unknown what actions the Medical Centre undertook to ascertain information in regards to this A&E attendance.

The victim also had contacts with the Medical Centre in regards to low mood that appear to have been related to relationship issues. On **26th May 2009** records noted that she was "weepy emotional, not coping, mood swings, check bloods and review". At a review appointment on 2nd June 2009 the victim was commenced on Prozac and a review of this medication occurred on 23rd June 2009. On the **24th June 2009** the victim attended an appointment at the practice with a counsellor and it was noted that there were "relationship & family issues". On **17th May 2010** she saw a practice nurse in regards to a urinary tract infection and it was noted that there had been "no recent change of sexual partner".

On **1st June 2011** the victim had contact with the same previous GP with regards to a chest infection and it was noted that she "feels low again, last 8 weeks, says has been terrorised by ex- boyfriend, police involved, may need to have SSRI (an anti-depressant) again, review after antibiotic review".

The electronic records indicate that the Medical Centre was made aware that the victim had taken an overdose of 60 x 500mg paracetamol with a bottle of wine on **22nd December 2011**. On the **30th December 2011** the Medical Centre received a discharge summary by fax; this was a self-harm attempt form from George Eliot Hospital, Nuneaton. The discharge summary indicated that the victim had been assessed as low risk and that she was to have follow-up by her GP after one week. She had not sought a follow up appointment. The fax was handwritten and difficult to read.

Analysis:

Contacts indicated that the victim had been or was in a relationship but do not indicate that she was co-habiting with anyone. Although both the victim and the perpetrator were registered with the same Medical Centre at the same address the electronic system does not identify any relationship between registered patients. An electronic address search can however identify all registered patients at the same address. It is unknown whether the Medical Centre had asked the victim to review her relationship status after the initial registration entry. The electronic records indicate that the victim did not attend a review appointment; it is routine practice that individuals arrange their own follow up appointments within primary care.

It was noted that correspondence from George Eliot Hospital to the practice was often hand-written, and sometimes difficult to read. After discussion with the Medical Centre it is highly probable that the correspondence was not received on the date of A&E attendances, correspondence regarding patients is added to the electronic records as per date of intervention to keep a chronological record of events and it

has not been practice to add a note on the record to state when the correspondence was received. The overdose incident notification was faxed to the practice on 30th December 2011 by George Eliot Hospital eight days after the overdose. The letter detailed that the victim had been advised to follow up with GP in one week's time and this would not be normal practice for the GPs. The letter was sent over the Christmas period and this may have contributed to the letter being delayed in being faxed

The last training completed for staff at the Medical Centre on safeguarding children and safeguarding vulnerable adults was held in 2010. It is unclear whether this included any training relating to domestic abuse.

Though she disclosed being terrorised by an ex-boyfriend, the IMR stated that the incidence and type of injuries known to the Medical Centre were not of a level to alert staff to consider domestic abuse being an area of concern. There was no flagging on the electronic system for risk of domestic abuse; however the GP who received the information was informed by the victim that the police were informed of issues with her boyfriend in June 2011. No other agency contacted the Medical Centre with concerns that she was at risk of domestic abuse

Additional Information requested by the Panel:

a) *Failure to engage with IAPT:* it was confirmed that there was no feedback recorded to inform the GP that the victim failed to attend counselling.

b) *Further clarification regarding regular urine infections:* It was confirmed that practice nurses explore sexual issues and are aware of sexual abuse indicators relating to repeated infections. However, records show that the victim had a long history of infections indicating an underlying problem and this was not suggestive of sexual abuse.

c) *Information about relationship:* records currently do not link people living at the same address, and unless the patient informs the practice of a change in circumstances, status is not changed on the system. This is addressed in the recommendations

d) *Non-specific injuries:* it was noted that the victim reported 4 non-specific injuries to either A&E or her GP over a period of 3 years; these including a sprain to her chest, a scald, a cat scratch and a foot injury – other than the cat scratch, no explanation is recorded for the other incidents. This seems a high number of incidents for someone who is otherwise healthy.

.

Lessons learnt:

a) Good practice

No examples of good practice were identified.

b) Areas for improvement

- The use of a flagging system to indicate a risk of domestic abuse would be helpful and enable GPs to take the opportunity to ask appropriate questions to enable the victim to disclose abuse and be signposted to support services. There are lessons to be learnt regarding information sharing and opportunities to look at good practice elsewhere and CAADA guidance has been recently released.

- Information received by the practice is entered onto the electronic records system on the date which the occurrence happened, not when it was received. A closer audit trail of the system would identify when the data was, and by whom, inputted and this would help identify undue delays.

- Although both the victim and the perpetrator were registered with the same Medical Centre at the same address the electronic system does not identify any relationship between registered patients.

- It is essential that essential information, such as an overdose incident notification, is faxed immediately to the GP practice to mitigate any delay in follow up and that there are not undue delays due to bank holiday periods.

- Staff training on safeguarding children and safeguarding vulnerable adults needs to incorporate domestic abuse and regularly refreshed. *(It is the view of the panel that this really should be stand-alone training on domestic abuse, to avoid it being dominated by the safeguarding content.)*

Agency Recommendations:

- When information in relation to correspondence is added to the electronic records a note of the date the information is received must be made in the record.

- Flagging system for Domestic Abuse history to be introduced onto Electronic record system

- Software producer for the GP practice IT system to be consulted to identify if an update to the electronic records system can be made to enable the system to make automatic links of registered patients by address

- Safeguarding and Domestic Abuse training to be completed by all staff at the Medical Centre, including awareness of MARAC process.

- Medical Centre to introduce a system to ensure that unreadable & unclear correspondence received is requested in a legible format from the agency sending correspondence and to escalate concerns if a pattern or theme is spotted with an agency.

- Procedures must be tightened up across agencies to reduce delays in sending correspondence to GPs especially related to a serious incident such as attempted suicide.

- That there is clarity for the respective agencies of follow up arrangements following an attempted suicide and less reliance on the patient to make contact for follow-up.

- That the CWPT serious incident review considers whether the assessment of the victim being identified as low risk at the time of the attempted suicide was the correct level of risk.

- That information from the MARAC process is shared with GP practices along with the new CAADA Guidance for GPs.

- To ensure that reduced staffing services over Christmas and New Year or other holiday periods do not negatively impact upon communication to other health and social care agencies.

3.1.6 Warwickshire Children's Services

Summary of involvement:

The victim: Warwickshire Children's Services had no contact with the victim who had no children residing with her.

The perpetrator: The only contact with the perpetrator was in July 2011 to follow up Ms V's allegation that he had given his daughter alcohol (see below) when she had contact with him, but the children's team were unable to contact him on the phone number provided by Ms V. The emergency duty team were asked for an Appropriate Adult for a PACE interview on 2nd January 2012, but police subsequently decided to give him a rest period and interview the following day.

Ms V and child T: North Warwickshire Children's Team received three referrals in relation to the perpetrator. Although Ms V reported that he had perpetrated domestic abuse during their relationship, it was not until July 2011, eight years after their relationship had ended, that a referral was received. Ms V reported that the perpetrator had given T some alcohol over the weekend during an overnight access visit and when Ms V had challenged him, he had threatened to 'kill her'. Ms V was offered advice about keeping herself safe but no domestic abuse risk assessment (DASH) was undertaken. The second referral from the Police was in November 2011 after Ms V had briefly resumed contact with the perpetrator. When she asked him to leave her alone, he began sending her threatening text messages. When it was established that T no longer had face to face contact with the perpetrator and was therefore safe, Ms V was offered advice about what she could do to protect herself. The third referral was following the death of the victim when a letter was sent to Ms V offering her and T support if needed.

Ms Z and her children including child Y: Bedworth Children's Team received their first referral in December 2008 following a domestic abuse incident between Ms Z and the perpetrator. Given that the perpetrator subsequently moved out of the family home and the children were safe, a decision was made to take no further action, although Ms Z was offered advice about how to obtain an injunction. Furthermore, given that Ms Z reported she was finding Y's behaviour challenging, she was advised to contact her GP about obtaining help with this. In November 2010, Bedworth Children's Team were notified by the Police about an incident where Ms Z and her partner visited the perpetrator's address and threatened him. The children were not present. Given that the incident was 'triggered' by child contact problems, Ms Z was offered support and advice if needed, but did not take up this offer. Following the MARAC meeting in June 2011 when the victim disclosed that the perpetrator had attempted to strangle her, in front of his children, Bedworth Children's Team contacted Ms Z to carry out an Initial Assessment in order to ascertain the contact arrangements for the children with their father. At this point, it was established that Y was staying with the perpetrator and the other children were visiting him alternate weekends. By August 2011, it was recorded that Y had returned to mother's care and given Ms Z's concern about their father's violence towards his partners, she now wanted to prevent all the children having contact with him. She was advised to seek legal advice to achieve this. Given that Ms Z was still finding Y's behaviour challenging, Bedworth Children's Services, with her agreement, tried to initiate a CAF to provide access to support but this was ultimately abandoned as Ms Z did not turn up to the meetings. The final referral from the Police was following the victim's death. Bedworth Children's Team arranged to make contact with the family with a view to facilitating Trauma Care counselling for the children.

Analysis:

Children's Services involvement with Ms V and her child T and Ms Z and her three children focussed primarily on ensuring that the children were protected from harm and that both women knew where to obtain advice and support to keep themselves safe.

With regard to child T, the risks were in relation to the perpetrator giving alcohol and exposure to domestic abuse between himself and his partners. Ms V took steps to curtail this contact and following the incident where he gave alcohol, T never had face to face contact with the perpetrator again. The North Warwickshire Children's Team responses to all the referrals were appropriate. However, when Ms V reported the threat to kill from the perpetrator no assessment of the risk posed to Ms V was undertaken i.e. no evidence of the DASH being completed. This may have identified risks not previously identified.

With regard to Y and siblings, the risks were primarily in relation to them being exposed to domestic abuse between their father, mother and other partners (and it was known they were present when the perpetrator assaulted the victim in April 2011). With regard to the first two referrals received, the responses from Bedworth Children's Team were appropriate - in the first instance as Ms Z separated from the perpetrator and the children were not present when the second incident occurred.

With regard to the third referral, it was over a month before the Bedworth Children's Team was able to make contact with Ms Z to complete an assessment and ascertain the contact arrangements for the children, by which time Y had elected to move in with the perpetrator. However, when Ms Z was finally contacted in July 2011, despite sharing with the Social Worker that her relationship with the perpetrator had been violent, she felt confident that as the children hadn't mentioned that the perpetrator had been violent towards the victim, there were no contra-indications to them having contact and she was sure they would talk to her if they were worried. Some two weeks later when the assessment was completed, Ms Z confirmed that the children had witnessed domestic abuse towards the victim and by now Y had returned to her care. She had agreed to seek legal advice and she intended stopping the children having any further contact with their father. Nevertheless, Y would have been living with the perpetrator for nearly two months and the other children were having some contact at weekends. It is possible therefore that they were exposed to incidents of domestic abuse between the perpetrator and The victim and this is regrettable.

Had the assessment commenced in June when Y had elected to live with the perpetrator, then Children's Services could have taken steps to ensure Y returned to mother's care. However, when the assessment was completed in August, because of the steps that Ms Z was taking to prevent the children having contact with their father, they were safe from harm.

Additional Information requested by the panel:

a) *Clarification as to whether all referrals were sent to Children's services in a timely manner:* The records show that all referrals were made except the civil matter relating to the alleged theft of Ms Z's laptop by the perpetrator, which was appropriate. The only gap was the delay in Children's services being unaware that a child had witnessed domestic abuse until the MARAC meeting. This was due to a gap in the paperwork relating to recording full names and home addresses of children.

***Lessons learnt**:*

a) Good practice

- Children's Services involvement in this case revealed a history of domestic abuse towards the perpetrator's former partners but this never came to the attention of Children's Services when he was in the relationship with either Ms V nor during his relationship with Ms Z, save for the one incident that precipitated their separation. Furthermore, these mothers continued to allow the four children to have contact with their father, which one might speculate was because both women continued to be intimidated by the perpetrator. Once this became known to Children's Services, the focus of the intervention was to support Ms V and Ms Z to cease the contact (and the exposure to domestic abuse) and protect them from harm. This case evidences that even where a victim of domestic abuse is able to end her relationship with the perpetrator and no longer expose the children to harm by witnessing such abuse within that relationship, if the children continue to have contact with the

perpetrator, they will still be exposed to incidents of domestic abuse in any new relationships. Had Children's Services not responded to the referrals received in respect of both Ms V and Ms Z, these contact arrangements may have continued for a much longer time.

- Children's Services involvement in this case did not commence until 2008 in respect of Ms Z's children which was prior to the setting up of the MARAC, the creation of the Police Liaison Children's Manager post and a revision of the protocol for domestic violence referrals from the Police to Children's Services. It should however be noted that Children's Services responses were appropriate following every referral, save for the delay in completing an assessment following the information that was presented to the MARAC concerning the victim in June 2011, which led to Y living with his father for around two months and siblings having contact at weekends. It should be noted however that Y was nearly twelve and had chosen to stay with him. Even if Children's Services had become aware earlier, Y may still have not returned to Ms Z's care until ready to do so.

b) Areas for improvement

- In the knowledge that women such as Ms V and Ms Z may continue to be intimidated by a partner such as the perpetrator or feel powerless to prevent their children having contact with their father, victims of domestic abuse who separate from violent partners need to have confidence in the legal process to support non-contact with these non-custodial parents.

Agency recommendations:

- To ensure and reinforce that Children's Teams follow the existing guidance in respect of referrals where children may be at risk of significant harm and the protocol for Domestic Abuse referrals in a timely manner.

