Domestic Homicide Review Overview Report

Derbyshire Community Safety Partnership

QDCNH/18

“Ruth”

Died aged 30 years

2018

Author: Amanda Clarke

Date completed: 22 January 2021

The Parents of Ruth said:

"In late 2018, we received a telephone call to inform us that our beautiful daughter had died. As parents there is no event in life that comes close to the devastation felt on hearing that news – we felt numb. But little did we know that learning the true cause of her death could compound that feeling of numbness and confusion by an unimaginable amount.

Ruth was born in the late 80s. She was a happy and energetic child with a little glint of mischief about her! We were a young and energetic couple, and soon after the birth, we moved abroad for work. We had a strong social group and after starting first nursery, and then primary school, Ruth had many friends and was always popular amongst her peer group.

We moved back to England when Ruth was 10 years old and she quickly established a new group of friends – many of whom remained as friends up until her death. Ruth grew to be a strong- willed but independent young woman. She left school at 16 and quickly found a job that she loved. She became a mum at an early age and was a very caring mother to five children.

We miss Ruth more than mere words can express and we think about her and talk about her every day. We are now caring for two of her children and we see the other three on a regular basis. Her children also miss her beyond words and whilst the younger three don't fully understand what has happened to their mum, the older two certainly do.

She will always live on in them.

Things like this make you realise how fragile and precious life is".

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1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to the victim to be known as Ruth, a resident of Derbyshire prior to the point of her death in late 2018.

1.2 In addition to examining agency involvement with Ruth and her family, the review will also try to illuminate the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community or elsewhere and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

2 Circumstances leading to the review

2.1 At the time of her death Ruth lived with her partner (the Perpetrator) and their three young children in Derbyshire. In late 2018 the ambulance service was called to their home address. The Perpetrator was present with Ruth who was found deceased with multiple injuries. The Perpetrator suggested Ruth had fallen downstairs but this was felt to be inconsistent by professionals in attendance. The police were requested by the ambulance service and the Perpetrator was arrested later the same day.

2.2 The cause of Ruth's death was recorded as 'inflicted trauma'. The Perpetrator was subsequently charged with murder. He was convicted in 2019.

2.3 The couple had been in a relationship for approximately 4 years. Ruth had a known history of being a victim of domestic abuse with two previous partners (Partners 1 and 2) and information obtained as part of this review suggests abuse was ongoing in the relationship with the Perpetrator, prior to the death.

2.4 Ruth had 5 children, 3 fathered by the Perpetrator and two older children from her relationship with Partner 1.

2.5 A summary of the known facts and events leading to the sad death of Ruth is below.

3 Purpose

3.1 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. Where possible and if applicable, good practice of professionals involved will be highlighted.

3.2 In conducting a DHR it is hoped the review will contribute to a better understanding of the nature of domestic violence and abuse.

4 DHR criteria

4.1 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force in April 2011. The death of Ruth, the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being assaulted by her partner within the home. The Home Office criteria for reviews includes "a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person to whom he or she was related or with whom he or she was or had been in an intimate relationship."

4.2 It is recognised that a domestic abuse incident which results in the death of a victim is often not a first attack and is likely to have been preceded by psychological, emotional abuse, coercive control and possibly other physical abuse. The DHR regarding Ruth's death will attempt to explore this theory.

5 Timescales

5.1 The Derbyshire Community Safety Partnership (CSP) were notified of the death by Derbyshire Constabulary on 3 January 2019. In line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews the decision was made to undertake a DHR once it was concluded that Ruth had died as a result of an assault, however discussion did take place with the Local Safeguarding Children Partnership regarding whether the circumstances met criteria for a Serious Case Review. The Independent Chair of the Safeguarding Children Partnership wrote to the CSP concluding that after scrutiny of the initial details of the case that a DHR was the appropriate means of addressing issues arising from the incident. The thresholds for commissioning a Serious Case Review were not met.

5.2 A number of requests were set out by the Safeguarding Children Partnership Independent Chair. These included that representation of children's agencies would be essential on the DHR panel and that the author appointed for the DHR had relevant experience in work within the children's arena, to ensure they were able to properly explore relevant learning and recommendations regarding prevention of harm to children.

5.3 Having agreed that DHR criteria was met the review began formally on 13 February 2019 with the first panel meeting taking place. At this point an Independent DHR Chair and Author had not been commissioned.

5.4 The Home Office were notified of the decision on 14 February 2019.

5.5 Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review met timescales regarding when the process commenced but the conclusion was delayed in order that all criminal proceedings regarding the perpetrator were finished. The Independent Chair and Author (to be known as the Author) met with the Panel in March 2019. The meeting included discussions regarding family involvement in the Review, and the most appropriate ways to approach the family, as

their contribution would help to see what life was like for Ruth and her children. The terms of reference for the Review were also developed at this meeting.

5.6 The criminal trial concluded in the summer of 2019 when the perpetrator was found guilty of the murder of Ruth and sentenced to life with a minimum of 24 years imprisonment.

5.7 The Review Panel was reconvened and a Panel meeting took place on 13 March 2019. Some further enquiries and information were identified as being required and a follow up Panel meeting took place in September 2019 when full information from all agencies involved was considered.

5.8 The first involvement of significant family members of Ruth took place in late October 2019. The Author and Panel waited for a convenient time to be agreed by the family but maintained a link with the family advocate who has supported the family on behalf of Advocacy After Fatal Domestic Abuse[1]. A further delay occurred whilst the family needed to focus on family court processes regarding the surviving children of Ruth and the Perpetrator.

5.9 Unfortunately, the overall completion of the review was impacted by restrictions necessary due to the response to Covid-19. However, the slight extended timescale did not affect any lessons to be learnt by agencies regarding practice which required immediate attention, as all parties were aware that any actions should be taken forward by the agencies without delay.

6 Confidentiality

6.1 The findings of this Review are confidential. Information is available only to participating officers, to professionals and their line managers. The pseudonym Ruth for the victim has been chosen by her parents and is used in the report to protect the true identity of Ruth and her immediate family, especially her children. Publication of the Review is discussed later.

7 Terms of reference

7.1 The full terms of reference for the Review are attached as Appendix A. The specific points were developed by the Author and the Panel and were bespoke to the particular circumstances known for Ruth and her children. The analysis section of the report reflects the agreed terms of reference.

8 Methodology

8.1 The Review Panel (to be known as the Panel) was convened by the Derbyshire Community Safety Partnership (CSP) and included representatives from the relevant agencies who had been involved with Ruth, her children, the two significant Partners and the Perpetrator. The Panel included local specialist domestic violence and abuse service representation. The Panel was chaired by the Independent Chair and Author of the overview report (the Author).

8.2 The Panel commissioned a chronology and Individual Management Reviews (IMRs) from each agency. In order for agencies to complete their IMRs they were asked to examine and analyse the contact and service provided to Ruth and her children, whilst considering the

terms of reference for the DHR and agency policy and procedures relevant at the time of each contact. Panel members were asked to identify key learning for the agencies they represented and to make recommendations, as necessary. The Panel analysed the IMRs together for themes and issues which were discussed in the Panel meetings.

8.3 Agencies sourced and reviewed a range of information from a variety of recording systems and interviewed some staff who had had direct involvement with, or management oversight of, the services provided to Ruth and her children. The Author, supported by the Community Safety Partnership (CSP), conducted follow up enquiries with some professionals for clarification purposes. Panel members were also reminded to highlight examples of good practice.

8.4 The Panel attended a total of four face to face meetings for the Review. Unfortunately, as said earlier, the final Panel meeting(s) and consideration of the draft report was affected by the Covid- 19 position within the UK with the Panel required to meet virtually after March 2020.

9 Involvement of Family

9.1 DHRs are enriched by the involvement of the family of the victim. The parents of Ruth (to be known as the Parents) were contacted by the Community Safety Partnership (CSP) and agreed to meet the Author.

9.2 The Parents were provided with the Home Office DHR information leaflet for family members. After contacting AAFDA[1] themselves the Parents were supported throughout the process by an AAFDA family advocate.

9.3 The meeting with the Parents of Ruth took place in October 2019 at their home. The AAFDA family advocate was also in attendance. A summary of the views of the Parents and their recall of events leading to their daughter's death is included after the summary of background and known facts. The Parents also provided a very personal description of their daughter and how her death has impacted their lives. The Author is very grateful for the Parents' contribution to the Review.

9.4 The Panel and Author explored whether any of the five children of Ruth would be approached to participate in the Review. It was agreed in consideration of their ages and on information currently known about the children that it was not appropriate to involve them at the time the Review was ongoing.

10 Contributors to the Review and Panel members

10.1 The panel membership is listed below, with details of which members provide IMR's or summary reports of involvement. All agencies providing IMR's or summaries of involvement also provided chronologies.

[1] AAFDA are a national charity providing peer and expert support to families and professionals after fatal domestic abuse.

~~10.2 The agencies completing IMRs or summary reports of involvement, and their membership of the Panel are listed below.~~

Name	**Organisation**	**Role in Panel**
Christine Flinton	Head of Community Safety, Derbyshire	Panel Member
Alison Boyce	Domestic Abuse Manager, Derbyshire	Panel Member
Julia Ashbrook	Business Services Officer, Derbyshire	Support to the Panel
Amanda Clarke	Independent Chair/Author	Independent Panel Member
Steve Shaw	Inspector, Public Protection, Derbyshire	IMR Author
Kay Simcox	Community Risk Reduction Manager (South), Prevention & Inclusion, Derbyshire Fire and	Panel Member
Deborah Whallett	Housing Enforcement Manager, Bolsover District Council	IMR Author
Janet Gardom	Solicitor, Legal Services, Derbyshire County	Panel Member
Karen Barden	Assistant Head of Service – Child Protection,	IMR Author
Michelle Grant	Designated Nurse, Safeguarding Adults/MCA Lead, NHS Derby and Derbyshire Clinical Commissioning Group	Panel Member IMR Author – Ed Ronayne
Juanita Murray	Designated Nurse, Safeguarding Children/ Chair of CDOP, NHS Derby and Derbyshire	Panel Member
Jane O'Daly-Miller	Safeguarding Lead, University Hospitals Derby and Burton Foundation Trust	Panel Member
Zoe Rodger-Fox	Head of Safeguarding, Chesterfield Royal Hospital Trust	Panel Member IMR Author –Marie Tann
Lucy Gascoigne	Head of Safeguarding, East Midlands	IMR Author
Karen Billyeald	Assistant Director Safeguarding Adults, Derbyshire Healthcare Foundation Trust	IMR Author
Elaine Offler	Named Nurse for Safeguarding Children, Derbyshire Community Health Services NHS	IMR Author
Tina Hymas-Taylor	Head of Safeguarding, Sherwood Forest	IMR Author
Jennifer Calverley	Chief Executive, The Elm Foundation[1]	Panel Member IMR Author – Jadah Shah
Marion Page-Smith	Deputy Head, Local Delivery Unit Derbyshire,	Panel Member
Andrew Wainman	Regional Support Manager, Action Housing	IMR Author
Jane Kirkwood	North East Derbyshire District Council	IMR Author
Ruth Attfield	Hampshire Constabulary	IMR provided – not a panel member
Julie Tomlinson	DHU Healthcare – 111 service	IMR provided – not a panel member

[1] The Elm Foundation, (formally known as both North Derbyshire Women's Aid and Derbyshire Domestic Violence and Sexual Abuse Service) are a specialist third sector Domestic Abuse Service Provider. They are commissioned as part of a consortia to provide emergency accommodation and community-based support to victims of domestic abuse. Historically they have also worked with perpetrators through delivery of a RESPECT accredited programme.

10.3 The CSP ensured all IMR authors and Panel members were confirmed as independent from the case, from previous involvement with Ruth and her family, with no management responsibility for the professionals who had been involved operationally in providing a service to the subjects of the review. Quality assurance was provided for IMRs by individual commissioners and within the Panel by the Chair/ Author.

10.4 Family members and the Perpetrator were invited to contribute to the Review, details of their participation are included later.

11 Author of the Overview Report

11.1 The Independent Chair and Author of the review (to be known collectively as the Author) was commissioned by the Derbyshire Community Safety Partnership but has never been an employee of the CSP. The Author has not line managed any of the IMR authors or Panel members. Her career history includes police specialist safeguarding roles within Nottinghamshire Police, an Inspector for the NSPCC Audit and Inspection Unit inspecting services throughout the UK and managing the Local Safeguarding Children's Board in Derbyshire from December 2013 until March 2016.

11.2 Currently the Author works independently as a safeguarding advisor across the country, being commissioned for children's Serious Case Reviews and Safeguarding Adult Reviews. She also provides safeguarding support to a local Diocese, which includes facilitating domestic abuse training for clergy and church volunteers. She has been the Independent Chair of a Safeguarding Children's Partnership in the north west since July 2019 and Independent Chair of the Safeguarding Adults Board in the same area since August 2020.

11.3 The Author has attended the DHR Chair and Author training facilitated by AAFDA (Advocacy After Fatal Domestic Abuse) and Standing Together Against Domestic Violence.

12 Parallel Reviews

12.1 There was a criminal investigation resulting in a successful prosecution which is detailed within the report. Liaison took place between the Panel and a police representative for the senior investigating officer throughout the investigation and criminal proceedings to inform the review.

12.2 The Coroner's Office was informed of the DHR by the Police. There were no on-going proceedings identified.

12.3 Consideration of Serious Case Review criteria regarding harm to the children did take place and the outcome is highlighted earlier, that the circumstances did not meet criteria but the DHR would place additional focus on the experiences of all children involved.

12.4 There were no other internal inquiries or reviews brought to the attention of the Panel to

inform the DHR.

13 Equality and Diversity

13.1 The nine protected characteristics[2] under the Equality Act 2010 were explored where relevant to the review, including barriers to accessing services and wider consideration as to whether service delivery was impacted. Further detail is included in the analysis of terms of reference section.

14 Dissemination

14.1 The final overview report will be shared with the Panel and the Derby and Derbyshire Domestic Abuse and Sexual Violence Governance Board which is made up of representatives from the following agencies: Derbyshire Police, Derbyshire County Council – Community Safety, Children's Services, Adult Care, Public Health, Office of the Police and Crime Commissioner, Derby and Derbyshire Clinical Commissioning Group – Safeguarding Children and Safeguarding Adults, Derby City Council, Derbyshire Community Rehabilitation Company, Derbyshire Criminal Justice Board, NHS England, Derby and Derbyshire Safeguarding Children Partnership, National Probation Service, Derbyshire Fire and Rescue Service and the Crown Prosecution Service.

14.2 The overview report was shared with the Parents of Ruth on two occasions whilst in draft form to provide them with opportunities to consider and make comment on the content and findings. They will be provided with a copy of the final overview report. Publication is discussed later.

15 Subjects of the DHR

15.1 Subjects included in the scope of the DHR were as follows:

- The victim Ruth - partner of the Perpetrator at the time of her death.
- The Perpetrator - partner of Ruth at the time of her death.

15.2 Relevant aspects of the relationships which Ruth had with two significant previous partners were also considered.

15.3 The five children of Ruth were not designated subjects within the DHR. However, the impact for the children living with domestic abuse was explored as part of the scope of the review after discussion with the Panel and consultation with the Derbyshire Safeguarding Children Partnership.

16 Scope of the review

16.1 The review has explored contact and involvement by services regarding significant incidents involving Ruth, previous Partners and the Perpetrator as below:

[2] age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

16.2 Agencies have provided summary reports with analysis of significant events between 01.01.2007 and 28.02.2012 to reflect the known period when Ruth was in a relationship with Partner 1 resulting in two children being born, and when incidents of suspected domestic abuse occurred, prior to Ruth's move to Derbyshire[3].

16.3 Significant events in service involvement for Ruth, her children and Partners 1 and 2 have also been reviewed between 01.03.2012 and 31.12.2013 to reflect the period when Ruth moved from her home area in the south of the UK into Derbyshire. This provided history and context to assist in understanding the lived experience of Ruth prior to her meeting the Perpetrator.

16.4 Finally, events in the lives of Ruth and the Perpetrator were reviewed in detail between 01.01.2014 to late 2018 to reflect the known period when the couple met and lived together, leading to the tragic death of the victim.

16.5 The three distinct periods above will be known as the review timeframe. However, it was made clear that if any agency believed there was relevant information outside of the review timeframe it was agreed by the Panel that the information must be included in their IMR.

16.6 As well as the IMRs, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. A merged full chronology was formulated by the CSP from the individual agency chronologies submitted. This provides a useful illustration of the combined agency involvement throughout the timeframe of the Review and is attached at Appendix B.

17 Summary of background information and known facts

17.1 This is a summary of background and known facts compiled through agency chronologies submitted for the timeframe of the review. Analysis of service involvement is found later in the report.

17.2 Ruth had lived for much of her childhood in the south of the country with her parents and sibling. Information provided by her Parents below indicated some problems with her behaviour during her teens, for example being disruptive at times in school, which the Parents viewed as common to many teenagers. As she settled into employment around age 17 years, she met a man through work and started a relationship. He will be known as Partner 1.

