Safer Sandwell Partnership

# Domestic Homicide Review Overview Report

## Marie (December 2018)

*"Marie was such a loving, bubbly, fun and kind person. She would always help anyone and everyone and was a wonderful daughter and sister. She adored her children, but he prevented her from being the mother she wanted to be and no doubt would have been.*

*We cannot put into words how much she is loved and how much she will always be missed."*

(Marie's family)

**Please note that this document contains descriptions of violence, including sexual violence, which people may find distressing.**

# Marie's thoughts – July 2014

*"My life has been completely turned around since [the perpetrator] was arrested, if I continued with him I would have ended up continuing to smoke crack cocaine and using heroin when I was on a comedown from the crack cocaine. I wish I had an image of myself before he was arrested compared to the way I look now, I am such a different person. My relationship with [the perpetrator] was the worst relationship I had ever been in, I never thought I would end up living on the streets with him but I did. I wasn't happy for the whole 2½ years we were together. I gave him everything I had and he took everything away from me, giving nothing back in return. I don't ever want to go back to that life. I want to be free to make my own decisions, to make my own mind up, to ask others for help when I need it and to never be in fear of anyone again.*

*During my relationship with [the perpetrator] he would want to know where I was going and who I was with. I could not even go to the toilet without him wanting to know where I was going. Everytime he demanded to know what I was doing. I used to believe everything he told me, even when he told me that he loved me but now I am not so sure, I also believed him when he often said he would chop me up and put me in the freezer, particularly if he did not like what I was doing or saying. If we had been arguing I would curl up on the settee or the chair with my legs pressed to my chest and my hands over my ears, he would make me feel so small. My heart would beat harder and faster in fear, I was so scared of him. When he was rattling from the drugs I wasn't afraid of him as much as I was when he wasn't. When he was rattling I could see where he was coming from, all his anger was plain to see. When he wasn't I was much more afraid of him because I had no idea how or what he was feeling until he took it out on me. On one occasion after he beat me with an umbrella he removed my shoes, threw them away and told me to walk back in my bare feet. It made me so upset, he would say 'you should have told me not to'. How could I say that to him? I was afraid of him and what he would do to me if I had, he never listened to me anyway. He made me feel so worthless and afraid but now he is no longer in my life I feel like a woman.*

*I found out I was pregnant 2 weeks before he was arrested. I felt that I didn't want to be pregnant at first but I had already given up seeing my first 2 children in favour of being with [the perpetrator] and I was not prepared to allow that to happen again. It was after I found out I was pregnant and after an argument with him, during which he smashed a mirror when I decided enough was enough. I was not going to carry on being with him anymore. Because of how I was feeling and where I was emotionally 6 months ago I feel I would have chosen [the perpetrator] over my unborn child but now there is no choice, I would not give him another look. My child and children are my priority and will always come first, head and shoulder above [the perpetrator], albeit with some trepidation regards to raising my baby as a single parent.*

*Since seperating from [the perpetrator] and being able to live my life without him I have put on about 3 stone in weight, I feel and look a lot more healthy. I have new clothes, perfume, make up and dresses – things I couldn't have when I was with him. When I was with him I felt there was a large 'STOP' sign infront of me preventing me*

*from achieving things for myself. It was a stop sign put up by [the perpetrator] and now I am so grateful for the life I have without him. Although I feel happy that my life can move on without him, I feel guilty for feeling the way I do. I felt that it was me who put him in prison and that it was my fault he was arrested. Now I am able to do things I want to do, things to keep me busy and a chance to do the things I dreamt and imagined with all my children, building my own independence I don't want him to interfere with that and I feel safe knowing he is in prison. I have turned my life around, he needs to do the same without me but I doubt he will want to.*

*I am looking forward to having my own home eventually, to decorate it and bring up my child in a happy and safe place. I want to get back on the road, sort out my driving licence and to be able to drive around visiting my family when I want to. I want to see my dad more, who I lost touch with over the past couple of years as a result of [the perpetrator] controlling everything I did.*

*I tried to request access to see my 2* [children] *whilst I was with him but things never really got off the ground. I have now had the chance to complete applications which are being progressed, this would never have happened if I remained with him. I feel so happy when I talk about my* [children] *and hate myself for leaving them for* [the perpetrator] *but now I have a chance to make up for it without him.*

*Around 5 weeks ago I sent him a note simply saying 'we're done'. By that note I meant that I want nothing more to do with him and I don't want to be in a relationship with him. I did not receive a reply and I did not want one, I don't want to read, hear or see anything from him again. I fear that he would not give up trying to find me and it frightens me to think what would happen if he did. I want nothing more to do with him."*

Marie's victim personal statement, July 2014

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# 1. INTRODUCTION

This domestic homicide review was commissioned by Safer Sandwell Partnership following the death of 'Marie'. She was 33 years old.

The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

*(a) a person to whom s/he was related or with whom s/he was or had been in an intimate personal relationship, or*

*(b) a member of the same household as herself/himse*lf

In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This report examined the contact and involvement that agencies had with Marie and the perpetrator between 2012 and the time of Marie's murder in December 2018. In addition to the agency involvement, this report also examined any relevant past history of abuse and incorporated the views, thoughts and questions raised by Marie's family.

The panel wishes to express their condolences to Marie's family and friends following her death. The panel would also like to thank all those who have contributed to this review.

## 1.1. Timescales

The Safer Sandwell Partnership was notified of Marie's death in January 2019. The information from partner agencies was shared with the Domestic Homicide Review Standing Panel and the Chair of the Partnership. On 6 February 2019, it was agreed that the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) had been met. The Chair ratified the decision to commission a domestic homicide review on 6 February 2019 and the Home Office was notified on 8 February 2019. An independent chair/author was commissioned in February 2019 to manage the process and compile the overview report. The trial caused a delay in the process. The review reconvened after the perpetrator was convicted in late 2019 but was delayed again whilst information was sought from Marie's family and West Mercia Police. Covid-19 and social distancing caused additional delay to acquiring some information and prevented the panel meeting. The review was concluded via virtual meetings.

## 1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the Domestic Homicide Review Panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Marie – victim deceased aged 33

Perpetrator – partner aged 32

} Age at the time of Marie's death

## 2. THE REVIEW PROCESS (MEHTODOLOGY) & TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9 (3) Domestic Violence, Crime and Victims Act (2004).

### 2.1. Time period

The Domestic Homicide Review Panel decided that the review should focus on the contact that agencies had with Marie and the perpetrator between 2012 and the time of Marie's murder in December 2018. The panel decided on this time frame because this would capture information about their relationship and any history of abuse and violence within their relationship from the time they arrived in England (from Ireland). The panel agreed, however, if any agency had relevant information outside of this period, this information should be included within the agency's individual management review or information report.

### 2.2. Family engagement

The independent chair wrote to Marie's family to explain that a domestic homicide review was taking place. The family was supported by Advocacy After Fatal Domestic Abuse (AAFDA). Marie's sister and niece met with the Independent Chair and the Domestic Abuse Team Manager (Sandwell Metropolitan Borough Council). Marie's sister and niece provided a wealth of information, much of which is within the body of the report. They had the opportunity to contribute to the terms of reference, review the completed draft and choose a pseudonym.

### 2.3. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

i. Black Country Healthcare NHS Foundation Trust (formerly known as Black Country Partnership NHS Trust)

ii. Black Country Women's Aid (formerly known as Sandwell Women's Aid)

iii. Cranstoun (drug and alcohol service)

iv. Black Country Healthcare NHS Foundation Trust (formerly known as Dudley and Walsall Mental Health Trust)

v. National Probation Service (Black Country Cluster)

vi. Sandwell & West Birmingham Clinical Commissioning Group - GPs

vii. Sandwell and West Birmingham Hospitals NHS Trust

viii. Sandwell MBC Neighbourhoods - Housing Services

ix. West Mercia Police

x. West Mercia Women's Aid

xi. West Midlands Police

Information reports and chronologies were requested from:

xii. Esteem

xiii. Sandwell Children's Trust (formerly Sandwell MBC Children's Social Care)

xiv. Sandwell MBC Floating Support Service

xv. West Midlands Ambulance Service (WMAS)

xvi. Russells Hall Hospital (Dudley Group NHS Foundation Trust)

All the authors of the individual management reviews and the information reports were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved. All agencies included any relevant information about both Marie and the perpetrator.

A letter was sent to the perpetrator in prison. He agreed to meet with the Independent Chair but when she arrived at the prison, he declined to see her.

## 2.4. Key lines of enquiry

The review addressed both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Marie might be at risk of abuse, harm, control or domestic violence and how did your agency respond to this information to protect her?
- If your agency had information that indicated that Marie might be at risk of abuse, harm, control or domestic violence was this information shared? If so, with which agencies or professionals?
- In what way did your agency's knowledge of Marie's history influence professionals' decision making?
- How did your agency assess whether Marie was able to articulate what was happening in her life (on those occasions when she accessed services whilst under the influence of drugs or alcohol, or when she was accompanied by the perpetrator)? Did your agency regularly use routine enquiry to establish if Marie was a victim of domestic abuse?

- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or controlling and might cause harm to someone and how did your agency respond to this information? How did your agency establish who he was living with?
- If your agency had information that indicated that the perpetrator was violent, abusive or controlling and might cause harm to someone, was this information shared? If so, with which agencies or professionals?
- When the perpetrator was released from prison, how did your agency mitigate the risk that he would locate Marie and continue to abuse her?
- What opportunities and services did your agency offer and provide to meet the needs of Marie and the perpetrator? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced?

## 2.5. Review panel

The review panel met three times and a further meeting was held via MS Teams. All the members were independent of the case i.e. they were not involved in the case and had no direct line management responsibility for any of the professionals involved in the case. The Home Office Quality Assurance Panel has given exceptional permission not to list the Panel members' names. The review panel comprised:

- Independent Chair and Author
- Head of Adult Safeguarding, Black Country Healthcare NHS Foundation Trust
- Business Support Officer, Sandwell Metropolitan Borough Council
- Deputy Head of Probation, Black Country Cluster, National Probation Service
- Designated Nurse, Head of Service, Sandwell & West Birmingham Clinical Commissioning Group
- Detective Inspector, Domestic Abuse Safeguarding Birmingham, Public Protection Unit, West Midlands Police
- Domestic Abuse Incidents Review Coordinator, Sandwell Metropolitan Borough Council (MBC)
- Domestic Abuse Team Manager Sandwell Metropolitan Borough Council
- Drugs Project Manager, Sandwell Metropolitan Borough Council
- Executive Director, Black Country Women's Aid
- Head of Housing and Communities, Wychavon District Council
- Manager, Sandwell Irish Society
- Safeguarding Coordinator for Neighbourhoods, Sandwell Metropolitan Borough Council
- Team Manager, Quality Development & Safeguarding Unit, Sandwell Children's Trust

## 2.6. Author of the overview report

The chair and author of this review has been a freelance consultant for 21 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. She has undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has chaired and authored over 25 serious case reviews/domestic homicide reviews. She has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011). She is independent of, and has no connection with, any agency in the Sandwell area; she has never been employed by any agency in Sandwell. She has not completed any previous domestic homicide review for the Safer Sandwell Partnership.

## 2.7. Parallel reviews

In addition to the criminal investigation, the case was referred to the Independent Office for Police Conduct (IOPC). It was reported to the Independent Office for Police Conduct because Marie had been reported missing, but her home address was not searched for five days. The Independent Office for Police Conduct concluded that an internal investigation by West Midlands Police Professional Standards should take place. The panel asked for a copy of the report but West Midlands Police declined stating that the report was confidential and not for dissemination. West Midlands Police did however provide an overview.

A review was undertaken of the five days between Marie being reported missing and West Midlands Police entering her flat and finding her dead. This identified that there were a number of reasons why officers decided there was insufficient justification to enter Marie's flat under permitted powers (s.17 PACE).[1] These included:

- Uncertainty over her address. It appeared "*void and was boarded up*" (although it was subsequently established it was boarded up following the execution of a drugs warrant)
- Other demands placed on police resources
- There was also information from Marie's sister that she was not overly concerned about Marie's whereabouts (she had seen her a few weeks before and was fine). Marie's sister stated to the call handler that she was only reporting her sister missing to appease her mother and she was not able to find her herself because she had childcare issues. Police records showed that there was another adult present at her property when she contacted police (thus implying that Marie's sister did not have childcare issues and she should have gone to find Marie herself)

[1] Entry and search without warrant – s.17 Police and Criminal Evidence Act 1984. S.17 provides a wide-ranging power to enter and search premises without a warrant in order to arrest persons or to save life, limb or property. So far as the entry and search for persons is concerned, reasonable grounds for believing that the person is on the premises must exist and there is a limitation on search in respect of separate dwellings and, like all search powers, it is a search only to the extent reasonably required for the purpose for which the power was exercised - https://www.policeprofessional.com/news/entry-and-search-without-warrant-s17-police-and-criminal-evidence-act-1984/ - accessed online 11 September 2020

- When officers attended at Marie's flat, there was "*no smell emanating*" from the address, and neighbours had not heard any disturbances in the preceding weeks.

West Midlands Police considered the risk and concluded that these combined factors reduced the concern for Marie in the first few days. Further enquiries with housing showed that the tenancy of the flat was still in Marie's name and when the case was reviewed, officers were instructed to force entry. The report concluded that consideration of s.17 PACE was deemed appropriate, even though it transpired that Marie had been in the property all along and had probably been dead for some weeks.

## 2.8. Equality and diversity

Marie was documented as white British and the perpetrator as white Irish in agency records (when ethnicity was recorded). Both were documented as Roman Catholic. Nevertheless, no agency documented that she came from the Irish travelling community. This was only established when the Independent Chair and the Domestic Abuse Team Manager (Sandwell Metropolitan Borough Council) met with Marie's family. Following this, the panel sought advice from the Sandwell Irish Society and a representative was invited to sit on the panel. All aspects of equality and diversity were considered throughout this review process including age, disability, race, sex and religion – where applicable they are discussed throughout the report. To ensure the review process considered issues around domestic abuse, the panel included representatives specialising in domestic abuse. Their thoughts and views are reflected throughout the report. The panel would also like to thank the Centre for Women's Justice for providing legal advice concerning restraining orders.

## 2.9. Dissemination

In addition to the organisations contributing to this review (listed in paragraph 2.3), the following will receive copies of the learning from this report:

- Local Scrutiny and Involvement Panel (Crown Prosecution Service)
- Sandwell Children's Safeguarding Partnership
- Sandwell Health and Wellbeing Board
- Sandwell Safeguarding Adults Board
- West Midlands Police and Crime Commissioner
- Women's Aid Federation of England
- Worcestershire Community Safety Partnership
- Judiciary and Court Service

# 3. THE THOUGHTS OF MARIE'S SISTER AND NIECE

Marie came from an Irish traveller family and travelled with her family in England for much of her childhood. Her father returned to Ireland when her grandfather became ill and Marie went there when she was about 14 years old, to be with her father.

She was described as having a great life until she met the perpetrator at a night club. He was physically abusive and controlled her from the beginning of their relationship. Her sister

described some of the abuse she suffered. When they were in Ireland, he once tied her up and left her in the bathroom for five days. He told her what she could wear and how she should look. Marie was described as being completely controlled by him. He would never let her wear make-up and she would do anything he asked. If he had no tobacco, he would send her outside to pick up cigarette ends. He would take her shoes away and watch her out of the window. It appeared he frequently took her shoes away, so she could not leave. Marie's sister described how whenever he bought drugs from a different supplier, he would "*test*" them out on Marie to see the effect – using her as a "*guinea pig*". He frequently "*starved*" her. He would order a chicken takeaway and eat the meat, then throw her the bones. The perpetrator once kicked Marie in the back so hard she was unable to stand up or walk properly. He was in complete control of her money. Marie's sister had a carrier bag full of letters that he had sent Marie whilst he was in prison. The letters described how much he missed her and that he was looking forward to seeing her soon and their baby. Although the letters appeared to be 'loving', given the information on the abuse he perpetrated, it was clear that this was a control method and (in most letters) he asked her to send him money.