- Where domestic abuse is disclosed to Children's Services an appropriate member of the team should undertake a domestic abuse risk assessment with the victim or refer to a specialist domestic abuse service for a risk assessment on their behalf, as per the Warwickshire MARAC Operating Protocol[2]

Multi-agency recommendations:

- That officers/agencies investigating or reporting domestic abuse incidents are reminded of the importance of recording the full names and home addresses of any children witnessing domestic abuse – this is especially important when they are visiting a parent and are not residing at their usual home address.

[2] http://www.talk2someone.org.uk/professional/documents-and-strategies/multi-agency-risk-assessment-conference-marac

3.1.7 Warwickshire Probation Trust

Summary of Involvement:

The perpetrator appeared at Nuneaton Magistrates Court on 22 August 2011 for driving offences committed whilst driving the victim's car: Fail to Stop; Fail to Report an Accident; Careless Driving; and Driving Not in Accordance with Licence (provisional licence). The Court requested an Oral Report stating sentencing purposes as 'punishment' and 'public protection'. A risk screening was completed by the Oral Report author, and assessed the perpetrator as Low Risk of Serious Harm (LROSH). He was sentenced to 150 hours Unpaid Work. He only completed 9 hours' work before he was arrested for Murder on 02 January 2012.

A brief summary of his previous convictions resulting in previous Community Orders is set out below.

11-04-2001	Burglary & Theft Dwelling	200 Hours Community Punishment Order and £203 costs
15-01-2002	Common Assault	£350 Fine and £150 Compensation
07-11-2002	Theft	Community Punishment and Rehabilitation Order 12 Months Supervision and 90 hours Community Punishment
05-03-2004	Theft Shoplifting	12 Months Community Rehabilitation Order with Supervision and specified Activity
17-05-2005	Criminal Damage	12 months Conditional Discharge with £175 compensation and £70 costs

Analysis*:*

The index offences for which an Oral Report was requested by the Court on 22 August 2011 were 'Failure to Stop After an Accident' and other driving related offences. The 'script' for the oral report states "following an argument with his partner, the perpetrator took keys and drove his partner's car". Previous convictions (not seen by the Oral Report author) contain details of Police Bail with Conditions "not to attend address in Nuneaton" and "not to contact the victim".

Officer 1 completed a risk screening without access to the full list of previous convictions. The initial screening was therefore inaccurate, as it omitted to reference current and previous bail conditions not to contact the victim. In the view of the IMR author, the perpetrator was incorrectly categorised as Low Risk at the Oral Report stage. As a result he was made subject to a Basic Layer 1 OASys (Offender Assessment System) assessment at commencement on Unpaid Work (UPW) and

the incorrect classification was confirmed. As it was a Basic Layer 1 OASys, Offender Group Predictor (OGP) and Offender Violence Predictor (OVP) scores were not calculated.

In interview, officer 1 stated she sometimes completes screening without previous convictions if they are not available. The supervising officer stated she was absolutely clear that this is not common practice in the team and not defensible. The officer could not offer an explanation as to why she was unable to obtain previous convictions, or why she went ahead and completed the screening without alerting the Court to the need for a brief adjournment. She also could not explain why she did not ask a manager for assistance or indicate to Unpaid Work that an appropriate and defensible screening had not been possible.

Officer 2 stated that previous convictions are often not available to Unpaid Work at the Post Sentence Assessment Interview (PSAI) Induction due to processing delays and that, in such circumstances, she feels it is acceptable to accept the screening completed at the Pre-Sentence Report (PSR) stage. Officer 2 stated she probably did not have the previous convictions when completing the Initial Sentence Plan (ISP), but the Offender Group Reconviction Score (OGRS – a 'static' actuarial predictor of risk) had been completed accurately by the Unpaid Work administrator so, on balance, the IMR author believes that the previous convictions were available to officer 2, but despite this, the Domestic Abuse Bail Conditions were not picked up. The comments of the Case Administrator for officer 1 supported those of the supervising officer in that she was clear all officers and administrators are aware of the need for previous convictions before completing risk screenings. She said however, that sometimes the officers took responsibility for forwarding previous convictions to Unpaid Work and sometimes administrators, so the system is not consistent. In the view of the IMR author the deficiencies relate to the knowledge and capability of officer 1, the knowledge of officer 2 and the system for processing pre-cons and risk screening immediately post PSR.

The perpetrator only completed 8 hours of Unpaid Work between 22 August 2011 and 02 January 2012. He provided a range of explanations including illness of his grandfather, medical certificates from his GP for 'low mood' and, eventually 'in-patient psychiatric treatment'.

Enforcement was managed appropriately. Verification was not sought for the grandfather's illness and death, but the situation was monitored carefully and limited to 2 acceptable absences. On balance this was appropriate, although further guidance on the practice of verification for the illness of offender's significant others may be helpful. Verification for other absences was sought proactively and obtained from both GP and In-Patient Treatment.

Domestic abuse checks were not carried out as they should have been because domestic abuse had not been identified as a relevant issue. Although Unpaid Work staff can have only limited input on domestic abuse issues this could have become significant in the event of Breach of Unpaid Work, when electronically monitored curfews are routinely considered as sanctions. The Offender Assessment System review compounded the original failure to identify domestic abuse issues.

The options for Unpaid Work staff to promote victim safety are limited, but the victim was also not identified as at risk due to failure of the original risk screening. This meant that the opportunity for a community sentence with more potential to improve her safety was not considered. In addition the potential opportunity to liaise with Police Public Protection staff when the perpetrator was discharged from In-Patient Treatment was missed.

Lessons learnt:

a) Good practice

- Enforcement was managed appropriately. Verification was not sought for the grandfather's illness and death, but the situation was monitored carefully and limited to 2 acceptable absences. On balance this was appropriate. Verification for other absences was sought proactively and obtained both from GP and In-Patient Treatment.

- There are elements of good practice in the management of the perpetrator's case, particularly in relation to liaison with Mental Health Services by the Unpaid Work manager.

b) Areas for improvement

- *Risk Assessment*: The Oral Report author (officer 1) stated she did not have access to previous convictions before completing the risk screening. The risk assessment was therefore innaccurate, having ommitted significant information about an alleged pattern of domestic abuse. (An attachment to the previous convictions made it clear that The perpetrator was on police bail in relation to allegations involving The victim). This error was repeated in the screening conducted as part of a Layer 1 Offender Assessment System, when officer 2 did did not access the previous convictions and accepted, in good faith, the screening completed by officer 1, a qualified probation officer, 4 days before. A defensible risk screening cannot be completed without access to previous convictions. Officer 1 therefore appears to have disregarded clear policy and procedural requirements by signing a risk screening without completing the mandatory checks. This included stating that the perpetrator did not have a history of domestic abuse when in fact he did and was currently on bail for alleged offences against his partner, the victim. The conduct of officer 1 is now the subject of a disciplinary investigation.

- *Risk Management:* Further guidance on the practice of verification for the illness of offenders significant others may be appropriate. Domestic abuse checks were not carried out as they should have been because domestic abuse had not been identified as a relevant issue. Although Unpaid Work staff can have only limited input on domestic abuse issues this could have become sigificant in the event of breach of Unpaid Work, when electronically monitored curfews are routinely considered as sanctions. The Offender Asssessment System review compounded the original failure to identify domestic abuse issues.

- Although there are elements of good practice in the management of the perpetrator's case, particularly in relation to liaison with Mental Health Services by the Unpaid Work manager, the omissions within the risk assessment subsequently compromised the risk management of this case. Officer 2 (who was allocated this case) explained that she had trusted the accuracy of the screening completed at court and did not see it as her role to verify the facts. As a result the Offender Assessment System assessment did not identify a history of domestic abuse, which, if identified, would have led to management oversight by the Unpaid Work supervising officer and interagency liaison with the police Domestic Abuse Unit.

- Overall the deficiencies identified relate to failure to follow established procedure by Officer 1 or to notify colleagues of this omission and the lack of knowledge and confidence of Officer 2. It is unlikely that identification of domestic abuse history at the commencement of Unpaid Work would have had a significant impact on the management of the case because the Unpaid Work intervention is primarily focussed on administering punishment. However identification at the Oral Report stage, if it had occurred, should have alerted the court to the need for a brief adjournment to gather information and may have triggered consideration of a different sentencing proposal to the court. It is very important to note that there is no guarantee of the sentencing outcome of a court, but, as a proposal, a Community Order with a Supervision Requirement would have made sense in the context of the information that should have been available. IF that had been accepted and become a court disposal it MAY have facilitated more proactive assessment and management of the perpetrator's risk

***Agency Recommendations**:*

- The actions, set out below, that have been agreed in relation to the Serious Further Offence (SFO) investigation already conducted, have been implemented within the agreed timescales:

    - Previous convictions must be used to inform every Pre-Sentence Report risk screening or their absence should be noted and corrected as soon as possible:
        - All court duty staff to be reminded of this core practice expectation
        - Advice to be taken from Human Resources regarding capability or disciplinary action regarding the conduct of Officer 1
        - Area Office Administrators to review court administrative practice to ensure pre cons are collected and passed to UPW immediately post sentence
        - Unpaid Work operational managers (UPW OMs) to be reminded that pre cons must be checked before risk screenings are signed. Also that in signing risk screenings they are confirming they are satisfied themselves that the information is accurate

- Potential for inconsistency and inappropriate judgements in relation to enforcement when offender reporting illness or death of significant others: Unpaid Work manager has circulated guidance to all operational managers on decision making in relation to this issue.

- In this case sufficient information should have been available to enable the Probation Trust to identify a domestic abuse risk; to make an appropriate proposal to the court and to manage the case based on that knowledge. This did not happen because the officer did not follow agreed procedure and the risk screening incorrectly stated there was no history of domestic abuse. This emphasises the importance of inter-agency checks at the commencement of Probation supervision and, in particular checks with the Police Public Protection Team. Approximately 65% of Probation Trust commencements in Warwickshire have domestic incident call out information recorded on the Police records. Approximately 35% have a history recorded in the last 12 months. The average number of previous call outs per identified case is 3.9. The administration of the checks against police records on *commencement* is carried out by a post holder funded by the Community Safety Partnership on an annual basis. The funding does not include cover for sick leave, annual leave etc. or resourcing for Unpaid Work commencements. The administration of checks in advance of sentence at *court* is carried out by liaison between Police and Probation staff in the justice centres *if* there are indications of risk identified through risk screening. It is therefore recommended that:

    - Police, Probation and CPS to consider prioritising resource allocation to the information exchange process

    - That the Court Service/sentencers tolerate adjournments for this to take place where it is recommended by the Probation Court Duty Officer.

- That information provided by friends and family is shared with the Offender Manager who is preparing post-sentence assessments as this will be of significant help in developing the perpetrator's profile

3.1.8 South Warwickshire NHS Foundation Trust

South Warwickshire NHS Foundation Trust provides a range of hospital based and community health services, including child health services, for the population of Warwickshire.

Summary of involvement:

The agency had no contact with either the victim or the perpetrator, but had contact with the children of the perpetrator through the child health service. The information was held in community child health records only. The only contacts relate to behaviour management advice given by the school nurse to Ms Z in relation to her

child, Y. Ms Z reported that she and her partner (the partner is not named in the records) argue on occasion. There is no record of MARAC information in any of the records.

Analysis:

The records reviewed showed that the children had accessed appropriate health services. The school nurse had offered behaviour management advice to Ms Z and she had accepted this advice and support. When Ms Z had said that she sometimes argued with her partner in front of Y which caused difficulties, advice was given and the possibility of seeking support from Relate services was suggested by the school nurse. Work on practical strategies was completed by the nursery nurse with Ms Z. Ms Z reported by telephone that Y's behaviour had improved and all the family working together on positive behaviour had encouraged Y. This seemed to be a proportional response to Y's behaviour and the strategies suggested were reported to have had a positive effect. No further support was requested following this. No MARAC information was recorded in the records reviewed so the IMR author was unable to assess if opportunities were missed in this case. The response by health staff on the information they had was appropriate and proportional.

Lessons learnt:

a) Good practice

- Appropriate support was provided by the child health service.

b) Areas for improvement

- There have been developments in practice, though not as a direct result of this case:
    - From April 2012 health visitors receive notification of 'medium' risk domestic abuse incidents from Warwickshire Police when the victim is pregnant and or there are children under five years of age in the household.
    - The Safeguarding Children Named Nurses attend MARAC conferences and share information with health visitors, school nurses and other health professionals if appropriate.

Agency recommendations:

- South Warwickshire NHS Foundation Trust Review all recommendations from the DHR and complete on action plan relating to the recommendations as appropriate.

3.1.9 West Midlands Ambulance Service

Summary of involvement:

West Midlands Ambulance Service had limited contact with the victim, the perpetrator and the victim's son, having received six separate 999 calls to attend to

the three individuals involved between 28th July 2011 and 22nd December 2011. Four of the callouts involved issues around overdoses and the use of alcohol and two of the calls were for assaults. The call by the victim's son in July 2011 has no relevance to the domestic homicide. However one of the assaults cannot be linked to any other individuals as no details of the attacker are known by West Midlands Ambulance Service.

On **22nd August 2011** at 20:29 there was a call from Warwickshire police asking for an ambulance to attend to the victim at the home address due to her being assaulted by her partner. The victim was complaining of rib and arm pain but refused treatment so was left in the care of the police officer on scene.

On **26th September 2011** at 18:35 a 999 call was received from the victim requesting an ambulance due to the perpetrator having taken an overdose. On arrival the history given to the crew was that the perpetrator had taken an overdose and had also used cocaine and alcohol. It was stated that the perpetrator had taken the overdose due to him having an argument with his ex-partner. The perpetrator was transported to hospital for further assessment.

A 999 call was received on **9th December 2011** from the victim to attend to the perpetrator who had cut his wrists, taken an overdose and was under the influence of alcohol. The victim stated on the call that the perpetrator had told her to leave the property so she was sitting in her car outside, it was also stated that the perpetrator's behaviour could be unpredictable and he still had the razor blade on his person that he had used to cut his wrist. An ambulance was dispatched and police back up was requested but on arrival of the ambulance the perpetrator absconded so no treatment could be administered and the case was left in control of the police.