17.3 The first recorded domestic abuse incident from Partner 1 on Ruth was in spring 2008 when their first child together was still a baby. Partner 1 was arrested, interviewed and received a police caution. A referral was made to local children's social care services regarding the child being present. After the incident the couple resumed their relationship and continued to live together as a family.

[3] The Parents thought the relationship with Partner 1 ended in June 2011.

17.4 After the first known incident there were four further reported incidents of domestic abuse by Partner 1 on Ruth (both physical and verbal) until the end of 2008. Two of the four incidents were reported by an unconnected third party. The last of the four incidents in 2008 was recorded as with the baby present.

17.5 In early 2009 a children's social care assessment was closed with no further action required. Ruth had retracted a complaint of assault against Partner 1 when the baby was present and no further risk to the baby was identified.

17.6 The second child of Ruth and Partner 1 was born later in 2009.

17.7 Ruth herself was arrested and convicted for being drunk and disorderly in early 2011. Later in the spring of 2011 Partner 1 was again arrested for a domestic abuse incident on Ruth. He denied the allegation and was not charged. A referral was made to children's social care for the couples' two young children and an initial assessment resulted in advice being provided to the family.

17.8 In mid-2011 a relationship between Ruth and a different male, to be known as Partner 2 commenced. After a very brief (believed by the Parents to be only two days) move to an area believed to be around the border of South Yorkshire and Derbyshire the couple returned to Ruth's original home area. Soon after the return Ruth was arrested for a disturbance at the home of Partner 1. Their two children stayed with Partner 1 as a result of the arrest. The relationship between Ruth and Partner 1 was over at this point.

17.9 After getting married in late 2011 to Partner 2, with family including Ruth's Parents and her two children in attendance, the couple moved to Derbyshire in spring 2012. Partner 2 had family links to the area. The couple immediately requested financial support from Derbyshire children's services and reported they were "fleeing domestic violence".

17.10 During 2012 Derbyshire children's services (social care) were involved with Ruth and Partner 2 regarding possible risks to the children. The Parents of Ruth were contacted by Derbyshire children's social care regarding the children's care, as was a relative of Partner 2. Two separate incidents of domestic abuse occurred by Partner 2 on Ruth over 3 months in the summer of 2012, in Derbyshire. Ruth was also arrested for assault on Partner 2. The children of Ruth returned briefly to live with Ruth's Parents (their grandparents) but then resumed living with Ruth in Derbyshire who at that point was living apart from Partner 2.

17.11 After Ruth moved address to a different Derbyshire property in early Autumn 2012, Partner 2 was arrested for causing damage to another property where Ruth was visiting. The children at that time were made subject to child in need plans[4] and a referral was made for outreach support for Ruth from a local Women's Aid provision.

[4] A child in need plan follows an assessment which has concluded that a package of family support is required to meet the child's needs under Section 17 Children's Act 1989. The plan should be multi-disciplinary with a lead professional identified to work with the child and family.

17.12 The children and Ruth spent Christmas 2012 with the Parents at their home in the south. On return to Derbyshire in 2013 Ruth appeared to be not engaging with the offer of support from Women's Aid.

17.13 In spring 2013 it seemed Ruth had resumed the relationship with Partner 2. Children's social care were still involved and a referral to MARAC[5] was considered but not completed. Around this time another move to a different property in Derbyshire took place for Ruth. The children at this point went to live with their father (Partner 1) at the request of children's social care due to the risk of domestic abuse whilst Ruth was still with Partner 2.

17.14 A section 47[6] referral was made regarding the renewed relationship of Ruth and Partner 2. At this point the children remained living with their father, Partner 1.

17.15 Around this time a disclosure of non-recent sexual abuse was made by Ruth against Partner 1, alleged to have occurred when they were together between 2007-2010. Derbyshire Police interviewed Ruth and the investigation was continued by the local force of Partner 1 where the alleged incidents took place. Partner 1 was not charged with any offences. A Derbyshire sexual violence service for survivors and the mental health crisis team offered support to Ruth.

17.16 In early summer 2013 Ruth and Partner 2 moved south to try to set up home near to where the children were living with Partner 1. Within two days an incident of criminal damage occurred to the car of Ruth's Parents resulting in Ruth being convicted for the offence. A restraining order was enforced by the court for Ruth to keep away from the Parents. Consequently, Ruth and Partner 2 returned to Derbyshire but the children remained with Partner 1.

17.17 Soon after the return to Derbyshire, Partner 2 was sent to prison for an offence not connected to Ruth or her family. At this time the relationship between Ruth and Partner 2 seemed to end. Ruth remained living in Derbyshire. Women's Aid continued to try to support her as did a community psychiatric nurse via the GP surgery. GP notes suggested Ruth had a borderline personality disorder[7].

17.18 In late 2013/ early 2014 Ruth had difficulties with her housing situation, with eviction threatened. At an appointment to discuss her medication she spoke to the GP about some of her experiences of domestic abuse.

[5] The Multi Agency Risk Assessment Conference (MARAC) is a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide. Meetings bring together representatives from both statutory and voluntary agencies with the aim of sharing information and developing a safety plan for victims and their families with a view to reducing the risks and the likelihood of repeat victimisation.
[6] Section 47 of the Children Act 1989 requires every local authority to make enquiries about children thought to be at risk, enabling them to decide whether they need to take further action to safeguard and promote the child's welfare.
[7] Borderline personality disorder is a disorder of mood and how a person interacts with others. It is the most commonly recognised personality disorder, www.nhs.uk

17.19 Around this time Ruth told her housing support worker she "had met someone" and was moving to a different area of Derbyshire. This was believed to be the Perpetrator. A case transfer took place to a CPN in the new area. The new CPN made referrals for a psychological assessment and requested, via the GP an appointment for Ruth with a dietician, linked to a possible eating disorder.

17.20 Later in 2014 an ambulance attended the new address of Ruth after a report of her being drunk and possibly self-harming. She had some cut injuries but was conscious. The police received an anonymous call at the same time which reported a woman screaming "get off me, leave me alone". The attendance by police and ambulance was recorded as self-harm related. Having been taken to hospital unaccompanied, Ruth said she had been drinking and self-harmed. She described her new partner (the Perpetrator) as "supportive". A request for rapid response psychiatry assessment was made at hospital but Ruth left before this could take place.

17.21 In late 2014 Ruth was discharged by the consultant psychiatrist as she had not been attending appointments. The plan for support for Ruth was for her case to remain with the community mental health team.

17.22 In early 2015 Ruth was pregnant with her first child fathered by the Perpetrator. At 16 weeks pregnant she attended the emergency department at hospital with him. Ruth had a six to seven cm cut to her face which she said was caused by self-harm as a result of an argument with her partner (the Perpetrator). She was recorded as being in good spirits and no routine enquiry[8] regarding domestic abuse was recorded as undertaken by emergency department staff. Ruth said she had not been taking her medication since being pregnant and after review by the rapid response psychiatry team it was decided no assessment was necessary. Ruth was discharged with a plan for her to see the GP the next day. Information was shared with the hospital's named midwife for safeguarding children who in turn liaised with the relevant community midwifery team.

17.23 At around 28 weeks into the pregnancy a routine ante natal home visit was completed with Ruth by the health visitor. Ruth shared history of depression, domestic abuse in previous relationships and social care involvement regarding her older two children. The health visitor contacted the named nurse for safeguarding for advice after the visit and checks were made to verify the information on children's social care electronic systems.

[8] The routine enquiry is an opportunity for health professionals to sensitively enquire with a woman about her experience of domestic abuse both present and past, regardless of whether there are indicators or suspicions of abuse. Should a response be received that domestic abuse is a concern then further safeguarding advice and/ or action must be taken. During pregnancy advice and action must include risks to the unborn child/ new baby as well as the mother being assessed. *Domestic Abuse: A resource for health professionals, March 2017*

17.24 Later in the summer 2015 when Ruth was around 33 weeks pregnant, she reported a domestic abuse incident to police. She said she had been punched to the head, kicked in the abdomen and legs and had pain to her stomach. She refused to make a formal complaint but the Perpetrator was arrested. He was later released without charge. A DASH[9] assessment form was completed by police and shared with children's social care locally and in the area where Ruth's other two children lived with Partner 1. The assessed risk was classified as 'medium'.

17.25 At hospital Ruth denied any previous incidents of domestic abuse by the Perpetrator and said she felt safe to go home. A full assessment of Ruth and the unborn baby's wellbeing took place by midwifery staff to whom she repeated the allegations of assault. The midwifery unit made a safeguarding referral to children's social care and planned for follow up by the community midwife.

17.26 As a result of the incident and hospital attendance a telephone discussion took place within one day between the community midwife and health visitor and a home visit by the health visitor to Ruth followed. A single assessment was planned by children's social care. Ruth was contacted three weeks after the incident took place for enquiries by a social worker, she (Ruth) confirmed the argument took place but said "things were now fine". The single assessment was closed.

17.27 The first baby of Ruth and the Perpetrator was born in the summer of 2015, six weeks after the domestic abuse incident. Ruth was documented as keen to return home to the Perpetrator as soon as possible after the birth. At the health visitor's first contact two weeks after hospital discharge Ruth shared some family history regarding her other two children. She described limited family support from her own and the Perpetrator's family.

17.28 In early 2016 hospital records show Ruth suffered a miscarriage. Her first child with the Perpetrator was four months old at the time.

17.29 In spring 2016 the CPN for Ruth left her post and wrote to Ruth explaining the case would be transferred. The newly allocated CPN attempted contact with Ruth six weeks later but it was nine weeks until a face to face meeting could take place.

17.30 In the summer 2016 Ruth told her health visitor she had resumed contact with her other two children, who lived with Partner 1. She also disclosed being around seven weeks pregnant with the second child in her relationship with the Perpetrator. At around thirteen weeks pregnant Ruth told the CPN she was not taking her medication. A plan was made that the CPN would have a discussion with the midwife. A week later Ruth told the same CPN she felt

[9] Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) assessments involved a number of questions asked of the victim by the attending officer to complete the DASH. This would then be forwarded in 2014 into the Central Referral Unit (CRU) where a computer-generated risk level was created based on the information provided. The DASH risk levels are standard, medium and high. The DASH risk assessment model was agreed by the Association of Chief Police Officers as the appropriate model for police officers attending domestic abuse incidents.

irritable towards her partner due to tiredness and she was feeling depressed. Liaison took place between the CPN and midwife regarding medication.

17.31 In the autumn 2016 a transfer between CPNs was required due to restructuring of areas to align with GP practices. Attempts were made by the two CPNs to meet Ruth together to handover but all attempts at joint visits were unsuccessful. The CPN taking over the case tried to meet with Ruth but there appeared to be no willingness by Ruth for this to happen. In early 2017 a decision was made to discharge Ruth from the CPN's caseload due to apparent lack of engagement. The GP was informed of the discharge.

17.32 One week later in early 2017 the second child for Ruth and the Perpetrator was born. Ruth herself had to return to hospital for treatment of an infection when the child was only one week old. She was discharged again after three days.

17.33 At the first new baby review with the health visitor Ruth described her partner, the Perpetrator as "supportive". For the first two months of the new baby's life Ruth was observed as content by the health visitor but in early spring 2017 she attended a GP appointment feeling depressed. Medication was discussed with anti-depressants recommenced.

17.34 In the summer of 2017 Ruth called the police to report the Perpetrator was drunk and on drugs, refusing to leave. The two children were said to be present. When police attended Ruth said the incident was a verbal argument only but she confirmed when being assessed feeling depressed and that she was pregnant. A domestic abuse notification was shared with Derbyshire children's social care and also children's social care in the south where the elder children of Ruth were still living. The notification did include the pregnancy information.

17.35 The health visitor involved for Ruth's second child was also notified and completed a home visit during which Ruth said the relationship was now stable. The health visitor recorded that the impact of domestic abuse on children was discussed and liaised with children's social care after seeing Ruth and the baby. The outcome of the children's social care assessment as a result of the incident was no further action required.

17.36 In the following months, the children were seen routinely with Ruth by health professionals (including at the minor injuries clinic and hospital emergency department). The Perpetrator was also seen accompanying the children at some routine health appointments.

17.37 In early 2018 an antenatal health visitor appointment took place at home regarding Ruth's pregnancy (for the third child with the Perpetrator). The pregnancy was described by Ruth as "unplanned but wanted". There were no concerns reported and the family was described as stable. The notes from the visit state Ruth's emotional needs and history were discussed.

17.38 The baby was born in spring 2018. This was Ruth's fifth child and third with the Perpetrator. In the health visitor's new baby review, Ruth was described as tearful and struggling to get her other two children to nursery despite the help of her partner. Records indicate the health visiting service offered listening visits to Ruth, however she declined and was

therefore made aware of how to access the service if required.

17.39 The GP around this time made a referral to the local community mental health team regarding possible post-natal depression. The referral was triaged and Ruth's previous involvement with mental health services considered. A perinatal service was suggested but not available in the area where Ruth's GP was located.

17.40 At the new baby's six to eight week check with the health visitor Ruth described her relationship with the Perpetrator as happy and supportive. She was noted as having good insight into her own mental health and although she said having three very young children was hard work appeared to be coping well.

17.41 In the early summer Ruth's appointment with mental health services was cancelled due to staff sickness. Ruth did not attend the reconvened date six weeks later and a letter was sent from the mental health team to the GP referrer. This contained incorrect information that Ruth had not engaged with two appointments.

17.42 In late 2018 the ambulance service was called to the home of Ruth and the Perpetrator. Sadly, Ruth was found with significant injuries and despite advanced life support being attempted she was deceased at the scene.

17.43 The Perpetrator was arrested the same day.

18 Summary of family information about Ruth

18.1 The Author and Panel appreciate the decision of the Parents in agreeing to contribute to the Review process.

18.2 Ruth's Parents told the Author Ruth had a happy early childhood. They explained that they were Birth Mother and Stepfather, the Stepfather having been in the life of Ruth and her Mother since Ruth was a baby, adopting her in 1999, and remaining involved throughout her whole life until her death.

18.3 After a period living abroad the family lived in the south of the country. Ruth was said to be a normal girl, the Parents described her as well behaved until her early teens. She elected to go to boarding school around secondary school age, as did her sibling. The school was a mixed school for female and male students. Unfortunately, at around age 14/15 years her behaviour started to become disruptive at school. The Parents recalled her moving schools and that they looked for help via GP services but Ruth did not want to engage with support at the time.

18.4 After a short period at a local college Ruth found a job working in catering. Her Parents said she was reliable at work, always attending on time despite unsocial hours. It was at this workplace when Ruth was around 17-18 years that she met the man who has been referred to as Partner 1. He was around 12 years older than Ruth. The Parents were involved in the lives of Ruth and Partner 1 and had regular contact with the two children born during the

relationship.

18.5 The Parents said they were now aware of some domestic abuse happening within the relationship of Ruth and Partner 1 but that Ruth shared few details with them about the abuse. The Parents had very little contact with services or professionals who became involved with Ruth as a result of the abuse. The Parents did not know or believe that alcohol was a problem to Ruth at this point in her life.

18.6 Around June 2011 the Parents said Ruth suddenly travelled with the children to the South Yorkshire area staying for two days. This was with another man known as Partner 2. The Parents said they understood that Ruth and Partner 2 had known one another at the boarding school which they had both attended, but the Parents had never met Partner 2 before. This was the end of the relationship with Partner 1.

18.7 Partner 2 and Ruth married at the end of 2011. They had returned briefly to live in the local area near to Ruth's Parents who supported them financially with a rental property. The Parents said they believed domestic abuse from Partner 2 started in early 2012 but they did not think this was reported to services by Ruth.

18.8 In Spring 2012 Ruth, the children and Partner 2 moved to Derbyshire. The Parents described that they did not see Ruth regularly but spoke to her frequently. They occasionally met halfway between the two areas in order that the Parents could look after the children.

18.9 The Parents described being worried about domestic abuse from Partner 2 on Ruth from this point. There was some contact between Derbyshire children's services and the Parents regarding the children. The Parents' view was that professionals dismissed the Parents' concerns for the children's welfare as "being over dramatic."

18.10 At one point the Parents say they reported concerns that Ruth and Partner 2 had resumed their relationship, when Ruth had been asked by children's services to keep away from Partner 2. Around this time the Parents were asked to care for the two children of Ruth, their grandchildren, and the children went to stay at the Parents' home. Eventually the children went to live with their father (Partner 1), a situation that they (the Parents) believed Ruth "bitterly regretted."

18.11 The Parents recall an incident of criminal damage to their car at this time (around mid-2013) for which Ruth was convicted. The Parents said Ruth told them some years later that Partner 2 was responsible but she took the blame for the damage. As a result of the conviction the court imposed a restraining order on Ruth to have no contact with the Parents, something which the Parents say they did not request.