The perpetrator often threatened Marie's family and she believed he would hurt them. On one occasion, Marie and the perpetrator stayed at Marie's sister's house. Marie's sister described how agitated he became. Marie's sister was terrified and slept with all her clothes on and her car keys in her pocket. After that she would not allow him near her house because she was scared for herself and her children. For over six years, Marie's family tried to get help for her. They made numerous calls to the police (both West Midlands Police and West Mercia Police). The family felt there were a number of questions that they wanted answering. For example:

- Why the GP practice thought she had irritable bowel syndrome when her weight loss was because the perpetrator starved her?
- Why housing let them live together despite knowing his history of abuse towards her?
- Why agencies (especially children's social care) did not make greater effort to protect Marie when she was pregnant and he was in prison?
- Why agencies had not arranged for her to be moved away from him when he was released from prison which could have prevented him from having such an influence over her?
- The family felt that children's social care was very quick to take Marie's baby from her.

The family felt that if Marie had had the opportunity to bond with her baby whilst the perpetrator remained out of her life, then she may have been able to separate from him. Marie's sister said that after he was released from prison in 2014, an officer told Marie that they would not be "*so quick to respond to her*" in future, as she should not have gone back to him.

## 4. THE FACTS

In December 2018, West Midlands Police received a call from Marie's sister. Her family was concerned because Marie had not been seen for around four weeks and she had arranged to meet with her family over Christmas. Officers visited Marie's address. There was a board over the front door, there was no smell emanating from it and officers concluded that Marie's sister did not appear overly concerned about Marie's whereabouts. After receiving information from housing that the flat was still in Marie's name, they forced entry and discovered her body. It appeared that she had died some weeks earlier following an assault.

The perpetrator was located in early January 2019. He was subsequently charged with Marie's murder. The day he was due to give evidence, he pleaded guilty to murder. He was sentenced to a minimum term of 17 years in late 2019.

## 5. BACKGROUND

In records, Marie described her childhood as a "*happy upbringing*", she remembered having toys, clothes and plenty of food. Her father returned to Ireland and when she was about 14 years old, she went to Ireland to live with her father. Whilst living in Ireland she had two children to different fathers.

She met the perpetrator in Ireland in December 2011. The perpetrator was her drug dealer. Their relationship started very quickly and he soon moved in with her. Marie described how he was violent and abusive from the start. Due to concerns about their relationship, Marie's children moved to live with their respective fathers. By March 2012, Marie and the perpetrator moved to Worcestershire and lived with various members of Marie's family. However, when the family found out about the perpetrator's criminality, they asked both Marie and the perpetrator to leave.

The perpetrator's offences in Ireland comprised:

| | |
|---|---|
| 1 | Offence against the person (false imprisonment) |
| 3 | Offences against property (criminal damage) |
| 13 | Theft and kindred offences (robbery, burglary and aggravated burglary) |
| 1 | Drug offence (possession with intent to supply, class not stated) |
| 3 | Firearms/shotguns/offensive weapons (possession bladed article – public place) |
| 1 | Miscellaneous offence (drunk and disorderly) |

Initially, they lived on the streets of Worcestershire in a tent. Throughout this period, they used heroin and crack cocaine, and Marie was subjected to severe violence from him. West Mercia Police first became aware of Marie and the perpetrator in May 2012. Marie's sister contacted the police to report that the perpetrator was abusing Marie. In December 2012, they moved into a shared flat. The perpetrator and Marie came to West Mercia Police attention a further 14 times between 2012 and 2014. These included direct contact with both of them as well as a number of police intelligence reports from family members or

partner agencies. Marie's sister and mother both contacted West Mercia Police about their concerns about the perpetrator's controlling behaviour towards Marie. Although when officers spoke to Marie alone (and away from the perpetrator) she always denied the issues and stated that her family did not like him and would do anything to "*split them up*". One of the incidents involved Marie's mother hitting him with a baseball bat. He declined to make a formal complaint as "*Things were not great between him and Marie's mother and he did not wish to make it worse*". Marie told her drug worker that the perpetrator would petrol bomb Marie's sister's house if Marie ever left him. In August 2012, a member of the public contacted West Mercia Police to report that Marie had been assaulted by him. He was arrested. At the time he had Marie's bank card on him. This supported previous intelligence that he was in control of Marie's money and bank card. The perpetrator was later released with no further action as there was no independent evidence and Marie did not wish to make a formal complaint. During February and March 2013, West Mercia Police received intelligence to suggest that the perpetrator and Marie were dealing drugs.

According to records, in early 2013 Marie became pregnant. Then in late July, when she was five months pregnant, she had a scan which showed there was no foetal heartbeat. Marie was asked to return for induction of labour at a later date. Marie, however, did not attend the appointment and informed staff that she could not, because she had no money. She eventually delivered her still born baby at home in August. Marie subsequently informed her drug worker that the perpetrator "*beat the baby out of her*".

## 6. CHRONOLOGY OF SIGNIFICANT EVENTS

On 26 February 2014, Marie's mother visited a police station in Worcestershire. She said that Marie was being held against her will by the perpetrator in the West Midlands area. West Mercia Police informed West Midlands Police.

The following day, officers went to Marie's home in Sandwell. Marie appeared shocked when the officers walked in and she sat "*trembling*" on a sofa like a "*scolded child*". She was described as very "*timid and nervous*". Whilst the perpetrator was depicted as "*agitated, belligerent*" and demanded to know why officers were there. When he was speaking, officers noted that Marie was visibly shaking. Every time the perpetrator raised his voice, she appeared to "*flinch*". He told the officers that Marie was fine and there was no reason for anyone to call the police. It was noted that when Marie was asked questions, the perpetrator answered for her. She appeared very reluctant to speak over him.

An officer spoke to Marie separately. It was noted that Marie was extremely pale, withdrawn, thin and gaunt. She was shaking uncontrollably. She was wearing the perpetrator's clothes, which were far too big for her. Marie began to cry and disclosed that the perpetrator had threatened to kill her over a two-and-a-half-year period (so many times that she had lost count). She said that he told her that if she ever left him, he would kill her and put her body in the freezer. Marie took these threats so seriously she never left the flat and had effectively become imprisoned. Marie also disclosed that he raped her in July 2013. The perpetrator was arrested on suspicion of rape, unlawful imprisonment and threats to kill and was charged the following day. Whilst in custody, the perpetrator was searched and he was found to have Marie's bank card.

Marie was referred to an IDVA (independent domestic violence advisor) in Sandwell and offered a place in a refuge which she declined. She was assessed as at high risk of harm following a DASH (domestic abuse, stalking and honour-based violence) risk assessment.[2] The IDVA (independent domestic violence advisor) referred Marie to Sandwell housing. She also organised food bank parcels for Marie, who was 5½ stone, as the perpetrator had withheld food from her before he was arrested.

Marie's case was heard at the Sandwell MARAC (multi-agency risk assessment conference)[3]in early spring 2014. The actions were to refer Marie to Sandwell children's social care because she was in the early stages of pregnancy; to discuss her housing options and refer her to the drug and alcohol service. The outcome of the referral to children's social care was that Marie would be monitored by the midwife and a further referral would be made when her pregnancy was deemed viable [for statutory involvement] at 16 weeks gestation.

On 21 March 2014, Marie retracted her statement and "*seemed happier*". Black Country Women's Aid referred Marie to Sandwell children's social care on 24 March. Whilst Marie was considered to be at high risk of harm, a referral was made to 'early help' services, because her pregnancy was not "*deemed viable for statutory intervention*". During March and April 2014, Marie engaged with mental health services and her IDVA (independent domestic violence advisor). She was putting on weight and her withdrawal symptoms were improving – she continued to be drug free.

Children's social care received another referral in May 2014. An assessment was to be completed with a view to holding a child protection conference or manage the case under the Public Law Outline.[4]

Marie was seen by the community midwife on 20 June and the specialist midwife on 1 July 2014. Marie's urine toxicology was negative for drugs of abuse (e.g. cocaine, heroin etc.). On 2 July 2014, an initial case conference was held. It was attended by children's social care, the IDVA (independent domestic violence advisor) and the specialist midwife. There was a unanimous decision that Marie's unborn baby should be placed on a child protection plan under the category of neglect. A referral was made from Black Country Women's Aid to West Mercia Women's Aid, so Marie could be relocated close to her family. Marie accepted a refuge place in Worcestershire, and on 9 July 2014 West Midlands Police transferred

[2] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model – for further information see http://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf – accessed online 11 September 2020

[3] A MARAC (multi-agency risk assessment conference) is a meeting where information is shared about high risk victims of domestic abuse. It is shared between representatives of local police, health, child protection, housing practitioners, independent domestic violence advisor (IDVA), probation and other specialists from the statutory and voluntary sectors. The aim is to increase the victim's safety and develop a co-ordinated action plan.

[4] The Public Law Outline (PLO) sets out the duties local authorities have when considering taking a case to court to ask for a care order or a supervision order.

Marie's MARAC (multi-agency risk assessment conference) case papers to West Mercia Police as they became responsible for her on-going safeguarding.

Marie's case was heard at the Worcestershire MARAC (multi-agency risk assessment conference) on 14 August 2014. An assumption was made at the meeting that the perpetrator would receive a custodial sentence and be referred to MAPPA (multi-agency public protection arrangements).[5] There was no mention of a restraining order being sought in case he was released. The following day, Marie was issued with a '28 days' notice to quit' from the refuge due to non-payment of a personal charge.

In August 2014, the perpetrator was convicted of 'putting a person in fear of violence' and was sentenced to twelve months' imprisonment (suspended for two years). He was ordered to attend a 'building better relationships' course and to be monitored by the National Probation Service for 24 months. The court did not put in place a restraining order. Marie's IDVA (independent domestic violence advisor) informed her of the outcome the following day. Marie was described as "*upset*". Marie was informed by her social worker that if she had any contact with the perpetrator, care proceedings would be initiated.

On 26 August 2014, a refuge resident informed staff that Marie had a Stanley knife in her room. A decision was reached that Marie should be given immediate notice to quit.

On 3 September 2014, a multi-agency safeguarding hub (Sandwell MASH) referral was made. Marie had not attended any antenatal appointments, nor had she registered with a GP. A strategy discussion took place and Marie's social worker commenced legal planning to seek an order for the unborn baby. On 4 September 2014, Marie accepted a place in another refuge.

On 18 September 2014, a core group meeting was held. Marie was in late stages of pregnancy. She was informed (for the first time) that her case had gone to legal planning and her child would be removed at birth. Marie became very distressed and the meeting had to end.

Marie's baby was born in the autumn of 2014 and 4 days later the social worker went to the hospital to take her baby to foster carers. Marie was discharged from hospital and returned to the refuge "*very upset*".

On 7 October 2014, Marie went to the emergency department at Sandwell because she was drunk and had sustained a head injury. She did not wait to be seen. Later police were called by West Midlands Ambulance Service because "*a female had been assaulted and fallen from a fence*". She had a bump to her head and a cut finger. Police took her back to the refuge.

On 4 November 2014, Marie's case was discussed at the Sandwell MARAC (multi-agency risk assessment conference). The perpetrator's drug worker's assessment of him was that he was "*the most damaged and dangerous man that he had come across*". There was

[5]MAPPA (multi-agency public protection arrangements) is the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public – for further information see https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome – accessed online 11 September2020

discussion about Marie missing a session of the Freedom Programme, but little thought was given to the perpetrator who had missed some appointments with his offender manager.

In early 2015, the final care order and placement order were granted for Marie's baby. Marie had some limited contact with Black Country Women's Aid during early 2015. She was diagnosed with appendicitis and her GP advised her to go straight to hospital. She declined because she wanted to see her baby for the last time. Throughout March 2015, Black Country Women's Aid tried numerous times to contact Marie, but she did not answer. They closed Marie's case on 20 April 2015, as she had not responded to calls or letters.

On 25 January 2016, Marie called West Midlands Police because she had had enough of her violent partner. She said he had not hit her that day, but she left her flat because he was threatening to "*smash up the property*". When Marie arrived at the police station, all the officers were committed with other incidents but when the allocated officers were available, Marie had left. Multiple attempts were made to call and visit Marie without success. Ultimately, on 6 February 2016, officers met with Marie and she told them she had been with a friend for a few days. She left her phone in her flat and the battery had died which was why she could not be contacted.

On 17 August 2016, a 999 call was made for an ambulance. Marie had allegedly taken an accidental overdose of two bags of heroin.[6] The perpetrator had administered naloxone[7] to her prior to the ambulance arriving. She was taken to the emergency department at Russells Hall Hospital.

Between December 2016 and November 2018, Marie was seen a number of times at her GP Practice, invariably she was accompanied by the perpetrator. In the latter part of this period, they were both seen approximately monthly at the drug and alcohol service. In November 2018, the police executed a drug warrant at their address. A small amount of cannabis was found and the perpetrator was cautioned. Marie attended an appointment with her recovery worker at the drug and alcohol service in early December 2018. She asked for a change to her medication collection as she was spending Christmas with her mother. In mid-December 2018, the pharmacist called the drug and alcohol service stating that Marie had missed three consecutive days of her medication. In December 2018, Marie's body was found at her property.

# 7. AGENCY INVOLVMENT AND ANALYSIS

## 7.1. West Midlands Police

Officers from West Midlands Police arrested the perpetrator in 2014 for rape, threats to kill and false imprisonment. They clearly identified that Marie was vulnerable and she was assessed as being at high risk of harm from him. Statements were also taken from family

[6] Marie's family said that the perpetrator tested new supplies of drugs on Marie. It is unclear therefore whether the overdose was accidental or intentional on Marie's part, or whether he was "*testing*" a new supply on her.

[7] Naloxone is a drug that can reverse the effects of opioids, and prevent death if used within a short period following an opioid overdose – for further information see https://www.changegrowlive.org/get-help/advice-information/drugs-alcohol/naloxone-the-opioid-overdose-reversal-drug - accessed online 11 September 2020

members, who confirmed that the perpetrator was abusive. It was documented that Marie appeared to be extremely frightened of him and totally under his control. Marie was assessed as high risk due to the fact that she was in immediate need of protection and the officers concluded that if they left without action then she would be subject to serious and significant physical and psychological harm.

On 2 April 2014, Marie told an officer that she had had contact with the perpetrator whilst he was in prison. She said that she had visited him, spoken to him on the phone and written him two letters. Officers had not been aware that Marie had been having contact with him. As soon as this was known, a notification was submitted to the prison to prevent Marie visiting or contacting him.

Despite the perpetrator being charged with threats to kill, rape and false imprisonment, he was only convicted of harassment with violence because Marie had retracted her statement. He received 12 months' imprisonment, suspended for 24 months. He was required to attend a 'building better relationships' programme.

**Although there was information to suggest that the investigating officer in the case had requested a restraining order, no restraining order was imposed by the court to prevent the perpetrator having contact with Marie. This was a clear missed opportunity to protect her – especially as she had made a significant effort to engage with agencies whilst he was in prison.**

At around 11pm on 7 October 2014, the ambulance service contacted West Midlands Police to report that a woman had been "*assaulted and fallen from a fence*". On arrival, officers spoke with Marie, who was heavily intoxicated, and had a bump to her head, a scratch to her forehead, cut to a little finger, and a bruised knee. Marie said that earlier that evening she had been taken to hospital due to her alcohol consumption. Sometime later she said that she had fallen over a wall, resulting in her injuries. She said that she went to the perpetrator's flat and whilst there they had an argument over money, resulting in Marie leaving the address and unintentionally leaving her bag inside. The perpetrator would not allow her in to collect it, so Marie left. A member of the public called the ambulance service.