On the **22nd December 2011** at 00:57 a 999 call was received to attend to the victim due to her taking an overdose with alcohol. The victim had taken over 60x 500mg paracetamol tablets and was conveyed to hospital for treatment. At 02:47 a second 999 call was received this time from the police asking WMAS to attend the home address again. The victim had left the hospital without being treated and the hospital had contacted the police asking them to do a safe and well check. The police found the victim at home and deemed her to still require treatment so requested WMAS transport her back to the hospital.

Analysis:

Due to the nature of the service provided by WMAS the staff only saw the individuals for a short time period and in an emergency situation. WMAS staff acted appropriately and in line with all policies and procedures for each incident. Due to the size of WMAS and the number of staff employed, it is quite usual for no member of staff to attend to the same address on more than one occasion and out of the 6 incidences only one member of staff had attended twice, dealing with two different family members.

WMAS alerted other agencies appropriately with details being passed to the police service and full handovers to the Accident and Emergency staff on each transfer to the hospital. However it would have been good practice for a referral to have been

made to social services so more professionals could have been made aware of the events taking place which in turn may have painted a picture or filled in some blanks for other agencies.

Lessons learnt:

Since this case in 2011 changes have taken place with the in-house referral system at WMAS. The question set used to complete referrals has been changed and also a lot of work has been done to raise more awareness around the need for referrals to be made even when other services are on scene e.g. the police. This awareness has been raised by articles in the WMAS weekly briefing paper which is distributed to all ambulance staff and is also available in paper format on all stations and via the internet. Also the mandatory training sessions have been updated to cover domestic violence on a wider scale.

Agency recommendations:

- WMAS to continue to raise awareness on Domestic violence and the need to report any concerns through the safeguarding process.

- To improve communication between services to highlight potential at risk individuals and families so these cases can possibly be picked up using early warning signs.

3.1.10 George Eliot Hospital

The victim: A&E services at George Eliot Hospital had contact with the victim on three occasions, once in 2008 and twice in 2011. The first two visits were for minor attendances and electronic records reviewed for these events document that no follow up was required.

The victim's third presentation at A&E on **22nd December 2011** was significant in terms of an attempt at self-harm. On this occasion the victim initially left the A&E Department before treatment was initiated. Staff recognised the risks to the individual and contacted the Police who subsequently contacted the ambulance service following which the subject was retrieved and returned to A&E for assessment and treatment. The victim was transferred into the A&E assessment area for observation and treatment and was seen by a Psychiatrist the following day **(23rd December)** when she was assessed as being medically fit for discharge. The outcome of the risk assessment was:

Risk of suicide - low
Risk of self- harm - low
Risk of neglect - low
Risk for others – low

The impression was that this was an impulsive overdose and disclosure was recorded relating to physical abuse noted by ex and current boyfriend. The victim was assessed as fit to be discharged for the GP to review in one week's time and to consider starting her on antidepressants if she is feeling low in mood. The Crisis

team number was given and the victim was advised to contact crisis team if needed. No domestic abuse risk assessment was undertaken and no information regarding domestic abuse services was provided.

The perpetrator attended the A&E department eleven times between 2008 and 2011, five times as the result of self-harm. The last occasion was in December 2011 prior to his admission to the mental health unit for assessment.

Analysis:

It was not until the period of medical management and treatment had concluded that the victim disclosed previous incidents of physical abuse by an ex-boyfriend and current boyfriend. Records do not contain any evidence of how the disclosure was explored or what actions were identified as a result.

Lessons learnt:

a) Good practice

- No areas of good practice were identified.

b) Areas for improvement

- There was a missed opportunity on the victim's last contact with the hospital in terms of recognising and responding to the disclosure of domestic abuse, providing information and support to the victim and ensuring that multi-agency considerations were explored or discussed with her. It is clear that improvements are required in order to ensure that lessons are learnt from the DHR are implemented across all partner agencies to improve awareness and ensure that victims are provided with appropriate advice and support.

Agency recommendations:

- To raise the profile of domestic abuse in both adult and child safeguarding training sessions. *(The Panel is of the view that there needs to be separate training on domestic abuse and that is is not sufficient to only link it with safeguarding training).*

- To target front line staff in A&E with specific domestic abuse training to enable them to identify people at risk and initiate appropriate supportive and protective actions.

- To develop and implement a Domestic Abuse Policy in collaboration with partner organisations.

- To engage with the Warwickshire Against Domestic Abuse Campaign to explore ways of improving detection of abuse and support for victims of abuse.

- To ensure that the profile of domestic abuse is not only raised under the umbrella of both child and adult protection, but in its own right

Multi-agency recommendations:

- Public awareness campaign e.g. production of information leaflets / posters which can be distributed throughout agencies.

The Panel asked for the following additional information:

With regard to the victim leaving the hospital before treatment, what is the hospital's DNA policy and would this ensure follow up in domestic abuse cases?

The Panel asked about ownership at a senior level – for example are senior managers aware of domestic abuse issues, including the role of MARAC and the DASH risk assessment process? The response was that it was unlikely that there was senior management awareness of the processes. GEH does intend to appoint a domestic abuse lead. *The Panel highlighted the need for leadership from the top of the organisation, otherwise staff training won't impact on practice – for example, training staff to use DASH does not mean they will use it, unless there is a clear expectation from senior management that this is a priority. It is also important that GEH fully engage with the MARAC and ensure that the representative attends – this could be written into the job description of the new domestic abuse lead.* The IMR author acknowledged the need for a wider understanding of domestic abuse at a senior level and intended to raise this at a meeting in February 2014.

With regard to the Domestic Abuse Policy, the Panel advised that GEH should seek external validation of the Policy. The Panel were unclear as to how the policy would improve practice at the front line and commented that training for front line staff must be adequately resourced and supported by senior management. Panel members offered to review the Policy and give feedback, and offered to share knowledge and experience.

Overall, the Panel noted that the IMR submitted by GEH was not robust and was only based on electronic records and case notes, rather than speaking to staff to find out what prevents them from responding appropriately to disclosures of domestic abuse. The Panel are of the view that this reflects the need for cultural change within the organisation in order to properly embed better awareness and practice regarding domestic abuse, and that this must be led from the top. The Panel were not assured that the organisation fully grasp this.

3.2 Information from friends, family and employer

Family and friends of the victim were identified from the police investigation and invited to contribute to the review, along with the victim's employer. In view of the delay of the trial, further letters were sent to all 8 contacts following completion of the trial to repeat the offer of involvement. One direct relative represented the family and contributed in writing and by telephone, one close friend of the victim was interviewed, as was her employer. A further long standing friend of the victim wished to be involved but was prevented from doing so by ill health. In addition the

perpetrator and his family were invited to contribute, but declined. The Panel also received a copy of the trial transcript which provided additional information from friends, family and other witnesses. This summary is therefore based on information from family and friends through written submission, interview, or as witnesses at the trial. All contributions were consistent in their views and information.

The victim grew up in Lancashire and moved to the Midlands when she was 18 and pregnant with her son. She was happy and outgoing and presented as confident and independent. She had two previous long term relationships which were also abusive. Prior to meeting the perpetrator, her second long term relationship had ended, leaving her feeling vulnerable and lonely. She was described as someone who needed people around her, and perhaps wasn't always as confident as she appeared. A popular, attractive and vivacious person, she was also clever and hard working - owning her own house and car, and having a good job, compared to the perpetrator who was unemployed and appeared to have no fixed address. She met the perpetrator in March/April 2010 and he moved in within a few days of them meeting. The perpetrator was described as initially charming, though manipulative, and her family liked him and thought they were a good match. Though the victim had many friends, her extended family lived some distance away and so rarely saw them together as a couple. There was regular telephone contact with her parents, though the victim didn't tell them about his violence towards her.

Their relationship was described as mixed – though the perpetrator could be charming and would "look after her", he could quickly turn nasty. He was described as a liar and a thief who stole from her and wrote off 3 cars, leaving her with increased debt. Over time, he isolated her from her friends, and she became more secretive, hiding the fact that she had reunited with him later in 2011. She started a new job during the time they were back together, but told work colleagues that she was single. Friends warned her about the risks of going back to him but she thought she could handle him – she saw herself as "the boss" in the relationship. However, there was also evidence that she was sometimes frightened of him (but "if she was afraid, she wasn't afraid enough"), that she predicted he would kill her, and at times, friends stayed overnight with her and "slept with hammers under the pillow". Due to the perpetrator's strength and size along with his volatility, friends warned her that he was more dangerous than anyone she had been previously involved with.

The possible reasons for the victim withdrawing complaints made to the police were identified as probably due to the perpetrator saying sorry and appearing to make amends, and the victim not wanting to involve his children (who witnessed the throttling incident). Mixed views were expressed about whether it was because of fear of reprisals, though she did tell friends that the "police have no power to do anything" – for example bail conditions didn't stop him from approaching her. However, a key factor appears to be her reacting badly to being referred to as a "victim" and this seems to have been a major barrier to her accepting help from agencies – she believed she could deal with it herself and that it would be a sign of weakness to accept help. Her suicide attempt in December 2011 was out of character and an indication of how bad it had become.

The evidence from family and friends and from the trial, paints a picture of a volatile relationship, with the perpetrator driven by jealousy and aggression. He was

considered to be a bad influence on her – for example, she started drinking more heavily when she was with him, he allegedly introduced her to drugs, and they frequented pubs that she wouldn't previously have entered. The victim told friends and family that she was ending the relationship, and that they had agreed that he would move out after the New Year.

3.3 Processes

3.4.1 Multi-Agency Risk Assessment Conference (MARAC)

Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of homicide or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA, a risk focused, co-ordinated safety plan can be drawn up to support the victim. The main purpose of the MARAC is to:

- Share information across agencies to increase the safety, health and well-being of victims, both adults and children
- Determine whether the perpetrator poses a significant risk to an individual or the wider community
- Jointly construct and implement a risk management plan that professional support to those at risk and reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability
- Improve support for staff involved in high risk domestic abuse case

MARAC is not a statutory requirement though overlaps with statutory processes; it is not a case management process but focuses on the victim and checks that agencies are doing as much as possible to provide support and reduce risks. Good practice guidance and principles is available from CAADA and processes can vary nationally. All cases assessed as high risk are considered by the MARAC in Warwickshire.

There are currently over 260 MARACs are operating across England, Wales and Northern Ireland managing over 57,000 cases a year. The Warwickshire MARAC operates geographically across 3 areas and as such holds 3 meeting per month as follows:

- Warwickshire North MARAC (covering Nuneaton and Bedworth Borough and North Warwickshire Borough)
- Warwickshire Rugby MARAC (covering Rugby Borough)
- Warwickshire South MARAC (covering Warwick District and Stratford on Avon District|)

The role of MARAC coordinators and administrators is to:

- help to establish communication between all parties
- give information to partner agencies about the MARAC process
- work with the chair to identify agency gaps
- establish links with these agencies to enable them to take part in the MARAC

At the time of the referral of the victim to MARAC, Warwickshire's MARAC co-ordinator was employed by Warwickshire Police, jointly funded by Warwickshire County Council, and based in the Protecting Vulnerable Person's Unit at Warwickshire Police. As the MARAC co-ordinator was a member of police staff, the process for receiving police referrals was different to that of referrals from other agencies. For police referrals the MARAC co-ordinator populated the nominal table with information found on the Domestic Abuse Unit's high risk case management spreadsheet. This, along with the details of referrals from other agencies, was then emailed to all MARAC agencies for research prior to the meeting. During this period, the allocated Domestic Abuse Officer would prepare the case information to be shared at the MARAC meeting.

Warwickshire has a MARAC Steering Group that provides strategic governance to the MARAC in order to ensure consistency across the 3 geographical areas, to reduce repeat victimisation and reduce levels of harm posed to high risk victims across Warwickshire. The Steering Group therefore completed an IMR of the Warwickshire MARAC to identify lessons that could be learnt.

Warwickshire North MARAC was assessed by CAADA in 2012 as part of the MARAC Quality Assurance Programme. The DHR Panel received a copy of the preliminary report and note that the findings are consistent with the findings of the IMR.

Summary of involvement:

The victim was referred to the MARAC by Warwickshire Police following the incident reported on 7th May 2011. The case was discussed at the Warwickshire North MARAC on 16th June 2011. No further referrals were received by the MARAC, nor was there a need for further follow-up identified. The minutes of the MARAC meeting record a brief outline of the case, the reason for high risk, a brief summary of the perpetrator's offending history, and the actions agreed.

Analysis:

Between April 2011 and March 2012, the average number of cases heard at the North MARAC was 25 per meeting, the lowest being 13 cases and the highest being 38 – the latter being at the June 2011 MARAC when this case was discussed. CAADA recommend that a maximum of 20 cases should be considered at any given MARAC to ensure that attendees remain focussed and give each case the level of attention that it deserves. In this case, if the referrals were discussed in the order they were listed (it is not known whether they were taken out of order), this case was listed as case number 30 out of 38. Documentary evidence shows that information about the case was distributed to MARAC agencies prior to the meeting.

There is no information as to whether the victim was aware of the referral to MARAC, whether she had consented to this, or if not, the grounds on which information was being shared. The information suggested that the perpetrator may have children, but the lack of any details meant that MARAC agencies were unable to research any records relating to children. This ties in with the Police IMR regarding delays in

inputting to CATs and the Children's Services IMR which identifies that the names of children (who were present during the incident) were not known to them prior to the MARAC meeting.

No information on the further incident of 25th May 2011 was provided to MARAC, resulting in agencies not being aware of the change in circumstances or risks posed to the victim. Furthermore, on 15th June 2011 (the day before the MARAC meeting), the perpetrator failed to appear in court and a warrant was issued for his arrest. Custody records indicate that he was arrested the same day and his bail conditions were varied. This new information was also not available to the MARAC.