18.12 There was therefore limited contact between Ruth and the Parents for around two years. Ruth and Partner 2 moved back to Derbyshire and the Parents were not fully aware about the circumstances of the end of her relationship with him. However, they were in telephone contact with Ruth and knew she had met a new man also from Derbyshire. This was the

Perpetrator. The Parents said Ruth described her new life as "happy and settled".

18.13 The Parents remembered being made aware of the incident when Ruth had a cut injury to her face. However, this was some time after the incident had occurred as the Parents recall being told around autumn 2015. They could not believe that Ruth would self-inflict a wound to her face as they thought she was always well groomed and cared about her appearance, particularly facially. They said that Ruth told them the wound was caused by her previous husband (Partner 2) who had allegedly smashed a glass in her face. It later became clear to the Parents that she did not have a scar from the injury until well after her last contact with Partner 2 and they now suspect the Perpetrator was responsible.

18.14 In summer 2015 after the first child of Ruth and the Perpetrator was born the Parents applied for the restraining order to be lifted by the court to enable them to visit. From then they remained in fairly regular contact with Ruth and the three children born within the relationship of Ruth and the Perpetrator. Ruth also had contact with the older two children from the relationship with Partner 1 who still lived in the Parents' local area, with their father (Partner 1). The Parents helped facilitate the contact and they remembered Ruth as "seeming happier".

18.15 Regarding the Perpetrator, the Parents said they met him "only a handful, three to five times". They were told by Ruth "he worked a lot" and he was mostly not at the home he and Ruth shared in Derbyshire when the Parents visited. He was said to have only visited the Parents' home twice when dropping off Ruth and the children but he himself did not stay and left after a very brief time. The parents said they accepted the explanation provided by the couple that he "had to get back to work".

18.16 She never told the Parents about domestic abuse occurring in the relationship with the Perpetrator, in fact the Parents were given the impression that Ruth "had turned her life around after a rocky few years" and that "she was living a happy and safe life".

18.17 The overall view of the Parents is that whilst Ruth was alive, they had limited contact with professionals or services involved with Ruth and the children, apart from on a few occasions. When contact did occur the Parents "felt dismissed" by Derbyshire children's social care when they (the Parents) tried to raise concerns about the children during the time that Ruth was with Partner 2.

18.18 Ruth told the Parents that she "had been diagnosed with a personality disorder" but did not talk to them about any service or support she was receiving for this. Having reflected since their daughter died the Parents feel the cause of her general unhappiness and mental ill health may have been due in some part to her feeling neglected. They thought she was neglected by her biological father before she was even born, and then by him again in her later childhood. They also thought she may have felt a degree of neglect from the Parents despite deciding herself she wanted to go away to boarding school. Later, it is the Parents' view that she may have felt let down and neglected by children's social care during the period with Partner 2.

18.19 The Parents believe that Ruth's feelings of being neglected led to her forming relationships with male partners very quickly. They said each of the three adult relationships became serious within a short time period. Their view was that Ruth "had an overwhelming desire for love and affection which made her vulnerable."

18.20 The Parents spoke positively about the support received from Derbyshire Police after the sad death of Ruth. A year after the death they assisted Derbyshire Police in a domestic abuse awareness raising campaign.

19 The Perpetrator

19.1 The Perpetrator was provided with an opportunity to meet with the Author but chose not to participate in the review. Therefore, little is known from his own perspective about his early life, his own family, or any other intimate relationships.

19.2 There was no known information or evidence to suggest he suffered with any significant health conditions including any mental illness. His alleged use of and involvement in illicit substances is documented within the chronology. Ruth herself reported that the Perpetrator was "drunk and on drugs" in 2017 but allegations of drug use or involvement in dealing drugs were not substantiated.

19.3 The Perpetrator had a previous conviction for criminal damage in 2003, an offence recorded as domestic abuse related with damage caused using a baseball bat but no further information was available regarding the specific incident. More recently he had been convicted for motoring related offences.

19.4 Another historical allegation of note against the Perpetrator was a rape complaint in 2010. There is limited information about the incident except that it happened in a neighboring county to where the Perpetrator lived and that he was not charged.

19.5 The Perpetrator had a reputation of being a businessman, busy with his work despite it not being fully clear what type of work, apart from property rentals, in which he was involved. The Panel were not made aware of any financial issues which the Perpetrator (or Ruth) had during their relationship.

20 The Partners

20.1 Ruth had two other significant partners in her life, referred to as Partner 1 and Partner 2. The Panel considered whether either should be invited to contribute to the Review and made the decision not to involve them. Information contained in the overview report about the Partners has been obtained from agency records and some brief information from the Parents.

21 Analysis of Involvement

21.1 In this section, practice is analysed and evaluated against agency policy and procedure via the Individual Management Review (IMR) of each agency. Further analysis takes place in the next section directly answering questions posed in the Terms of Reference. Developments and changes within organisations, relevant to the DHR are reflected here.

21.2 Due to the long period which the timeframe of the review comprises reporting on each agency below covers the organisations' involvement individually across the whole timeframe. Whilst being repetitious at times this ensures transparency that thorough and consistent scrutiny has been applied.

21.3 The practice and service delivered by the agencies involved has been examined against the terms of reference for this DHR, and not for a Serious Case Review of a significant incident or serious harm regarding the children of Ruth. Therefore, the analysis and findings regarding the interventions of all agencies have focused on domestic abuse and on Ruth primarily. It is acknowledged that a number of learning themes highlighted would have been identified in a children's Serious Case Review and the Panel agreed it was important to consider focus on the children of Ruth as part of the review's terms of reference. However, the level of scrutiny applied by the Author to the detail of agency responses, particularly children's services, was with a focus on Ruth, the domestic abuse and associated factors for the family; examination of the minutiae of children's services' involvement, as in a Serious Case Review process, has not occurred.

Constabulary A

21.1.1 When Ruth was a young adult and in a relationship with Partner 1 she lived in the area covered by Constabulary A. This has not been named in an attempt to protect the identities of the children of Ruth.

21.1.2 Constabulary A were asked to provide a summary report with analysis of significant events between 01.01.2007 and 28.02.2012. This timeframe was to reflect the known period when Ruth was in a relationship with Partner 1[10], resulting in two children being born, and when incidents of suspected domestic abuse occurred, prior to the move to Derbyshire.

21.1.3 On all occasions where police responded to domestic incidents positive action was taken with the identified perpetrator being arrested and, where possible, formal action being taken.

21.1.4 Domestic abuse risk assessments (AD232r) were completed on each occasion with the level of risk identified being appropriate to the circumstances and in accordance with the grading policy at the time.

[10] As stated previously the Parents believed Ruth and Partner 1 to be separated in June 2011.

21.1.5 During the period under review Constabulary A were operating 4 levels of risk in relation to the assessment of domestic abuse incidents – low, medium, high and very high. Cases identified as high or very high risk were considered appropriate for referral to the MARAC process (see earlier reference). The level of risk identified throughout this review period was assessed as not reaching the threshold for MARAC referral.

21.1.6 On a number of occasions the risks to Ruth were identified as medium. Accordingly, contact was made by a Constabulary A domestic abuse co-ordinator (DAC) and safeguarding advice and other relevant information was shared. On some occasions Ruth advised that the relationship with Partner 1 was over and she did not need any assistance in relation to safeguarding.

21.1.7 On other occasions safeguarding advice was offered and accepted, with follow up information being sent through the post. This included in spring 2011 Ruth accepting a referral to Victim Support, the DAC undertaking safety planning over the telephone, a warning marker being placed upon her address for information of police response officers and also leaflets regarding the support available from external agencies being sent in the post.

21.1.8 It is evident that there was consideration of coercive and controlling behaviour[11] from the perspective of the DAC in understanding the nature of the relationship and the cycle of abuse that was being reported. Unfortunately, prior to 2015 and the introduction of this. offence in intimate and family relationships, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within such relationships.

21.1.9 Alcohol was identified as a feature within the relationship between Ruth and Partner 1. Both appeared to regularly consume alcohol and were assessed as 'in drink' on a number of occasions when police attended the address. Partner 1 did agree on one occasion for a referral for treatment for alcohol related issues but the outcome was unknown. Following the arrest of Ruth herself in early 2011, she declined the offer of a referral to alcohol treatment services.

21.1.10 On each occasion that Constabulary A attended the couple's home address in response to a report of domestic abuse when the couple's child or children (depending on the timing) were present, the child or children were seen by the officers. The home address was noted to be neat and tidy and equipped appropriately for a young baby.

[11] Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour; Section 76 of the Serious Crime Act 2015.

21.1.11 On each reported incident to Constabulary A, except one, a Children and Young Person at Risk (CYPR) form - now referred to as a Public Protection Notice 1 (PPN1) - was completed. This form documented the details of the incident attended and the potential risks to the child. In accordance with policy at the time, the CYPR was shared with the local children's services department and colleagues within health.

21.1.12 On the one occasion that a CYPR was not completed, officers attended the address and found no evidence of a disturbance and no disclosures were made by the couple. Both said they had been watching a film at high volume and there were scenes with a woman screaming. Officers gave advice regarding noise levels and left the address with no action being taken. Despite no disclosures being made, the incident was still recorded as a possible domestic abuse dispute due to the previous known history.

21.1.13 There are no identified lessons specifically for Constabulary A as a result of this review. The timeframe of the review commenced over 10 years ago with the last involvement being in 2011. The practice demonstrated was of the required standard at the time. However, the Author and Panel were told practice has evolved and developed to the present time. Constabulary A continues to identify the need for positive action to be taken when responding to domestic abuse incidents, including arrests and the pursuit of offences through the criminal justice process.

21.1.14 It is Constabulary A's policy that every incident of domestic abuse requires a domestic abuse risk assessment to be undertaken. There is now a single risk form being used (PPN1) which enables risk in relation to domestic abuse, children and vulnerable adults to be captured in one place and shared with partner agencies. It is also policy that every incident of domestic abuse where there is a child resident at the address/linked to those involved requires a PPN1 to be completed and shared with children's services.

21.1.15 All assessments of domestic abuse are reviewed within the local Multi Agency Safeguarding Hub (MASH) to aid in the consistency of decisions made and also the sharing of information with partner agencies.

21.1.16 Constabulary A told the Author that significant resources have been placed into the training and continuing professional development of officers and staff in relation to domestic abuse. Training has been delivered across all work strands with the aim of increasing the knowledge and understanding of domestic abuse, including the psychology of victims and perpetrators. Training has included material specifically related to coercive and controlling behaviour.

21.1.17 In spring 2013 Ruth reported to Derbyshire Police a non-recent allegation of sexual abuse by Partner 1 during a period between 2007 and 2010. She was interviewed by Derbyshire Police and the investigation was transferred to Constabulary A as that was the area where the alleged offences occurred. She was provided the option of IDVA[12] and ISVA support by Derbyshire Police but this was not taken up possibly due to Ruth returning briefly to Constabulary A's area. On her return to Derbyshire she was referred to a local sexual violence organisation for additional support.

21.1.18 Partner 1 was interviewed and denied the sexual abuse allegation. In interview he described a volatile relationship with violence (in his opinion) occurring from both sides (he and Ruth) throughout their time together. He also described acrimony regarding the living arrangements for their children. He at the time of the interview had care of their two children having been awarded a full residency order for the children to live with him in 2013.

21.1.19 Constabulary A conducted a full investigation including making enquiries with friends of Ruth who said they were aware of physical violence between the couple and on occasions Ruth had phoned them to seek help. No sexual offences were ever disclosed to friends interviewed by Constabulary A.

21.1.20 There was no independent or medical evidence to support or undermine either account. Contact with the GP identified one brief reference in the notes of Ruth stating she had been previously assaulted physically and sexually but it has not been possible to clarify this further through GP records.

21.1.21 The decision was made by a Constabulary A Detective Inspector (in line with local policy) that no formal action would be taken as a result of the sexual abuse allegation due to insufficient evidence which is considered to be an appropriate decision.

Children's Services Area A

21.2.1 The local reception and assessment team, for the geographical area where Ruth and Partner 1 lived was previously one of eight reception and assessment social care teams forming part of Area A's children's services front door service. The reception and assessment team were responsible for responding to referrals into children's services when concerns were raised. This resulted in assessments being initiated or child protection investigations.

[12] The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. IDVAs serve as a victim's primary point of contact. The role of the independent sexual violence advisor (ISVA) is to tailor support to the victim's/survivor's individual needs, to provide accurate and impartial information and to provide emotional and practical support.

21.2.2 In the period when Ruth and Partner 1 were known to be together four CYPR reports (see above) triggered contact from social workers from the local reception and assessment team due to incidents of police involvement with the couple. Two led to initial assessments being completed and all four incidents resulted in no further action being taken by children's services other than signposting and advice.

21.2.3 The local children's services records for the time depict the relationship of Ruth and Partner 1 as characterised by accusations and counter accusations being made against each other. The move north to another part of the UK with Partner 2 was recorded but it was not clear in records as to why this occurred. Children's services were aware that the relationship between Ruth and Partner 1 was over around this time.

21.2.4 During the relationship of Ruth and Partner 1 details of the Freedom Programme[13] were provided to Ruth but due to the children's services involvement being intermittent it was not clear whether she accessed this support. It is clear from the records that both Ruth and Partner 1 gave assurances following incidents that they would engage in appropriate services and were 'committed' to avoiding future incidents but this did not happen. Reasons may have related to possible coercive and controlling behaviour by Partner 1 to Ruth and it is possible that there was an element of disguised compliance[14] by the couple to try to convince children's services of their capacity to change.

21.2.5 Follow up of signposting, uptake of support services, and associated disguised compliance was highlighted as a learning point for Children's Services A as a result of the individual management review. However due to the time elapsed since the service involvement with the family, and development and improvement in the service the Author was told the learning has been addressed through local policy and practice changes.

21.2.6 In late spring 2013 children's services in Area A were made aware by Derbyshire Police that allegations of sexual abuse had been made by Ruth against Partner 1 reported to have occurred between 2007 and 2010. Within a multi-agency meeting it was agreed that the investigation should be undertaken as single agency, by the police.

[13] The Freedom Programme is a domestic violence programme primarily designed for women as victims of domestic violence, since research shows that the vast majority of cases of serious abuse are male on female. However, the programme, can be suitable for men, whether abusive and wishing to change their attitudes and behaviour or whether victims of domestic abuse themselves.
The Freedom Programme examines the roles played by attitudes and beliefs on the actions of perpetrators and the responses of victims and survivors.

[14] Disguised compliance involves parents and carers appearing to cooperate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993); learning.nspcc.org.uk

21.2.7 An update was provided by Constabulary A in late summer 2013 that Partner 1 had been arrested and interviewed regarding sexual abuse but it was likely that there would be insufficient evidence for criminal proceedings. The decision within children's services in Area A was that single agency (police) process should continue and no further information is on record relating to the allegations.

Derbyshire County Council- Children's Services

21.3.1 Derbyshire County Council children's services operates across 6 geographical localities with a 0-19 population of approximately 170,000 (21.8%) which is expected to rise by 2.4% by 2025. 17% of children live in income deprived households. From 2015-17 Derbyshire moved to integrated management of early help and safeguarding and to a 'Stronger Families Safer Children' operating model[15]. The "front door" known locally as 'Starting Point' was established during this time with closer working relationships with police and health practitioners in screening referrals and the opportunity for assessments based on multi-agency decision making.

21.3.2 The first recorded contact from Ruth and Partner 2 with Derbyshire children's services (from now to be referred to as children's services) was in early spring 2012. Partner 2 reported the family, which included Ruth and her two children with Partner 1, were fleeing domestic abuse in Area A and needed financial support. Liaison took place between children's services and the local health visiting service. It was positive, as a result of the inter-agency communication that a timely transfer in visit took place by the health visitor during which Ruth's mental health and previous abusive relationship were discussed.

21.3.3 It is apparent now, from the contact with children's services over the next two months (and other agencies in Derbyshire), that a chaotic and harmful relationship existed between Partner 2 and Ruth with risk factors of domestic abuse, alcohol and substance misuse, housing problems and mental health issues for Ruth. Concerns, predominantly for the safety and wellbeing of the children, were recorded as being received from an extended family member of Partner 2 who lived locally to the couple, and from the Parents of Ruth, who lived several miles away in Area A.

[15] The "Stronger Families Safer Children" operating model was developed by Derbyshire County Council Children and Younger Adults Department to provide an overarching framework for early help to safeguarding and specialist services. It is a strengths-based approach.

21.3.4 Within one month of the first contact with children's services a core assessment had commenced regarding the family leading to development of a child in need plan which included multi-disciplinary child in need meetings. The plan was to focus on work around parental substance misuse and Partner 2's aggressive behaviour. Recent data shows domestic abuse is the most common factor amongst children assessed as being 'in need' of support from local authority children's services in England[16].