Officers went with Marie to the perpetrator's address and retrieved her belongings. Officers returned Marie to the refuge. Contrary to current policy, a DASH risk assessment was not completed because she was intoxicated. The incident was however recorded on a non-crime report and Marie graded as at high risk, resulting in her case being referred to the MARAC (multi-agency risk assessment conference). Marie did not make any complaint or allegation. Marie declined a referral to the National Centre for Domestic Violence.[8]

**The perpetrator later recounted his version of events to his probation officer. He said that he bumped into Marie and took her handbag back to his home so she would have to go there. Despite the initial report from the West Midlands Ambulance Service stating that Marie had been assaulted, the police appeared to accept the perpetrator's version of**

[8] The National Centre for Domestic Violence provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances, race, gender or sexual orientation – for further information see https://www.ncdv.org.uk/ - accessed online 11 September 2020

**events. It was also documented in Marie's refuge records that she said she had been assaulted, but the "*police advised that prior to the incident she had jumped over a wall and hurt herself so police are reporting the incident as a DV no crime report*". Thus, there appeared to be little professional curiosity as to how or why she had fallen. No consideration appeared to be given to his past history of abuse towards Marie, the fact that he was subject of a suspended sentence order for putting Marie in fear of violence, or the barriers that might have prevented her from directly reporting the assault to the police.**

Over a year later, at around 1pm on 25 January 2016, Marie called West Midlands Police because she had had enough of her violent partner. She said he had not hit her that day, but she left her flat because he was threatening to "*smash up the property*". She wanted to get away from him so had called the police whilst she was alone. Marie provided the perpetrator's full name. She said a friend was picking her up and would go to West Bromwich Police Station. When Marie arrived, all the officers were committed with other incidents. Marie agreed to return to the police station later that evening. She returned just after 7pm and again all officers were still committed with other incidents. By 8.30pm when the allocated officers were available, Marie had left. At 10.45pm the allocated officers visited Marie's home address. There was no reply on the intercom, the premises appeared in darkness and Marie's phone was turned off. The officers concluded that Marie may be staying with her friend.

Multiple attempts were made to call Marie's phone without success until midday the next day (26 January). At 1pm, an officer spoke to Marie's mother. She had not seen or heard from Marie and had no idea with which friend Marie might be staying. On the morning 29 January 2016, officers learned that Marie's mother had spoken to Marie the previous night. Her mother provided a new phone number for her, but again there was no answer. At around 11am, Marie answered and stated that she was on a bus and staying with friends. She said that the perpetrator did not know where she was and she had not returned calls because she had no credit. Marie agreed to go to a police station on 30 January 2016, but she did not attend.

On the evening 30 January 2016, contact was made with Marie but she said she had flu and that her phone was on silent so she was not aware that the police were trying to contact her. Marie said that she was back at home alone and asked for a phone call in a few days. On 2 & 3 February, police made unsuccessful visits to Marie's home. There was also no response from neighbours. Police records were updated to acknowledge that this had been on-going since 25 January. Although Marie's family had not seen her, police records documented that her family had seen and heard from her, which suggested she was safe.

On 6 February 2016, Marie's mother informed the police that she had been trying to call Marie for four days with no answer. Marie's mother was "*worried*" for her. Shortly afterwards, West Midlands Police was informed by West Mercia Police that Marie's mother had reported her missing. Despite Marie's mother not seeing her, and the police being unable to meet with her, West Midlands Police informed West Mercia Police that they were not treating Marie as missing as there had been "*sporadic*" contact with her. Officers forced

entry into Marie's home but she was not present. There was no sign of disturbance in the property and fresh food was in the fridge. The locks were changed at Marie's home. At around 3pm, Marie called the police because she could not get into her home. Officers met with her and Marie told them that she wanted to break up with the perpetrator. She was signposted to Women's Aid and the National Centre for Domestic Violence. Officers assessed Marie as at standard risk of harm. When they returned to the police station and conducted historical checks, they learnt of the background surrounding Marie's relationship with the perpetrator. The officers then reassessed her as at high risk of harm and recorded that had they known of the history between Marie and the perpetrator, they would have completed a DASH (domestic abuse, stalking and honour-based violence) risk assessment with her. The grading was subsequently downgraded to medium – it appeared to have been downgraded once it was established that Marie had had her baby removed.

A text was sent to Marie's phone but there was no response, so a letter was sent to Marie's home address on 1 March 2016. The letter asked Marie to make contact with police if she wished to discuss safety planning, and that a marker had been placed on the address meaning all calls would be treated as urgent. Contact details were provided for Women's Aid, the National Centre for Domestic Abuse and the National Domestic Abuse Helpline.

**As Marie did not disclose any offences when she was finally located, the officers created a non-crime report. Nevertheless, Marie had told officers on 26 January that the perpetrator was violent (although he had not hit her that day) that he had threatened to damage her property. Therefore, a crime report could have been generated for that offence, regardless of the likelihood of Marie co-operating or providing a statement.**

Throughout this incident (25 January – 6 February 2016), there appeared to be little thought given by the police to the circumstances in which Marie found herself. She disclosed that the perpetrator was violent, she gave police his identity but no one appeared to review his records and identify the danger he posed to her. In fact, despite Marie's mother reporting her missing to West Mercia Police, West Midlands Police informed them that they were not treating her as missing. When Marie was eventually located, no DASH (domestic abuse, stalking and honour-based violence) risk assessment was undertaken.

It was clear from the West Midlands Police individual management review that resources were extremely limited during this period. Nevertheless, had anyone reviewed the perpetrator's offending history, there may have been a greater recognition of the danger Marie faced. Police did not liaise with any other agency concerning the perpetrator or Marie.

**West Midlands Police receive an average of 3000 calls for service a day (not including those unsuitable for police response or nuisance calls). West Midlands Police said it is "*not realistic for officers (or controllers) to routinely liaise with other agencies and have discussions about calls for service and those making such calls*".**

**This is disappointing. Had discussions taken place, the police may have not only been aware that the perpetrator was subject of a suspended sentence and he was being supervised by probation, but also the threat he posed to Marie.**

On 16 February 2016, Marie's mother contacted the police because she was concerned about Marie's welfare and had not heard from her. Marie was seen by officers at her property and she said she had spoken to her mother the previous week but had then run out of credit. Marie's mother called the police on 10 March 2016 again because she had not heard from Marie. Marie was again seen at her property and she said she would contact her mother. Marie's mother made a third call in November 2016 because she had not heard from Marie in five months. Marie's mother was advised to go to see Marie and report any signs of domestic abuse to the police. On 1 January 2017, Marie's sister called the police because in telephone calls with her, Marie had been crying because she was scared of the perpetrator and he had taken three mobile phones from her. Officers went to Marie's address twice but there was no response. The second time they spoke with neighbours, who had seen Marie and the perpetrator. By 4 January 2017, police noted that Marie had been seen by third parties but not by the police. A voicemail update was left for her sister and the case was closed.

**The call from Marie's sister indicated Marie was being controlled. Being seen by third parties did not in any way negate the level of risk to which she may have been exposed. Closing the log was premature and inappropriate.**

Nowadays, an officer would see Marie in person to complete a domestic abuse risk assessment. This would give her the opportunity to disclose domestic abuse or any other criminality.

In November 2018, West Midlands Police executed a drug warrant at the perpetrator's home. Sandwell Council (housing) was also present. Both Marie and the perpetrator were at the address and a search of the premises found a small quantity of cannabis, consistent with personal use. The perpetrator accepted ownership and he was cautioned. Weapons were also found under a mattress at the property including a kitchen knife, machete and crowbar. Both the perpetrator and Marie stated that they were there for their protection. [9]

Housing records showed that Marie appeared nervous and distressed during the raid. Nevertheless, the police officers do not appear to have documented (or recognised) Marie's demeanour as that of a victim of domestic abuse. There was nothing recorded to suggest that either the police or the council had considered whether executing a drug warrant may have placed Marie at risk of harm.

The West Midlands Police individual management review stated that "*in partnership with the Police and Crime Commissioner, West Midlands Police had identified preventing and detecting domestic abuse as a strategic priority*". West Midlands Police has made a number of improvements to protect victims of domestic abuse like Marie. In 2014 dedicated domestic abuse teams were created to ensure that all cases are handled by specially trained officers who have a good understanding of all aspects of domestic abuse. This ensures that there is an improved and more consistent approach to domestic abuse. In December 2015 coercive control legislation was enacted which gives police greater powers to deal with these offences. In late 2016, West Midlands Police introduced 'mobile devices' which

[9] The possession of such items in a dwelling do not constitute a criminal offence.

enables officers to access intelligence systems remotely. By summer 2017, these devices were available force wide. Officers are now able to conduct address and person checks whilst on the way to an incident. This provides officers with a greater understanding of the history within a relationship and a more in-depth understanding of what they may face upon arrival. Officers are also able to read the entire log created by the call taker which ensures they have a full understanding of the circumstances as provided by the call taker. In November 2016, 'Axon Capture' was introduced onto the mobile devices. This enables officers to photograph any injuries. The rollout of body-worn cameras enables officers to video record the entire incident and can provide irrefutable evidence. In November 2017, DASH (domestic abuse, stalking and honour-based violence) risk assessments became available on the mobile devices and their completion became mandatory. In September 2018, it became mandatory to complete a DASH (domestic abuse, stalking and honour-based violence) risk assessment even in the event that victims refused to provide any details i.e. officers are expected to complete risk assessments based on the evidence that they had been able to gather. In December 2018, a 'vulnerability referral form' was introduced on the mobile devices so officers can make to make referrals immediately whilst still with the victim. In July 2019, DASH (domestic abuse, stalking and honour-based violence) risk assessment was replaced with DARA (domestic abuse risk assessment). This risk assessment provides officers with a greater understanding of coercive control than the previous DASH (domestic abuse, stalking and honour-based violence) risk assessment.[10]

West Midlands Police identified no single agency recommendations from this review.

## 7.2. West Mercia Police

On 26 February 2014, Marie's mother went to a police station in Worcestershire. She told officers that Marie was living in Birmingham with the perpetrator and he was being abusive towards her. She said that he kept Marie tied up, she wanted to leave him but he had threatened to kill her. The information was immediately shared with West Midlands Police. He was arrested the following day on suspicion of rape, threats to kill and wounding Marie and remanded in custody pending his trial.

Following his arrest, Marie moved back to live with her mother. Despite the perpetrator being in custody and there being a low level of risk at the time, West Mercia Police instigated a 'Risk Management Plan' and a 'gazetteer warning'[11] was placed on relevant addresses.

On 3 March 2014, Marie's mother contacted West Mercia Police to inform them that Marie had moved back to the West Midlands. West Mercia Police passed the information to the officer in the case for West Midlands Police. Records showed that Marie returned to live

[10] For further information on the 'domestic abuse risk assessment (DARA) – see https://whatworks.college.police.uk/Research/Documents/DA_risk_assessment_pilot.pdf - accessed online 11 September 2020

[11] Domestic violence gazetteer warning flags are placed against the address of any person who is the subject of a risk management plan. This ensures that police responders are aware of the possible risk. The history of previous incidents and the existence of a risk management plan are not identified if an incident takes place in a public place or at a different address.

with her mother briefly in April 2014 before being placed in a refuge in Worcestershire in July 2014.

West Midlands Police transferred Marie's case to the Worcestershire MARAC (multi-agency risk assessment conference) and West Mercia Police chaired the meeting on 14 August 2014. The information transferred to West Mercia Police was based on the MARAC (multi-agency risk assessment conference) that took place in the West Midlands earlier in 2014. No one from West Mercia Police contacted West Midlands Police for an update on the case. Therefore, an assumption was made at the meeting that the perpetrator would receive a custodial sentence and be referred to MAPPA (multi-agency public protection arrangements).[12] There was no mention of a restraining order being sought in case he was released.

On 27 August 2014, the (Worcestershire) independent domestic violence advisor (IDVA) contacted West Mercia Police to inform them that Marie had disengaged from all support and she had re-kindled her relationship with the perpetrator. The 'risk management plan' ended on 27 August 2014 with no further input.

**There was information sharing and liaison between West Mercia Police, West Midlands Police and partner agencies whilst the case against the perpetrator was in progress. There was no evidence of any further discussion or meetings between West Mercia Police, West Midlands Police and partner agencies concerning the continuing risk to Marie after she returned to the West Midlands area and their relationship resumed.**

## 7.3. West Mercia Women's Aid

On 3 July 2014, Marie was given a place at a West Mercia Women's Aid refuge. The staff were aware that Marie was pregnant and she was open about the abuse she had suffered and her records recorded that:

> "*Marie disclosed that the last incident of physical violence was on 25 February 2014 where he raped her, held a knife to her throat and threatened to kill her, Marie told me that she dropped the charges as she is fearful of him. Marie told me that she ended the relationship on 28 June 2014, she wrote a letter to him telling him it was over. Marie told me that she was not able to have contact with her friends or family whilst she was with [the perpetrator], she has recently started having contact with her mum and dad again after 2 years. Marie told me that [the perpetrator] controlled everything she did, he had all the money, bank cards and Marie's phone. She never went anywhere on her own. Marie told me that she felt responsible for him and by leaving him, everything she had given up has been for nothing. Marie told me that he has used objects to hurt her, he has thrown a cider bottle at her, hit her with an umbrella and held a knife to her throat. Marie stated that he threatened to kill her and her family, he stated that he would chop her up into little pieces and put her in the freezer if she tried to leave him. Marie told me that he would put his hands around her throat, put rope around her wrists and cut all of her clothes up if he thought she was going to leave him. Marie told me that [the perpetrator] used to rape her all the time, on one occasion he ripped out her contraceptive coil*

[12]MAPPA (multi-agency public protection arrangements) is the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public – for further information see https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome – accessed online 11 September 2020

*and then anally raped her. Marie said that he has shot a cow previously, he uses crack cocaine, heroin, smokes cannabis and is addicted to tramadol*."

During her stay at the refuge, Marie was supported by refuge workers and an IDVA (independent domestic violence advisor). Marie clearly struggled whilst at the refuge not only to manage her money, but also to deal with her emotions about the perpetrator. She felt guilty that he was in prison and that it was her fault. Marie was offered support with budgeting but declined it. We now know from Marie's family that he frequently wrote to Marie from prison asking for money. On 24 July 2014, Marie met with the police officer in charge of the case and the IDVA (independent domestic violence advisor) to support her to write a 'victim personal statement' (see page 2 for the full transcript). The officer also told Marie that a restraining order had been requested.

On 15 August 2014, Marie was issued with 28 days 'notice to quit' the refuge because she had not paid her personal charge. Marie became angry, aggressive and abusive towards staff. She went to her room to pack her belongings. Despite eventually calming down and apologising, Marie was issued a final written warning for her behaviour.

On 18 August 2014, the perpetrator was released from prison with no restraining order. Marie was described as shocked and upset. On 21 August 2014, Marie told a refuge support worker that she had been contacted by the perpetrator's mother. He was going to court the next day to be issued with a restraining order. Marie said she was upset because she had not asked for a restraining order. Marie said she no longer wanted the support of an IDVA (independent domestic violence advisor). Marie then left the refuge to spend time at her mother's house.

**It was clear from Marie's witness statement that she wanted no more contact with him. Yet she was placed in an impossible position when his mother phoned her. Marie was obliged to say very publicly that she did not want a restraining order, otherwise it would have been reported back to him**

On 26 August 2014, Marie received a call while at her mother's house. She was issued with an 'immediate notice to quit' because a fellow resident told staff that Marie had threatened to "*stab a member of staff with a fork*" and that she had a Stanley knife in her room. It was decided that Marie posed a significant risk to the safety of both the staff and residents. Marie disputed this information but she was not given the opportunity to contest the information nor was her room searched to ascertain the veracity of the allegations. She was not provided with any details of how to appeal. After Marie's eviction, two staff at the refuge cleared her room and documented all her belongings. There was no Stanley knife found within her possessions. Marie was in the late stages of pregnancy.

**Unsurprisingly, it was from this point onwards that Marie ceased to engage with agencies. Up until then, she had tried hard to change her life in order to protect herself and her unborn child from the perpetrator**

Since this incident, West Mercia Women's Aid licence agreements have been updated. There is clearer guidance on the expectations of the residents. The housing association that owns the refuge buildings is involved in discussions and decision making around issuing

warnings and notices to quit. The process is explained to the residents when they arrive at the refuge. There is also information on how to make a complaint or appeal a decision.

## 7.4. Sandwell Children's Trust

Marie and her unborn baby came to the attention of Sandwell children's social care in early spring 2014 following a case discussion at MARAC (multi-agency risk assessment conference). She was identified as a victim of severe domestic abuse, who was dependent on drugs. The outcome of the referral was for Marie to be monitored by the midwife and another referral to be made back to children's social care when Marie's pregnancy was deemed viable (for statutory involvement) at 16 weeks gestation.

In the meantime, a second referral was made by Black Country Women's Aid in March 2014. Whilst children's social care agreed the case was high-risk, a referral was made to Early Help Services, as Marie's pregnancy was not deemed viable for statutory involvement.

A third (MASH (multi-agency safeguarding hub) referral was made in May 2014. Children's social care noted the concerns around the power and control that the perpetrator exerted over Marie. The outcome was for a single assessment to be completed with a view to holding a child protection conference or management of case under Public Law Outline.