The minutes of the MARAC include a record of the initial interventions/referrals made, but this is incomplete. For example, the minutes indicate that no referral had been made to WDVSS, although it is now known that WDVSS received a referral from the police on 1st June 2011. This referral may have been related to the repeat incident of 29th May 2011 which was not passed to the Domestic Abuse Unit. The minutes also imply that the IDVA was continuing to attempt to contact the victim (in contrast to understanding of the Refuge/IDVA as set out in their IMR). The minutes template used at the time was not an effective record of the meeting. The minutes don't reflect the detail of the discussion of the case or the rationale of why actions were agreed or not pursued. Most importantly, they do not record the risks posed, how these risks will be addressed, by whom and by when – the very essence of the MARAC. They are therefore not a defensible record of the actions taken. Although there is a section for details on criminal justice developments, this had not been completed. The template also lacked anywhere to record the support agency identified for the victim, who would update the victim after the meeting, and any actions that were considered but dismissed. The minutes are not comprehensive as they do not record the contribution from agencies at the meeting, and either information was not shared, or it was shared but not recorded. For example, the minutes show that CWPT only knew the perpetrator, though we now know that the victim was referred to the IAPT service in 2010. Probation provided no information though knew the perpetrator well. WDVSS provided no information, though we now know that referrals were received and the victim refused the service. All of this information would have helped the MARAC develop the risk management plan – without it, the meeting was making decisions without knowing the full situation. The minutes show that two MARAC members did not attend the meeting, or send deputies or notes from their agency.

Lessons learnt:

a) Good practice

- All cases assessed as high risk are referred to the MARAC

b) Areas for improvement

- The high number of cases presented to the MARAC meeting held on 16th June 2011 suggests that not all cases are likely to have the same level of focussed discussion. Whilst attendees remain committed, it is inevitable that attendees become tired both mentally and emotionally and it has to be asked

whether case number 30 will have the same quality of discussion as case number 1. Agendas need to be planned in line with CAADA recommended best practice – i.e. a maximum of 20 cases per meeting.

- It is important to establish whether the victim consents to have their information discussed at MARAC or whether the case is taken forward without consent. CAADA have produced an Information Sharing Without Consent Form which agencies can use in order to come to a balanced and defensible decision as to whether to share information without the victim's consent. Clearly, though consent is not compulsory, it is better to have the victim's consent wherever possible and the ability to explain how the MARAC works and what it can offer will be instrumental in obtaining this. There should also be processes for giving feedback to the victim after the meeting. Furthermore, it is essential that all information is accurate and comprehensive, including the names of any children.

- It is essential that repeat incidents and other critical information identified subsequent to the referring incident are reported to the MARAC, otherwise the meeting will make decisions that are not based on a full understanding of the circumstances and the risks.

- The minutes of the MARAC did not provide a comprehensive and full record of the meeting. The template used at the time was not effective and therefore not a defensible record of the actions taken. The template used had not been fully completed, and so there were gaps in the information available to the meeting, and the template also had gaps that meant that the main focus of the discussion was not recorded including the rationale underpinning the actions agreed.

- The minutes indicate that information about the victim and perpetrator that was known to agencies was not effectively shared. These omissions may have been for a number of reasons including agencies not effectively researching the case, not understanding they needed to contribute what they knew, not feeling able to contribute or thinking their information wasn't relevant, or deciding not to share information for legitimate reasons.

- It would appear that neither individual agencies or the MARAC had a robust system in place to identify and re-refer victims to the MARAC following any further domestic abuse incidents in a 12 month period. If this had been the case, the victim would have been re-referred following repeat incidents on 29th May 2011 and 22nd August 2011.

MARAC Steering Group recommendations:

- To develop and ensure implementation of an induction programme for new MARAC agencies and representatives to support them in understanding their roles and the requirements of MARAC agencies.

- To complete the revision of the MARAC Operating Protocol to ensure that it is compliant with the CAADA checklist.

- To complete the MARAC Information Sharing Protocol to ensure that it is compliant with the CAADA checklist.

- To improve and re-format the MARAC minutes template to ensure that it includes:
    - Whether the victim is aware of the referral
    - The contribution of each agency
    - Detail of the discussion of the case
    - The rationale of why actions were agreed or not pursued
    - The risks identified, how these risks will be addressed, by whom and by when
    - Identification of the support agency for the victim

- To clearly define the role of the IDVA in relation to the MARAC, including the requirement to contact the victim prior to the meeting and to ensure that there is clarity about ongoing contact

- The MARAC Steering Group should make a formal decision regarding the flagging of files, and inform all agencies of the outcome

- Remind all agencies of their responsibilities relating to attendance, including sending deputies and/or written notes in the absence of the usual representative.

- In view of the high number of cases referred to the North MARAC, to split the monthly meeting into 2 (if less than 20 cases referred, the second meeting can be cancelled).

- MARAC Steering Group to complete a feasibility study as to whether a multi-agency web-based database for MARAC cases (e.g. Paloma's MODUS database) would be beneficial.

- To implement all the additional recommendations of the CAADA Quality Assurance Report that are not covered above.

3.4.2 Risk Assessment – DASH

A key issue emerging from the chronology and IMRs is that risk assessments of domestic abuse incidents involving the victim and perpetrator varied over time:

24th April 2011: Standard Risk
7th May 2011: High Risk
29th May 2011: Medium Risk
22nd August 2011: Medium Risk

To gain a better understanding of the risk assessment process, the Panel received a presentation from an independent consultant who delivers CAADA risk assessment training and who ran training sessions for front line workers in Warwickshire during

2011. The aim of the DASH (Domestic Abuse Stalking and Honour Based Violence) Risk Assessment is to:

- Help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- Decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- Offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- Enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

The checklist is aligned to the Association of Chief Police Officers (ACPO) policy and is designed to be a snapshot of risk at a particular time. The form contains 24 questions, with the police form using 27 questions, and the number of ticks are tallied up with 14+ ticks being classified as high risk. Good practice identified by CAADA is that people should be offered support if there are at least 10 ticks. It was also noted that the terminology has changed – originally, there were 3 terms used: Standard Risk, Medium Risk and High Risk. This has now changed to 2 terms of High Risk and Non High Risk.

CAADA guidance sets out the recommended referral criteria to MARAC as having 3 elements:

1. ***Professional judgement:*** *if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence. This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.*
2. ***'Visible High Risk':*** *the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.*
3. ***Potential Escalation:*** *the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.*

It was confirmed that the form used within Warwickshire is designed to capture professional judgement. Within police procedure, 3 lower risk incidents do not trigger a referral to MARAC unless the case is already known to the committee. It is also quite possible that agencies are not aware of disclosures made to other agencies – i.e. 3 agencies may each have one disclosure. Once accepted into the MARAC

process, any further incident where a crime has been committed within 12 months, regardless of the risk level, is referred back to the MARAC.

Analysis

The following issues were identified in relation to this case:

- Each incident appears to have been risk-assessed in isolation of the wider context or previous incidents – the view of the panel was that each incident was probably correctly assessed based on the circumstances at the time, but it raises a question as to whether subsequent incidents following the 7th May assessment should have been assessed as high risk on the basis of the seriousness of the previous incident, a sign of escalation, and the fact that the perpetrator was in breach of bail conditions to not contact the victim or visit her address.

- Professional judgement is essential when a victim either doesn't co-operate fully in the process, retracts, or subsequently underplays the level of risk

- The risk assessment process is applied to the victim only – there is no assessment of the risks posed by the perpetrator and is therefore not a full assessment of the circumstances. However, it was noted that MARAC does look at the perpetrators actions as well and the DASH risk assessment of 29th May 2011 also noted that the perpetrator posed high risks.

- It is unclear why the subsequent incidents were not referred back to MARAC. The incident of 29th May did not meet the CAADA criteria of a repeat incident as it did not involve a crime being committed – however, the incident happened after the throttling incident and prior to the MARAC meeting and should therefore have been included in the information presented to agencies. The incident of 22nd August 2011 should have been referred to MARAC as a repeat incident as it did involve an assault and thus met the CAADA criteria. The impact of this is that MARAC were not aware of the escalation of incidents between May and September 2011. It could also be argued that had MARAC been aware of these incidents, the breach of bail conditions would have been clearly identified, as would the information identified by Children's Services relating to the perpetrators history of abuse against previous partners.

Lessons Learnt:

a) Good practice

- The DASH form used in Warwickshire has been designed to capture professional judgement in addition to checklist ticks.

- There is a clear policy that repeat incidents where a crime had been committed within 12 months must be referred back to MARAC

b) Areas for improvement

- It can be argued that each incident should be risk assessed in the context of the whole picture – that is, by taking into account previous incidents – i.e. each incident should not be assessed in isolation. However, if the policy on escalation is followed correctly, repeat incidents should be re-referred to MARAC regardless of the level of risk of the new incident

- There needs to be a risk assessment of the risks posed by the perpetrator as well as the risks posed to the victim

- It is essential that repeat incidents are referred back to MARAC regardless of the seriousness of the specific incident, in line with local policy.

- There has been an over-reliance on DASH being used by the Police - DASH should be used by all agencies as a tool to determine risks and identify when a multi-agency approach is required. DASH was endorsed as the preferred domestic abuse risk assessment tool by the Warwickshire Safer Communities Partnership in January 2010.

Recommendations:

- To develop and implement multi-agency training on the use of DASH to assess risks and ensure that risk assessments are in line with CAADA guidelines, specifically in relation to the use of professional judgement in cases where the victim is unable or reluctant to fully disclose information that might highlight the risks more clearly

- To improve processes to ensure that all repeat incidents are referred to MARAC

- To explore the options for developing risk assessments of the risks posed by perpetrators, and linked to this, the identification of serial abusers

3.5 Summary/overview of what was known to agencies

The perpetrator was well known to police and probation due to his history of offending including a pattern of breaching community punishment orders. This included 12 previous convictions for 24 offences including driving offences, burglary/theft, assault and criminal damage. In addition, he was arrested, but not charged, for 4 domestic abuse incidents including assault occasioning actual bodily harm, criminal damage, threats to kill, and theft from the victim. There was one known incident reported to the police of domestic abuse involving a previous partner.

Following the MARAC meeting in June 2011, during the involvement of Children's Services with the previous partners and children of the perpetrator, there were disclosures that evidenced that the perpetrator was a serial domestic abuser, with a history of violence towards women and making threats to kill. These incidents had not been referred to police at the time but provide historical information regarding a

pattern of behaviour that support the judge's summing up that the perpetrator is a risk to any woman he is in an intimate relationship with.

It is unsurprising that the full extent of the perpetrator's history of domestic abuse was not known to agencies given that research has shown that a woman is on average assaulted 35 times before her first call to the police (Jaffe 1982) and that only 35% of all incidents are reported to the police (Home Office 2002).

The perpetrator was known to mental health services between 2009 and 2011 – each episode was linked to low mood and suicide attempts, and he was subsequently diagnosed with a moderate depressive illness. A pattern emerged of presentation to A&E following self-harm/overdose at a time of crisis, usually linked to relationship breakdown or difficulties, followed by a failure to consistently engage in ongoing counselling or follow up treatment. It was identified that alcohol and drug misuse were key factors, and the perpetrator was advised to seek support in addressing this. However, records suggest that he did not engage with follow up support. At appointments during late 2011, the perpetrator made several references to "trashing the flat", "grabbing his girlfriend" and arguing in front of the children. These were not however followed up within the context of domestic abuse.

The victim had contact with the police on 5 occasions between March and August 2011 as a result of domestic abuse incidents. On each occasion the victim subsequently withdrew her complaints, or wouldn't provide sufficient evidence to press charges. The victim was given appropriate advice and support by the Domestic Abuse Unit, including putting locks on doors and windows. Each incident was referred to either the Refuge (IDVA) or WDVSS. However, their attempts to make contact with her were unsuccessful and on the occasions that telephone contact was made, the victim refused support.

The victim made disclosures of domestic abuse to health professionals including her GP and the clinician who completed the psychiatric assessment following her overdose in December 2011. Research has identified that medical staff are more likely to hear about incidents than the police (Home Office, 1999) and are in a good position to signpost people for support. However, on these occasions, though the indicators of domestic abuse were identified and recorded, no risk assessment was completed and no strategy was put into place to protect the victim and no advice appears to have been given.

3.6 Analysis against Terms of Reference

TOR1: To establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk to the victim or other partners, and whether any action could have been taken to prevent the homicide. To establish whether the homicide was predictable or preventable.

There was a known history of domestic abuse between March 2011 and August 2011, with police attending 5 incidents, one of which was a serious assault in front of the perpetrator's children which resulted in the case being referred to MARAC. A pattern was emerging of criminal damage, theft from the victim and threats to kill. By August/September 2011, it was known by Children's Services that the perpetrator

had been abusive and violent in previous relationships. There was an escalation of incidents emerging throughout the year that indicated a clear cycle of abuse that was based on creating fear, and causing disruption to her life, rather than regular physical assaults. Appropriate actions were taken by Police on each occasion, including fitting locks, giving advice to the victim, tracking down the victim to ensure she was safe and referring the victim for support from Refuge or WDVSS.

However, incidents did not result in any convictions, due to lack of evidence as the victim either withdrew charges, or failed to co-operate with police in providing sufficient evidence to secure a successful prosecution. There were examples of good practice in line with CPS guidance – for example police officers insisted on interviewing the victim when she rang to withdraw complaints, and also tried to ascertain whether she had been coerced into doing so. There was evidence that victimless prosecutions were also considered.