21.3.5 Unfortunately, the abusive behaviour from Partner 2 towards Ruth continued throughout 2012 with six domestic abuse incidents recorded by police. Police responses are scrutinised below. The couple appeared to regularly separate then reconcile and services becoming involved appeared to respond in isolation to each incident. The children eventually went to stay with the Parents in Area A but on an informal basis. At this time in the early part of Ruth and Partner 2' relationship the Parents recall "feeling dismissed" by children's services staff when they tried to highlight concerns for the children's safety and welfare, due to the lifestyle of both Partner 2 and Ruth.

21.3.6 Contact did take place between Derbyshire children's services and children's services in Area A for historical information to be obtained. However, there was limited focus given to Ruth being a survivor of domestic abuse from one relationship (with Partner 1) and that she was now suffering another abusive relationship (with Partner 2) from which her children were also at significant risk. It is not uncommon for a woman to experience abuse in more than one relationship.

21.3.7 The case in Derbyshire appeared to be managed in an optimistic way by children's services in view of the reported behaviour of both Partner 2 and Ruth and the impact on the children, who were spending time in both Area A with the Parents, and in Derbyshire.

21.3.8 The couple behaved chaotically, did not make themselves available to professionals but also used disguised compliance, and were untruthful about their relationship status at times. It must be highlighted that the mental health and experience of domestic abuse may have impacted on Ruth's capacity to accept support and comply with the requests of children's services. In one abusive incident in late spring 2012 Ruth was pushed down the stairs by Partner 2 and received a cut to the head. She refused to make a complaint to the police but initially spoke of leaving with a return to Area A with the children. Children's services tried to support this with travel arrangements but within days Ruth said she had decided to stay in Derbyshire with Partner 2.

[16] DFE Children in need statistics
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762527/Characteristics_of_children_in_need_2017-18.pdf

21.3.9 The decision during 2012 to manage the risks outside of formal child protection protocols, using a written agreement[17] with the threat of more formal processes as a consequence of non-compliance, was too optimistic regarding the couple's lifestyle, deceptiveness and capacity to change. At times records show the children were allegedly speaking about witnessing domestic violence and more proactive action should have been taken. Research suggests there is a major overlap between direct harm to children and domestic abuse[18]. Learning points from *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Peter Sidebotham, Marian Brandon et al, May 2016* conclude "domestic abuse is always harmful to children. Furthermore, any evidence of domestic abuse in a relationship where there are children should prompt a careful consideration of the harms those children may be suffering and how they can be effectively protected".

21.3.10 There was evidence of some help being facilitated via children's services for Ruth in terms of domestic abuse support and for the children and family as a whole via Surestart and nursery. However, the engagement of Ruth and by the children was sporadic. It must also be considered that Ruth could have been suffering coercive and controlling behaviour from Partner 2 which would have impacted on her ability to accept support for herself and the children.

21.3.11 After 12 months in Derbyshire and several incidents of concern reported to children's services and the police, in early spring 2013 the relationship between Ruth and Partner 2 was found to be still ongoing. The couple and children had secured a different property in joint names. It was positive, albeit overdue that a section 47 enquiry was commenced by children's services as the children were considered to be at risk of significant harm. Records show that management oversight within children's services suggested all agencies were to be notified of escalating concerns. A MARAC referral was to be completed by the social worker but there is no evidence that this occurred; the reason for this has not been ascertained.

21.3.12 At this time the children returned to live with their father, Partner 1 away from Ruth and Partner 2 who remained together in Derbyshire. The move was agreed by both children's services in Derbyshire and Area A and eventually Partner 1 was granted a residency order for the children to live with him.

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[17] A Derbyshire serious case review published in 2017 identified the need for a review of the use of written agreements and the (limited) circumstances in which they may be useful in safeguarding and promoting the welfare of children be clarified. A revised Use of Written Agreements by Practitioners working with Children and Families was agreed in April 2019 by Derby and Derbyshire Safeguarding Children Boards

[18] In plain sight: Effective help for children exposed to domestic abuse CAADA (Coordinated Action Against Domestic Abuse) 2nd National Policy Report, February 2014

21.3.13 In the following months children's services liaised with mental health services regarding Ruth as her mental health appeared to deteriorate but at this point the children's services case for the family was closed due to the children living in a different area. Children's services were informed that Ruth had alleged non recent sexual abuse against Partner 1, as discussed earlier.

21.3.14 There was no further involvement by Derbyshire children's services with Ruth until early summer 2015. By this time Ruth was no longer in a relationship with Partner 2 and her eldest 2 children were settled in Area A. Ruth was living with the Perpetrator and was over seven months pregnant with their first child together.

21.3.15 The contact in summer 2015 with children's services was via a referral from the hospital midwifery service after Ruth had attended hospital with the police. She had reported being kicked in the abdomen by the Perpetrator and had a small cut near her nose. The referral to children's services was appropriate and timely. A strategy meeting was not considered necessary to explore risk of harm to the unborn child and which would also have provided the opportunity to discuss previous domestic abuse and support for Ruth. Children's services were unaware of an incident which had occurred in spring 2015 when Ruth, after a reported argument with the Perpetrator had allegedly self-harmed causing a cut to her face. The early pregnancy of Ruth had been disclosed to hospital staff at the time of the treatment for the self-harm. The named midwife for safeguarding from the hospital trust was informed for her to liaise with the Derbyshire community midwife for Ruth, but risks to the unborn child and mother relating to any possible domestic abuse were not identified. A referral to children's services was not made.

21.3.16 As a result of the early summer 2015 incident an assessment was completed by children's services. It has since transpired that there was confusion over Ruth's address after the incident as the perpetrator owned other rental properties on the road where they lived. A no access home visit was attempted to see Ruth with a follow up contact between a social worker and an involved midwife concluding no further action was required due to no other reported domestic abuse incidents for the previous two years. The view of the children's services Panel representative was that this decision met threshold criteria for intervention at the time but the Author maintains that possible risks to the unborn child and mother were not seen. Whilst accurate that no incidents had been reported there were other risks to be considered to the unborn child and to Ruth herself as a pregnant mother. The importance of domestic abuse being considered during pregnancy and after a baby is born should not be underestimated. Pregnancy can be a trigger for domestic abuse and existing abuse may worsen during pregnancy or after giving birth[19]. In Home Office analysis, nine of twenty four DHRs[20] examined where vulnerability issues and heightened risk were overlooked the vulnerability was identified as the woman being pregnant.

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[19] Domestic abuse in pregnancy, www.nhs.uk

[20] Key Findings from Analysis of Domestic Homicide Reviews, The Home Office, December 2016

21.3.17 Ruth had volunteered information about her experience of domestic abuse in previous relationships, which was supported by records within children's services of both physical and sexual abuse. Of further concern was the mental health of Ruth who had recently reported feeling depressed and suicidal. Enquiries with other services would have shown incidents of alleged recent self-harm. Furthermore, substance misuse of the Perpetrator had also been alleged to some professionals but does not appear explored.

21.3.18 Ruth herself refused to make a complaint against the Perpetrator and after being interviewed he was released without charge. The report was filed as "undetected" with insufficient evidence to consider a victimless prosecution. Coercive and controlling behaviour by the Perpetrator and his influence over Ruth does not appear considered by any professionals in contact with Ruth after the domestic abuse incident when she was heavily pregnant. The law regarding coercive and controlling behaviour was introduced in 2015, therefore may not have been at the forefront of all professionals' minds at the time.

21.3.19 The children's services decision was for the unborn child's needs to continue to be managed through the universal services already involved. There appears to have been no further recorded attempt to signpost and encourage Ruth towards domestic abuse support services after the initial information provided to her by the hospital. Three weeks after children's services had closed their involvement with Ruth, a notification was recorded from the hospital that the first child of Ruth and the Perpetrator had been born.

21.3.20 The incident just prior to the birth of the first child was an opportunity for the local Multi-Agency Pre-birth Protocol[21] to be used and for a plan for coordinated support and monitoring for the family to be put in place. Instead no further contact was recorded by children's services with Ruth, or by children's services with any other professionals who continued to support her. Another baby was born to the couple in early 2017 and Ruth was pregnant with the Perpetrator's third child when children's services were next required to become involved in Ruth's life.

21.3.21 In summer 2017 Ruth reported to the police a verbal argument with the Perpetrator who she alleged "was drunk and on drugs". She did not allege physical violence by him at the time or previously. During the police assessment of risk, she did confirm being affected by depression and that she was pregnant. At the time she already had two very young children living with her who were said to have been present during the argument.

[21] The Derbyshire and Derby City Safeguarding Children Procedures Multi-Agency Pre-birth Protocol was developed to support agencies and practitioners in their decision making and assessment processes when working with a pregnant woman, their partners and families. The aim of the protocol is "to ensure that all unborn babies with additional needs are identified as early as possible and ensure that appropriate and timely services are delivered in an integrated manner".

21.3.22 Notifications of the incident were shared electronically with the front door of children's services (Starting Point) and the health visiting service but there was a delay of over two weeks of the information being received. The Author was told at the time there was a backlog in processing standard risk DASH reports but that processes have changed and standard risk DASHs are now subject to automated processing rather than the previous manual processing. This followed learning from a previous DHR after which Derbyshire police, the 0-19 children's service (health visiting and school nursing) and children's social care reviewed and developed the new pathway to ensure domestic abuse notifications were received without delay.

21.3.23 Starting Point received a timely update after a health visitor's home visit with Ruth who told the health visitor that her relationship was now "stable". Starting Point were told no other concerns were noted and the pregnancy as disclosed to the police by Ruth was not discussed. The health visitor's contact demonstrated appropriate focus on the children's immediate needs during the visit and the impact of domestic abuse was discussed. There was limited attention to the mental health of Ruth, despite depression being disclosed to the police responding to the incident.

21.3.24 As a result of the liaison between Starting Point and the health visitor the decision was that no further action was required by children's services. This was despite the latest pregnancy of Ruth (fifth in total, third with the Perpetrator), additional pressure of her caring for a baby and toddler, and a record of a domestic abuse incident within that same relationship during pregnancy two years before. The latest pregnancy, as disclosed to the attending police officer and included on the notification, which was shared, seemed overlooked by all professionals as was the possibility of the presence of reproductive control or coercion[22] within the relationship.

21.3.25 This was at least an opportunity to introduce early help processes to a vulnerable family but there is no record that this was considered. The early help offer within Derbyshire was well embedded across all partners and within children's services at this time.

21.3.26 Children's services had no other involvement with Ruth or her family until after her death.

21.3.27 The Author was told that the Derby and Derbyshire Safeguarding Children Partnership Pre-Birth Protocol has been refreshed and strengthened and includes a reminder for practitioners to undertake a thorough early help assessment or single assessment at the earliest opportunity. Briefings and promotion work are taking place from May 2020.

Derbyshire Constabulary

21.4.1 Derbyshire Constabulary covers the geographical county of Derbyshire.

[22] Reproductive control or coercion over decisions about becoming pregnant or continuing or terminating a pregnancy, Reproductive control by others; S.Rowlands, S.Walker. BMJ Sexual and Reproductive Health January 2019

21.4.2 Derbyshire police first became aware of Ruth in spring 2012. Ruth and Partner 2 were said to have moved to Derbyshire to escape domestic abuse from Partner 1. Police records stated there were drug and alcohol issues in the relationship of Ruth and Partner 2 but at that point no initial role for the police.

21.4.3 Over a period of six months in 2012 Derbyshire police attended six domestic abuse related incidents involving Ruth and Partner 2. DASH assessments (see earlier reference) were completed for every attendance with risks rated as either standard or medium. Information sharing with children's services took place for every incident.

21.4.4 In October 2013 Derbyshire Police introduced criteria which identified when a referral required a further risk assessment. The criteria include three standard DASH assessments in a one month period. However, the assessments which applied to the reported incidents involving Ruth and Partner 2 pre dated the criteria by twelve months and there was no other police oversight of the incidents collectively which would have applied additional scrutiny to the pattern of domestic abuse attendances. Therefore, despite information being shared with children's services by police due to Ruth's children often being present when domestic abuse occurred, each incident appears responded to and assessed in isolation.

21.4.5 The police did take some positive action during this six month period. A victimless prosecution was attempted after an assault on Ruth by Partner 2, a complaint which Ruth then retracted. Unfortunately, this was refused by the Crown Prosecution Service and Partner 2 was not charged. There is also evidence that Ruth was signposted by the police to local domestic abuse support services.

21.4.6 In spring 2013 after a period of five months when no incidents were reported to the police a domestic incident between Ruth and Partner 2 with the children present was reported. No specific complaints were made and the DASH assessment was medium. Information was shared with children's services and as a result of the apparent refusal or ability at that time of Ruth to prioritise the children's safety a section 47 investigation was commenced. As stated above the children then went to live permanently with their father (Partner 1).

21.4.7 Derbyshire police responded appropriately to the complaint of non-recent sexual abuse which was reported by Ruth in 2013 a month after the children had returned to Area A. After initial enquiries the investigation was transferred to the police area A where the offences were alleged to have occurred. This met expected practice standards. The Derbyshire investigating officers tried to facilitate support for Ruth by offering the services of a local sexual violence support organisation.

21.4.8 This was the last contact by Derbyshire police with Ruth for twelve months. Ruth was next seen by officers at their first attendance relating to Ruth and the Perpetrator in early spring 2014. Partner 2 was in prison and it is now known that the relationship with the Perpetrator had started by this point. A friend of Ruth's reported (unsubstantiated) concerns for Ruth about the drug use of the Perpetrator and his involvement in other criminality. Officers did visit Ruth who at the time said she was safe and well therefore there was no further police

action which could have occurred. The couple had no children together at that time and Ruth's own children lived in Area A.

21.4.9 Six months later in late summer 2014 the police attended a call from a member of the public who reported hearing a woman screaming "get off me, leave me alone" from inside the address where the Perpetrator and Ruth lived. The attendance was not recorded as domestic abuse as Ruth was recorded as saying she had self-harmed. This is also corroborated in ambulance and hospital records as Ruth went to the emergency department for treatment.

21.4.10 It is unclear what history was explored in terms of previous police involvement with Ruth but the sequence of domestic abuse between her and Partner 2 had occurred at different addresses, therefore a link would not be obvious on an initial basic check through the 'Command and Control' system. However, the Author was told incidents would have been evident on 'Guardian'[23] which recorded DASH reports at the time. The lack of children present (as Ruth's children resided with their father) may also have prevented further scrutiny in terms of Ruth's wellbeing and current circumstances.

21.4.11 Alcohol was mentioned as a feature regarding the self-harm incident as was her poor mental health but neither seemed to prompt follow up by the police in terms of adult safeguarding more generally. Derbyshire police explained since 2016 adult public protection notices (PPNs) have been used to refer safeguarding issues to social care in relation to vulnerable adults. They said Derbyshire police will always now consider an adult PPN referral for victims of domestic abuse.

21.4.12 The police were not contacted regarding another incident of reported self-harm to Ruth's face in spring 2015, as mentioned above, when she was pregnant with the Perpetrator's first child.

21.4.13 The next contact with Derbyshire police was by Ruth in early summer 2015. She reported a verbal argument at home had escalated into a physical incident. The Perpetrator had punched Ruth in the head and kicked her in the legs. She said she was over seven months pregnant and was taken by Police to the hospital for a check-up. Fortunately, her only physical injury was a minor cut.

21.4.14 Ruth declined to make a formal complaint but initial positive action ensued with the Perpetrator arrested and interviewed. He denied any offences and actually said Ruth had assaulted him before he had left. He also spoke about Ruth's alleged previous self-harm. The Perpetrator was not charged. A DASH assessment was completed as medium risk and information was shared with children's services due to the pregnancy. Responses by children's services to this and other incidents were explored earlier.

[23] Guardian was used as a record management system within Derbyshire police until 2016, It was a data base used to record crime, intelligence and risk assessments such as DASHs. It was searchable so officers could, for instance, view a person's previous history, including addresses, whether they were recorded as victims or perpetrators of crimes and domestic abuse history.

21.4.15 A follow up was requested of and carried out by the police safer neighbourhood team, which is a local policing unit. Ruth declined any offer of further police assistance but was provided with domestic abuse support contact details. The difficulties faced by domestic abuse survivors in engaging with offers of support, particularly survivors with additional vulnerabilities such as mental ill health and pregnancy, as in Ruth's case, should not be underestimated.

21.4.16 As explained above the Author was told improvements in raising awareness around vulnerability and information sharing have been made during the intervening five years which has led to a significant increase in adult referrals. In 2017 839 referrals were made for the whole calendar year. For the first five months of 2019 (1/1/19 to 20/5/19) a totals of 1862 referrals were made, indicating a significant improvement in identification of vulnerabilities for adults and information sharing.

21.4.17 There are also now a number of links to ensure improved information sharing around mental health of adults, including via relationships with the Criminal Justice Liaison and Diversion Team, Police Risk and Referral Unit and generally within the multi-agency safeguarding hub.

21.4.18 The police had only one further contact with Ruth before her death. This was in early summer 2017 two years after the alleged assault in the summer 2015. By this time Ruth had had two children with the Perpetrator, the youngest being less than six months old when Ruth called the police for help. She reported the Perpetrator "was high on alcohol and drugs", that their children were present and he was refusing to leave.