**Effectively between March and May 2014, valuable time was lost when children's social care could have been supporting Marie to be independent of the perpetrator**

An initial child protection conference (ICPC) was held on 2 July 2014 and Marie's unborn baby was made subject of a child protection plan under the category of neglect. A core group meeting was held as part of child protection process on 20 August 2014. It was known that the perpetrator had been released from prison on 18 August 2014. Marie was told that if she had any contact with him, the local authority would consider seeking legal advice with a view to issuing care proceedings. On 21 August 2014, information was received from the refuge that Marie had been in contact with the perpetrator and was planning to abscond with him. Then on 26 August 2014, Marie was given notice to quit the refuge with immediate effect.

In autumn 2014, a strategy discussion was held where it was agreed that the case would be presented for a legal planning meeting. It was decided that the local authority would issue care proceedings once the child was born, with a plan of removal at the point of discharge from hospital. Marie was informed of this decision a week before she gave birth. Marie became very distressed at the meeting and the meeting ended. From this point onwards, Marie stopped working with children's social care and would only text the social worker without informing them of her whereabouts.

Marie's baby was born in autumn 2014. The local authority issued care proceedings a few days later and was granted an interim care order. Marie attended all the contacts with her baby, she planned activities, her interaction was good and she showed great commitment. She also engaged with all the assessments that were required as part of the legal proceedings. She tried really hard to show that she was able to care for her baby, but records showed that she could not detach herself from the perpetrator and she could not explain why. The social worker was clear that Marie loved her baby very much. Even when

the assessments concluded that Marie could not keep her baby safe, she still remained focussed on her baby and attended a final contact meeting and ensured that it was a positive experience for her baby. She also helped the transition of her baby to the adoptive placement by providing as much information and support as she could.

Marie's family was also assessed as carers for Marie's baby, but they disclosed that they were too afraid of the perpetrator and thus the assessments determined they would be unable to keep Marie's baby safe. The final care order and placement order was granted in early 2015. Following this, Marie disengaged.

**There did not appear to be any consideration about the impact the subsequent removal of her baby would have on her mental health and what support would be offered to support Marie postnatally.**

## 7.5. Crown Prosecution Service

As part of this review, the Crown Prosecution Service was asked to provide a response to three specific questions:

i. Why was the perpetrator's conviction in August 2014 for 'harassment with violence', when he was charged with rape, making a threat to kill and false imprisonment?

ii. What was the rationale for a restraining order not being obtained at the time?

iii. How did the Crown Prosecution Service think that the risk the perpetrator posed to Marie was going to be mitigated?

Following the perpetrator's arrest, Marie was video interviewed and she provided "*a credible account of a controlling and abusive relationship and described a specific incident on 8 July 2013 when she alleged that the defendant had anally raped her*". The perpetrator denied the allegations during his police interview and he asserted they were all lies.

He appeared at court on 28 February 2014 and the prosecution opposed bail on the grounds of (a) belief that further offences would be committed and (b) that the defendant would interfere with witnesses, should bail be granted, regardless of any conditions imposed. Following a full bail application by the defence, he was remanded into custody by the court and thereafter he remained in custody for the entirety of proceedings until sentence.

The case was transferred to Crown Prosecution Service West Midlands Rape and Serious Sexual Offences Unit and allocated to a specialist lawyer. The lawyer reviewed the case and added two further charges, namely 'making a threat to kill' and 'false imprisonment'.[13] The additional charges were consistent with the account provided by Marie and her relatives.

On 23 May 2014 Marie attended court for the Plea and Case Management Hearing and informed the prosecution counsel that she wanted to drop the charges. The hearing was

[13] Controlling and Coercive Behaviour did not come into force until 29 December 2015, under s.76 Serious Crime Act (2015).

adjourned for a formal statement to be taken by the police. Marie provided a retraction statement to the police on 27 May 2014, stating that she had fabricated the allegations and that they were all untrue. She also wrote a letter to the perpetrator in prison apologising for lying, for blaming him for something which had not happened and asking for his forgiveness.

Prison calls and prison visiting logs also showed that Marie had made two visits to see him in prison which (whilst not uncommon in a situation such as this) was additional undermining material.[14] In light of Marie's retraction, the reviewing lawyer determined that there was no longer a realistic prospect of conviction for the three existing offences. A conclusion was reached that the retraction and nature of the retraction, namely the assertion of lies (whether or not those were in fact true), were fatal to the case since the charges hinged on the credibility of Marie's evidence.

The reviewing lawyer considered that there was sufficient evidence to provide a realistic prospect of conviction for an alternative charge of 'harassment causing fear of violence'.[15] The case was listed in July 2014 and the perpetrator pleaded guilty to this charge. The case was adjourned for sentence with no pre-sentence report requested, as the perpetrator indicated that he would not co-operate with the Probation Service.

The case was listed for sentence in August 2014 and prosecution counsel had earlier been instructed to seek a restraining order as follows, "*Should this defendant be released from custody he poses an obvious and dangerous risk to both the complainant and her family and a restraining order must be applied for upon conviction or acquittal*".

He was sentenced to 12 months' imprisonment suspended for 2 years and the court ordered that the domestic abuse programme was required to be completed. A restraining order was not imposed (it was not possible to establish the reason for this).

The reviewing lawyer arranged for the case to be re-listed to enable a restraining order to be imposed. The perpetrator was not present at the hearing so the Judge indicated that he could not impose a restraining order in his absence. The case was adjourned till late August 2014.

At that hearing, Marie attended court in person and informed the prosecution barrister that she did not want a restraining order. Counsel recorded in a post-hearing email the next day that she held a conference with Marie and went through her statement of 26 July 2014. Counsel's email records that Marie said she had felt pressured into making that statement by the police officer in charge of the case. Counsel took Marie through the contents of her statements, including the fact that she stated that she was frightened of the perpetrator. Counsel records that she asked Marie if the content was correct. Marie replied that "*it was at the time the statement was made but that had been when they were both on drugs and now they weren't the situation was better. They are not in a relationship but she has seen*

[14] The Crown Prosecution Service stated that it would be for the police and prison service to manage any risk posed by the defendant when the victim met him in prison. Any further possible offences committed, for instance 'intimidation of witnesses', could only be considered by the Crown Prosecution Service after a referral of the allegation by the police following an investigation into the possible offence.

[15] S.4 Protection from Harassment Act (1997)

*him on several occasions and she would like him to help raise the children. She was very clear that she did not want and had never wanted a restraining order*".

The prosecution counsel explained the position and Marie's views to the Judge and as a result, a restraining order was not imposed.

**Marie was placed in an impossible situation because if she told the prosecuting barrister that she wanted a restraining order, the perpetrator would know and this would have placed Marie and her family in danger. The only option to protect her, was for the Judge to recognise the perpetrator's controlling behaviour and take the decision out of Marie's hands and impose a restraining order. Ultimately, it is for the court to decide whether or not to impose a restraining order.**

The Crown Prosecution Service guidance[16] states that "*In some cases a victim may not want a restraining order to be imposed on a defendant: for example, when the victim wishes to continue a relationship with the defendant. In such instances the prosecution should not object to the victims' wishes but inform the court as ultimately it will be a matter for the court.*" It is not known whether prosecuting counsel considered or set out the legal principles to the court, in particular the principles in *R v Brown*[17] where the Court of Appeal stated that:

> "This young woman wishes to continue in a relationship with a man who has been repeatedly violent to her. That is a decision that she is entitled to make, however dispiriting it may be. There is no suggestion that she lacks capacity, or that she has been forced to do this, or that she is in fear of the applicant. She genuinely wishes to pursue her relationship. In those circumstances the restraining order should not have been imposed."

This indicates that it is part of the court's role to explore whether the victim has capacity to make the decision, has been forced to put forward the view that she has put forward, or is in fear of the applicant. The court should have been given guidance on the caselaw and provided with all the available information before hearing evidence from Marie in order to establish whether her request was genuine or arose from fear or coercion. That information included the fact that Marie had confirmed to the prosecutor that day that she had been in fear at the time she provided her statement on 26 July 2014, a month earlier, and that improvement since then was due to them both ceasing drug use. The truth of that latter claim and the likelihood of return to drug use by one or both of them would have been relevant to the court's decision.

In this case, although the prosecution barrister discussed in detail why Marie did not want a restraining order imposed, it would have been useful for the court to hear Marie's evidence. This would have meant that the issues in the relevant case law could have been explored

[16] https://www.cps.gov.uk/legal-guidance/restraining-orders-section-5-protection-harassment-act-1997
[17] *R v Brown* [2012] EWCA Crim 1152 as applied by the Court of Appeal in *R v Herrington* [2017] EWCA Crim 889

more fully e.g. she may have been forced to do this, or that she was in fear of the perpetrator (or his family).

Ideally, the Crown Prosecution should review its guidance on restraining orders in cases where the victim asks that one is not imposed. This guidance should not only refer to the relevant case law, but also consider how intimidated victims can be protected. For example, a judge could allow an adjournment in order for the police or an independent domestic violence advisor (IDVA) to explore more fully the wishes of the victim in the absence of the perpetrator.

As far as mitigating the risk that Marie faced, the Crown Prosecution Service stated that "*The role of the Crown Prosecution Service at the conclusion of a criminal case is to seek to obtain such ancillary orders as are appropriate and proportionate to the individual case. The management of risk posed by the offender beyond the application for such orders falls within the remit of the relevant police force, rather than the Crown Prosecution Service. In this case, there was no other suitable order available other than a restraining order*".

## 7.6. National Probation Service

On 16 July 2014, the perpetrator pleaded guilty to a charge of putting people in fear of violence. A pre-sentence report was requested by the court to assist the Judge in their sentencing decision. He wanted to be sentenced without a pre-sentence report, as he did not intend to co-operate with the Probation Service in the report's preparation.

Whilst in custody he was however interviewed by the probation officer (1) who was preparing the report. The probation officer (1) assessed that he presented a high risk of harm to Marie and any potential future partner. The definition of high risk is that "*there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious*". The probation officer (1) also completed a spousal assault risk assessment (SARA).[18] This assessment also indicated that the perpetrator posed a high risk of harm to intimate partners.

The probation officer (1) concluded that although a custodial sentence would remove the risk the perpetrator posed to Marie, it would not address the issues that underpinned his offending (drug use). Therefore, the probation officer (1) proposed a suspended sentence supervision order with a requirement for the perpetrator to complete the 'building better relationships' programme and a requirement for him to be supervised for two years.

**Although the pre-sentence report mentioned that a restraining order may have reduced the risk of further offending, it is not within the remit of probation staff to propose a restraining order within a pre-sentence report.**

[18] The spousal assault risk assessment (SARA) is a structured evaluation tool used by the National Probation Service to assess the level of risk of harm to an intimate partner from those convicted of domestic abuse or with a history of domestic abuse.

The 'building better relationships' programme is an accredited programme specifically for individuals convicted of offences relating to domestic abuse. The programme consists of 29 sessions comprising 24 group sessions and five individual sessions. The programme uses a "*strengths approach*" to address domestic abuse which uses a "*collaborative approach*" with the offender in order to support them. It was expected that following completion of the programme the perpetrator would be better able to identify and manage his abusive behaviour within relationships.

International evidence to support the effectiveness of perpetrator programmes is inconsistent and inconclusive. This makes it hard to draw any firm conclusions about 'what works' or whether one intervention approach is better than another. "*We do not yet know what works best, for whom, and under what circumstances*". Lack of clear evidence means we can only view perpetrator programmes as experimental.

https://www.gov.uk/guidance/intimate-partner-violence-domestic-abuse-programmes

The perpetrator was seen by the duty officer in July to commence the order and was then seen by his offender manager. His offender manager was probation officer (1) who wrote the pre-sentence report. This is considered good practice as the report author will already have ascertained knowledge about the offender and they will have begun to build a working relationship. The offender manager (probation officer 1) completed the perpetrator's initial sentence plan in autumn 2014 (outside the expected 15 working days of sentencing). The initial sentence plan recorded a high risk of serious harm to a known adult (Marie), medium risk of harm to the public, and a low risk of harm to children and staff. Whilst the risk to Marie, the public and staff were supported by the evidence, it would appear that he posed (at least) a medium risk to children in terms of witnessing or being involved in incidents of domestic abuse (particularly as Marie's baby was in foster care because of the risk he posed). The sentence plan had three objectives which focused upon him attending the 'building better relationships' programme, doing work to address his substance use and engaging in work to improve his emotional wellbeing.

Once he was accepted onto the 'building better relationships' programme, Marie was allocated a 'women's safety worker'. The women's safety worker was attached to the programme and her role was to keep Marie informed of the perpetrator's progress through the programme and to provide support and guidance to safeguard Marie. The women's safety worker had one contact with Marie during which Marie was reluctant to tell the women's safety worker about the abuse she suffered from the perpetrator – although she did describe how he had injected her in her neck, that he threw a cider bottle at her when she was pregnant and how she left her children because of her relationship with him. Additionally, there were several emails from the women's safety officer outlining concerns that the perpetrator and Marie were in a relationship and the risk that this posed to Marie. In October 2014 there was a multi-agency safeguarding hub (MASH) referral about Marie going to his property and concerns that "*Marie was placing herself at risk*". This would have been a good opportunity for the offender manager to discuss with the women's safety worker how to support Marie and indeed build a stronger relationship with Marie and

perhaps uncover the veracity of the perpetrator's disclosures. Marie moved address and the women's safety officer lost contact with her. It was not clear what measures the women's safety worker took to locate Marie.

The perpetrator completed the pre-programme work and attended the first session of group work on 17 November 2014. He attended sessions twice a week. The first module ended on 8 December 2014 and the programme started again on 5 January 2015. He completed the programme on 30 March 2015. During the programme he admitted that he would take things "*too far*". He described how Marie would "*flinch*" when he moved and this would "*aggravate him further*". He reported that he would take out the anger (he felt about being abused as a child) on Marie. He also disclosed getting a "*buzz*" from putting Marie in fear. He admitted taking her bank card and making threats to her family. He also indicated that Marie's statement was correct i.e. that he had tied her up, cut up her clothes and threatened to "*chop her up*" when she tried to leave. On 21 April 2015, a three-way meeting took place between the perpetrator, a facilitator and his offender manager (probation officer 1). It was identified that the perpetrator should complete further work around jealousy with his offender manager (probation officer 1).

During the first eight months of his order, he was seen five times by his offender manager (probation officer 1). Despite attending the 'building better relationships' programme, it would be expected that offenders assessed as high risk of serious harm should be seen weekly. Between 8 December 2014 and 14 January 2015 when group sessions were not taking place, there was no contact with him. During the eight months of case management his offender manager (probation officer 1) also had three planned telephone contacts with him and there was one unplanned office appointment. This was not sufficient contact to establish a meaningful working relationship or to be monitoring changes to his circumstances and any associated risk issues.

The perpetrator's offender manager (probation officer 1) showed a lack of professional curiosity. The perpetrator's account of events was accepted without any attempt to corroborate or disprove them. There was an incident in October 2014 when Marie was hospitalised and West Midlands Police went to the perpetrator's address. This information was conveyed to his offender manager (probation officer 1) however there was no evidence that this was addressed. On 25 November 2014 the perpetrator's offender manager (probation officer 1) received information that the perpetrator had stayed at Marie's refuge accommodation. Whilst this was discussed with him on 28 November 2014, there is no evidence that enquiries were made with other agencies to check the information.

In fact, the perpetrator was never fully confronted regarding whether he was still in a relationship with Marie, despite him giving differing accounts about staying at the hostel where Marie lived. He admitted taking her bag to his house so that she had to go there to retrieve it. He appeared on several occasions with love bites. She was seen in the waiting room at the probation office. He mentioned a "*one-night stand*". There were suspicions throughout his engagement with probation that he was still in a relationship with Marie but he denied this and it was always taken at face value. A home visit was carried out and

Marie's coat was at his property. His explanation was that she had left it behind when she was living there.

During the period under review only two home visits were undertaken. The guidance on managing domestic abuse cases highlights the importance of making regular home visits, both planned and unannounced, to get a better insight into the offender's lifestyle and home circumstances. When it was suspected that the perpetrator had resumed his relationship with Marie, home visits may have provided evidence to support this. The Risk Management Plan completed as part of the offender assessment system (OASys) review did not specify home visits as a means of managing risk which would have been expected in a domestic abuse case. This appears to have been a missed opportunity to gain a clearer insight into the perpetrator's home circumstances.