On several occasions, the perpetrator was found to be in breach of police bail conditions to keep away from the victim. Police bail conditions are used pre-charge, whilst an investigation continues and CPS advice is taken on progressing charges and do not have the same status and powers as bail conditions issued by a criminal court. An arrest can be made when Police bail conditions are breached in order to mitigate any immediate threat, but it is not an offence in its own right to breach conditions of Police Bail. If there have been no other changes in circumstances since the Police Bail was initially granted, and no additional criminal offences have been committed, then the only possible outcome (other than to cite the event at any future trial) is to release the perpetrator on Police Bail again. In this case, on each occasion a breach occurred, officers were assured by the victim that all was well. However, evidence from friends suggests that this was a critical issue in that it gave the victim a message that the police were powerless to stop him.

Both the victim and perpetrator had contact with mental health services during December 2011 respectively, the last contacts being the week before the homicide, when the victim disclosed she was trying to end a relationship with an abusive partner (who had tried to strangle her when previously trying to leave the relationships), and the perpetrator referred to grabbing his girlfriend and trashing property. These were separate contacts with different clinicians and, unless the home address was flagged, no link would have been made between them. However, though mental health issues were responded to appropriately, with both individuals issues relating to domestic abuse were not explored further or support offered.

With regard to whether the homicide could have been predicted, there was clear evidence that the victim was at high risk of serious harm or homicide, based on the following factors:

- there had been a serious throttling incident and repeated threats to kill
- there was an emerging pattern of escalation (which does not necessarily mean each successive incident has to be more severe than the previous one)
- the victim stated in May 2011 that he would kill her
- the evidence from friends suggest that the risks were very high – he was perceived as dangerous and they, and the victim, believed he was capable of killing her

– there was evidence from mental health services that the perpetrator had issues relating to anger and the breakdown of relationships
– the victim was trying to end the relationship

All cases referred to MARAC are cases where the victim is deemed to be at "high risk of serious harm or homicide" and this case represented a fairly typical profile. Most of the incidents were at a fairly low level, with the throttling incident somewhat under-played. CPS advice on each incident was that the evidential test was not met and charges could not therefore be progressed, and there was insufficient evidence to purse a victimless prosecution. The DASH tool is based on predictors of serious harm and the Panel are of the view that serious harm could therefore be predicted. The fact that the victim refused to accept support increased the risk of harm. However, it is difficult to judge whether the homicide, as opposed to serious harm, could have been predicted.

No single agency held the full information about the circumstances and wider context, much of which was known only to the victim and her close friends. Though the case had been referred to MARAC, not all information known to agencies was shared, including information relating to further incidents. Additional information elicited about the perpetrator's previous relationships was also not discussed at a MARAC meeting (see TOR2 below). Though this would have given agencies more intelligence about the level of risk, it would not necessarily have meant that the homicide was predictable. A significant missed opportunity was the failure to complete the DASH risk assessment when the victim presented at A&E the week before the homicide. Completion of a risk assessment at that stage may have elicited additional information that demonstrated that the risks had increased (e.g. the intention to separate).

With regard to whether the homicide could have been prevented, it is the view of the Panel, that on balance, the homicide could not have been prevented for the following reasons:

- Had the MARAC had access to all the information available about the victim and perpetrator, and a better assessment of risk, it is unlikely that this would have made any difference to the outcome given the reluctance of the victim to engage with agencies and accept support
– There were regular attempts by support agencies to engage the victim and offer support – she did not see herself as a victim and was clear about her decision to decline support
– Despite appearing to understand the level of risk posed by the perpetrator (i.e. predicting that he would kill her and understanding that he was capable of doing so), she also appeared to believe that she could handle him. This is not unusual within a cycle of abuse.

The evidence of the trial points to a set of circumstances on New Years' Eve that made the homicide inevitable – the relationship ending, the social environment feeding his intense jealousy, fuelled by alcohol, combined with the kindness and trust of the victim permitting him to continue living in her home over the holiday period. If the hospital had been flagging files and the psychiatrist had checked this and was able to access the previous MARAC minutes pre-discharge, a call might have been

made to the DAU officer who managed the victim and a safety plan could have been devised, e.g. regular welfare checks for a period. As they didn't flag files appropriately this did leave a missed opportunity for a plan to be developed. However, based on the history, it seems unlikely that, had the victim been signposted to domestic violence support on 23rd December, it would have either not been accepted or made any difference to the decisions made and chain of events – the victim had told family and friends that she was separating from the perpetrator and that he was moving out on the Tuesday after the New Year holiday. This was corroborated by the perpetrator when he gave evidence at the trial – the victim therefore appeared to believe that this was an amicable agreement.

TOR2: To establish how effective agencies were in identifying the victim's vulnerability to domestic abuse and the level of risk to which she was exposed, and whether the single agency and inter-agency responses were appropriate and proportionate in supporting the victim and her family.

All incidents reported to the police were assessed using the Domestic Abuse Stalking & Harassment (DASH) Risk Assessment Process – the process is in line with recognised best practice, focuses on the victim and allows professional judgement as well as tick boxes. However, each individual incident was risk assessed in isolation of the wider context, thus providing a risk assessment score of each specific incident at that point in time, but not of the full circumstances:

24th April 2011: Standard Risk
7th May 2011: High Risk
29th May 2011: Medium Risk
22nd August 2011: Medium Risk

It is to be expected that the seriousness of individual incidents will vary over the time – however, the important factor is how each incident fits within the bigger picture. For example, the incident of 24th April related to theft from the victim and though she mentioned an attack, she refused to give more information about it. In fact, this incident was the serious attempt to throttle the victim. The next incident of 7th May included criminal damage and threats to kill, plus the more detailed disclosure of the attempt to throttle her in April, so is correctly assessed as high risk. The next incident on 29th May was triggered when the perpetrator turned up at the house, in breach of police bail conditions. As the victim went out for a drink with him, was subsequently found safe and well, and insisted that "he had been fine", it was assessed as medium risk, though it was also noted that the "risk from the perpetrator may be high". The three incidents together demonstrate escalating abuse and the unwillingness of the perpetrator to accept that the relationship was over. The fact that the victim probably managed to diffuse the situation herself (by agreeing to go for a drink with him) does not reduce the overall level of risk. Though the incident of 7th May was referred to MARAC and discussed on 16th June, the repeat incident on 29th May was not brought to the committee's attention. Though it did not meet the CAADA criteria for a repeat incident (because no crime was committed) it was important information because of the breach of police bail conditions and indicated the level of risk. This was a missed opportunity that would have given agencies better information on which to make a judgement about overall risk and how best to

manage it, though it is unlikely that it would have changed the outcome for the reasons set out in TOR 1 above.

The perpetrator had a record of breaching community orders and police bail conditions, with warrants issued for his arrest in terms of breaching civil actions (CSA) this altogether provides a picture of an individual with little regard for authority or the law and suggests he believes he can act as he likes. This should be seen as a significant risk in itself.

It is known that attendance at court increases the risk to victims of domestic abuse and the assault on 22nd August occurred in the evening following his court appearance for the driving offences. The officer investigating the driving offences and overseeing the case should have recognised this potential increase in risk to the victim and considered engaging with the DAU around developing a risk management plan. However, it is doubtful if thus would have had changed the outcome as it is still unlikely she would have engaged.

The subsequent assault on 22nd August 2011 did result in the victim sustaining bruising and cuts, but she retracted her statement and said she believed he would change. CPS advised that the evidential test for pressing charges was not met due to inconsistencies in the evidence. The victim told police the perpetrator had told her that he was attending anger management sessions – however, there is no evidence to support this. The risk assessment of medium does not appear to adequately reflect the wider history, the incident was not recognised as escalation, and was not re-referred to MARAC. Had this incident been re-referred to MARAC, it would have created an opportunity for Children's Services to share the additional disclosures that had been made by the perpetrator's previous partners. Furthermore, this incident was just a couple of weeks prior to the date that the police decided to take no further action against the perpetrator for the May incidents, bail was cancelled and the IDVA closed the case. Had the case been re-referred to MARAC there would have been an opportunity for agencies to consider all of the new information that was available and discuss the level of risk going forward and agree how this could have been managed. Though this would have been better practice it is doubtful whether it would have significantly impacted on the outcome due to the reluctance of the victim to engage - the case was referred to WDVSS who made contact after 3 attempts, when the victim declined support and was allegedly angry at being contacted.

Subsequent contacts with any agency prior to the homicide were when the perpetrator was admitted to hospital and referred to mental health services, and the victim's overdose on 22nd December, this being the day the perpetrator was discharged from hospital. In both of these events there was a missed opportunity to respond to domestic abuse issues – though the indicators of abuse were recognised and recorded, there was a failure to complete a DASH risk assessment, and to put in place a strategy or offer signposting for appropriate support. It would also appear that no links were made to the case being known to MARAC – this raises issues about how cases are flagged and how medical staff can get easy access to information about known risks of domestic abuse. This does however raise issues about how large numbers of medical staff, including transient staff such as trainee doctors, can be sufficiently expert in domestic abuse issues, in addition to all the other elements of their roles. The answer to this is not necessarily more training, but

supporting front line staff with easy access to people who do have the expertise required – for example, in some areas of the country there have been trials involving IDVAs being based within A&E departments, who can respond quickly to referrals.

The review has also highlighted the emphasis on risk assessments being victim-focussed. Whilst it is essential that the victim is put at the centre of the assessment, this case also raises issues about serial abusers – that is, how are known perpetrators identified and how are the risks that they pose to others assessed? For example an initial incident may not be serious, but if it is perpetrated by someone known to present high risks to partners, how can this be factored in and influence the overall risk assessment and risk management plan? It should be noted that "Claire's Law" (where anyone can ask for access to information held by police about an abusive past) would not have assisted in the case, as the perpetrator had never been convicted of an offence relating to domestic abuse and there was only one previous incident on police records, which contained no detail.

It is known that the victim told her GP that she was being terrorised by an ex-boyfriend and that the police were dealing with it. This provided a further opportunity to offer signposting for support. We know from friends of the victim that she reacted badly to police referring her for support because she did not see herself as a victim. However, the different relationship someone has with a health professional may mean that they are more open to accepting advice or a referral for support, perhaps because it is not linked to the criminal justice system and pressure to press charges.

TOR3: To establish how easily the families of both victims and perpetrators of domestic abuse are able to access appropriate and timely support.

This case highlights the difficulties in providing support to someone who is unwilling to accept it, who believes that they can handle it alone. This is not uncommon – the cycle of abuse results in victims trying to manage the situation themselves, being unable to see a way out and being ground down and isolated from friends and family. Under no circumstances should a reluctance to engage ever be considered to be the "fault" of the victim or a sign that they really do not want support – it must be recognised that this is often a direct result of the impact of the abuse, and the victim being drawn into a controlling relationship. This does not alter the fact that agencies depend upon what the victim tells them, and that the sharing of information is within the victim's control. The review has identified that friends of the victim held information that was not known to the agencies. On all occasions, police made referrals to agencies offering support to victims of domestic violence – Refuge who provided the IDVA service to women at serious risk, and WDVSS, these being the organisations contracted to provide support in Warwickshire at the time of the incidents. There was a clear pattern of agencies making attempts to contact the victim and on the occasions that contact was made, she declined support. As records only identify brief details regarding contact, it is impossible for the Panel to judge the quality of the service offered – for example, we do not know what information was given to the victim, or whether she received advice on how to access support in the future if she changed her mind.

The Refuge IMR identified the pressures on the service to support high risk victims across the county. The service was commissioned to employ 2 IDVAs to support 120

of the 1200 high risk victims across Warwickshire, and priority was given to those cases where criminal charges were proceeding. The CAADA QA report identifies that 3.5 posts are required to cover demand in the Northern MARAC area, with 8 posts needed to cover the whole county, clearly indicating that the service is grossly over-stretched. All cases that do not meet the criteria for referral to the IDVA were referred to WDVSS, this being a generic domestic abuse support service with more staff and greater capacity. Some incidents were referred to IDVA and some referred to WDVSS and whilst this meant that different agencies attempted to offer support, there was a lack of clarity as to which agency was taking the lead role in trying to engage the victim. The countywide helpline was in place at the time providing a single point of contact for all affected by domestic abuse, including friends/ family and professionals. This number was publicly advertised and the police included it in letters to victims following police reports. Following the re-modelling of services in April 2012 the helpline now sits with the domestic abuse support service that provides all commissioned community based domestic abuse support for the county, from outreach through to IDVAs. The decision to reduce the number of contracts was to address the feedback from individuals that the pathways were too complicated with too many services and not knowing where to go. All agencies need to include the link to the Warwickshire Against Domestic Abuse website on their safeguarding websites.

The review identifies the lack of any feedback loop to alert referrers of a failure to make contact, or that support was declined. There was no multi-agency strategy in place to identify cases where there is a repeated failure to engage the victim in a high risk case.

We do know from friends that she had reacted very strongly to being referred to as a victim during one discussion with a police officer – that she considered herself to be strong, and that accepting help would be seen as a weakness. She was not seen by others as the stereotypical "domestic abuse victim". This theme was consistent across all family, friends and employer – those who were not aware that she was subject to domestic abuse were shocked by her murder as they had no suspicion that she was in an abusive relationship, assuming that a strong independent woman could not be subject to domestic abuse. Friends who were aware of the abuse and the level of risk felt helpless and are of the view that agencies must try and help someone understand the level of risk – *"if she was afraid, she wasn't afraid enough"….."any woman dealt with by the domestic abuse agencies should be told that in these circumstances most men will continue to be violent and the risks that they take by returning to these men are great".* However, friends had warned her of the risks, and when the she returned to the perpetrator she became isolated from her friends during the last few months of her life, including lying to people about being with him over the Christmas period. This raises a question about how friends and family can seek advice themselves from domestic violence agencies, on how they can best support someone in this situation, when the person themselves is reluctant to accept support. It also raises issues about how domestic abuse is portrayed in promotional literature and in the media, as this often reinforces the stereotypical image of a downtrodden, "cowed" victim.