21.4.19 When the police attended Ruth said the incident was "only a verbal argument" and no complaints were made. A DASH was completed with Ruth disclosing she was pregnant and also that she was feeling depressed. The assessment of risk was graded as standard despite the additional vulnerabilities for Ruth and her children including the unborn baby.

21.4.20 Expected practice was followed with information being shared with children's services and health via the county triage. There was no evidence of follow up by the safer neighbourhood team but involvement normally follows only after medium risk is identified. It is unclear if another attempt was made to encourage engagement by Ruth with domestic abuse support services. Derbyshire police had no further involvement with Ruth or her family until her death.

21.4.21 Derbyshire police were requested to attend incidents directly involving Ruth and the Perpetrator three times over a period of three years (or four times over a period of four and a half years if the death of Ruth is included). Seven attendances were required by the police responding to incidents involving Ruth and Partner 2 over a shorter period of thirteen months from 2012 to 2013.

21.4.22 In total eleven reports required a police response for possible domestic abuse related incidents affecting Ruth and her children between spring 2013 and the end of 2018 when Ruth died.

21.4.23 The linking of domestic abuse episodes for all organisations is easier when incidents occur closer together, and for the police if they occur at the same location or address. There were several incidents which occurred when Ruth was with Partner 2. However, the response from both Derbyshire Police and Derbyshire children's services was that reports of domestic abuse involving Partner 2 appear mostly dealt with in isolation. This was also a point in Ruth's life where she was at times in crisis regarding her own mental health and making choices or being controlled by Partner 2 into using alcohol and living chaotically which caused other life challenges, for example with housing. The culmination of risk factors faced by Ruth was not recognised by those coming into contact with her most, such as the police, during the period with Partner 2. Therefore, support offered and Ruth's response and engagement to this was not seen as positive and overall impact of police involvement was minimal.

21.4.24 As Ruth moved into a new relationship with the Perpetrator which is now known as being abusive from an early point, she was not able or equipped to recognise, or respond to the abuse which eventually escalated.

21.4.25 Derbyshire police told the Author that Safe Lives have delivered "Domestic Abuse Matters" training to Derbyshire police first responders, which includes front line officers, control room operators, custody staff and neighbourhood policing staff. It is positive that the training was also offered to and attended by local partner agencies including health, education, social care and domestic abuse support service providers.

21.4.26 Furthermore, there is a new instruction to Derbyshire officers to capture the voice of every child present at a domestic incident which police attend. Together with a child public protection notice, the child's voice is shared with relevant partner agencies.

<u>Derbyshire Healthcare NHS Foundation Trust</u>

21.5.1 Derbyshire Healthcare NHS foundation Trust (DHCFT) is the leading provider of mental health, learning disability and substance misuse services in Derby City and Derbyshire County employing over 2,500 staff based in over 100 locations across the whole of Derbyshire.

21.5.2 DHCFT's first involvement with Ruth was in spring 2012 after contact with a local Derbyshire community mental health team. Ruth reported she had an eating disorder and was advised to self-refer to a local eating disorder service.

21.5.3 At this point Ruth reported to DHCFT professionals she had been in an abusive relationship with her ex-partner (Partner 1) but that her husband (Partner 2) was supportive. Stress factors for Ruth noted at the time included her two children living with Partner 1 a long distance away on a residence order, possible eviction for Ruth and the possible sentencing of Partner 2 to a term of imprisonment (for a reason unconnected to Ruth or to domestic abuse). It was also noted that Ruth had not self-referred as had been advised to the eating disorder service.

21.5.4 Ruth provided a history to DHCFT of seeing a psychiatrist and counsellor organised by her Parents when she was younger and living in the south of the country (in Area A). She

disclosed some substance misuse from age 17, sometimes drinking alcohol excessively and occasional problems managing her anger. She disclosed she had suffered postnatal depression with her firstborn child. The GP records could not be checked regarding any treatment requested or provided for this period in Ruth's life.

21.5.5 Ruth agreed to support from the North Derbyshire Mental Health Crisis Resolution and Home Team (Crisis Team). The most effective levels of engagement with mental health services appears achieved when Ruth was under the care of the North Derbyshire Crisis Resolution and Home Team and the Recovery Team. There are records of times where Ruth took anxiety-induced overdoses of paracetamol and self-harmed by cutting. Admission to acute mental health services was considered in early summer 2013, however, Ruth was reluctant to accept an informal admission as Partner 2 was due in court (for an unrelated matter) and she wanted to be there to support him. It is positive a worker from the Crisis Team accompanied the couple to Court. If Partner 2 had been sentenced to prison it is highly likely that Ruth would have been admitted, however, the case was adjourned and therefore daily home visits resumed.

21.5.6 Whilst under the care of the Crisis Resolution and Home Treatment team Ruth's risk level reduced prior to transfer to the Recovery Team.

21.5.7 The Crisis Team did communicate with other professionals who were involved around this time with Ruth. This included professional liaison with North Derbyshire Women's Aid. Ruth had sought advice from Women's Aid regarding the abusive relationship with Partner 2 in autumn 2012 on the advice of children's social care. Records show that when Partner 2 was sent to prison later in 2013 Ruth started to open up to some professionals about the abuse from Partner 2, including alleged continuing emotional abuse from him whilst he was in prison.

21.5.8 Unfortunately, in late 2013/ early 2014 Ruth's housing situation changed and this is the period it is believed that she first met the Perpetrator. She moved areas in early 2014 and her case was formally transferred to a different community mental health team in another part of Derbyshire. Information shared about Ruth with the new team included a copy of her care plan, risk assessment and a consultant's letter regarding her care.

21.5.9 Through 2014 no direct mental health service was provided to Ruth from the mental health team in the area where Ruth was residing with the Perpetrator. Appointments were offered by the community psychiatric nurse but were either cancelled or not attended by Ruth. There is no record of attempted home visits during this period.

21.5.10 In early autumn 2014 Ruth attended the accident and emergency department at hospital after an incident of possible self-harm. She was referred for psychiatric assessment whilst at hospital but unfortunately left the department before she could be seen by the Rapid Response Liaison (Psychiatry) team (RRLT). Staff at hospital did attempt to make immediate contact with Ruth but she did not return. Ruth had reported to staff that she had been feeling low in mood, suicidal and that she had been drinking alcohol but that her boyfriend (the

Perpetrator) with whom she lived "was supportive".

21.5.11 There was no obvious liaison or follow up by the community mental health team after this incident. The hospital consultant psychiatrist did attempt follow up for unattended outpatient appointments provided as a result of the accident and emergency attendance. Ruth was eventually discharged as an outpatient, having not been seen, in late autumn 2014. A letter was sent by the consultant psychiatrist to the GP informing of the discharge. The letter said the community psychiatric nurse was to continue to work with Ruth, but this is considered optimistic as at that point since the transfer in early 2014 there had been no face to face contact between the community mental health team and Ruth.

21.5.12 A further attendance at the accident and emergency department was recorded in early spring 2015 when Ruth was sixteen weeks pregnant with the first child from her relationship with the Perpetrator. She had allegedly self-harmed after an argument with the Perpetrator but was noted as seen joking with him at the hospital. Ruth said she had no suicidal thoughts. There was robust follow up of Ruth during this attendance in terms of her mental health with an assessment by the Rapid Review Liaison Team (RRLT). Referrals were made to local mental health services but there is no record on community mental health team documentation that notification was received relating to this incident or that any community mental health team follow up occurred. A letter was sent to the GP but no communication appears to have taken place or actions agreed with the community mental health team.

21.5.13 The Author was told that DCHFT, other hospital trusts and GPs do not share patient record systems. Where an agreed protocol for individual patients is in place information is shared, for example between the Rapid Response Team and the Derbyshire CMHT and, sometimes, with the safeguarding lead in DCHFT. There was no protocol in place for Ruth at the time but the GP should have always been informed of any treatment/ contact.

21.5.14 Information was shared by the hospital with relevant health professionals involved for the pregnancy. Maternal health responses will be explored later. There was no documentation other than the entry regarding her behaviour around her partner (the Perpetrator) to suggest domestic violence was considered, or that the self-harm may have been a result of living with domestic abuse. The nature of the self-harm; a significant cut to the face was also not explored. The Parents of Ruth, whilst accepting possible self-harm occurred on other areas of her body, were insistent in the view that she would never have intentionally self- harmed her face due to how she felt about being well groomed and "always made up" facially. Research suggests the most common places to self-harm by cutting are wrists, upper arms and inner thighs. Facial self-harm by cutting is thought to be less common.

21.5.15 A further emergency attendance of Ruth at hospital had taken place in summer 2015, when her pregnancy was more advanced. On this occasion Ruth had initially disclosed domestic abuse by the Perpetrator. This incident has been scrutinised in more detail earlier. At a follow up antenatal appointment at hospital after the alleged assault the records show the involvement of community mental health services was known as Ruth was encouraged to engage with the service. Again, a letter was copied to the GP about the follow up

attendances but no triangulation of information sharing took place with the community mental health team. This was around the time that community mental health service was being transferred between areas.

21.5.16 The first face to face contact by the community psychiatric nurse with Ruth took place towards the end of 2015. The first baby of Ruth and the Perpetrator had been born three months earlier and two incidents of note as detailed above had occurred during the pregnancy relating to possible escalating domestic abuse. Whilst at times Ruth was seen by the service as 'hard to reach' there had been limited community mental health provision for her for over twenty months since the transfer to the different team. Within that period, as a person diagnosed with a borderline personality disorder and a history of domestic abuse, Ruth had demonstrated suicidal ideation, possible self-harm, excessive alcohol consumption and had reported further domestic abuse. She had also had a baby having suffered previously from postnatal depression. In short, she was a vulnerable individual with identifiable mental health needs.

21.5.17 After the home visit in 2015 another contact was attempted one month later but with no reply. The next contact in early 2016 was a letter from the community psychiatric nurse informing Ruth that she was leaving and that Ruth's case would be transferred. A new CPN was allocated after six weeks and attempted contact with Ruth through the spring of 2016. Eventually, after collaboration with the health visitor allocated to the first child born to Ruth and the Perpetrator, an initial face to face home visit with the newly allocated CPN took place in early summer 2016.

21.5.18 Over the next two months five home visits took place by the newly allocated CPN. A positive relationship appeared to be developing with records indicating some trust forming between Ruth and the CPN. Ruth volunteered she was pregnant again and much of the contact focused on medication and Ruth's mood as a result. Domestic abuse was not recorded as discussed.

21.5.19 Around this time in 2016 Derbyshire Healthcare NHS Foundation Trust (DHCFT) configured its neighbourhood teams to align with GP practices, leading to Ruth's GP practice moving from one community mental health team to another. Therefore, a transfer of Ruth's case to a different CPN was required. The CPN who had been supporting Ruth attempted to conduct a joint handover and introduction with the new CPN and Ruth. A brief initial visit took place in early Autumn 2016 but despite other joint visits being authorised by managers and arranged these did not take place, recorded mainly as due to Ruth being unavailable. The last visit before the formal transfer took place was made by the outgoing CPN alone; at this point Ruth was over halfway through her pregnancy with the Perpetrator's second child. Their other child together was just over one year old. Ruth was recorded as feeling well, with no suicidal thoughts. She said she was occasionally moody due to lack of sleep and due to her partner (the Perpetrator) "winding her up".

21.5.20 As with the transfer of CPNs the consultant psychiatrist also transferred Ruth across areas by writing to the new area's consultant psychiatrist. An offer of psychological therapy was also

made in writing from the new area but this was dependent on a patient engaging and agreeing therapy goals. Records demonstrate some no access home visits by the new CPN from late 2016. In early 2017 after management agreement Ruth was discharged from the CPN's caseload because of perceived lack of engagement. Normal practice was for the GP to be informed of the discharge.

21.5.21 Compared to other periods of community mental health service history for Ruth within the review timeframes, this is considered to be a decision made too quickly and particularly as Ruth and the new CPN had had little opportunity to develop a trusting working relationship. The discharge letter from the community mental health team was sent one week before the second child of Ruth and the Perpetrator was born.

21.5.22 In early routine postnatal check-ups Ruth reported to health professionals to be feeling well mentally and physically as a new mum despite "worrying of being haunted about the difficult birth". However, in spring 2017 she attended the GP feeling depressed with low self- esteem. The GP notes made no reference to her recent discharge from the community mental health service but mental health services are required to inform a patient's known GP when a case is closed or when there is a transfer of care.

21.5.23 In early summer 2017 Ruth reported an incident to the police when she alleged the Perpetrator was drunk and using illegal substances. Within the report, which was recorded as a domestic abuse incident, she volunteered that she was pregnant again, just six months after the birth of her last child and having recently reported feeling depressed to the GP. Unfortunately, at this time apart from universal services, Ruth was in receipt of no other specialist mental health support in the community. Being pregnant and due to her home and family circumstances (caring already for two other very young children isolated from extended family) she was particularly vulnerable at this point in her life. None of the professionals receiving information via the domestic abuse notification system considered Ruth's own vulnerability in terms of her mental health in their responses. The specific incident is referenced throughout the report.

21.5.24 There was no further community mental health service provided to Ruth. The third baby of Ruth and the Perpetrator was born in spring 2018. Ruth had engaged with antenatal services during the pregnancy. Records show Ruth was prescribed and resumed her use of anti-depressant medication soon after delivery and was noted as feeling low in mood. Support for maternal mental health was offered and encouraged by the health visitor but declined. Had a relationship been developed before the quick closure by the community mental health service in 2017 this may have been different.

21.5.25 Within one month of the birth the GP had referred Ruth back to the community mental health team for possible postnatal depression. With the referral the GP included for information a copy of the CAADA-DASH risk assessment completed by the police after the domestic abuse incident in early summer 2015 which indicated domestic abuse being considered as a possible risk factor. The health visiting admin team had entered the risk assessment onto the recording system which was accessed by the GP.

21.5.26 The referral was triaged by the community mental health team. The notes indicate a focus on the past perceived non engagement by Ruth rather than the presenting problem. It is not clear if the previous experience of domestic abuse was considered in the triage.

21.5.27 Furthermore, at that point in 2018 a community perinatal service was not commissioned or operational in terms of the referral being linked to post-natal depression, therefore this service could not be offered.

21.5.28 In the summer 2018 an appointment was sent to Ruth with a CPN which was two months after the referral but this was cancelled due to staff sickness. A further appointment was offered to Ruth for six weeks after the cancelled appointment but Ruth did not attend. The Author was told these were expected timeframes for appointments. The case was then closed by the community mental health team due to lack of engagement. The GP who had referred was incorrectly informed in a letter that Ruth had cancelled one appointment and failed to attend another. There was no evidence of challenge by the GP service to the decision. There is no record of liaison between the community mental health team and the health visiting service who were in contact with Ruth and her young family. The health visitor may have given a professional view of Ruth's mental health and current circumstances, including thoughts on her ability to attend appointments with such a young family. The notes from health visiting contact at this time demonstrate that the health visitor did discuss mental health and wellbeing with Ruth during the early summer of 2018. Domestic abuse was also explored but Ruth denied any current abuse.

21.5.29 The GP's referral was closed in late summer 2018. Ruth had no further contact with any community mental health professional before her death three months later.

21.5.30 Research suggests that women experiencing domestic abuse are more likely to experience a mental health problem, while women with mental health problems are more likely to be domestically abused. 30-60% of women with a mental health problem have experienced domestic violence. *Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., AgnewDavies, R., & Feder, G. (2009). Domestic violence and severe psychiatric disorders: Prevalence and interventions. Psychological Medicine, 40(6), 881–893.*

21.5.31 Ruth through her time living in Derbyshire was involved with different community mental health team areas. Transfer of cases and engagement with newly allocated professionals can be a challenge to both patient and professional. However, it was demonstrated that Ruth was capable of developing relationships with health professionals, engaging well at times, including with the allocated community psychiatric nurse in summer 2016. Caring for very young children and living in an abusive household would have presented practical difficulties in terms of engagement with appointments for Ruth. Vulnerable patients can be labelled too quickly as reluctant to engage by stretched services who have not yet been able to properly develop a working relationship or rapport with an individual and may not know a person's full circumstances. As a consequence, some mental health issues can be left possibly untreated with no apparent liaison or follow up requested of other professionals who could be involved,

such as the GP or health visitors in Ruth’s case.

21.5.32 Furthermore, historical information available on file which could inform treatment plans and actions relating to patients’ ongoing safety may be overlooked when individuals are moving between teams and receiving services from both community and hospital- based settings. A coordinated and collaborative approach which shares and considers all available information, both internally and externally, should be developed.

Sherwood Forest Hospitals Trust

21.6.1 Sherwood Forest Hospitals Trust (SFHT) is an acute hospital trust comprising of three hospital sites in the county of Nottinghamshire. Geographically service users access the hospitals from the local areas in Nottinghamshire but also some districts from the bordering county areas such as Derbyshire and Lincolnshire. As an acute trust, the hospitals provide emergency department services, maternity, and general inpatient and outpatient hospital care to its local communities.