There is an expectation that in cases involving domestic abuse, there is regular contact with police to check if there have been any call outs to the home address or other concerning behaviour reported to the police. This was identified as an action in the 'risk management plan' which states the "*offender manager (2) to liaise with the Police Domestic Violence Unit to monitor any calls that involve* [the perpetrator]". There is no evidence that this took place.

There was a lack of urgency in the offender manager's (probation officer 1) response to information that indicated that the risk the perpetrator posed towards Marie was increasing. The MARAC (multi-agency risk assessment conference) meeting on 4 November 2014 identified actions for the offender manager (probation officer 1) to support a referral to the Esteem team (counselling service) and to make a home visit. There was no evidence that either of these actions were carried out.

Despite being given a suspended sentence, the perpetrator was eligible for MAPPA (Multi-Agency Public Protection Arrangements) management. This would have allowed all agencies to share information and to formulate a shared risk management plan.

**Given the number of agencies involved with the perpetrator and Marie and the concerns about whether their relationship had resumed, it would have been beneficial for consideration to have been given to referring the case to MAPPA (Multi-Agency Public Protection Arrangements). There was no evidence that the perpetrator's offender manager (probation officer 1) was aware that the case was eligible for MAPPA (Multi-Agency Public Protection Arrangements) management or that his eligibility was considered.**

When the perpetrator completed the 'building better relationships' programme, his supervision was transferred to a different offender manager (2). Offender manager (2) completed a review of the offender assessment system (OASys) and following positive feedback from the facilitators of the 'building better relationships' programme, the offender manager (2) reduced the perpetrator's risk of harm to a known adult to medium. A medium grade is defined as: "*there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship*

*breakdown, drug or alcohol misuse*". Considering his index offence, a review of the spousal assault risk assessment (SARA) should have been completed. There was no evidence that this was done.

**A review of the spousal assault risk assessment may have provided evidence to support the offender manager's (2) view that the risk he posed to Marie had reduced or it may have provided grounds for the risk reduction to be reconsidered. This was a missed opportunity.**

In addition, when a risk assessment is reduced from high to medium there should have been a discussion with a senior probation officer to endorse that decision. There is no evidence that this oversight took place.

When an offender is assessed as presenting a medium risk of harm, the frequency of reporting changes. Consequently, the perpetrator was given fortnightly appointments. Unfortunately, this reduced the likelihood of his offender manager (2) being able to establish a meaningful working relationship with him. This made it less likely that the perpetrator would discuss concerning thoughts or behaviour. It would have been good practice to initially maintain weekly reporting to establish a working relationship and to monitor his application of the learning from the 'building better relationships' programme. This may also have provided further evidence to support the reduction in risk at a later date.

When an offender is the subject of a court order there is an expectation that if he does not comply with the order (either by breaching its terms or failing to report as required) then he will be returned to court. In these circumstances, the court has the option of revoking the order and resentencing, which in this case would probably have meant activating the suspended sentence, or to allow the order to continue but adding a punitive element such as a fine or unpaid work. There were several instances when the perpetrator failed to attend planned appointments or 'building better relationships' programme sessions. The offender manager had the authority to mark an absence as acceptable if evidence was provided to show that the offender had a legitimate reason for his absence. There was no record that when he missed sessions that he provided evidence to support his absences and his offender managers appeared to accept his explanation without verification. He missed meetings for various reasons – his mother was ill, his father was dying, his cousin died, his brother died – none of this was really questioned in depth or investigated further. In addition, if an offender is given three acceptable absences, there is an expectation that this is discussed with a manager to endorse this use of professional judgement. There was no evidence that this management oversight took place. In the later stages of the order when the offender manager had changed to offender manager (2) there was a period of two months when he was not seen and he missed two appointments. There was an opportunity here to enforce the order and return him to court. However, given that the order was close to completion, it was unlikely that a court would have activated the suspended sentence.

**Throughout the perpetrator's engagement with probation, there were plenty of opportunities to challenge him and his behaviour, but he was afforded too much flexibility to his reporting. This left Marie vulnerable to continued manipulation and abuse from him.**

There are significant learning points from this review including:

- Importance of officers exercising professional curiosity in their work, seeking verification for information presented by the offender and regularly liaising with other professionals who have contact with the individual.
- Importance of making regular home visits, both planned and unannounced, in case of domestic abuse.
- Importance of making regular contact with police to seek information on call outs or other contact in cases of domestic abuse.
- Ensuring that before reducing risk levels that a suitable time has elapsed for the offender to demonstrate their learning from a programme after that group has finished.
- Decisions to reduce levels of risk should be discussed with a Senior Probation Officer and this management oversight should be recorded in the case notes.
- Appropriate enforcement action should be taken when necessary and if this is not done the reasons for this should be recorded.

The single agency recommendations for the National Probation Service reflect these learning points.

## 7.7. Black Country Healthcare NHS Foundation Trust (formerly known as Black Country Partnership NHS Trust)

Black Country Healthcare NHS Foundation Trust first became involved with Marie in 2014 when she was referred to the 'single point of referral' team by a paramedic following an episode of self-harm. She reported that her partner was in prison and she was staying at a refuge for the next 5 months. Marie also suggested she would be moving closer to her family (Worcester). There was no indication she was going to see him again, and Marie had reported she had been told by children services she was not allowed to see him when he was released. Therefore, the domestic abuse appeared historical at this time and it did not appear she was in imminent risk of abuse, harm or coercive control. Marie was encouraged to register with a GP close to her new address, who could then refer her to local services. During the assessment there were missed opportunities to explore a number of issues including the perpetrator's release date, her concerns about his release and what support she had. At the time, there were no 'standardised' risk assessment tools used. The TAG (threshold assessment grid) risk assessment[19] is now used, this explores risk to self, risk from others, risk to others, as well as survival, psychological and social risks.

Marie was also known to Black Country Healthcare NHS Foundation Trust as she was referred three times to the ‘Wellbeing Hub’. These referrals were screened and then sent to

[19] The threshold assessment grid (TAG) is a short, quickly completed assessment of the severity of an individual's mental health problems. It aims to help identify people who should be referred to community mental health services for adults and older people – for further information see https://www.researchintorecovery.com/TAG - accessed online 11 September 2020

Sandwell counselling and IAPT (improving access to psychological therapies service).[20] She was referred in 2014 by her GP, 2015 by her GP and 2017 by the Kaleidoscope Group. On each occasion, Marie was asked (or sent a letter asking her) to contact the team to make an appointment. On all three occasions she did not respond and was discharged unseen. Thus, she was never assessed.

Marie was again referred to the 'single point of referral' team in August 2017, by her GP. The referral indicated Marie had experienced anxiety and depression for many years and that she had constant thoughts of self-harm. There was no mention of any previous or current domestic abuse in the referral. An appointment was made for her to attend for assessment with the team on 7 August 2017. Marie rang to cancel this appointment and a further appointment was then offered. Marie attended the appointment on 14 September 2017. Unfortunately, the clinician had double booked the assessment and so Marie was not seen that day and an appointment was rearranged. She cancelled that subsequent appointment on 20 October 2017 and was discharged unseen due to non-attendance.

**This was one of the only times mental health services had the opportunity to see Marie. It was unclear whether the perpetrator prevented her from engaging but considering his manipulative, controlling behaviour, it is likely that she had very limited opportunities to seek help.**

Today, the Trust has a 'did not attend' policy. The service user will be offered another appointment and the referrer will be contacted, the GP will be contacted as well as any other agencies involved. A clinician also discusses 'did not attend' cases at a weekly meeting. If it is deemed safe to discharge a patient, a clinician is required to discuss this with another 'band 6' clinician and document how the decision was reached.

THE PERPETRATOR

The Trust first became involved with the perpetrator when he was referred by his probation officer to the 'criminal justice mental health liaison' team in September 2015. His identified risk factors were his drug use and potential risk to partners. He reported he had completed a domestic violence course and his violence had increased due to drug use. He also said his violence stemmed from the abuse he suffered as a child. The outcome was that he was referred to the Wellbeing Hub for counselling for past abuse. The Sandwell counselling and IAPT (improving access to psychological therapies service) sent the perpetrator a letter asking him to make contact to arrange an appointment. He did not respond to this letter and was discharged unseen in November 2015.

His GP referred him again to the Wellbeing Hub on 20 June 2017. It was forwarded to the Sandwell counselling and IAPT (improving access to psychological therapies service). In the referral it stated that the perpetrator was having aggressive outbursts and had been involved in a terror attack in London, where a friend had died in his arms. He was

[20] IAPT (improving access to psychological therapies service) provides evidence based treatments for people with anxiety and depression – for further information see http://talkshopsandwell.co.uk/services-on-offer/talking-therapies-service-iapt - accessed online 11 September 2020

experiencing panic attacks and flashbacks and wanted counselling. There was no mention of any previous convictions or domestic abuse nor any details about his "*aggressive outbursts*".

The perpetrator received a telephone triage appointment with a counsellor on 5 July 2017. The counsellor did not use routine enquiry to explore safeguarding issues such as whether he felt he posed a risk to others or if he felt at risk from anyone else. The practitioner instead focussed on the perpetrator's potential risk to himself, as he had reported trying to end his life. He told the counsellor that his ex-girlfriend had moved in with him and he felt safe with her there. He reported she was with him 24 hours a day. It would have been beneficial to explore further who the person was, what their relationship was like, did she ever leave his side and what he would do if she ever left the house.

**The counsellor had not read the previous referral from the Criminal Justice Team in 2015 so was unaware of his history of domestic abuse. The counsellor did not have access to the secondary care electronic system (Oasis). It would have been robust for all previous referrals and electronic systems to have been checked and read before the triage.**

The perpetrator did not engage further with the counselling team and was eventually discharged. Another counsellor from IAPT (improving access to psychological therapies service) arranged a face-to-face appointment with him in October 2017. The perpetrator contacted the service to notify them he could not attend that appointment. Another appointment was sent but he did not attend this appointment and he was discharged from the service.

Currently, 'opt in' letters are used. This places the emphasis on the client to contact the service. If certain patients have identified risks (such as the perpetrator), it would be more proactive to send fixed appointments to increase the chance of a patient attending. This would then provide an opportunity to explore and manage risk more effectively. In line with the Trust's 'did not attend' policy, it is important to send more than one fixed appointment before a patient is discharged from the service.

Records from Black Country Healthcare NHS Foundation Trust showed that routine enquiry about domestic abuse was not standard practice in 2014 (although it is now). It varied across disciplines and departments. There was also inconsistency about exploration of all safeguarding issues, including a client's potential risk to others.

## 7.8. Clinical Commissioning Group – General Practitioners

The perpetrator was registered at a GP Practice (B) between September 2014 and December 2018. During this period, he saw the GP seven times. He presented with low mood, self-harming and depression. He was seen twice in 2014 for treatment of depression, twice in 2016 for the same symptoms and a further 3 times in 2017. There was no link to indicate that he was the perpetrator of Marie's abuse.

During the period of this review, Marie had over 140 contacts with primary care staff. Despite this, neither the C nor D GPs Practices could provide a 'pen portrait' of her; none of the practice or reception staff could recall her. This was attributed to the fact that Marie was seen by a plethora of GPs and other clinical staff.

| | | |
|---|---|---|
| **GP Practice A**<br>Worcestershire | March 2012 – September 2014 | 15 GP contacts |
| **GP Practice B**<br>West Midlands | September 2014 – January 2015 | 10 contacts;<br>8 with 5 different GPs |
| **GP Practice C**<br>West Midlands | January 2015 – September 2017 | Approx. 80 contacts;<br>23 with 9 different GPs<br>4 with nurses<br>23 with reception staff (repeat prescriptions) |
| **GP Practice D**<br>West Midlands | September 2017 – December 2018 | 42 contacts<br>26 with 11 different GPs<br>3 with nurses<br>13 with reception staff (repeat prescriptions) |

Marie presented frequently with low mood, anxiety, depression as well as other ailments such as gastric symptoms. The physical effects and symptoms of domestic abuse are well documented. Given that victims are four times more likely to suffer from mental health problems including low mood, depression and anxiety,[21] Marie's home circumstances and whether these may have been a catalyst for her problems was never explored. The NHS spends more time dealing with the impact of violence against women and children than almost any other agency and is often the first point of contact for women who have experienced violence. Frequent attendances at health settings have been identified as risk indicators of domestic abuse.[22] Although Marie suffered with depression for a considerable amount of years, the root cause was never explored.

Clinical staff appeared to be responsive and sensitive to Marie's mental health. Three referrals were made to counselling services. However, Marie did not engage and was therefore discharged without ever being seen. Following the interview with the safeguarding lead for the practice, it would appear that at the time non-engagement at services was not routinely followed up. The practice now has a procedure where a member of the reception team will invite patients to a clinical appointment to discuss the reason for non-engagement. Since this time, all GP Practices have received a 'did not attend' protocol. This aims to prompt staff to consider non-attendance as a potential safeguarding concern.

Marie's GP records did not document her engagement with the MARAC (multi-agency risk assessment conference) in early spring 2014, August 2014, and November 2014. In October 2015, the revised and updated GP toolkit[23] was circulated to all GP practices in Sandwell and West Birmingham. In addition, the Clinical Commissioning Group (CCG) provides a lead nurse within the MARAC (multi-agency risk assessment conference) to enable Sandwell GPs to share relevant medical information within the process. The lead nurse also shares the information and outcomes from the MARAC (multi-agency risk assessment conference) with GP practices.

[21] See https://link.springer.com/article/10.1023%2FA%3A1022079418229 – accessed online 11 Sept 2020
[22] Department of Health. http://www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_113837 [cited June 2011]
[23] http://www.rcgp.org.uk/clinical-and-research/toolkits/~/media/Files/CIRC/Safeguarding-Children-Toolkit-2014/RCGP-NSPCC-Safeguarding-Children-Toolkit.ashx - accessed online 11 September 2020

There were numerous missed opportunities to talk to Marie about her home life, her relationship, the father of her unborn child and the reason why children's social care removed her child from her care. For example, at one consultation Marie became upset, she disclosed that she was in the late stages of pregnancy and children's social care had made the decision to put her baby into care when the child was born. There was no discussion around the father of the child and a missed opportunity to ask about domestic abuse, or to even gauge the risk of abuse and the fact she was living in refuge accommodation. Research shows that women who are directly asked about domestic abuse are more likely to disclose domestic abuse.[24] It would appear that patients who are residing in refuge accommodation are not flagged routinely. It was clear that following the majority of subsequent contacts that Marie had with primary care staff that domestic abuse was not considered as part of their assessment, if a domestic abuse flag was present this would have potentially changed successive consultations. For example, in February 2018, Marie saw her GP, she was accompanied by the perpetrator and she complained of worsening mood, poor sleep, reduced appetite and poor concentration. The GP's assessment indicated that she was suffering from a significant episode of depression. As the perpetrator was present, she was not asked about personal relationships and domestic abuse. Nevertheless, had an alert or flag been present on her records, this could have prompted the GP to try to create an opportunity to speak to Marie alone.

Occasionally, Marie did go to her GP without the perpetrator accompanying her, unfortunately these opportunities were not used to explore her personal relationships or domestic abuse. It appeared that during the latter 2 years of Marie's life, the perpetrator frequently attended medical appointments with Marie, especially in relation to her mental health, which Marie had openly disclosed had been worsening since August 2017.

In November 2017, Marie saw her GP following exacerbation of back pain. During this consultation the perpetrator was very aggressive and demanded treatment and investigations straight away. He was unhappy that the GP advised Marie to go the hospital emergency department. He said that if they were told to come back to the GP he would "*smash up the surgery*". This incident appeared to coincide with one described by Marie's sister when the perpetrator kicked Marie in the back. Following this, she had great difficultly standing upright or walking unassisted. There was no reference made within Marie's records regarding the perpetrator's behaviour. No alerts or flags were placed on Marie's records or the perpetrator's records, as he was not registered at the same GP practice. As Marie and the perpetrator were not registered at the same GP practice there was no link made between them as a couple.