Very often, when someone discloses abuse of any kind, it is a one off, unique opportunity to help them. This was highlighted in the police IMR – "*it is rare that*

police get more than one chance to obtain evidence for a specific incident from a victim of domestic abuse.....efforts were subsequently made to take a further statement but the nature of the relationship between victim and perpetrator had changed by that point, and she had changed her mind about pursuing the complaint, and providing information about the incident.". People change their mind for many reasons – perhaps because the perpetrator has shown remorse, or promised to change, or because they have thought through the consequences of pursuing action (in this case, the implications of involving children as witnesses), or because of fear of repercussions…..or simply because the victim doesn't believe the police have the power to make any difference. None of the incidents in this case resulted in immediate charges or an application for court bail. CPS guidance highlights that delays in processing charges will often increase the risk of withdrawal or retraction by the victim as well as potentially jeopardising the victim's safety.

There was clear evidence from friends that by September 2011, the victim believed that the police were powerless to stop him as they didn't have the grounds to arrest him, and bail conditions were ineffective in keeping him away from her – this will have increased her feeling of isolation. It would have required skilled support to persuade her that, only by pursuing complaints and providing sufficient information to support a prosecution, would the police be able to protect her through the criminal justice system. In future the new domestic violence protection orders (DVPOs) that will be rolled out across England and Wales from March 2014 could be used. Domestic violence protection orders are a new power that fills a gap in providing protection to victims by enabling the police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident. A perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

Despite the reluctance of the victim to accept support, she did disclose to her GP that she was "being terrorised" by an ex-boyfriend, and indicated to the clinician completing the psychiatric assessment on 23rd December that she was in an abusive relationship. Like many primary care patients, the victim had usually booked appointments with the same GP at the practice. The relationship with a GP or other health professional is very different to the relationship a victim would have with police, and provides a unique opportunity to discuss the issues with someone who isn't directly involved with the criminal justice element of incidents. These were missed opportunities to further explore the domestic abuse issues with the victim and signpost back for support from voluntary agencies, rather than just assuming that the issues are being dealt with through police involvement.

It would appear that the victim was not aware of the referral to MARAC and it is unlikely that she had consented to this. Discussion with the victim prior to the MARAC meeting would have created another opportunity to offer support, and would have given a clear message that agencies had serious concerns about her safety and considered her to be at high risk.

As the perpetrator and his family declined to be involved in the review, it is not possible to establish from their perspective what support may have made a difference. However, it is known that the perpetrator disclosed issues relating to

potential domestic abuse to health professionals, for example, he referred to relationship problems, “trashing the flat” and “grabbing his girlfriend”. However, these comments were not further explored and opportunities were therefore missed to either adequately assess the risk the perpetrator posed to the victim, or to engage the perpetrator in appropriate support to manage his anger and violence.

TOR4: To establish how well agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency practice, policies and procedures to improve the identification of, and safeguarding of, people subject to domestic abuse in Nuneaton and Bedworth, Warwickshire, and perhaps more widely, in the future.

The review has identified a number of weaknesses in the MARAC process and agencies implementation of MARAC procedures, and has identified changes that need to be made to strengthen inter-agency practice. Minutes show that two agencies did not attend the meeting when the case was discussed, and did not send deputies. Panel discussion also identified that, for some agencies, attendance appeared to depend on the interests of the manager concerned, rather than the agency being committed to sending a representative. However, most representatives do show a high commitment to attending the MARAC and sharing information within and across agencies.

The MARAC meeting of 16th June 2011 considered a high number of cases and it is questionable whether the case (30th on the list) could realistically receive the same level of discussion of cases earlier on the agenda. The minutes of the meeting were poor – they did not identify the victim’s consent to the referral, did not record the detail of the agency discussion, the risks posed, how these would be managed and by whom, or the rationale for decisions taken. There was a dispute identified in the IMRs regarding the accuracy of the actions agreed – i.e. implying that there were continuing attempts being made to contact the victim, which was not the case.

It is clear from the minutes and the IMRs that not all agencies had identified information that was known to them at the time and there was a failure to share information with the MARAC. In some cases, this was because the information sent to agencies did not include the names and dates of birth of the perpetrator’s children who were present during the incident. Delays in inputting data onto CATs meant that Children’s Services did not know the names of the children until the date of the meeting, almost 6 weeks after the incident.

Though the case had been correctly referred to the MARAC following the attempted throttling incident, information regarding the repeat incident of 29th May had not been shared, and neither was the MARAC meeting aware that the perpetrator had been arrested the day before the meeting and his bail conditions varied. This was critical information that would have enabled a more accurate multi-agency assessment of the risks. In the absence of this new information, combined with a lack of information being shared by agencies who also knew the perpetrator or victim, the MARAC made decisions without knowing the full situation and the extent of the risks. Regardless as to whether this would have impacted on the outcome, this identifies the need to improve practice.

The further incident in August 2011 was also not identified as a repeat incident and was not therefore re-referred to the MARAC. Had it been, it could be argued that agencies would have had further discussion and greater awareness of the risks posed by the perpetrator, including the sharing of information now held by Children's Services regarding the perpetrator's history of domestic abuse with his previous partners. Though it may not have made a difference to the outcome, this was a missed opportunity to review the risks and develop a more appropriate risk management plan, particularly given the increased risk posed by charges and bail conditions being dropped in September, leading to the closure of the case by IDVA.

The review also identified that procedures had not been followed when the Probation Service prepared a Pre-Sentence Report in August 2011, for an offence in February, where the perpetrator had left the scene of an accident, (whilst, it subsequently transpired, driving the victim's car without her consent). On that occasion the Pre-Sentence Report author completed the report without a risk screening, in contravention of expected procedures, which meant the history of domestic abuse and its possible connection to the car accident, was not identified. This emphasises the importance of inter-agency checks and in particular, with the Police Public Protection Team. It is unlikely that identifying the history of domestic abuse would have impacted significantly on the management of the case, but it would have alerted the court to the need for a brief adjournment to gather more information and could have triggered a different sentencing proposal. At the very least, it may have facilitated a more proactive assessment and management of the perpetrator's risk.

Though both the victim and the perpetrator had made disclosures to health professionals that identified indicators of domestic abuse, these were not followed up. Cases were not flagged, and though DASH risk assessments are routinely completed by police, the evidence suggests that other agencies, and particularly A&E, are not aware of the need to use these proactively to assess risks. This links back to the CAADA QA Report identifying the need to increase referrals to MARAC from agencies other than the police. If agencies are not aware of the history of abuse and previous referral to MARAC, they are not going to be aware of the need to refer repeat incidents – incidents that may not necessarily have been reported to the police. Generally, the review highlights a broad lack of awareness and training across agencies relating to domestic abuse.

TOR5: To identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office

A critical factor in this case was the fact that a breach of police bail is not a crime and that the police are powerless to take action unless a crime has been committed, other than remove the perpetrator from the scene. This appears to have had a significant impact on the victim, who told friends that police were unable to stop him from returning to her property. Breach of bail conditions is however a key indicator of risk, and in this case was part of a wider pattern of the perpetrator breaching community orders and appearing to have a total disregard for the criminal justice system. Of all the questions listed on the DASH Risk Assessment currently used in

Warwickshire, breach of bail conditions is not considered to be a high risk indicator. Furthermore, if breach of bail conditions does not result in a crime being committed, the incident doesn't meet the CAADA definition of a repeat incident that requires to be reported back to MARAC. This is a gap that needs to be closed. This raises national issues relating to the sanctions that police need to be able to employ when police bail conditions are breached, as well as issues that need to be addressed within CAADA guidance on repeat incidents, especially in cases where the initial statement/evidence is insufficient for immediate charging and an application for court bail. However, the roll out of Domestic Violence Protection Orders may offer a better alternative to police bail in the future.

The biggest barrier to completing the DHR within the recommended timescale was the delay in waiting for the completion of the trial due to the impact of the mis-trial. This not only delayed the involvement of family and friends, who are listed as potential witnesses in the trial, but in this case, CWPT were asked to delay their Serious Incident Review, which in turn impacted on the agency's ability to effectively complete an IMR. Whilst it is understandable that the trial must not be jeopardised, and the key factor in that case was the need to establish the impact of the perpetrator's mental health, this meant that, by the time the Serious Incident Review and IMR were completed, some staff had left the organisation, or could not recall detail due to the time lapse. Contact with family and friends also took some time to arrange to enable people to contribute at their own pace.

Some agencies, particularly some health agencies, do not seem to understand the requirement to co-operate with a DHR, with delays in receiving information whilst the agency took advice from its Caldicott Guardian or legal team. In one case this resulted in the query being passed around several managers in the organisation, with no-one knowing who was responsible for making the final decision to release the information to the panel. This was particularly a problem in relation to releasing information about the perpetrator where the standard response is to refuse to disclose information without consent with no consideration of the public interest.

SECTION 4: CONCLUSIONS & RECOMMENDATIONS

4.1 Conclusions & Lessons Learnt

The general consensus of the review panel was that serious harm to the victim could have been predicted but it is less clear as to whether homicide could have been predicted, and that agency intervention is unlikely to have prevented the victim's death, given the information that has come to light through the review. No single agency held the full information about the circumstances, some of which was only known to the victim and friends. It is difficult to judge whether, had full information been shared in a timely manner, the multi-agency picture would have been different. There was a history of domestic abuse and clear evidence that the victim was at high risk of serious harm, based on the following factors:

- there had been a serious throttling incident and repeated threats to kill
- there was an emerging pattern of escalation
- the victim stated in May 2011 that he would kill her
- the evidence from friends suggest that the risks were very high – he was perceived as dangerous and they, and the victim, believed he was capable of killing her
- there was evidence from mental health services that the perpetrator had issues relating to anger and the breakdown of relationships
- the victim was trying to end the relationship

However, this is a fairly typical profile of many similar high risk domestic abuse cases referred to MARAC. The probability of homicide in similar cases with these factors is usually low, though this statement needs a cautionary note as it is not known whether this is because the risks were not as well managed in this case compared to other cases, and the risks would have been increased due to the victim's lack of engagement with support agencies. Though the review has identified a number of weaknesses in inter-agency practice related to domestic abuse, including improvements that are required to the MARAC process and how agencies implement MARAC procedures, the panel does not feel, on balance, that this would necessarily have impacted on the outcome. The Panel believes that the homicide could not be prevented for the following reasons:

- The pattern and extent of the abuse was only known to the victim and a few close friends – when police were involved, the victim was reluctant to provide detailed evidence to support charges and would usually withdraw complaints
- There were regular attempts by support agencies to engage the victim and offer support – she did not see herself as a victim and was clear about her decision to decline support
- Despite appearing to understand the level of risk posed by the perpetrator (i.e. predicting that he would kill her and understanding that he was capable of doing so), she also appeared to believe that she could handle him.

None of this is unusual within a cycle of abuse and creates challenges for statutory agencies and voluntary organisations within the field of domestic abuse to reach out

to victims and work effectively with them to both fully identify the risks and to put in actions to reduce them.

The lessons learnt by each individual agency have been set out in agency reports along with individual agency recommendations for improving both internal procedures and multi-agency working. This section summarises the overarching lessons that have been learnt from the review. Though it is unlikely that these would have impacted on the outcome, it is clear that practice could be improved and could therefore make a difference to how victims at risk of serious harm or homicide are supported across Warwickshire in the future.

4.1.1 The implementation of MARAC processes by agencies, and the MARAC administrative procedures that were in place at the time, were inadequate

Multi-Agency Risk Assessment Conferences (MARAC) are a mechanism by which agencies come together in a partnership forum to consider high-risk domestic abuse cases. The purpose of the MARAC is to share information across agencies, to identify risks and to develop a safety action plan to support the victim. Though not a statutory requirement, they overlap with statutory processes. CAADA (Co-ordinated Action Against Domestic Abuse) is a national charity that provides professional advice and support to agencies, including good practice guidance. CAADA also operates a Quality Assurance programme, assessing the performance of the local MARAC against the standards of practice.

The effectiveness of the MARAC hinges on 2 elements – robust local procedures that support best practice, and agencies implementing them correctly. There were significant weaknesses in the administration of the MARAC and how procedures were implemented, and this was not in line with CAADA best practice. In summary this included:

- Absence of some agencies from the meeting
- Agencies not sharing information known to them
- All known information about the case not being shared resulting in the MARAC making decisions about risk that were not based on all the facts
- Lack of information regarding the victim's consent to share information
- Lengthy agenda (38 cases)
- Poor minute taking and no record of the risks posed and the rationale for decisions and actions taken
- Failure to refer repeat incidents

Research[3] into supporting high-risk victims of domestic violence indicates that MARACs (and IDVAs) have the potential to improve victim safety and reduce re-victimisation and therefore may be a highly cost-effective measure. The research identified that the three areas that are central to a MARACs' effectiveness are enhanced information sharing, appropriate agency representation, and the role of the IDVA in representing and engaging the victim in the process. Factors which were seen as supporting effective practice included having strong partnership links

[3] Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs) *Nerissa Steel, Laura Blakeborough and Sian Nicholas*

(including a commitment from agencies to tackle domestic violence in general), strong leadership (through the MARAC chair), good co-ordination (through a MARAC co-ordinator) and the availability of training and induction. The findings of this review are consistent with this research.

4.1.2 Information that was known by agencies was not shared in a timely way.

This issue has been highlighted in relation to the sharing of information at the MARAC, as referred to in 4.1.1 above. However, the failure to effectively share information extends beyond the formal MARAC process and was a key theme across agencies. There were delays in inputting data onto the CATS database resulting in a delay of almost 6 weeks before Children's Services were aware of the names of the children who had witnessed abuse. Inter-agency checks were not properly completed by the officer from the Probation Trust as part of the pre-sentence screening. The case was not flagged, so health professionals were not aware of the history of domestic abuse when this was disclosed to them. There is also a lack of clarity as to how health agencies, particularly A&E, communicate with each other and share critical information. Each of these examples relate to circumstances when it was quite lawful to share information. Info sharing in itself will not always reduce risk - on receipt of the information agencies need to use the information and respond through action e.g. updating safety plan, flagging files to alert members of staff, welfare check instigated etc..