21.6.2 Records of SFHT involvement with Ruth document a service provided to her from 2014 when she was in a relationship with the Perpetrator. When Ruth and Partner 2 were together they lived in a locality which would be reasonably considered as out of range of the normal SFHT patient area.

21.6.3 For the three pregnancies between 2015 and 2018 Ruth was booked to deliver the babies at SFHT. However, for where she lived in Derbyshire with the Perpetrator her antenatal and postnatal care was provided by community midwives employed by a different Derbyshire hospital trust. A decision was made within panel meetings that SFHT would include the Derbyshire community midwifery contact with Ruth in the SFHT IMR.

21.6.4 In early spring 2015 at 16 weeks of pregnancy Ruth attended the emergency department at hospital following an incident of self-harm which she disclosed was following an argument with her partner. The information was shared with mental health teams and the hospital’s named midwife for safeguarding for liaison with the Derbyshire community midwife who was providing routine antenatal care. Ruth did not disclose any suicidal ideation, and although there is no documentation to suggest that emergency department staff proactively sought to make routine enquiry, they documented clearly that Ruth showed ‘’no evidence of acute distress’’ and that she was ‘’laughing and joking with (her) partner’’.

21.6.5 There was robust follow up of Ruth during this attendance in terms of her mental health. She was assessed by the rapid review liaison team. Referrals were made to local mental health services for Ruth and information shared with relevant health professionals such as the GP. Action taken by other services as a result of information shared is explored in the report. However, there was no documentation in SFHT records to suggest domestic abuse was considered, other than a note regarding her behaviour around her partner, the Perpetrator (perceived as happy in his company). There was no evidence to suggest that emergency department staff proactively sought an opportunity to make routine enquiry

with Ruth (being as her partner was present), or consideration that the self-harm may have been as a result of living with domestic abuse.

21.6.6 Despite domestic abuse not being suspected or alleged during this attendance the risk to the unborn child was not explored in terms of the self-harm and Ruth's general mental wellbeing. Hospital records for Ruth would have shown a previous attendance for another episode of alleged self-harm in 2014, albeit she was not pregnant at that time.

21.6.7 Regarding the spring 2015 alleged self-harm attendance during pregnancy a referral to children's social care, or request for a professional discussion did not happen indicating a lack of focus on the unborn child's needs. A contact with children's social care would have allowed for consideration of the recent history of Ruth as a survivor of domestic abuse from her ex-partner (Partner 2), and the fact that she was separated from her other children as a result.

21.6.8 In the summer 2015 when much further into her pregnancy, Ruth attended the hospital after reporting an assault by the Perpetrator. It was recorded that she denied any previous incidents of domestic abuse by the Perpetrator and told midwifery staff that she did not feel scared or intimidated by him. It is positive that the need to refer the incident to children's social care was recognised and an appropriate and timely referral was submitted. Other positive practice at the hospital included signposting to local domestic abuse support services, exploration of Ruth's mental health and encouragement given to engage with community mental health services who were known to be already involved. When the first baby of Ruth and the Perpetrator was born six weeks after the assault the hospital demonstrated focus on risks to the child and mother by contacting children's social care to check the current family position prior to the discharge.

21.6.9 Ruth attended the emergency department at SFHT on three other occasions between 2015 and 2018 but as the attendances were for medical reasons and assessed as not related to issues around mental health or self-harm, domestic abuse would not have been considered as part of any assessment.

21.6.10 There was routine and regular contact between Ruth and SFHT for all three pregnancies and births between 2015 and 2018. Records indicate that Ruth was mostly accompanied at appointments by the Perpetrator which may have limited opportunities to explore experiences of domestic abuse, despite there being a reason to enquire as the incident in summer 2015 was recorded and accessible on hospital systems due to the attendance at SFHT for that assault. Therefore, professionals should have noted the recent history of domestic abuse and SFHT involvement on record and created opportunities to explore any current risks.

21.6.11 Throughout all the pregnancies, there was minimal recorded consideration of routine enquiry by SFHT maternity professionals during her attendances to acute care areas. The Author was told this is an area of focus for SFHT maternity. Procedures are now in place to ensure routine enquiry is carried out not just in community settings but in all areas of maternity care including triage and on the maternity ward.

21.6.12 Community midwives in Derbyshire had regular contact with Ruth throughout her pregnancies with no lack of engagement recorded by community midwifery staff.

21.6.13 Prior to the death of Ruth the three children from her relationship with the Perpetrator had routine attendances at SFHT none of which related to any safeguarding concerns for the children or which could have highlighted concerns within the wider family. The engagement of Ruth and the Perpetrator in terms of seeking out support for their children's health issues was appropriate.

21.6.14 The Perpetrator's own involvement with SFHT as a person requiring a service was minimal and gave no cause for health professionals to take further safeguarding action.

Derbyshire Community Health Services NHS Foundation Trust

21.7.1 The 0-19 Children's Service within Derbyshire Community Health Services NHS Foundation Trust (DCHS FT) is a universal public health service that every child and their family have access to and incorporates the Healthy Child Programme. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families in need of additional support and children who are at risk of poor outcomes. The 0-5 element is led by health visiting services and the 5-19 element is led by school nursing services.

21.7.2 Health visitors' expertise lies in pre-school children and their families. They aim to reduce health inequalities through promoting good health and prevention of illness by offering information, guidance, support and referral to wider children's services for specific help.

21.7.3 DCHS FT became aware of Ruth and Partner 2 moving to Derbyshire from Area A in spring 2012 with Ruth's two children from the relationship with Partner 1. Records show Ruth disclosed a previous abusive relationship with the children's birth father, Partner 1. The health visitor undertook appropriate contacts during the 2012- 2013 timeframe when Ruth and Partner 2 were in a relationship and until the point when the children moved areas to live with their father, Partner 1.

21.7.4 During this period concerns were identified around domestic abuse, alcohol and drug misuse by both Ruth and Partner 2, housing and maternal mental health. The health visiting team were aware that the two children (of Ruth and Partner 1) became supported as children in need by Derbyshire children's services during 2012.

21.7.5 The records of health visiting involvement at that point indicated good professional curiosity, sound partnership working including attempts at joint visits, and appropriate information sharing between relevant agencies. For the moves across health visiting areas when Ruth and Partner 2 changed addresses appropriate handover of care was undertaken by allocated professionals with subsequent transfer in visits to see the children, and Ruth. The input of the health visiting service into the child in need processes is less clear from available records for late 2012- early 2013. However, the Author was told the 0-19 children's service (health visiting and school nursing) implemented a visiting pathway for children who are subject to

safeguarding procedures in January 2018 which ensures now that children under the care of 0-19 children's service (health visiting and school nursing) have regular contacts according to their level of need.

21.7.6 Records indicate the health visiting service were informed in spring 2013 that the two children of Ruth had left Derbyshire to live with their birth father (Partner 1) in his home area. The health visiting service received routine notification of Ruth being pregnant in early 2015 (which was the first child of Ruth with the Perpetrator).

21.7.7 The first contact between the health visitor and Ruth took place in early summer 2015 which met expected timescales for the antenatal visit. Records demonstrate that the health visitor showed good professional curiosity, evident through the information gathered from Ruth. She spoke about her historical depression, previous domestic abuse, children's social care involvement with her other children, recent illness in pregnancy and the current social situation. The health visitor took some positive steps to try to explore the information provided by contacting children's social care. However, there was no contact made with community mental health services or with community midwifery meaning other information was not shared or discussed.

21.7.8 Ruth did not disclose to the health visitor the incident of alleged self-harm to her face in spring 2015 following an argument with the Perpetrator. The health visitor had not checked the previous health records prior to the visit as the self-harm incident was documented, therefore she was unable to professionally challenge Ruth about what happened.

21.7.9 The first contact with the health visitor was actually 10 days before the assault by the Perpetrator (in summer 2015) which resulted in Ruth attending hospital. Good, timely information sharing took place by the community midwifery service with the health visitor after the incident occurred enabling an early visit to Ruth but the full domestic abuse police notification was not received until five days later. The delay resulted in the health visitor not having the opportunity during her contact with Ruth, the day after the abuse, to question the difference between Ruth's version of events and those recorded as reported to the police. As highlighted earlier learning from a previous domestic homicide review has resulted in positive developments by the 0-19 children's service and partners to ensure domestic abuse notifications are received expeditiously. The 0-19 children's service have also embedded the pathway to ensure once the notification is received it is processed appropriately and in a timely way.

21.7.10 Despite the contact being immediately after the incident, which is good practice, there is no evidence of the health visitor trying to gently challenge Ruth about the Perpetrator's behaviour or her apparent justification of the behaviour. However, Ruth did feel able to disclose information around the previous self-harm in spring 2015, her feelings of anger and isolation, and her reluctance to seek GP support for medication. Unfortunately, there was no discussion around safety planning, signposting to domestic abuse services or liaison with the community mental health team. Electronic health records also had no significant event marker recorded which acts as an alert to other health professionals in the future, which is expected

as part of the 0-5 children's service (health visitor) Domestic Abuse Aide Memoire process. The Author was reassured that now a significant event marker is automatically generated at the time of the notification being attached to the electronic health record.

21.7.11 A conversation did take place between the health visitor and Ruth's community midwife who was the health lead at that time for Ruth. This was to ensure all relevant information was shared as the health visitor was due to move on to take up a new role. An electronic task was sent by the outgoing health visitor to the GP to update their information.

21.7.12 Unfortunately, a verbal handover did not take place between the outgoing health visitor who had worked with Ruth and the receiving health visitor as there was no overlap. A verbal handover would have been best practice given the vulnerabilities that had been identified.

21.7.13 Of significance is the lack of evidence that any professional involved identified the need for a pre-birth assessment or at least for early help processes to be considered and for the family to be encouraged to engage with this type of support. The current position relating to the pre-birth protocol was highlighted earlier.

21.7.14 The newly allocated health visitor first met with Ruth after the birth of the baby in late summer 2015. Information was explored relating to the previous abusive relationship as disclosed with Partner 1, and the two elder children of Ruth and their living arrangements were discussed. However, there was no evidence of professional curiosity and further exploration regarding Ruth's known vulnerabilities and no routine enquiry about domestic abuse within the current relationship. It was unclear whether the Perpetrator was present at the visit and this was not formally recorded as should have been to meet best practice guidance.

21.7.15 Social circumstances and routine enquiry were not explored at the 6 to 8 weeks review undertaken by the health visitor in early autumn 2015, which could have been a prime opportunity to develop rapport and be professionally curious as the perpetrator was not present.

21.7.16 As the family were assessed as requiring universal services the next health visiting contact was 9 months later in early summer 2016. At this point Ruth divulged she was 7 weeks pregnant with her second child with the Perpetrator. Other records available to the Author show she had suffered a miscarriage in early 2016 but it is unclear which professionals had knowledge of this as impact on Ruth appears unexplored. For some people pregnancy loss may be part of what causes a mental health problem or makes one worse[24]. Of note at this contact, despite a new pregnancy being disclosed was there was no attempt at routine enquiry despite the known history of Ruth. She admitted to still being under community mental health services but this did not lead to a conversation regarding other possible vulnerabilities.

[24] The Miscarriage Association-Your Mental Health -Link can be found here.

21.7.17 In late 2016 whilst the pregnancy was continuing a discussion took place took place between the health visitor and midwife for Ruth as part of a safeguarding liaison meeting. Her mental health was discussed and records indicate a focus on Ruth as a perpetrator of domestic abuse in the past herself and limited attention on her own extensive experiences as a survivor of domestic abuse. The health visitor antenatal visit to Ruth occurred early in 2017, 2 weeks prior to the birth, when mental health and social circumstances were discussed but no recorded evidence of routine enquiry being carried out.

21.7.18 The health visitor's new baby review with the second child of Ruth and the Perpetrator took place within timescales, 2 weeks after the birth. There was no specific routine enquiry recorded as undertaken but Ruth was noted as describing her partner, the Perpetrator as supportive. The Perpetrator as the father was not recorded and linked on the child's electronic health records which was expected 0-5 children's service practice following the birth of a child until their 6 weeks review.

21.7.19 In early spring 2017 within expected timescales the 6 to 8 weeks check of the new baby took place and a week later the postnatal questionnaire visit occurred with Ruth. A thorough discussion using appropriate research tools explored Ruth's mental health, social circumstances and feelings about parenthood but there was no evidence of any historical risk factors or previous domestic abuse in Ruth's current relationship being revisited. Of note within the chronology of involvement, Ruth described herself as feeling emotionally well to the health visitor but attended a GP appointment the next day "feeling depressed". There was no evidence of liaison between the GP service and health visiting service as a result despite Ruth's known history of mental ill health, including postnatal depression.

21.7.20 In early summer 2017 the health visiting service received a domestic abuse notification of an incident assessed as standard risk by the police, which had occurred 16 days earlier. Delay in notifications being received and the current position were discussed earlier. In police records Ruth had disclosed being pregnant and this was included in the notification shared by police with relevant partner agencies. The domestic abuse notification contained inaccurate information regarding there being no history of violence. Available electronic health records for Ruth indicated this was the second domestic abuse notification received from the police about Ruth and the Perpetrator. It can be assumed that the health visitor, who was a different professional to health visitors involved previously, did not review the electronic health records as the information about history shared in the notification was not challenged.

21.7.21 A timely telephone contact was made by the health visitor with Ruth following the notification where the impact of children witnessing domestic abuse was discussed as well as signposting to local domestic abuse support services. Standards in the health visitor Domestic Abuse Aide Memoire were not met as the domestic abuse incident was not recorded as a significant event on any of the relevant electronic health records (adult or children), meaning the information was not visible to health staff accessing the records in the future. It was positive that a face to face home visit by the health visitor with Ruth and the two children followed up the telephone conversation. Ruth was noted as minimising the domestic abuse incident, possibly as an

indication of the coercive control she may have been living with. She said it was an isolated incident and the Perpetrator had apologised which was a common response from women living with domestic abuse[25]. There was no recorded professional challenge to Ruth's view and her apparent minimising may have influenced the health visitor's assessment of risk and led to an element of professional optimism.

21.7.22 Of concern was the lack of attention to the latest pregnancy and possible risks to the mother and unborn child. The notification received by the health visiting team from the police did include notification of the pregnancy, which was at an early stage. It is unclear if the health visitor had acknowledged this as there is no other documentation relating to the new pregnancy. Ruth did not disclose being pregnant during the face to face visit with the health visitor. A week after the contact with Ruth the health visitor received a children's social care update that no further action was being taken as the matter was being treated as an "isolated incident". This was a missed opportunity for all professionals to become involved due to the history and continued risk to a pregnant mother.

21.7.23 In early autumn 2017 the health visiting service was informed via the midwifery service antenatal form of the third pregnancy for Ruth with the Perpetrator (as mentioned by Ruth to the police attending the domestic abuse incident in early summer 2017, and shared within the police notification to health visiting and children's social care). The antenatal form included Ruth's mental health history, self-harm and the previous social care involvement in 2015, but not in 2017.

21.7.24 Ruth was seen in late autumn by a different health visitor. She was halfway through the pregnancy at this time and when asked about the last domestic abuse incident she reported her relationship as "happy and supportive". The health visitor demonstrated professional curiosity taking time to identify vulnerabilities of Ruth with a plan to follow up. The antenatal contact two months before the birth of the third baby was with the same health visitor. The visit was thorough with the health visitor enquiring about history relating to all risks and discussion around protective factors.

21.7.22 The same health visitor carried out the new baby review after the spring 2018 birth of the third child. Ruth was anxious about coping with 3 young children and reported feeling low. There was no evidence of domestic abuse routine enquiry carried out despite the Perpetrator not being present. Ruth was mostly seen alone without the children's father but domestic abuse was not always a priority for discussion, even with the known history in the relationship.

[25] The Cycle of Abuse explains patterns of behaviour in an abusive relationship which includes four stages: tension building, incident/acute violence, reconciliation/honeymoon, calm. Lenore E Walker

21.7.23 At the 6 to 8 weeks core contact for the new (third) baby a month later the same health visitor noted Ruth as feeling more stable and back on medication. Domestic abuse was explored both past and present and Ruth denied any current abuse in her relationship. Analysis by the health visitor of the visit was that Ruth was an experienced mother of 5 children (including the two older children living with Partner 1, although the circumstances of this arrangement were not revisited having been discussed with Ruth at the antenatal contact). She had a past history of depression, but her own emotional needs were not impacting on the care of the three children living with her. The health visitor's plan was for universal care to continue with Ruth encouraged to contact the service before the next planned visit if support was needed. This was the last recorded visit by the health visiting service before Ruth's death six months later.