Marie was seen in May 2018 by the GP. She disclosed that she was losing weight and was not eating well. At this time Marie weighed 6st 9lbs. A previous weight check (2015), she weighed 8st. The GP requested to recheck her weight in one months' time. However, the next four contacts Marie had with the surgery were for repeat prescriptions for various medications. Marie did not attend a couple of appointments so she was not seen at a face-

[24] See for example https://www.ncbi.nlm.nih.gov/pmc/articles/PMC196400/ - accessed online 11 Sept 2020

to-face until August. Then she requested a food voucher and was advised to contact social services for help.

**This was a missed opportunity for the GP to make further enquiries into why Marie needed a food voucher and link this to her weight loss – this would have been particularly important in light of the fact that the perpetrator withheld food from her in the past when her weight had been as low as 5½ stone.**

Numerous attendances by Marie with various ailments shows that clinical staff failed to see the escalation of abuse potentially being experienced by Marie and simply treated each consultation in isolation. This supports the view that primary care often misses potential symptoms which are frequently intensified when patients are victims of domestic abuse. Domestic abuse is a major public health and clinical problem and it requires a healthcare response.[25] Historically GPs (and clinicians in general) have not responded effectively to the needs of patients experiencing domestic abuse. Most clinicians have little or no training, fail to identify patients experiencing abuse and are uncertain about further management after disclosure.

Clearly there are challenges within primary care when victims do not see the same GP at each consultation. Demands on general practice have intensified – a heavier workload together with increasing complexity and intensity of work has put the service under tremendous strain. In addition, the shift within primary care to form primary care networks and encouragement from government for GPs to work across partnerships led to fragmented patient care in Marie's case.

**A significant learning point within this individual management review concerns the importance of flagging records. Thus, it is imperative that risk factors relating to domestic abuse are recorded and flagged so that clinicians are able to respond to these risks within their assessments.**

To improve GPs response to domestic abuse, a pilot project was introduced in 2014 to roll out IRIS to all GP practices in Sandwell. IRIS is a domestic abuse training support and referral programme for GP practices which provides training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic abuse services. An advocate educator is linked to a GP practice and based in a local specialist domestic abuse service. The advocate educator works in partnership with a local clinical lead to co-deliver training to GP practices. The project has developed since 2014 and currently (September 2020) 96% of GP practices in Sandwell are engaged.

## 7.9. Sandwell Metropolitan Borough Council Neighbourhoods

In early spring 2014, Marie approached the neighbourhood services (housing) asking for assistance. She stated that her accommodation was unsuitable to live in with a baby (she

[25] Ramsay J, Rutterford C, Gregory A, Dunne D, Eldridge S, Sharp D *et al*. Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. British Journal of General Practice 2012; 62(602):647-655 – accessed online 28 July 2019 @ https://bjgp.org/content/62/602/e647

was pregnant at the time) and she was a victim of domestic abuse. She explained that her ex-partner was in prison at the time. She was seen by a housing advisor who concluded that Marie was not "*threatened by homelessness at the moment*". Normally, cases of domestic abuse would be allocated to a 'housing options officer'. These officers are more experienced and handle cases of domestic abuse. At that time, there was only one staff member within the organisation trained to complete the DASH (domestic abuse, stalking and honour-based violence) risk assessment and hence an assessment was not completed during either of Marie's approaches. Since Marie's approach in 2014 staff have received training and there is now a greater awareness of safeguarding throughout the workforce with 160 officers receiving training on domestic abuse and DASH (domestic abuse, stalking and honour-based violence).

Marie presented again as homeless at the end of August 2014 having been evicted from the refuge. Her housing options officer liaised with Women's Aid and established that she had been asked to leave because of her threatening behaviour. Marie (whilst heavily pregnant) was offered alternative accommodation in a hostel. She declined it saying she would rather stay with friends. Several follow-up appointments were made but Marie did not attend them. In autumn 2014, Marie informed housing that she had left a refuge in Sandwell and was again homeless. By this time, she had given birth and her child had been taken into care. Marie was placed in temporary accommodation.

In late autumn 2014, Marie's case officer and officers from West Midlands Police went to her address twice. The reason for the visits was not recorded in either the police or housing records. The property was for women and children only. Nevertheless, on both occasions a man was found and removed from the address. His name was not documented – although notes referred to him as Marie's ex-partner. Housing records stated that Marie was "*advised of risks*". Housing informed children's social care, but neither the police nor housing informed probation.

**This was a missed opportunity for a multi-agency response in order to support Marie. Had the perpetrator been formally identified and the issue raised with his probation officer, sanctions could have been placed upon him. Instead Marie was advised that she was in breach of the terms of her licence agreement. After these incidents, face-to-face contact with Marie was minimal and housing officers experienced difficulties in contacting her.**

Marie was not seen again until late 2014 when she went to sign for her council tenancy. Marie's tenancy ran from early 2015 to summer 2017. It was noted that the property was sparsely furnished. Marie was assisted by officers with a grant for furnishings via the council's local welfare provision scheme. Marie accessed the scheme several times throughout her tenancy which suggested that she experienced financial difficulties. No other issues of concern were noted by officers undertaking visits.

Marie's mother rang housing on 18 April 2016 because she was concerned about the lack of contact from Marie. This was followed up by an enquiry from West Midlands Police. The housing records were "*scant*" however it is documented that a lock change had been arranged by the police (dated 21 April 2016) but was later cancelled as the police had had contact with Marie's ex-partner who confirmed that Marie had been seen and would be

contacting them. The identity of Marie's ex-partner was not recorded on the housing records – neither did this incident appear in the police records. Therefore, it was not possible to understand why they would have accepted the perpetrator's assurances that he had seen Marie the day before and she was okay.

Contact throughout 2016 was minimal. There were concerns that Marie had abandoned the property and a home visit was undertaken in May 2016. Whilst the property was sparsely furnished, the housing officer undertaking the visit was satisfied that Marie was living at the property and the condition satisfactory. Marie signed a visit form confirming that she was the sole occupant.

At a home visit in August 2016, the same housing officer asked Marie whether she was still living at the property, as she did not have any gas. The housing officer was concerned because she had no cooker or washing machine. Marie's explanations were accepted i.e. she was using the local laundrette and eating sandwiches and fast food.

**There was a theme around scarcity of belongings as well as a lack of facilities (such as gas) at Marie's accommodation. Nobody considered whether this might be as a result of economic abuse, rather than her not living at the property.**

In late-November 2016, a neighbour reported a leak from Marie's property. Despite attempts, access was not gained so a decision was made to force entry and change the locks. On 1 December 2016, Marie collected the keys and explained that she had been staying with a friend who was ill. She was accompanied by a man who she referred to as "*****" (a name very similar to the perpetrator). The same man was present at the property the following day when officers visited. The relationship was not investigated further.

From January 2017 onwards, Marie reported issues of anti-social behaviour from a neighbour. This resulted in a harassment report being submitted in July 2017. It was noted that Marie's boyfriend (the perpetrator) had been harassed and threatened by a man who was a known perpetrator of anti-social behaviour on the estate. The housing officer investigating the reports met with Marie and the perpetrator together and commented that the perpetrator came across as more protective of Marie, rather than controlling.

Marie completed a housing transfer application. If officers had compared Marie's and the perpetrator's address history it would have been apparent that both had lived at, at least two properties together. This suggested that their relationship extended beyond the friendship that was being portrayed. Marie had previously stated in June 2014 that she was the victim of domestic violence and her ex-partner was in prison. This link was not made. Had it been, housing may have explored their relationship more. Furthermore, if the perpetrator's criminal convictions had been disclosed, the application would have been referred to an inclusions panel and his suitability to join the housing register would have been considered in greater depth.

Marie secured a move in summer 2017 and the perpetrator was added as an occupant. From summer 2017 until November 2018, there was nothing out of the ordinary about their tenancy. Then in November 2018, a resident complained that the perpetrator had been

verbally abusive to an unidentified workman in the block. This was recorded and the information passed to a manager. The officer requested a flag for violence and aggression be recorded against the perpetrator to warn other housing officers with whom he might come into contact. There was no evidence to suggest that either Marie or the perpetrator were spoken to in relation to these allegations, or that Marie's safety was considered in light of the perpetrator's abusive behaviour.

In November 2018, a housing officer went to their home with the local police team (West Midlands Police) to execute a drug warrant. Marie's demeanour was described as "*nervous, very quiet, visibly shaking, downtrodden and tearful*". When Marie was asked questions, the perpetrator talked over her. He was described as being "*irate and very vocal*". Weapons were found during the search; a machete, crow bar and a large kitchen knife were beneath the mattress in the bedroom. The perpetrator stated that the weapons belonged to him and were used for his protection. A small amount of cannabis was found along with foil and scales. He admitted possessing cannabis and using heroin that morning. He was cautioned for possession. As he was only cautioned for possession, the housing officer felt there was insufficient evidence to progress the case. Therefore, a warning letter was sent to Marie as the tenant.

A further report of drug use, loud music, shouting and banging around was made by a neighbour later in November 2018. A letter was sent to Marie asking her to attend a meeting. This meeting never went ahead, as Marie telephoned and instead spoke with the anti-social behaviour officer. The sparse notes from the telephone conversation suggested that the discussion was brief and did not encompass all that it should. Marie was advised that if further complaints were received, it may lead to another written warning. A further report in December 2018 of the perpetrator buying drugs outside the block was not actioned.

**The anti-social behaviour housing officer did not follow up the information from the raid or the complaints about noise and drugs. This could have led to action being taken against the perpetrator in the form of a civil injunction. There was not enough professional curiosity in relation to Marie. She was not asked any questions regarding her relationship with the perpetrator so she was treated as a perpetrator of anti-social behaviour rather than being considered a victim of domestic abuse.**

A rolling training programme started in 2019 to assist frontline housing staff to recognise the signs and symptoms of domestic abuse. The training is being delivered by Black Country Women's Aid and it includes information about undertaking DASH (domestic abuse, stalking and honour-based violence) risk assessments. In June 2019, Sandwell Metropolitan Borough Council Housing and Communities directorate achieved accreditation with the Domestic Abuse Housing Alliance (DAHA).[26]

[26] DAHA (Domestic Abuse Housing Alliance) Accreditation is the UK benchmark for how housing providers should respond to domestic abuse in the UK – for further information see www.dahalliance.org.uk – accessed online 11 September 2020

## 7.10. Sandwell and West Birmingham NHS Hospitals Trust

Marie was known to the safeguarding midwife from June 2014. Information was recorded regarding the severity of the domestic abuse Marie suffered. Yet, a MARAC (multi-agency risk assessment conference) referral was not considered. When Marie was seen postnatally in autumn 2014, there was no exploration of where the perpetrator was living and whether she had contact with him. In addition, no referral was made to the health visitor even though Marie's baby had just been removed from her care. This would have been an opportunity to meet Marie's psychological needs and potential depression as records showed she was feeling anxious.

During the period under review, Marie presented six times at Sandwell emergency department. Most of these attendances were for back pain and abdominal pain. It was known that she used drugs and that she suffered with anxiety and depression. In early spring 2014, following the MARAC (multi-agency risk assessment conference), an alert was added to her records stating she was a known domestic abuse victim.[27] Overall there was a medical focus when Marie presented at the emergency department. This demonstrates poor practice given that the 'independent domestic abuse project' [28] was in place. This service supports professionals if they are unsure how to ask questions about domestic abuse. In addition, in September 2014 there was a working domestic abuse policy which recommended routine enquiry in both the emergency department and maternity services. Despite this, domestic abuse was never considered when she presented. There were a number of missed opportunities to safeguard Marie which not only demonstrates a deviation from policy and good practice, but also lack of professional curiosity. This was evident both in the emergency department and the maternity services.

The record keeping in the emergency department was poor. In fact, on most occasions there was no record of who accompanied Marie. On two occasions it was recorded that her "*partner*" or "*spouse*" was with her but there was nothing indicating his identity. Following a medical model is a common feature in a busy space emergency department. There has been a lot of work done to embed the independent domestic abuse project since this date. Nowadays, the emergency department IDVA (independent domestic violence advisor) is vital in providing a safe space for victims. The IDVA (independent domestic violence advisor) will take referrals from the emergency department staff or make discreet approaches to individuals with injuries suspected of being related to domestic abuse. They offer confidential advice and support with follow-up support from Black Country Women's Aid. The emergency department IDVA (independent domestic violence advisor) undertakes risk assessments and where necessary will make a referral to MARAC (multi-agency risk assessment conference). This unique service offers victims the opportunity to seek help, understand their options and identify support agencies. Currently, all emergency department staff attend level 3 safeguarding children training where mental health, drug and alcohol and domestic abuse are all discussed. In addition, the domestic abuse lead

[27] The alert stays on the victim's records for a year and is removed if there are no further referrals to MARAC (multi-agency risk assessment conference).

[28] This is a joint venture with Sandwell Women's Aid (now known as Black Country Women's Aid) which commenced in November 2015.

nurse has delivered a number of bespoke training sessions on domestic abuse at nurse induction and junior doctor training.

## 7.11. Black Country Women's Aid

Marie was referred to Black Country Women's Aid in August 2013. She was supported by them until her case was closed in November 2013 because Marie said, "*things were looking up*" and she no longer required support.

Marie was re-referred in February 2014 and was supported until 3 July 2014 when she moved into a refuge in Worcestershire. At this point, a referral was made to West Mercia Women's Aid. Marie made contact with Black Country Women's Aid again in August 2014 when she was heavily pregnant and homeless because she had been evicted from the refuge in Worcestershire. The perpetrator had been released from prison in August 2014. She was supported to access housing but she decided to stay with a friend. She was re-referred to the Sandwell MARAC (multi-agency risk assessment conference). Then in September 2014, Marie accepted a refuge place.

During her time in the refuge, Marie had difficulty paying her personal rent charges and she was issued with a seven-day notice. In October 2014, Marie started attending the Freedom Programme and then in mid-October moved out of the refuge into a shared property. From then onwards she received community support from Black Country Women's Aid. Marie continued to attend the Freedom Programme and have one-to-one support but her contact began to dwindle towards the end of 2014. At the beginning of 2015, there was sporadic telephone contact with Marie but by March 2015, Marie ceased to answer her phone. Her case was closed in April 2015.

Marie was re-referred again on 8 February 2016 following a multi-agency safeguarding hub (MASH) referral. Her case was closed on 19 February 2016, as Black Country Women's Aid was unable to make contact with her.

On several occasions, Black Country Women's Aid was contacted by members of Marie's family because of their concerns about the perpetrator and his threats towards Marie. The family was advised to call the police. Although records showed that the police were informed, it did not always stipulate which police force, as Marie's mother lived within West Mercia Police area and Marie in West Midlands Police area.

There was no doubt that Black Country Women's Aid worked hard to keep Marie engaged and accessing their service. They supported her to engage with other agencies and shared information and attended meetings.

## 7.12. Esteem (counselling service)

Esteem supports those with mild to moderate mental health issues and complex needs at an early stage to prevent deterioration and admission to secondary care services. Marie was referred to the service in 2014 because she was "*pregnant and was suffering depression, high risk MARAC* (multi-agency risk assessment conference) *case*". The link worker arranged an appointment to see Marie on 17 April 2014. On the day of the appointment, Marie was held up so it was agreed that the link worker would call her after the Easter break. Another

appointment was arranged for 14 May 2014 and the link worker met with Marie at Marie's house. Throughout the assessment Marie was tearful, she said everything was a mess. She was obviously "*struggling with loneliness*", she was distressed and blamed herself for the perpetrator being in prison. Marie "*wished she was dead, then it would all be over*". The link worker concluded that Marie needed to be referred to psychiatric liaison services because of the decline in her mental health. A referral was also made to Black Country Women's Aid.

## 7.13. Black Country Healthcare NHS Foundation Trust (formerly known as Dudley and Walsall Mental Health Trust)

On 7 March 2014, Marie was seen for a mental health assessment following a referral from her GP where she had presented with mild anxiety and depression. She informed the primary care mental health nurse that she had a history of drug use and abuse. She disclosed that her partner abused her and she was pregnant. She had stopped using methadone and had been clean from any substances for the last 5 weeks. She described her partner as being controlling and both verbally and physically abusive. He had also made threats to kill her, held her in false imprisonment and cut up her clothes. Marie explained that her partner was on remand but she had been feeling guilty and felt that she could not cope without him and wanted to retract her statement. She was being supported by a domestic abuse worker based at Black Country Women's Aid. She was observed to be facially "*flat and tearful*". A safeguarding alert was placed on Marie's records and a follow up telephone call was planned for the following week.