It is, however, also important that agencies make informed decisions about sharing information and only share when it is safe to do so, preferably with the victim's consent, to ensure that the victim is not placed at greater risk. This requires a greater understanding by agencies, and front line staff, about the nature of domestic abuse and how this aligns to the Data Protection Act. There seems to be a real issue for NHS agencies regarding sharing information with each other, and not just with external agencies. The new Code of Practice on information sharing in the NHS is due to be published shortly by the Health and Social Care Information Centre (HSCIC) and should give some clarity on this issue.

4.1.3 There were missed opportunities by agencies to identify indicators of domestic abuse, or when they did, to assess the risks or develop appropriate strategies to address the issues or offer timely support.

All agencies should ensure that all front line staff are able to spot the signs of domestic abuse, know how to identify the risk that a victim is experiencing and be able to take quick and effective action to manage this risk. The Home Office publication "Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned" identifies that there appear to be gaps in awareness and understanding of what constitutes domestic violence and abuse especially where the power and control aspects of domestic violence have not been recognised. This finding is mirrored in this case, with a pattern of the perpetrator using fear and threats rather than regular physical violence.

The victim had made disclosures to her GP and other health professionals, but on each occasion does not seem to have been asked for more information, and disclosures were not followed up or referred on to the appropriate agencies. This

suggests a culture whereby it is perceived that domestic abuse sits outside of the role, or is perceived as a private matter. This has identified the need for improved training and awareness on domestic violence and abuse for GPs and healthcare professionals as well as flagging the importance of front line staff being able to easily access specialist support when required. However, this also needs to be supported by senior management ownership of the issues. It is essential that GPs are aware of the guidance published by the Royal College of General Practitioners (RCPG), Identification and Referral to Improve Safety (IRIS) and CAADA on responding to domestic violence. Clinical Commissioning Groups can also commission the IRIS project, which is a general practice-based domestic violence and abuse training support and referral programme, based on collaboration between primary care and third sector organisations specialising in domestic violence abuse. The Department of Health is also funding some roll-out of IRIS through its Innovation, Excellence and Strategic Development (IESD) Fund.

The role of the IDVA service is critical in supporting front line staff with specialist advice, as well as reaching out to victims of abuse. Ideally, the IDVA service should be used more flexibly – for example by being available where victims are most likely to disclose abuse, such as in A&E departments or GP practices. However, this has resource implications for services that are already seriously over-stretched. In the Government Action Plan to end violence against women and girls[4] the Home Office has committed to provide £3.3m in every year up to 2015 for IDVAs and MARAC co-ordinators, who provide vital support to high-risk victims of domestic violence. Warwickshire County Council received funding for IDVAs in the 2011/12 – 2014/15 allocation – however, this funding was only sufficient for one part time IDVA post across the whole County. Given the current economic climate, and further cuts to public spending, it is highly unlikely that resources will be available to increase the current IDVA service to meet CAADA recommendations.

4.1.4 The inability to apply sanctions following breaches of police bail conditions led to the victim believing that police were powerless to act

CPS guidance highlights that delays in processing criminal charges will often jeopardise the victim's safety and will increase the risk of the victim withdrawing from the process and retracting complaints. In the event of criminal charges resulting in an initial court appearance, a bail hearing will be held whereby the court may impose bail conditions prohibiting the perpetrator from contacting the victim, known as Post-Charge Bail. However, this is only an option once the CPS have reviewed the case and made a decision to charge.

Police bail, known as Pre-Charge Bail, can be used in three scenarios:

- where there is insufficient evidence to charge with an offence and it is necessary to continue to investigate without the suspect having to be held in custody (s 37(2) PACE)
- where the police consider there is sufficient evidence to charge but the case has been referred to the CPS for a charging decision (s 37(7)(a) PACE)

[4] Call to End Violence to Women and Girls: Action Plan, HM Government March 2011

- Where there is sufficient evidence and the person is charged with an offence (s 37(7)(d) PACE).

Police are required to refer all cases of domestic abuse to the CPS for a decision to charge. It is not therefore unusual for alleged perpetrators of domestic abuse to be released on police bail subject to ongoing police investigation, and pending a decision from CPS. In this case, the reported incidents required further police investigation before charges could be considered, with the CPS asking for further statements. Police followed the correct process, submitting evidence to the CPS for consideration. On each occasion, the CPS advised that the evidential test was not met. The victim was generally reluctant to provide information to the police, and usually withdrew her complaint fairly soon after her initial statement. CPS guidance was followed by the police on each occasion, to interview the victim and obtain a statement of retraction. Throughout the process, the perpetrator was released on police bail with conditions not to contact the victim or go to her address. The bail conditions relating to the May incident were varied over time, before being lifted in September 2011 when the decision was taken to not proceed with charges.

The police have a power of arrest where conditions imposed on pre-charge bail have been breached (see section 46A PACE 1984 as inserted by CJPOA 1994 Section 29 (2)). Where a person has been re-arrested, section 37 C (2) (b) PACE gives the police the power to release (again) "without charge, either on bail or without bail". Section 37 C (4) states explicitly that if a person is released on bail under section 37 C (2)(b), then that person shall be subject to whatever conditions applied before the 're-arrest'. It appears that there is no power to change conditions of bail at this point. This contrasts sharply with a breach of court bail (post charge bail) - Section 7 of the Bail Act 1976 confers power upon the Police to arrest a person if there are reasonable grounds for believing that that person is likely to break any of the conditions of his bail or has reasonable grounds for suspecting that that person has broken any of those conditions. A person so arrested must be brought as soon as practicable, and in any event within 24 hours of his arrest, before a Justice of the Peace of the Petty Sessions for the area in which he was arrested.

Police bail conditions do not therefore have the same sanctions as court bail conditions – the perpetrator can be removed from the premises, but unless a criminal offence is committed, will simply be released again on bail. On each occasion, the victim stated that she was safe, implied the perpetrator was there with her consent, and that the perpetrator was “fine”. CPS guidance makes several references to breach of bail conditions as an indicator of high risk, along with abuse happening in the presence of children and threats being made after the attack. All three risk factors were present during May 2011.

The evidence presented to the Panel clearly indicated that the victim felt that the police were powerless to protect her from the perpetrator. She was aware that no action was taken against him for breaching bail conditions, and that the police had no powers to hold him in custody. As she also felt unable to accept support from the IDVA, and became more isolated from friends, her sense of isolation would have been significant. This is a significant issue and a breach of police bail conditions should result in some kind of sanction, initiate a new risk assessment and potentially be considered as a reason for re-referral to MARAC.

4.1.5 Each incident was risk assessed in isolation of the wider history and circumstances

Risk assessment is not a predictive process and there is no existing accurate procedure to calculate or foresee which cases will result in homicide or further assault and harm. However, a number of high risk factors have been identified as being associated with serious harm and homicide through researching many cases. Warwickshire uses the DASH (Domestic Abuse Stalking and Honour Based Violence) Risk Assessment, which is aligned to the Association of Chief Police Officers policy. Any professional using the DASH risk identification checklist must be trained in its use. This is crucial to understanding what the high risk factors are and how they apply in each situation, and what needs to be done to keep the victim safe.

Each incident reported to the police was assessed using the DASH process. The review identified some inconsistencies, with risks changing over time, due to each incident being risk assessed separately as a specific incident. As the Domestic Abuse Unit maintains a database of high risk victims, there should be oversight of all incidents relating to a named victim. However, it is still essential that the overall risk to the victim is assessed taking into account the history and all episodes. This is especially important in cases where intimidation and harassment are being used to create fear – for example, minor damage to property, texts or contact with the victim may not be perceived to be serious threats, or even constitute a criminal offence, when considered in isolation, but build up a pattern of abuse that indicates a high level of escalating risk to the victim. It is essential therefore that DASH risk assessments take into account the whole circumstances, and are used at other key points – for example, when the victim withdraws her complaint, when bail conditions are breached, and when a decision is made not to charge and/or rescind bail conditions. It is essential that any risk assessment should also consider the risks posed by the perpetrator, not just assessed from the victim's perspective.

The review identified that, though DASH was used routinely by police, it was not used by other agencies. This included episodes when the victim disclosed abuse to health professionals, including when she attended A&E. Though the indicators of abuse were recognised and recorded, no risk assessment was completed and no action taken to protect or support the victim. In some instances, this may have been because the victim referred to the police already being involved – however, this information, or assumption, should not prevent front line staff from completing the risk assessment and offering support to the victim. Given the different relationships with health professionals the victim may disclose additional information to them, leading to a higher risk classification. It is known that some victims disclose different information to different professionals, sometimes to tell just enough, but not enough to raise high concerns. No professional should assume that just because the police are involved or have risk assessed that the victim has disclosed everything. As risks can change over time, especially if there is an escalation of incidents, each agency should always do their own assessment. The Panel also noted that when Children's Services identified a history of abuse against previous partners, that DASH was not used to assess risks. In cases where perpetrators have continued contact with ex-partners due to contact with their children, there may continue to be risks to both the

victim and her children. It is essential therefore that DASH is used to identify risks and ensure that safety management plans are implemented where required.

4.1.6 There was a failure to refer repeat incidents to MARAC, who did not therefore have the full information available to enable an effective understanding of the escalation of risk and to develop an appropriate risk management plan

Nearly 1 million women experience at least one incident of domestic abuse each year as reported in latest cross-government Violence Against Women and Girls Strategy. Victims of domestic violence are more likely to experience repeat victimisation than victims of any other types of crime (British Crime Survey Reports), and 76 per cent of all Domestic Violence incidents are repeat[5]. Women experience an average of 35 incidents of domestic violence before reporting an incident to the police[6], with a third of all incidents being reported to the police being repeat incidents.

Since 2001 the CPS has issued clear guidance to prosecutors on bringing domestic violence cases that makes it clear that whatever form it takes, domestic violence is rarely a one-off incident. It is often a series of incidents, often increasing in frequency and seriousness, capable of a cumulative effect on the victim. Indeed the new national definition of domestic violence and abuse which was adopted in March 2013 was drafted to recognise this very point:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

CAADA defines a case at MARAC as one between the same victim and perpetrator(s), where the victim has been identified as meeting the MARAC threshold for that area. A repeat MARAC case is one which has been previously referred to the MARAC and at some point in the twelve months from the date of the

[5] Flatley, Kershaw, Smith, Chaplin and Moon (July 2010) BCS - Crime in England and Wales 2009/10, Home Office
[6] Yearnshaw 1997

last referral a further incident is identified. Any agency may identify this further incident (regardless of whether it has been reported to the police). A further incident includes any one of the following types of behaviour, which, if reported to the police, would constitute criminal behaviour:

- Violence or threats of violence to the victim (including threats against property)
- A pattern of stalking or harassment
- Rape or sexual abuse

Where a repeat victim is identified by any MARAC agency, that agency should refer the case to the MARAC, regardless of whether the behaviour experienced by the victim meets the local referral threshold of visible high risk, escalation or professional judgement. To identify repeat victims of domestic abuse regardless of to whom it is reported, all MARAC agencies should have the capacity to 'flag and tag' their files following the latest referral so that they are aware if a service user/client experiences a repeat incident.

The review has identified an issue with the definition that the "further incident would constitute criminal behaviour" – in the case of the incident of 29th May 2011, though there was clear evidence of breach of bail conditions, there was no identifiable criminal offence. The incident, however, occurred before the MARAC meeting and so should have been reported to MARAC regardless of whether the definition was met, to ensure that agencies were aware of the full information to inform their discussion. The further incident in August 2011 was not reported to MARAC as a repeat incident, though the CAADA criteria was met, regardless of whether or not it resulted in charges.

4.1.7 There were no strategies in place for identifying and engaging high risk victims who repeatedly decline support.

People who are not abused find it hard to understand why anyone would stay in an abusive relationship or refuse to co-operate with police to enable criminal charges to be successfully pursued. Victims are often wrongly blamed for failing to engage with support agencies. However, a reluctance to engage can be for many reasons - abusers use verbal, emotional, and physical violence along with apologies, promises, and affection to control their victims. A victim may feel that the abuse is their fault, or hold on to the hope that the abuser will change. Along with abuse, there may be genuine love. Victims may feel tremendous shame and embarrassment and use denial as a way of coping with the abuse. Above all, abuse wears people down; the victim develops strategies to try to manage the abuse, and falsely believes that they can handle it better alone. Abusers isolate their victims from friends and family, and this may be reinforced when friends also feel powerless to help someone who returns to the abuser against their advice.

Existing research indicates that MARACs and IDVAs have the potential to improve victim safety and reduce re-victimisation. However, this tends to depend on the successful engagement of the victim in the process. In this case, attempts were made to engage the victim and provide support – this was timely though usually limited to between one and three attempts to make contact. On the occasions that

contact was made, the victim declined support. There was clear evidence from friends that she reacted strongly to being referred to as a “victim” and considered herself strong enough to cope alone. This raises a number of issues about engaging victims successfully as clearly it is victim’s choice and decision to decline support and as such must be respected. The case identifies the need to develop a strategy that addresses the following issues:

- The publicity relating to domestic abuse – often using images of women who meet a stereotypical perception of a “battered woman” rather than highlighting that domestic abuse may be a hidden secret of many women, regardless of class, ethnic origin or wealth
- Maintaining a balance between respecting personal choice and ensuring easy access to support services
- The importance of developing trusting relationships over time with those in regular contact with the victim
- Being clear about which agency is responsible for case management and what strategies are being deployed to engage the victim
- The level of resources available to support victims and ensuring that they are deployed in the most efficient way to avoid duplication of efforts, or assumptions that another agency is offering support

4.2 Recommendations

The recommendations of the panel are set out below. The Panel analysed agency IMRs during the first stage of the DHR, prior to the mis-trial that caused a lengthy delay in completing the review. It should therefore be noted that many of the recommendations set out in this report have already been implemented by the MARAC and by key agencies. The Action Plan arising from this review will therefore give timescales that may pre-date completion of the report. It is not the role of the DHR Panel to confirm or evidence which actions have already been completed - the Nuneaton & Bedworth Community Safety Partnership will need to assure itself that these actions have therefore been fully delivered.

There were some common themes identified leading to a duplication of recommendations across agencies. These have been grouped together recognising that some recommendations may be a bigger issue for some agencies than others. Agencies may wish to consider working in partnership to action some of these recommendations to share learning and solutions.

Safer Warwickshire Partnership Board

1. Safer Warwickshire Partnership Board to develop Domestic Violence and Abuse Procedures that include:

    a. Clear, written policies for all agencies in the county explaining when and how to refer to specialist domestic violence support services e.g. Refuge (for accommodation services) and Stonham Home Group (the organisation now running IDVA and outreach services in the county) to ensure vulnerable victims do not fall between services.

b. A process to ensure that feedback is requested and given on the outcome of referrals, especially if no contact can be made or support is declined, so that alternative options can be explored.
c. A reminder to officers/agencies investigating or reporting domestic abuse incidents of the importance of recording the full names and home addresses of any children witnessing domestic abuse – this is especially important when they are visiting a parent and are not residing at their usual home address

2. Safer Warwickshire Partnership Board to direct the MARAC Steering Group to take the following actions to improve the DASH risk assessment process and :

    a. Develop and implement multi-agency training on the use of DASH to assess risks and ensure that risk assessments are
        i. in line with CAADA guidelines
        ii. use professional judgement in cases where the victim is unable or reluctant to fully disclose information that might highlight the risks more
        iii. take into account the history and full circumstances of the case
        iv. repeated when circumstances change – i.e. following a withdrawal of statement, a breach of police bail conditions and when a decision is made not to charge
    b. Explore the options for developing risk assessments of the risks posed by perpetrators, and linked to this, the identification of serial abusers.

3. Safer Warwickshire Partnership Board delivers a public awareness campaign (e.g. production of information leaflets / posters which can be distributed throughout agencies) that addresses the myths about stereotypical victims of abuse.

4. Safer Warwickshire Partnership Board develops an Information Sharing Protocol, with accompanying guidance, for all partner agencies regarding sharing information within DHRs. This should include guidance on collecting information in a timely way so that any information that cannot be shared with the Panel pre-trial has been secured internally, thus avoiding the difficulty caused by staff moving on or forgetting detail.

5. The Chair of the Safer Warwickshire Partnership Board raises with the Home Office and with CAADA the following national concerns:

    a. The lack of sanctions available to police regarding breaches of police bail.
    b. The need for CAADA to revise the guidance on the definition of repeat incidents, to include incidents where bail conditions have been breached

6. The Chair of the Safer Warwickshire Partnership Board raises with the CPS the following national concern: that the CPS explores whether there are opportunities to speed up the process for progressing charges to reduce the risks of withdrawal or retraction

Warwickshire County Council – Community Safety and Substance Misuse

7. Warwickshire County Council, as the commissioner of domestic abuse services, completes a review of the IDVA service to ensure that resources are maximised and deployed effectively to adequately support high risk victims across the County. This should include exploring alternative, flexible models of multi-agency support. The findings of the review should be reported to the Safer Warwickshire Partnership Board and identify the strategy for managing workload within the context of diminishing resources.

MARAC Steering Group

8. The MARAC steering group develops and ensures implementation of an induction programme for new MARAC agencies and representatives to support them in understanding their roles and the requirements of MARAC agencies.

9. The MARAC steering group implements the following improvements to MARAC processes and procedures, ensuring that these are all compliant with CAADA guidance and checklists:

    a. Completes and circulates the revision of the MARAC Operating Protocol
    b. Completes and circulates the MARAC Information Sharing Protocol
    c. Improves and re-formats the MARAC minutes template to ensure that it includes:
        i. Whether the victim is aware of the referral
        ii. The contribution of each agency
        iii. Detail of the discussion of the case
        iv. The rationale of why actions were not pursued
        v. The risks identified, how these risks will be addressed, by whom and by when
        vi. Identification of the support agency for the victim to feedback the outcome of the MARAC to the victim
        vii. That clear SMART action points are included in MARAC minutes following all MARAC meetings to prevent ambiguity.(refuge)
    d. Clearly defines the role of the IDVA in relation to the MARAC, including the requirement to contact the victim prior to the meeting and to ensure that there is clarity about ongoing contact
    e. Makes a formal decision regarding the flagging of files, and inform all agencies of the outcome and the procedure for doing so
    f. Reminds all agencies of their responsibilities relating to attendance, including sending deputies and/or written notes in the absence of the usual representative
    g. In view of the high number of cases referred to the North MARAC, to split the monthly meeting into 2 (if less than 20 cases referred, the second meeting can be cancelled).
    h. Completes a feasibility study as to whether a multi-agency web-based database for MARAC cases (e.g. Paloma's MODUS database) would be beneficial.

10. The MARAC steering group develops a robust process for identification of MARAC repeat cases from other agencies along with subsequent MARAC referral, as part of the MARAC Improvement Plan.

11. The MARAC steering group ensures that all recommendations of the CAADA Quality Assurance assessment have been implemented.

Warwickshire Police

12. Warwickshire Police review the investigative decision-making process relating to 'high risk' domestic abuse incidents, to ensure that the appropriate level of skill and type of resources and supervision is allocated to each specific Domestic Abuse investigation.

13. Warwickshire Police ensure that the findings of the review of the police Referrals & Assessment Unit (RAU), which identified the need for better levels of supervision and processes to facilitate more efficient management of caseloads of staff, has been fully implemented, including:
    a. Development of a policy that identifies acceptable levels of inputting backlogs dependant on risk level, and that includes a mechanism for reporting when the levels are exceeded.
    b. Embedding the new process that has already been introduced to actively manage and triage any backlog to identify any case that relates to either a pre-existing or subsequent 'high risk' incident is working effectively
    c. That the business case to introduce a new structure within the RAU with dedicated supervisory roles has been fully implemented. (This was accepted as part of the new joint policing arrangements between Warwickshire Police and West Mercia Police with new posts to be in place by December 2013.)

14. Warwickshire Police share the learning points from the IMR and the DHR as a whole with all police officers and staff using DASH to ensure that the risk assessments are applied with consideration of all available information.

15. Warwickshire police ensure that they take positive action to:

    a. Arrest perpetrators of all alleged crimes relating to domestic violence when the opportunity arises
    b. Collect all available evidence including at initial call-out to increase chance of prosecution (always assume the victim will not support the prosecution.)

16. Warwickshire Police to review the DASH "aide memoire" card to include breach of bail conditions as a high risk indicator

Local Criminal Justice Board

17. The local Criminal Justice Board to improve the process for completing inter-agency checks by:

    a. Considering prioritising resource allocation to the information exchange process

b. Liaising with the HMCTS/sentencers to tolerate adjournments for this to take place where it is recommended by the Probation Court Duty Officer

Probation Trust

18. The Probation Trust ensures that the actions, set out below, that were agreed in relation to the Serious Further Offence (SFO) investigation have been fully implemented in line with agreed timescales:

    a. Previous convictions must be used to inform every Pre-Sentence Report risk screening or their absence should be noted and corrected as soon as possible:
        i. All court duty staff to be reminded of this core practice expectation
        ii. Take appropriate internal action in relation to the conduct of officers not following procedures
        iii. Area Office Administrators to review court administrative practice to ensure pre cons are collected and passed to Unpaid Work immediately post sentence
        iv. Unpaid Work operational managers to be reminded that previous convictions must be checked before risk screenings are signed. Also that in signing risk screenings they are confirming they are satisfied themselves that the information is accurate

    b. Address the potential for inconsistency and inappropriate judgements in relation to enforcement when offender reporting illness or death of significant others: the Unpaid Work manager to circulate guidance to all operational managers on decision making in relation to this issue.

    c. Ensure that these requirements are incorporated into new contracts/SLAs with the new Community Rehabilitation Company.

19. That information provided by friends and family is shared with the Offender Manager who is preparing post-sentence assessments as this will be of significant help in developing the perpetrator's profile.

George Eliot Hospital

20. George Eliot Hospital develops and implements a Domestic Abuse Policy and seeks multi-agency validation via members of the Review Panel to ensure that the policy is fit for purpose and reflects best practice.

21. George Eliot Hospital targets front line staff in A&E with specific domestic abuse training to enable them to identify people at risk and initiate appropriate supportive and preventative actions.

22. George Eliot Hospital put in place appropriate training for senior managers and ensures that there is effective leadership to support cultural change within the organisation to improve practice in domestic abuse cases.

23. George Eliot Hospital puts in place procedures to ensure that correspondence from A&E to GPs is legible and forwarded without delay following presentation of a patient with serious issues such as self-harm, a suicide attempt or abuse.

24. George Eliot Hospital to either explore the possibility of an IDVA being based on site, or to put in place a procedure by which A & E staff can contact the on call IDVA.

ALL AGENCIES including Warwickshire Police, Probation Trust, Coventry & Warwickshire Partnership Trust, George Eliot Hospital, West Midlands Ambulance Service, South Warwickshire Nhs Foundation Trust, Harmoni, Warwickshire County Council, Nuneaton & Bedworth Council, And Children's Services

25. All agencies disseminate the learning from this DHR and review the recommendations to identify any changes that need to be made to their internal practice or procedures

26. All agencies ensure that all 'client facing' staff, particularly those undertaking assessment, complete training regarding Domestic Violence and Abuse (DVA) awareness that is in line with the NICE Guidance (Feb 2014), proportionate and relevant to their role. This needs to include:

    a. Understanding of indicators of domestic abuse from the perspective of perpetrators and / or victims, and the impact upon victims, particularly children
    b. Responding to disclosures of domestic abuse including knowledge around specific assessment tools such as DASH, support services available and professional responsibilities.
    c. Explicitly highlighting domestic abuse issues in the current safeguarding sessions delivered within induction to all staff, and including awareness of how to access specialist advice and support that is available both within and external to the agency

27. All agencies review administrative procedures and support within front line services to ensure that correspondence to other agencies is completed within an appropriate timescale.

28. All agencies include a link to the Warwickshire Against Domestic Abuse website on their safeguarding website.

Warwickshire North Clinical Commissioning Group and Local Area Team

29. The CCG and Local Area Team, as the commissioner of primary care services, ensure through their contractual arrangements that all GP practices are aware of, and complying with, guidance published by the Royal College of General Practitioners (RCGP), Identification and Referral to Improve Safety (IRIS) and CAADA on responding to domestic violence

30. The CCG considers commissioning the IRIS project, which is a general practice-based domestic violence and abuse training support and referral programme, based on collaboration between primary care and third sector organisations specialising in domestic violence abuse. The CCG should note that the Department of Health is also funding some roll-out of IRIS through its Innovation, Excellence and Strategic Development (IESD) Fund.

31. The CCG and Local Area Team, as the commissioner of primary care services, disseminates the learning from this DHR to all GP practices within the County and request that GP practices implement the following improvements to their administrative procedures:

    a. When information in relation to correspondence is added to the electronic records a note of the date the information is received must be made in the record.
    b. To introduce a flagging system for Domestic Abuse history to be recorded on the electronic record system
    c. GP practices to consult their Software producer for the GP practice IT system to identify if an update to the electronic records system can be made to enable the system to make automatic links of registered patients by address
    d. Safeguarding and Domestic Abuse training to be completed by all staff at the primary care practice, including awareness of MARAC process.
    e. To introduce a system to ensure that unreadable & unclear correspondence received is requested in a legible format from the agency sending correspondence and to escalate concerns if a pattern or theme is spotted with an agency.

32. The CCG and Local Area Team, as the commissioners of health services, put in place measures to improve the sharing of information between health agencies around domestic abuse and violence, including:
    a. Disseminating the new Code of Practice on Information Sharing within the NHS, when this is issued by the Department of Health
    b. Focussing specifically on the context of deliberate self-harm and other mental health assessments within A & E.
    c. Working with NHS providers to improve communication between services to highlight potential at risk individuals and families so these cases can possibly be picked up using early warning signs, including links to any “frequent flyer” programmes. This applies in particular to communication across mental health, A & E, GP and substance misuse services.
    d. Reducing delays in sending correspondence to GPs especially related to a serious incident such as attempted suicide
    e. Improved clarity for the respective agencies of follow up arrangements following an attempted suicide with less reliance on the patient to make contact for follow-up
    f. To ensure that reduced staffing services over Christmas and New Year or other holiday periods do not negatively impact upon communication to other health and social care agencies

33. That the CCG ensures that all NHS providers have a Domestic Abuse Policy in place as a contractual requirement.

34. The CCG/Local Area Team circulates information about the MARAC process to all GP practices along with the new CAADA Guidance for GPs.

35. The CCG, through the Health Panel, takes action to improve awareness of domestic abuse at a senior management level to ensure better leadership and cultural change across organisations. This could be linked to implementing the NICE guidance which is due to be published in February 2014 and should include embedding domestic abuse in the "Making Every Contact Count" approach to addressing health inequalities.

Warwickshire County Council - Children's Services

36. Children's Services ensure and reinforce that Children's Teams follow the existing guidance in respect of referrals where children may be at risk of significant harm and the protocol for Domestic Abuse referrals in a timely manner.

37. Children's Services to develop guidance/ process for frontline staff to support them in risk assessing victims when domestic abuse is disclosed by clients/ children. This should also extend to when historic abuse is disclosed by a partner who still has contact with the perpetrator due to child access arrangements.

Author: Kathy McAteer
Independent Social Care Consultant

Date: 29th January 2014