A GP referral to the Early Access Service (EAS) was received on 13 March 2014. Marie contacted for initial telephone screening on the same day. She reiterated her story to the community psychiatric nurse (CPN) although she said that she had falsely blamed a rape on her partner and that was why he was in prison. Marie was advised that the referral would be discussed with the Early Access Service (EAS) and she would be informed of the outcome via telephone or letter. In the interim she was provided with crisis support contact details.

The primary care mental health nurse contacted Marie on 19 March 2014. Marie was upset and tearful. She stated that she felt alone and she was still feeling guilty about her partner being in prison so she was going to retract her statement. She said that she was eating adequately and taking care of herself for the sake of her unborn baby. She was due to see her domestic abuse support worker but she had no credit to call them. The nurse agreed to contact the support worker on her behalf and ask them to contact her.

Marie attended her Early Access Service (EAS) appointment on 26 March 2014. She complained of a further deterioration in her mood. The outcome of the appointment was for Marie to be referred to the Community Recovery Service (CRS) for a psychological assessment and outpatient appointment.

Marie was offered an appointment with the Community Recovery Service on 17 April 2014, which she declined, as she had a prior engagement. She informed the service that she was due to see a psychiatrist from Sandwell Mental Health Services in May and wanted to attend that appointment. She was not given any further appointments. Although she declined the

appointment, the clinician did contact her GP to seek assurances that Black Country Healthcare NHS Foundation Trust would be involved in her care.

Marie only had two face-to-face appointments and was discharged from Black Country Healthcare NHS Foundation Trust on 2 June 2014.

## 7.14. Sandwell Metropolitan Borough Council Floating Support

Sandwell floating support service supports vulnerable people living in their own homes. Marie was referred to the service in autumn 2014 by the homeless team because she had been evicted from a women's refuge. She was allocated a support worker. Marie stated that she wanted short term help to ensure she had a safe and comfortable home so her baby would be returned to her. Marie's overall risk (it did not state of what risk) was considered to be "*low*". Between November 2014 and January 2015, Marie's support worker contacted her six times by letter and six times by telephone. Marie either cancelled the appointment or did not attend. Her case was closed in January 2015. There was no evidence that information was shared with any other agency.

**Clearly, there was a lack of information sharing with housing and other agencies when contact could not be made with Marie. It would also have been more appropriate if floating support had undertaken a joint visit with housing.**

## 7.15. West Midlands Ambulance Service

There were two significant calls to West Midlands Ambulance Service. A 999 call was made on 15 October 2013 because Marie had abdominal pain. A man could be heard shouting and swearing in the background. As Marie did not require hospital treatment, the ambulance service arranged for a GP to contact Marie. There was no documentation about any violence or aggression whilst paramedics were at the scene.

On 17 August 2016, the ambulance service received a phone call. Marie was unconscious having taken an overdose. Her partner told the paramedics that Marie had taken an accidental overdose of two bags of heroin. She had a tonic clonic seizure[29] lasting about eight minutes. She stopped breathing and he administered naloxone. Marie regained consciousness and she was taken to Russells Hall Hospital and the perpetrator escorted her. No details were recorded of her partner or his name.

**Further enquiries should have been made in October 2013 when a man could be heard shouting and swearing in the background.**

## 7.16. Russells Hall Hospital

Marie attended Russells Hall Hospital (part of the Dudley Group NHS Trust) for her antenatal care in 2014. She was initially booked in by the community midwife in early spring 2014. It was noted that she had two previous children who lived with their respective fathers, that she had a past history of drug use and that she had current mental health issues. Referrals

[29] Generalised seizures are more distributed and affect both sides of the brain at once. There are different types of generalised seizure, the most recognised of which is the tonic–clonic seizure which was formerly known as a grand mal seizure, where the person goes stiff and then has jerking movements. During a generalised seizure, the person may lose consciousness, fall or have muscle spasms.

were made to the obstetrician, specialist midwife (drug use and mental health) and children's social care because of the risk posed by the perpetrator to Marie's unborn baby.

During a consultation with the community midwife in May 2014, Marie was tearful because "*her partner*" was going to be released from prison on bail. She said she was unsure what to do. Marie agreed for a referral to be made to Sandwell children's social care. Nevertheless, this referral was not made for a further month (June 2014) but no explanation was documented. A possible reason for the delay may have been that her pregnancy was not considered viable at the time, and the referral would not have been accepted.

The specialist midwife attended the initial child protection conference and there was evidence of good communication between agencies and midwifery services in other boroughs when Marie was housed in refuge accommodation. It was noted that throughout Marie's pregnancy she experienced depression. At the core group meeting in autumn 2014, Marie heard for the first time about the plan for her baby to go into foster care following the birth. No consideration appeared to be given to the impact of her child being removed might have on her mental health or what support she would be offered in the post-natal period.

Marie delivered her baby at Russells Hall Hospital in autumn 2014. The baby was discharged into care four days later and Marie was discharged the same day.

**Records showed that whilst delivering her baby, Marie became "*demanding and aggressive, throwing equipment to the floor and swearing*" when she was told that she would have to wait for the anaesthetist to carry out an epidural. The specialist midwife spoke to Marie about her behaviour the following day and Marie apologised.**

**There appeared to be little empathy towards Marie, considering she had only found out a week earlier that her baby would be taken into care at birth. Understandably, labour would be a distressing time for her.**

There was no further contact with Marie until August 2016 when Marie went to the emergency department following an alleged accidental overdose of heroin. The records stated that she was accompanied by her partner. No name was documented. During the assessment, Marie stated that she was on a methadone programme but had smoked crack cocaine and injected heroin. A short time after injecting she had a seizure which lasted approximately 8 minutes and caused her to stop breathing. Her partner reported giving her naloxone and she recovered quickly. During this contact, Marie complained of generalised pains in her back and shoulder.

**This was a missed opportunity to explore the substance misuse further and possibly enable a disclosure of domestic abuse. At the time, staff did not receive the level of training regarding domestic abuse they have now. Mandatory training now includes the importance of documenting who a patient is accompanied by and whether they have parenting responsibilities.**

There was no evidence to suggest that staff considered that the substance misuse may be a coping mechanism for domestic abuse or that the low-level generalised pain may also have

been a symptom of domestic abuse. Currently, routine questioning is not built into the emergency department electronic documentation. The Trust is in the process of moving to a new electronic patient information and documentation system. The new documentation aims to prompt staff to consider the signs and indicators of domestic abuse and make the appropriate referrals.

## 7.17. Drug and alcohol services

Three services were contracted to provide drug and alcohol services in Sandwell during the period under review. Both Marie and the perpetrator self-referred to Swanswell drug service in March 2013 and continued engaging with the service until January 2014 when they were transferred to the new service provider (IRiS) for two months before relocating to Worcestershire in February 2014. During this period, although Marie disclosed that her two children lived with their respective fathers due to her relationship with the perpetrator, no risk assessment concerning domestic abuse was undertaken. Immediately following Marie's miscarriage in July/August 2013, there was no evidence in her case notes that the circumstances of the miscarriage were explored with her. During an interview for this review, her support worker stated that Marie had said that the perpetrator "*beat the baby out of her*". The support worker could not recall why this was not documented.

At a meeting on 8 August 2013, Marie disclosed that the perpetrator was violent towards her and protective to the point of being controlling. He threatened to "*chop her up*" if she ever left him and he had control of all her possessions. She clearly believed his threats and she wanted to leave the relationship. Owing to the threat that he posed, three-way meetings between Marie, her drug worker and Women's Aid took place at the drug service. Marie did not attend the first meeting but came to the second meeting in September 2013. She felt guilty about discussing the perpetrator's violent, controlling behaviour, so she had told him, and since then she said his behaviour had dramatically improved. In fact, she said that he had not hit her since the discussion. It was also noted in the records that she had new clothes and was wearing make-up – which was something that he did not normally allow.

In late-October 2013, the drug service received a call from Worcestershire drug services. Marie's sister had contacted them because she had not heard from Marie for several months. Marie's sister was concerned because of the perpetrator's abusive behaviour. Despite being seen by her support worker in November 2013, Marie's risk assessment was not updated. No attempt had been made to undertake a safe and well check even though she had not been seen since mid-September. Swanswell risk assessment policy stated that risk assessments should be updated when risk changes or every three months as a minimum requirement.

**Throughout his engagement with drug and alcohol services, his risk as a perpetrator of domestic abuse was not fully explored, assessed or realised – nor was his role as a drug dealer. This was a missed opportunity for Marie's and the perpetrator's support workers to share information.**

Drug and alcohol services had no contact with either the perpetrator or Marie between February 2014 and October 2015. Yet, to reduce the risk of overdose, records showed that the perpetrator was issued with a naloxone kit in April 2015. In mid-October 2015, his offender manager re-referred him. The case notes did not record the reason for the referral or provide any details of his offence. His case was closed in November 2015 because he had not engaged.

Marie presented to the drug and alcohol service (IRiS) again in mid-May 2016. She asked for help with heroine and crack cocaine use. At the time, she described herself as single. The following day, the perpetrator also self-referred to the service. He also described himself as single but did disclose he was being supervised by an offender manager because of domestic abuse and threats to kill. Although Marie and the perpetrator were seen together at the service, Marie denied that they were in a relationship and this was not explored further. For example, following an alleged accidental heroin overdose in August 2016, Marie attended an appointment with the perpetrator (who had administered naloxone to her),[30] Marie was not spoken to alone. Then in October 2016, Marie stated that she was not in a relationship with him as she realised, they were "*better off as friends*". Yet, in January 2017 Marie again was accompanied to an appointment by him and again she was not seen alone. From May 2017 onwards, Marie stated that there was no domestic abuse within her relationship with him. She did however disclose in July 2017 that she had to make a joint benefit claim with her partner, although she would have "*preferred to keep her independent claim*".

**Marie's reason for wanting to keep her benefit claim independent of him was not explored. This was a missed opportunity to discuss the level of control (including financial control) that he was exerting over Marie.**

Marie had 146 face-to-face appointments with the drug and alcohol service (IRiS) between May 2016 and January 2018. She did not attend 14 appointments. From February 2018 – November 2018, Marie attended 38 face-to-face appointments with drug and alcohol service (Cranstoun). She did not attend 10 appointments.

There were numerous instances where practice was not in line with policy and procedure. For example, issues around domestic abuse was not routinely considered on the assessment forms. Furthermore, risk assessments were not routinely completed nor were issues around risk considered, investigated or triangulated. Staff did not appear to consider what was happening in Marie's world. They did not pick up her references to the financial abuse she was suffering nor did they appear to fully comprehend the extent to which she was controlled by him. They failed to see her alone when the perpetrator frequently attended appointments with her. There was no clear evidence that their respective support workers shared information appropriately to ensure that Marie was safe.

**There was no evidence of a DASH risk assessment being undertaken or any consideration that Marie should be referred to the MARAC (multi-agency risk assessment conference). Staff were not professionally curious and did not document why the perpetrator was**

[30] Records showed that Marie was issued with naloxone kits in June 2016 and August 2016.

**being supervised by probation. Indeed, it did not appear that his role as a drug dealer was ever considered or even known about.**

The final contact Marie had with the service was on 4 December 2018 with her recovery worker. The records stated that she looked well and asked for a change to her medication dispensing regime, so she could spend Christmas with her mother. The last contact with the perpetrator was on 21 November 2018. A call was made to the dispensing pharmacy on 31 December 2018, to check whether he had collected his medication. He had not missed any collections.

# 8. CONCLUSIONS AND LESSONS LEARNT

## 8.1. Blaming the victim

Throughout this review, there was the impression that professionals viewed Marie as an "*unworthy*" victim. She used drugs, she had mental health problems, she had a child removed and her other children didn't live with her, there were reports of her being aggressive, using "*bad*" language, carrying a knife and being involved in anti-social behaviour. There were times when she did not do what professionals told her to do. The result of Marie being viewed as "*unworthy*", led to her being blamed for the situation in which she found herself, with barely any consideration being given to the perpetrator's role in her life. Professionals did not consider his role in Marie's drug use e.g. whether she was coerced into using drugs or whether he used drugs as a control mechanism. The fact that Marie remained drug free whilst he was in prison indicated that he played a hugely influential role in her use of substances.

Marie came from the Irish traveller community and yet this was never recorded in any agency's records. The specialist on the panel thought that professionals almost certainly knew her background but failed to recognise its significance. Therefore, by not documenting her background, it meant that professionals did not consider the additional difficulties and barriers she faced. For example, discrimination, prejudice and racism are still part of everyday life for many travellers.[31] A survey carried out by the charity 'Traveller Movement' found that in 2017, 91 % of respondents had experienced discrimination and 77% had experienced hate speech or a hate crime.[32] Ethnicity classifications are not consistently included in police and Crown Prosecution Service statistics, so it was difficult to know whether these figures were reflected in reported hate crime numbers.[33] However, the Equality and Human Rights Commission stated in a 2009 report that:

[31] See for example, "Fighting Gypsy discrimination: What people ask me is insulting" June 2017 Guardian https://www.theguardian.com/world/2017/may/16/gypsy-travellers-discrimination-stigma-poster-campaign - accessed online 11 September 2020

[32] Traveller Movement, *The last acceptable form of racism? The pervasive discrimination and prejudice experienced by Gypsy, Roma and Traveller communities* accessed online 11 September 2020

[33] Tackling inequalities faced by Gypsy, Roma and Traveller communities, Seventh Report Session 2017 – 2019 House of Commons Women and Equalities Committee April 2019 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html#heading-6 accessed online 11 September 2020

*Racism towards most ethnic minority groups is now hidden, less frequently expressed in public, and widely seen as unacceptable. However, that towards Gypsies and Travellers is still common, frequently overt and seen as justified.*[34]

It is estimated that between 60% – 80% of women from travelling communities experience domestic abuse during their lives. Domestic abuse is accepted as normal for many women. They can be trapped by culture, poor literacy and education, distrust of the police and social services, and fear of separation from family and friends – this makes traveller women far less likely to report an incident or to seek help. [35]Women face multiple barriers to accessing services and support including:

- Fear of racism
- Belief that it is impossible to escape abuse as the partner will find her
- Lack of knowledge of mainstream services and mistrust of authority
- Racism by or within some refuges
- Many refuges unable to take large families
- Some refuges will not take more than one traveller woman

Issues such as difficulty reading correspondence makes contacting services difficult for victims. We know that Marie travelled as a child and only became "settled" in later years. Sandwell Irish Society explained that it is normal for Irish Traveller girls to attend primary school up to year six, but very often they do not continue on to secondary school or beyond. This raises significant issues around levels of literacy. In this case it was documented by several agencies and on a number of occasions that Marie did not respond to letters and also failed to return phone calls due to lack of credit on her phone. An awareness of Traveller culture and norms would have indicated the need to explore this further, rather than close Marie's case because she was 'not engaging'. Agencies and service providers make allowances for people with low levels of literacy and for those whose first language is not English to enable them to engage with services. These opportunities did not appear to be afforded to Marie at any time by any agency. Frequent movement and difficulty reading may have had an impact on Marie's knowledge of the services available to her. This lack of knowledge and awareness often means that victims are left with little choice but to remain with the perpetrator. When a victim decides to leave an abusive relationship, they may also have to leave their whole community.

First Light[36] states that "*cultural and social taboos exist amongst all travelling groups against involving the police when violence occurs*". Often travellers do not engage with the police for fear of repercussions from within their community. There is often a lack of understanding amongst professionals about the cultural issues and the barriers faced by

[34] Equality and Human Rights Commission, *Inequalities experienced by Gypsy and Traveller communities: A review*, 2009 – accessed online 11 September 2020
[35] https://www.firstlight.org.uk/gypsies-and-travellers/ - accessed online 11 September 2020
[36] First Light is a charity supporting people affected by domestic abuse and sexual violence - https://www.firstlight.org.uk/about-us/ - accessed online 11 September 2020

travellers. Frontline services which may be able to identify cases of domestic abuse such as GPs are not always accessible to traveller women.

Marie's drug and alcohol use were a sign of her distress. When the perpetrator was on remand in prison, Marie worked hard to turn her life around. She stopped using drugs, she gave up smoking, she put on three stone and she engaged with professionals. Her victim impact statement is testament to what she achieved. Nevertheless, he was able to leave prison with no restraining order and (needless to say) he sought her out immediately. The fact that he controlled Marie and she had told professionals that she was scared of what he would do if he found her, appeared to be dismissed and Marie was consistently blamed for having contact with him and "*putting herself in danger*". Even when her baby was removed, there was no consideration given to the impact that it might have on her life and her mental health.

In fact, examples of victim-blaming can be seen throughout Marie's engagement. The most devastating example was when she was evicted from the refuge. It is unfortunate that the 'zero tolerance' to the abusive behaviour of service users means that sometimes those who are in greatest need are the ones who are turned away. Professionals need to understand a person's experience and their reaction to it – rather than judge, or determine what is acceptable language, acceptable behaviour, or an acceptable response. Marie turned to people for help. Professionals need to recognise victim-blaming and understand the destructive impact that this has not only on victims, but also on the relationship between victims and professionals. Understandably, Marie found it very hard to trust professionals.

Marie's family frequently sought help from agencies because of their concerns for Marie (West Midlands Police five times, West Mercia Police three times, Women's Aid twice, housing once and the drug and alcohol service once). It was clear that her family thought she was being held against her will and was effectively imprisoned by him. Considering his offending history against Marie, agencies should have done more to explore the family's concerns. It is uncomfortable to consider that individuals' response to Marie may have been lacking because she was blamed for her situation or considered undeserving in some way.

## 8.2. The invisible man

As agencies considered it was Marie's fault for resuming her relationship with the perpetrator, the focus was always on her to change what was happening. The perpetrator and his behaviour featured little in agencies' records and he remained unseen by the agencies working with Marie. This meant that he could control and manipulate her, whilst agencies still continued to view her as the problem. [37]

Indeed, the agencies working with him did not appear to consider his behaviour either. There was a lack of challenge throughout the review. He missed appointments with his offender manager and was not challenged. He attended meetings under the influence of drugs and was not challenged. He disclosed that he calculatingly took Marie's handbag so

[37] Agencies could have used the 'Safe and Together' model to consider how to keep Marie and her child safe from the perpetrator and enable the child to remain in Marie's care – see for example https://www.edinburgh.gov.uk/downloads/file/22788/safe-and-together-edinburgh-implementation-report

she would have to go to his property – this information was not shared, so Marie was blamed for deliberately going to his property. Even his role as a drug dealer was lost over time.

The lack of consideration concerning the perpetrator's behaviour meant he was able to manipulate professionals and the system to his advantage. In February 2014, he was remanded in custody having been charged with rape, unlawful imprisonment and threats to kill. This was an ideal opportunity for professionals to provide adequate support to Marie and encourage her not only to assist a prosecution but also to help her to leave him. Nevertheless, he was able to contact Marie and put pressure on her to write to him and visit him in prison. Undoubtedly, he used these opportunities to coerce Marie to withdraw her statement (which she did). However, there was no evidence that any consideration was given to investigating him for the possible offence of witness intimidation.

When he was moved to a prison in the north of England, Marie appeared relieved as it gave her respite from his overwhelming controlling behaviour. She moved on with her life and even sent him a letter saying it was over. This was a window of opportunity that was missed. Marie had managed to remain drug free during her pregnancy. She had the support of her family around her, she was feeling more confident and was looking forward to the birth of her baby. Yet in 2014 following his trial, he was released from prison with no restraining order. It was obvious (even without the benefit of hindsight) that he would pursue Marie to resume their relationship. Yet no professional or agency appeared to consider the danger that Marie faced. He escorted Marie to appointments, he policed her – yet no agency documented his identity or recognised that he was the 'ex-partner' who had been convicted of abusing Marie.

Furthermore, when West Midlands Police and Sandwell Metropolitan Borough Council housing undertook a drug raid on Marie's property in November 2018, it was Marie who was considered a perpetrator of anti-social behaviour. Despite both agencies being aware that she was a victim of domestic abuse, they viewed weapons at the property being for Marie and the perpetrator's protection, rather than a tactic he may have used to control Marie. It was clear from housing records that even a passing thought to Marie's demeanour on this occasion should have given rise to concern.

Throughout the review, the perpetrator told professionals that the reason he was abusive was because of his traumatic childhood, yet there was no evidence to suggest he targeted his aggression at anyone else other than Marie. It is therefore reasonable to conclude that he was capable of self-control. Professionals such as mental health practitioners and GPs appeared to accept his explanation. Even the Judge and defending QC during his trial for Marie's murder appeared to accept this explanation as an excuse for his abuse.

"*I accept you are a damaged individual. You loved her in your own way and she had a real affection for you but you both came under the disruptive influence of hard drugs and neither of you could rid yourself of that addiction*."

"*His wickedness is greatly reduced by the awful treatment he suffered in his youth*."

Professionals need to have a good understanding of how they too can be manipulated by perpetrators of domestic abuse.

## 8.3. Questioning, triangulating and corroborating information

A lack of professional curiosity meant that professionals failed to question, triangulate and corroborate information. This review contains a catalogue of incidents where professionals did not seek further information or share information. For example, housing officers did not make the link between Marie's ex-partner who spent time in prison for domestic abuse and the friend who often accompanied Marie. Police did not link Marie with the perpetrator. Probation did not question him or challenge him when he was clearly having contact with her. The result of this lack of professional curiosity meant that the perpetrator was not held accountable for his actions, his offending, his drug dealing or his abusive behaviour, whilst Marie was the focus of attention and blamed for her situation. Professionals were very ready to accept his version of events. The information that was known about him was never pieced together and therefore the risk he posed to Marie was never fully recognised.

## 8.4. Failure to use the available civil and legal remedies

Whilst the perpetrator was on remand in prison, Marie had contact with him. She visited him and sent him letters. Inevitably, this may have been a factor in her retracting her statement. Prisons have no legal grounds on which to restrict visitors. Nevertheless, if any statutory agency/body[38] such as the police, children's social care, MAPPA (multi-agency public protection arrangements), MARAC (multi-agency risk assessment conference) requests a restriction, the prison governor would consider imposing that restriction.

Equally, his contact with Marie could have been investigated by the police as witness intimidation. The Crown Prosecution Service asserts that "*such offences go to the heart of the administration of justice. If there is sufficient evidence of witness intimidation the public interest requires that normally such cases should be prosecuted*".[39]

Perhaps the greatest omission was the failure to impose a restraining order on him when he was released from prison. It was disappointing that there appeared to be a complete lack of understanding around domestic abuse, and the degree to which he (and potentially members of his family) used intimidation to control Marie. It was clear from Marie's victim personal statement that she did not wish to continue her relationship with the perpetrator and she explicitly stated that she thought he would try to find her.

> *"Around 5 weeks ago I sent him a note simply saying 'we're done'. By that note I meant that I want nothing more to do with him and I don't want to be in a relationship with him. I did not receive a reply and I did not want one, I don't want to read, hear or see anything from him again. I fear that he would not give up trying to find me and it frightens me to think what would happen if he did. I want nothing more to do with him."*

[38] The Crown Prosecution Service stated that such a request would not fall within its remit.

[39] For further information on witness intimidation see https://www.cps.gov.uk/cps-page/witness-intimidation - accessed online 11 September 2020

Marie could not have been more explicit. She told professionals that his mother had contacted her to prevent the restraining order. No one appeared to understand that she may have been threatened. Knowledge of the cultural and faith norms within Irish Traveller culture would have indicated that the community is very 'closed' and the inter-connectedness of families is very strong. Women are often 'persuaded' not to speak out about a violent husband or partner – these things have to be kept quiet. Yet it appeared that there was no awareness of any cultural or familial pressures Marie was experiencing and no effort to understand this and support her accordingly.

Records showed that even after his release from prison, Marie asked the support worker from Women's Aid how to get an injunction against him. The worker helped her call a solicitor's office in relation to the legal proceedings. At the time Marie said that she was trying to do everything possible to get her baby back. Yet there's no evidence that professionals were able to offer her the continued support to go ahead with an injunction.

Similarly, agencies did not use other avenues available to them. The perpetrator could have been supervised under MAPPA (Multi-Agency Public Protection Arrangements). There were further opportunities to undertake a DASH (domestic abuse, stalking and honour-based violence) risk assessment or to refer Marie to MARAC (multi-agency risk assessment conference). Nevertheless, Marie's case was heard three times at the MARAC (multi-agency risk assessment conference). The first time in early spring 2014 the focus was completely on Marie, as the perpetrator was in prison. The second hearing (August 2014) was a few days before he was sentenced. On this occasion, agencies appeared certain that he would receive a custodial sentence and thus little thought was given to Marie's safety if he was released. The third MARAC (multi-agency risk assessment conference) was in November 2014 did not appear to consider the risk that he posed to Marie, his behaviour was minimised and the focus was on her actions rather than his.

The first domestic homicide review undertaken by Safer Sandwell Partnership in 2011 identified (amongst other things) that there was a need to strengthen the MARAC (multi-agency risk assessment conference) arrangements. Since then, a number of improvements have been put in place including:

- Appointing a MARAC (multi-agency risk assessment conference) co-ordinator and administrator
- Commissioning SafeLives to undertake work to identify MARAC (multi-agency risk assessment conference) outcomes
- Improving the induction and training for representatives and partner agencies
- Auditing of cases and identifying subsequent recommendations
- Developing a programme of multi-agency domestic abuse training available to all professionals
- Improving the oversight and governance arrangements for MARACs (multi-agency risk assessment conference) with regular reporting to the Domestic Abuse Strategic Partnership

- Creating (April 2019) a West Midlands Police team of coordinators and administrators to provide support to all MARACs (multi-agency risk assessment conference) across the West Midlands
- Establishing a single protocol for all MARACs (multi-agency risk assessment conference) across the region.

## 8.5. Non-engagement and missed appointments

After Marie's baby was removed from her care, she began to disengage from services. Disengagement and not answering calls can be a tactic for avoiding scrutiny, but it could also be a sign of the perpetrator's controlling behaviour. It was not possible to establish whether he controlled Marie's calls but professionals should have considered the possibility. This in turn should have increased their concerns for Marie's welfare, especially as his contact details were sometimes provided for Marie, and Marie's sister told police that he often took her phone. Marie was seen as failing to engage with services – but due to the perpetrator's control, agencies should have considered how to reach out to her – and how to disrupt his behaviour.

Whilst support services were available to Marie, the onus was always on her to take responsibility and work with these agencies. Although Marie was viewed as vulnerable, there was a lack of understanding within agencies about the extent to which the perpetrator controlled all her actions. He had control of her phone, her food, when she could use the bathroom and undoubtedly controlled when she could attend appointments.

In the last months of Marie's life, he frequently escorted her to all her appointments. Her opportunities to seek help were very limited. By this time, she had also ceased to engage with most agencies. This was seen as non-engagement rather than her being prevented from attending appointments.

## 8.6. Economic abuse

In Marie's case there were clear indications that she experienced economic abuse. Records showed that her accommodation was sparsely furnished. She did not have basic amenities such as a washing machine or cooker. When the perpetrator was arrested, he was in possession of her bank card. There were times when he denied her basic resources such as clothing and food. In 2018, Marie approached her GP requesting a food voucher. Inevitably, by controlling not only the money but all the resources in the household, he made Marie completely dependent on him.

Research[40] shows that economic abuse is complex. A perpetrator may make a victim continually ask for money. They may refuse to contribute to the household bills whilst spending money on other things and building up debt for the victim. Inevitably, this contributes to making the victim more dependent on the perpetrator. Economic abuse creates a barrier to leaving and it exposes women to other types of abuse such as sexual violence. Studies show that women are three and a half times more likely to suffer domestic

[40] See for example: Dr Nicola Sharp-Jeffs "Supporting Survivors of Financial Abuse: Learning for the UK, 2016

abuse if they cannot find £100 at short notice.[41] As agencies did not share information, economic abuse was never really considered and Marie's inability to pay the refuge fees was not fully explored.

## 8.7. The danger of ending a relationship

Marie tried to end her relationship with the perpetrator whilst he was in prison ("*To ***** – just to let you know, I'm done*") but he would not allow it. According to Women's Aid, there are many reasons women do not leave an abusive relationship including danger and fear, isolation, trauma and low confidence. Ultimately, Marie probably returned to him through fear. She had to protect herself from him. He terrorised her and she was clearly frightened of him. She had to resume the relationship otherwise she may have thought that he would carry out his threats of harming her, her family and her children.

It is likely (with hindsight) that between his release from prison in August 2014 and Marie's murder in December 2018, Marie was effectively "imprisoned". His behaviour never changed and he was never challenged. Marie's family tried to seek help by contacting agencies at least nine times but Marie was never in a position to disclose what was happening to her or to accept help. The one time she sought help from West Midlands Police in 2016, there were no officers available to speak with her immediately – and the opportunity was lost.

# 9. RECOMMENDATIONS

There were 34 single agency recommendations arising from the domestic homicide review. These single agency recommendations aimed to make improvements to a wide range of issues including (amongst other things):

- Training
- Record keeping
- Risk assessment
- Policies and procedures
- Information sharing
- Reflective supervision

Work has already been completed on some of these recommendations. Some of the detail about improvements to services has been included within the body of the report. A full list of recommendations and subsequent activities can be seen in the attached action plan. Nevertheless, a number of issues arose that the panel felt required further consideration.

1. Sandwell Community Safety Partnership should write to the Women's Aid Federation (enclosing a copy of the final report) to ask them to consider strengthening the Women's Aid Quality Standards concerning evictions from refuges. This should ensure that when a woman is evicted from a refuge, she will still have an exit plan tailored to her individual need and access to ongoing appropriate support. In addition, she should

[41] Walby, S. and Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey London: Home Office Research Study 276 cited in Sharp-Jeffs, N (2016) "Supporting Survivors of Financial Abuse: Learning for the UK

be provided with information on how she can make a complaint or challenge the decision to evict her.

2. Sandwell Community Safety Partnership should request further detailed information about the training on domestic abuse that is currently provided to staff working in the West Midlands National Probation Service, West Midlands Police, the Crown Prosecution Service, HM Courts Service and the Judiciary. The information should include:

    a. The number of staff who have accessed both single agency and multi-agency domestic abuse training
    b. Demonstrate how this training has improved the outcomes for victims of domestic abuse

3. Sandwell & West Birmingham Clinical Commissioning Group to sustain funding for Sandwell IRIS domestic abuse intervention until 2022 and beyond, to maintain the current level of 96% uptake by Sandwell GPs.

4. This domestic homicide review should be used as a case study for domestic abuse training (and other training e.g. substance misuse training). The training should give professionals the confidence to:

    a. Understand how attitudes of professionals can undermine a victim's ability to escape domestic abuse
    b. Recognise the specific barriers facing domestic abuse victims from the Irish Traveller community
    c. Recognise victim-blaming, worthy and unworthy victims, and 'minoritised' victims and how these impact on the lived experience of women
    d. Challenge organisational culture so that agencies move away from victim-blaming to focus on ways to disrupt perpetrators' activity thus preventing men from being invisible to services
    e. Identify the local pathways that are in place for victims to access services
    f. Appreciate how perpetrators can use drugs as a mechanism to control victims

5. When considering safety planning for victims and children, the West Midlands MARAC (multi-agency risk assessment conference) processes should clearly consider the need for relevant partner agencies to seek to make applications for restraining orders/injunctions/domestic violence protection orders as appropriate. The Chair of the conference and wider attendance should be clear where the responsibility lies for each order, and the thresholds for application.

6. The Crown Prosecution Service should consider strengthening its guidance in cases where victims object to the making of an order. The guidance should include the need

for a prosecutor to consider the principles arising from the caselaw[42], namely the need to balance respect for the wishes of the victim and her right to autonomous decisions about her life, with consideration of whether she is in fear, has been coerced, or does not have capacity to make the objection. Such guidance should include a requirement for the prosecutor to set out those legal principles to the court as well as the available evidence on either side of that equation, whilst remaining in a neutral position with regards to the granting of an order, which remains a matter for the court.

7. A judge making a decision on whether to grant or decline a restraining order where the victim objects to the making of the order should hear oral evidence from the victim in order to explore whether she is in fear, has been coerced, or does not have capacity to make the objection.

[42] R v Brown [2012] as applied by the Court of Appeal in R v Herrington [2017] EWCA Crim 889