21.7.24 The 3 children of Ruth and the Perpetrator were all born whilst Ruth was living in the same area and registered at the same GP practice. However, 5 different health visitors were allocated to Ruth's case for the 3 children born over 3 years. Ruth did mostly engage with the health visiting service throughout the review timeframe relating to the Perpetrator with no concerns raised about professionals' access to the children or the home. It might be assumed that there was an opportunity for a more trusting professional relationship to be developed with Ruth had there been less change in the number of professionals she was required to see. Turnover of staff is a challenge in many teams but for positive, transparent relationships to grow some individuals, particularly those with vulnerabilities, need familiarity, with contact from the same professional.

21.7.25 Previous history of domestic abuse was discussed but the professional curiosity required to sensitively explore current experience of abuse did not always occur. There was evidence that risks and impact of domestic abuse on the children was highlighted to Ruth by the health visiting service but the combined risks to Ruth herself, from mental ill health, domestic abuse (past and current) and being isolated from her close family were not fully identified. Health visiting service mostly met required standards but there was limited evidence of a deep dive into Ruth's own lived experience or any attempt to develop a closer professional relationship with Ruth which might have made this more possible. It is positive that the health visiting service is available for all parents, including Ruth during the review's timeframe, outside of planned visits and calls when they may need additional advice or support. However, if Ruth was living in a controlling relationship, as is now known, she was unlikely to take the opportunity herself to call the health visiting service outside of routine contacts.

NHS Derby and Derbyshire Clinical Commissioning Group - GP service

21.8.1 When Ruth moved to live with the Perpetrator, they were both registered at the same local GP practice. The GP service provided to the Perpetrator has been examined and there were no entries of relevance to the review process. The same GP surgery was where the 3 children born during the relationship were registered. The surgery provides primary medical services to approximately 9500 patients through a primary medical services contract, which is a

nationally agreed contract with NHS England. The surgery is part of a community hub where information about domestic abuse and support is well displayed. The public toilets have posters with tear off slips containing phone numbers for domestic and sexual abuse services. Leaflets regarding domestic abuse are readily available, including in some GP consulting rooms.

21.8.2 In the GP notes for Ruth there was information that she had been treated by the mental health team for borderline personality disorder and there was also reference to an overdose attempt and self-harm in the past. There were some references to domestic abuse. In early 2014 the notes refer to "abuse by 'an ex-husband' hence the reason for the move". There was evidence in the notes that Ruth suffered from anxiety and depression which she herself seemed to attribute to the abuse in her previous relationship. The Author was told it has not been possible to check GP records for any reference to the non-recent sexual abuse alleged by Ruth against Partner 1.

21.8.3 It was positive that she felt able to disclose some of her history to the GP from an early stage of involvement at a new surgery. However, there was no evidence of a flagging system in use to notify or remind GPs looking at the record that domestic abuse had been or was a feature for Ruth. Such flagging would allow patients to be better supported by a GP accessing the record as the GP, even if the appointment was for an unconnected reason, may then sensitively approach the patient regarding the known history. Research has shown that if women are asked about abuse routinely and at times which may suggest that it has happened, they are more likely to disclose abuse with that professional should it occur in the future.

21.8.4 Furthermore, it is known that the GP is the professional to whom most women are likely to disclose, therefore if GPs are professionally inquisitive when seeing patients who are possibly being abused, disclosure of the abuse may follow. Ruth's records show that she would talk about some if not all the abuse she suffered and therefore it was imperative that any opportunity was taken to explore what Ruth might be experiencing.

21.8.5 Two known incidents of alleged self-harm by Ruth occurred in autumn 2014 and spring 2015, the latter when Ruth was known to be pregnant with her first child with the Perpetrator. As both episodes resulted in hospital emergency department attendance the GP would have been notified of the treatment. The spring 2015 incident whilst Ruth was pregnant was reported by her to have occurred after an argument with the Perpetrator. Hospital notes show Ruth "discharged with plan to see the GP tomorrow for urgent review and possible referral to perinatal services". Records suggest this follow up with the GP did not occur. Due to the self-harm incident in spring 2015 not being referred to children's services no multi-agency discussion took place to explore risks to the unborn child or pregnant mother took place, with or without a contribution from the GP.

21.8.6 In early summer when Ruth was over 30 weeks pregnant the domestic abuse incident occurred when Ruth alleged the Perpetrator kicked her in the abdomen before changing the account later. Relevant notifications occurred to midwifery and health visiting professionals and follow up was explored earlier. A copy of the police report and completed DASH was

shared and placed on the GP notes for Ruth but there was no evidence of professional discussion between the GP service and involved community midwifery or health visiting staff to explore ongoing safeguarding concerns for the unborn child or Ruth. The health visitor had sent an electronic task to the GP notifying the GP of the domestic abuse incident and liaison did take place between the health visitor and the midwife. Records show the health visitor did advise Ruth to attend the GP re her low mood but an appointment did not occur. In some GP surgeries regular safeguarding meetings take place between involved health professionals where concerns for patients can be discussed. The Author was told monthly safeguarding meetings do take place in Ruth's surgery but there is no specific record that follow up conversations took place about the original incident or Ruth's mental health. Due to the outcome of the referral to children's social care being for no further action to be taken the GP was not able to participate in any wider multi-disciplinary safeguarding discussions.

21.8.7 The GP was informed of the clinical follow up with Ruth as a result of letters from her revisiting hospital for antenatal review but no GP involvement is recorded in relation to the summer 2015 domestic abuse incident.

21.8.8 GP records for Ruth show no GP involvement was requested until 2017. Notifications are in Ruth's notes that she was pregnant again with the second child of the Perpetrator and that other health professionals were seeing her for the pregnancy. The community mental health team remained involved but around this time Derbyshire Healthcare NHS Foundation Trust configured its neighbourhood teams to align with GP practices. This led to Ruth's GP practice moving to a community mental health team in a different location requiring a transfer of care for patients including Ruth. Her engagement with community mental health around this time, as explored earlier, was sporadic but it must be considered that she may have been unable to engage with professionals if living in an abusive relationship, as is now known.

21.8.9 A GP appointment took place in spring 2017 soon after the difficult birth of the second child. Ruth reported feeling depressed and was assessed as feeling worthless with low self-esteem. Despite the recorded history, but possibly due to no obvious alert on records regarding previous domestic abuse, no enquiry took place by the GP about domestic abuse and the current relationship. As highlighted above any GP consultation is an opportunity for the GP service to engage a vulnerable woman in case she may have decided to disclose domestic abuse then or in the future. The appointment was an opportunity to further explore the experiences of Ruth as she disclosed at the time that she was separated from who she called her "husband" (believed the Perpetrator) who was recorded as "struggling to cope with her labile mood[26]". No unprompted domestic abuse disclosure was forthcoming from Ruth and she agreed to being prescribed antidepressants and a referral for counselling as this was said to have helped her in the past. There is no record that the counselling occurred.

[26] Labile mood is a medical term used to describe people who experience irregular emotional responses. Associated with severe mood swings and with intense emotional reactions.

21.8.10 In early summer 2017 a domestic abuse notification was received by the health visiting service involved with the two babies of Ruth and the Perpetrator after police attended a verbal argument between the couple. Ruth disclosed no other domestic abuse but did volunteer information when asked that she was feeling depressed and that she was pregnant. This information does not appear shared with other professionals. The outcome of the children's social care referral made by the police was no further action and it is not recorded that the GP service had any opportunity to contribute to wider decision making about risk to Ruth or any of her children. Records show the antenatal booking of the pregnancy for the third child of Ruth and the Perpetrator happened over two months after the verbal argument had taken place. The baby was born in spring 2018. Ruth had not requested GP support herself during the pregnancy but had been seen at other GP attendances for routine complaints relating to her children. She had engaged appropriately with other health professionals for the pregnancy as required.

21.8.11 A month after the birth, Ruth was referred by the GP service to the community mental health team. Concerns outlined by the GP included possible postnatal depression and Ruth generally struggling to cope. It was positive that attached to the referral for information was a copy of the DASH assessment shared by the police to the GP after the summer 2015 domestic abuse incident, but there was no record of domestic abuse being discussed with Ruth at the time of the referral being made.

21.8.12 Unfortunately, the perinatal service in the relevant area was not operational until May 2019 so could not be provided. The health visitor's 6 to 8 week visit to the new baby included discussion with Ruth about post-natal depression. She was invited to the postnatal group but declined support. Ruth said she felt stable on her medication and described her relationship as happy and supportive with no domestic abuse disclosed.

21.8.13 In early autumn 2019 the GP was informed that Ruth had not engaged with appointments for an assessment by the community mental health team after the GP's referral. No further service was offered by the GP or community mental health as sadly Ruth died two months later.

21.8.14 A recommendation in a previous local domestic homicide review was for GPs to be made aware of the need to be professionally inquisitive and to create opportunities to ask questions about home life, relationships and the safety of patients, particularly when information on the patient record indicates a history of domestic abuse. It appears this requirement has not yet been fully met through the available evidence in this case.

21.8.15 It is important to note that across all health services provided, GPs are the one consistent feature in a person's service provision at any given time.

East Midlands Ambulance Service

21.9.1 East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region. The region, which covers approximately 6,425 square miles, includes the county of Derbyshire

where Ruth had lived.

21.9.2 EMAS had attended or had contact from Ruth on a number of times during the identified review time frame. All attendances and contacts have been reviewed. A number were for medical conditions at which Ruth received appropriate care and assessed as non-relevant to the review.

21.9.3 In autumn 2014 EMAS received a request from the police to attend Ruth who was reporting self-harm, being intoxicated and felt depressed. Ruth was assessed and conveyed to hospital. This was expected practice. Further detail from EMAS records show Ruth told the crew that she was on medication for her mental health but stated that these had been lowered. The records indicated that her partner (believed the Perpetrator) was at the scene and was spoken to, however no name for him was recorded. The Author was told EMAS continue to work with staff in promoting the importance of recording the names of any other people on scene, whether this be partners (particularly alleged or suspected perpetrators), friends or children.

21.9.4 Based on the patient's needs at the time of the attendance it was evident that Ruth was vulnerable, having had a self-disclosed history of depression and being known to the mental health team, self-harming and expressing suicidal ideation. A care concern referral should have been shared with the GP and adult social care. This is in line with the EMAS Adult Safeguarding Policy and Procedures but did not happen.

21.9.5 In summer 2015 a call from the police was received for EMAS to attend a female (Ruth) who was reported to be over 30 weeks pregnant and had had an argument with her partner and reported pain in her abdomen. A call back occurred from a clinician in the clinical assessment team when telephone triage was undertaken. An ambulance was not sent as police transported Ruth to hospital. Records indicate that there was no exploration around the alleged assault and no consideration whether a referral should have been made due to Ruth being pregnant and a possible victim of domestic abuse.

21.9.6 There is clear evidence that pregnancy is a recognised risk factor in domestic abuse. Expected practice would have been for the clinician to raise a referral for both Ruth and her unborn child. As EMAS did not attend it would have been the responsibility of the clinician completing the telephone triage to raise the referral. The Author was told that reflective practice has occurred with the clinician who thought because the police were attending that officers have made the referral.

21.9.7 In late 2018 EMAS attended the incident where Ruth was found to have died. The request for service was a 999 call to attend a female who was unconscious. On attendance advanced life support was attempted but Ruth was recognised life extinct at the scene. She was left in the care of the police. The crew did not make a safeguarding referral in line with the EMAS children's safeguarding policy, despite there being a baby (Ruth's third child with the Perpetrator) at the address. The Author was told the attending crew have reflected on the case and advised they were made aware of the children in the family; 2 children being in

nursery but another child (a baby) was present at the scene. As for the incident above in 2015, a safeguarding referral regarding the children was not considered due to the police being at the address. The attending clinician felt the safeguarding element was being managed and reported on by the police.

21.9.8 As highlighted earlier, EMAS have bespoke adults and children safeguarding policies which are explicit in staff responsibilities regarding raising of referrals. The Author was told compliance with policy and procedure is demonstrated through audit. EMAS have increasing referrals rates from 2010 through to 2018 with the steepest increase noticeable from the implementation of the new process which went live in April 2018 allowing staff to raise referral directly from the patient report form.

The Elm Foundation (North Derbyshire Women's Aid)

21.10.1 During the identified timeframe of the review the Elm Foundation was known as North Derbyshire Women's Aid, a domestic abuse charity that provides support to women, men and children who have been affected by domestic abuse. North Derbyshire Women's Aid covered a specific area of Derbyshire where Ruth lived with Partner 2.

21.10.2 On the advice of a social worker involved at the time with Ruth's older two children, Ruth contacted North Derbyshire Women's Aid in autumn 2012. Support was provided by the outreach team to address the abuse and harassment Ruth was receiving at the time from her ex-partner (Partner 2). The outreach worker worked in face to face contact with Ruth for almost 4 months until early 2013 when Ruth said the domestic abuse support was no longer required. At this point she appeared to be apart from Partner 2. There was evidence of joint working and liaison between Women's Aid and the social worker including sharing of pertinent information by the outreach worker regarding a possible unknown man suspected of becoming involved with the family.

21.10.3 Contact was made by Ruth with the organisation's advice service in autumn 2013. She was being supported by an Action Housing worker to request assistance with legal advice. Attendance at the Freedom Programme (see earlier reference) was also discussed at this time. Partner 2 was in prison for unrelated offences which provided a safer window of opportunity for Ruth to be helped to think about the abuse she had suffered. Unfortunately, despite strenuous attempts to engage Ruth appointments were either cancelled by her or she did not attend.

21.10.4 In early 2014 Action Housing updated Women's Aid that it was suspected that Ruth had moved out of the area but her actual whereabouts were not known. This is believed to be the point when Ruth may have met the Perpetrator. North Derbyshire Women's Aid had no further involvement. Records after this time, when Ruth was with the Perpetrator, indicate Ruth was signposted to local domestic abuse support but did not make contact. Professionals should be aware of the difficulties women living with domestic abuse may face in terms of accessing support, in particular those with additional vulnerabilities such as mental ill health.

Action Housing

21.11.1 Action Housing works across South Yorkshire and Derbyshire providing support to vulnerable adults. This service provided housing related support and floating support to Ruth via a keyworker.

21.11.2 Action became involved in early summer 2013. Ruth's two older children were living with their father Partner 1, and Ruth with Partner 2 had returned to Derbyshire after a brief move back to Area A had been unsuccessful. The allocated keyworker was immediately proactive with Ruth, completing a risk assessment which considered previous experience of abuse, supporting her at a GP appointment, arranging domestic abuse advice and liaising with other involved agencies within the first month of service. Despite the efforts of the keyworker, with records demonstrating a trusting relationship beginning to develop due to some of the information which Ruth felt able to share, Ruth did not continue with the Action Housing support service. This was at a period of particular vulnerability for Ruth as her children had recently moved away from her care. The worker liaised with other involved professionals to inform them of Ruth exiting the service and moving out of the area.

North East Derbyshire District Council Housing Support

21.12.1 North East Derbyshire District Council (NEDC) Housing Support were involved with Ruth and Partner 2 for three months from spring 2013 when the couple made an application for temporary homeless accommodation. They were given priority due to the elder two children of Ruth living with them at the time. The housing officer was initially unaware of any domestic abuse between the couple as this was not disclosed by the pair, despite extensive involvement of police and children's services leading up to the homeless application.

21.12.2 It was positive that liaison did take place between community mental health services and NEDC during the housing support involvement, regarding Ruth's mental health needs. A social worker also had contact with NEDC, to share details regarding Ruth's children and their move to live with their father (Partner 1). The housing officer sought information from the police to inform the service provided to the couple. Overall, the records of multi- disciplinary information sharing and gathering demonstrates that housing services did recognise their safeguarding responsibilities for Ruth and her family despite the limited opportunity, due to the short time involved for any further support to be offered to Ruth or the children.

Bolsover District Council

21.13.1 The involvement Bolsover District Council had with Ruth was the processing of her housing benefit and council tax claim which started in early 2014 when she took the assured shorthold tenancy of a property on the same street where the Perpetrator lived in a different address. The Perpetrator was named by Ruth as landlord of the property. Expected processes were followed by the Council, taking into account the relevant legislation for both departments.

21.13.2 It is clear that there was no declaration by Ruth of her relationship with the Perpetrator (her

landlord) nor the fact that she had children during the period of the claim which was a change of circumstances. If the relationship with the Perpetrator had come to light, the claim would have been treated as fraudulent by the Council. It is not known what pressure or control Ruth was under from the Perpetrator to continue the false claim.

Nursery education information

21.14.1 Contact was made by the Community Safety Partnership regarding the attendance of the eldest children of Ruth and the Perpetrator at a local nursery provision. The nursery reported having some contact with both Ruth and the Perpetrator but highlighted no information relevant to the DHR.

22 Analysis against terms of reference

22.1 The analysis section of the report will address the terms of reference and the key lines of enquiry within them. This section will also try to examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken reflecting on scrutiny of practice of individual agencies as above. It will consider whether different decisions or actions may have led to a different course of events, and any good practice will be highlighted.

1. Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

22.2 Ruth, the Perpetrator and both Partners (1 and 2) were all white British and there is no evidence that their ethnicity or background required special consideration by professionals involved. Similarly, there are no known gender, sexual orientation, marital or religious issues which were overlooked or which impacted on service delivery.

22.3 Learning disabilities were not known to be a factor for any adult involved, but detailed medical history of the male subjects of the review is not known and has not been examined.

22.4 Mental health problems were suspected to have started for Ruth from her mid to late teens, as reported by her Parents. Counselling was attempted but did not occur due to Ruth's wishes not to engage at that time being respected. The catalyst for the deterioration in Ruth's mental health is not easily identifiable if there was a specific starting point for the change. However, the abusive relationship with Partner 1 did commence when Ruth was a young adult and would have impacted on Ruth's mental health. Ruth was considered by Derbyshire community mental health services to have a history of trauma in terms of abuse reported in relationships as an adult.

22.5 Other services becoming involved with Ruth during the timeframe of the review were aware of the mental health issues faced by Ruth as she was mostly open with professionals about her past experiences. There is evidence she would disclose her emotions to professionals including

the police and health visiting when she said she was feeling depressed or low. There is also evidence that Ruth sometimes declined to describe her true feelings and experiences to professionals. This may have been due to her own perception and optimism about her current experiences, but also possibly due to the level of control which she may have been living with particularly during the relationship with the Perpetrator.

22.6 It is well known that individuals who experience mental ill-health are at additional risk of being a victim of domestic abuse. What is now known about Ruth's mental health and the impact on her and her children's lives demonstrates that mental health of victims of domestic abuse is a factor for all professionals becoming involved with a family to consider as a priority. Multi-disciplinary liaison must occur and professionals with less specialist knowledge about mental health must recognise the additional risks faced by a person with poor mental health suspected to be living in an abusive relationship.

22.7 Pregnancy occurred regularly for Ruth and whilst professionals were aware of her pregnancies there is evidence that the increased risk which pregnancy can bring to a victim of domestic abuse was not always specifically considered. Furthermore, the risk of reproductive coercion which may have been a factor in the relationship of Ruth and the Perpetrator was not identified.

2. *Was the victim ever subject to a Multi-agency Risk Assessment Conference (MARAC)? If so, can minutes from the relevant meetings be released?*

22.8 Ruth was never subject to a MARAC process. On one occasion a MARAC referral is recorded as considered in Derbyshire children's services records, but this did not occur. At the time Ruth was in an on/off relationship with Partner 2 and her two children were open to children's services due to ongoing risks. Despite several reports of domestic abuse incidents involving the couple across a short period, all had been assessed as standard or medium risk which did not meet the MARAC high risk threshold requirement at the time. The Author was told that locally a review took place of the high-risk threshold in 2013 recommending a reduction in factors (ticks)to 14 ticks from 17 for a high-risk identification. The overall MARAC referral criteria has remained the same since then but referrals may also be made using professional judgement about the circumstances and risk.

22.9 Information was also provided that whilst Derbyshire Police do not currently initiate a referral to MARAC as a result of repeat DASH submissions, that this process is under review. It is expected changes will occur in the near future with the creation of a MARAC+ team part of the remit being to re-examine all DASH submissions and holistically assess the risk considering all other recorded information.

22.10 The reported incidents with the Perpetrator when Ruth was pregnant were never considered for referral into the MARAC process, despite a number of services having knowledge and involvement at the time. This is now seen as a missed opportunity, as was the lack of use of the Pre Birth Protocol[27], for all partners to have been able to join together in a formal information sharing setting to discuss risk to both Ruth and an unborn child. Pregnancy, risk and responses have been explored earlier.

3. *Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)? If so, a request may be required for the release of the minutes (subject to relevant legal considerations)?*
4. *Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)? If so, is there information known to professionals working with him relating to the homicide? How was risk posed by the perpetrator managed?*

22.11 None of the men involved with Ruth (both partners 1 and 2 and the Perpetrator) were subject to MAPPA or to a DVPP. Records show that the Partners and the Perpetrator did not accept responsibility for any abusive actions and behaviour whenever required to answer formally to known episodes of abuse. It is unlikely therefore that they would have been considered as prospective participants in a perpetrator programme, which would require at least some acknowledgement by a perpetrator of the abusive circumstances, and some level of cooperation and motivation to engage.

5. *Did the victim have any contact at any time with a domestic violence and abuse organisation or helpline? If so, explain the type of support and subsequent outcomes.*

22.12 Throughout the timeframe of the review Ruth was offered and did access some domestic abuse support. In the area covered by Constabulary A she was supported briefly by a domestic abuse coordinator, a role linked to Constabulary A. She was provided details of the Freedom Programme by children's services in Area A but did not or was not able to engage.

22.13 In Derbyshire specialist domestic abuse services had contact with Ruth in the period relating to Partner 2. Her engagement appeared sporadic but the amount of control which Ruth was under was unknown which would affect her ability to accept offers of support. Participation in the Freedom Programme was suggested to Ruth but again this was not taken up.

[27] Derby and Derbyshire Multi Agency Protocol for Pre-Birth Assessments and Interventions, updated April 2019. Developed to support agencies and practitioners in their decision making and assessment processes when working with a pregnant woman, her partner and family. The aim is to ensure that all unborn babies where there are additional vulnerabilities or needs are identified as early as possible and ensure that appropriate and timely services are delivered in an integrated manner.

22.14 The barriers to Ruth accessing help were likely to be a combination of her own mental health, possible alcohol use, fear of ongoing child protection processes (when with Partner 1 and 2), shame, and the power and control exercised over her by the men in her life. Housing and homelessness were also a significant issue for Ruth at the point when the relationship ended with Partner 2. At that time Ruth's focus and attention was taken up by her own housing challenges as well as the loss of the children who had moved to stay with their father. Collectively these issues meant the opportunity to access support on offer was not a priority for Ruth and was not taken, despite all efforts.

22.15 As the circumstances above resulted in domestic abuse support being intermittent outcomes from the support are difficult to identify.

22.16 During the period when Ruth was with the Perpetrator signposting Ruth to domestic abuse support took place by different professionals including hospital staff, the police and health visitors. When suspected domestic abuse incidents had occurred professionals attempted to raise awareness of available support verbally and through written promotional material. After initial reports were made Ruth mostly denied or minimised abusive behaviour by the Perpetrator, which was normally at the time that signposting to support was being offered. Therefore, there is no record of contact with any domestic abuse support services by Ruth during the relationship with the Perpetrator.

22.17 The ability of survivors of domestic abuse to self-refer for support whilst still living with an abusive partner is limited. When other risk factors, as for Ruth, are also present such as mental illness, pregnancy and parenting young children the chance of self-referral is even more rare, making any constructive interaction and positive outcome from domestic abusive services unlikely.

22.18 In *A Cry for Health, November 2016*[28]*,* it is suggested the location of specialist domestic abuse professionals in mainstream services such as hospitals can allow earlier identification of victims of abuse. At hospital there is a window of opportunity to raise awareness and recognition of domestic abuse with victims. A specialist support worker in hospital, such as an IDVA (see earlier reference) can help victims to recognise that their experiences are domestic abuse and prompt them to seek help. Missed opportunities to intervene are likely to result in later identification and support not being requested, with situations then escalating and the negative impact on the victim and their family increasing.

6. *Were all available opportunities taken by professionals to explore domestic abuse with the victim, in order that appropriate protective action could be considered? For example, use of 'routine enquiry' by health professionals.*

[28] A Cry for Health - Why we must invest in domestic abuse services in hospitals, SafeLives, November 2016

22.19 When Ruth reported abusive incidents herself as did occur throughout the whole timeframe, professionals offering an initial response to the report took opportunities to explore domestic abuse.

22.20 The analysis of other service contact with Ruth and her family did demonstrate that opportunities to discuss Ruth's experiences were not always taken. Ruth engaged normally with the universal services required to be in contact with her and the children, for example health visiting and midwifery. She also asked for appropriate support for herself and the children from the local GP service.

22.21 The health agencies with whom Ruth was in contact had mostly been informed of abusive incidents though agreed information sharing protocols. Agency records had been updated with the details shared. Other non-recent domestic abuse experience was also disclosed to some professionals by Ruth herself. Despite the information available, the opportunity of making the 'routine enquiry' (about domestic abuse) at every contact was often not taken, meaning Ruth was not consistently reminded of the professional interest in and support for her experiences should she have decided to disclose. The expectation of the routine enquiry being completed and the possible outcomes was discussed earlier.

22.22 The service provided by Derbyshire children's social care, Derbyshire police to Ruth has been described above as some incidents being responded to in isolation with the full chronology of Ruth's experiences not being linked to provide a fuller picture of all risks presented. However, domestic abuse was continually explored for each incident reported and protective action taken, albeit this may have been in the immediate, short term.

22.23 There is limited evidence of domestic abuse being routinely and regularly discussed with Ruth by mental health services involved with her during the Review timeframe. Whilst domestic abuse was known and acknowledged by mental health professionals the opportunities to revisit such abuse as a trigger for changes in Ruth's mental health were not robustly taken and protective action was not explored.

7. *Were risks of coercive and controlling behaviour considered by professionals in their contacts with the victim?*

22.24 Elements of coercive and controlling behaviour will have always been a feature in relationships where domestic abuse occurred well before the definition and legislation were agreed in 2015 and when organisations and workforces became more professionally aware of how to identify this type of abuse. Having said that, the involvement of professionals with Ruth during the period when she was with Partners 1 and 2 was before the formal identification of coercive and controlling behaviour as a type of abuse and therefore before any multi-agency training packages could be amended to fully reflect the issue. The Author was told all domestic abuse training locally now includes the theme of coercive and controlling behaviour as a specific type of abuse.

22.25 After 2014 when Ruth and the Perpetrator were together there is limited evidence that

coercive and controlling behaviour was considered specifically. It is known from the police investigation into the death that evidence was discovered of the Perpetrator's controlling and threatening behaviour towards Ruth when she was alive but it seems Ruth was not able to talk to anyone about her experiences. An example provided by the police included the Perpetrator video recording Ruth on his phone when she was drinking alcohol and then when asleep, causing Ruth to fear this would be shared and that people would question her abilities as a mother. Regular attempts by professionals to explore domestic abuse with those living in abusive settings are key for victims/ survivors to feel enabled to speak out. Routine enquiry by involved health professionals, discussed above, is a prime example of giving such opportunities.

22.26 One aspect of Ruth's response to some services, which is relevant when considering her experience of coercive and controlling behaviour was her engagement. Community mental health services and other organisations offering assistance, including specialist domestic abuse support and housing support, recorded intermittent engagement by Ruth or offers of service being declined.

22.27 It is known that individuals living in abusive relationships are often controlled in terms of the contact they may have with family, friends and professionals. What may be perceived as lack of engagement with a service is possibly due to the person being unable to engage as a result of another person's threats or actions. Furthermore, even when a person does appear to engage with a professional, as Ruth did with most health visitors during the period with the Perpetrator, the control may still be there in terms of what is said and shared. Ruth presented a mostly positive relationship to health professionals and even when abusive incidents had been reported she later minimised these. This was despite mostly being seen alone by professionals without the Perpetrator, which further suggests the significant control and power imbalance within the relationship.

8. *Was either the victim or the perpetrator a 'vulnerable adult' – a person —who is or may have care and support needs - be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation?*

22.28 Due to the agreed time frame of this review, 2007 - 2018, both the *No Secrets, 2000* definition of a vulnerable adult and the *Care Act 2014* definition of an Adult at Risk apply.

22.29 No Secrets states that "a vulnerable adult is defined as a person aged 18 years and over who is or, maybe, in need of community care services by reason of mental or other disability, age or illness and who is or, maybe, unable to protect him or herself against significant harm or exploitation."

22.30 The Care Act 2014 describes "an adult at risk as an adult who has needs for care and support (whether or not the local authority is meeting these needs) and is experiencing or at risk of abuse and neglect, and as a result of those care and support needs, is unable to protect themselves from either the risk of or the experience of abuse and neglect."

22.31 Ruth met the criteria of No Secrets and the Care Act due to vulnerability factors of mental health and domestic abuse which she experienced throughout the whole review timeframe. She was in receipt of services, all of which should have considered the impact that mental ill health had on Ruth's ability to acknowledge that she was at risk and was experiencing abuse, and how to protect herself. There was no suggestion through all recorded service involvement that Ruth did not have mental capacity (the ability to make decisions for herself). However, other factors, such as the controlling behaviour from the Perpetrator, would have affected her ability to make clear decisions and choices

22.32 A Vulnerable Adult Risk Management process (VARM) has been introduced by the Derbyshire Safeguarding Adults Board. This is a positive process which aims to support adults with mental capacity who are thought to be at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. Unfortunately, none of the reported incidents leading to the death of Ruth would have been assessed as a serious risk of harm therefore Ruth would not have met the threshold for VARM intervention. The Author was told that a MARAC process to support Ruth regarding domestic abuse would take precedence over a VARM process but none of the reported incidents with the Perpetrator were seen as meeting the criteria for MARAC referral. In short, despite being "vulnerable" and receiving some services Ruth's experiences, treated in isolation, were not known to be significant enough to warrant additional attention.

22.33 From the information known about the Perpetrator he would not have been considered as a vulnerable adult, or a person with care and support needs.

9. *Was substance misuse (drugs and alcohol) identified as a risk factor for the victim, perpetrator and the victim's ex partners, and was appropriate support offered?*

22.34 In the early part of the timeframe there is evidence that alcohol was a known risk factor. In the records of Constabulary A both Ruth and Partner 1 were noted as affected by alcohol during police responses to incidents involving the couple. Partner 1 did consent for a referral for treatment for alcohol related issues but the outcome was unknown. In early 2011, Constabulary A records show Ruth declined the offer of a referral to alcohol treatment services.

22.35 When Ruth met Partner 2 and moved to Derbyshire records for children's services and police indicate that alcohol and substance misuse was a known and regular feature within the relationship. There is limited evidence of signposting to focused support for either individual from children's services or the police although both services acknowledged the negative impact of drug and alcohol misuse on the relationship. In 2009 prior to being with Ruth, Partner 2 as a result of a court appearance and conviction had been required to attend an alcohol treatment programme. There was evidence in children's social care records that enquiries were made about the treatment Partner 2 received as part of information gathering about the couple when concerns were being investigated in summer 2012. Partner 2 failed to re-engage with treatment in 2012 and no further action appears taken.

22.36 In 2012 Ruth admitted to children's social care that she was using amphetamine and voluntary drug testing was undertaken intermittently with negative results, indicating Ruth was not using when tested. Specialist drug and alcohol treatment services for Ruth do not appear to have been considered at this point, probably due to the negative test results.

22.37 Other agencies were aware of the couple's misuse of alcohol for example community mental health professionals and health visitors because of involvement with Ruth and with the multi-agency safeguarding and child protection processes throughout 2012-2013. Again, there was acknowledgement of the risks the use of alcohol and drugs presented but no apparent coordination of a plan for support.

22.38 When Ruth and Partner 2 separated later in 2013 drug and alcohol support was suggested to Ruth by the housing support worker. Of note was the reason Ruth gave in declining the offer which was included in an updated housing risk assessment ; records state she explained there was no longer a need for support as she "only used drugs and alcohol to numb the domestic violence" from Partner 2 with whom she was then not in contact. It is well known that women experiencing domestic abuse sometimes use alcohol or drugs as a response to or an escape from abuse[29].

22.39 During the relationship with the Perpetrator Ruth's use of alcohol was documented only once in their first year together when she was treated at hospital for suspected self-harm and admitted to professionals that she had consumed a bottle of wine. Despite being psychiatrically assessed the alcohol use was not explored in detail and not identified as an obvious risk factor.

22.40 In the other episodes with the Perpetrator from 2015 to 2018, which are now suspected to involve domestic abuse, Ruth was either pregnant or had recently given birth. Therefore, professionals may have assumed her alcohol use was minimal if drinking at all as there is no evidence on record that alcohol or substance use was explored. Had previous records and history been reviewed sufficiently, as should happen prior to any professional interaction, those seeing Ruth would have realised the need to explore alcohol use with her.

[29] Women suffering domestic abuse are more likely to misuse alcohol than women generally, World Health Organisation Intimate Partner violence and Alcohol Fact Sheet

22.41 Through the same period the Perpetrator was reported to police anonymously, and by Ruth. He was said to be using or involved in the supply of drugs but there was no evidence recorded to substantiate the information. No further action could be taken regarding the Perpetrator's alleged involvement in drugs and the information was not used as an identified risk factor for him as a suspected perpetrator of domestic abuse. It is difficult to offer support as a result of anonymous intelligence due to the risk of potentially identifying the source of the information.

22.42 It is unknown due to his lack of participation in the Review whether the Perpetrator had previously been in receipt of treatment or support for alcohol or substance related issues. Panel members did not highlight any agency information to suggest this.

10. Was focus on the children of the victim and consideration of the children's lived experience evident through all professional contact with the family?

22.43 Whilst local authorities, through their children's social care teams, play the lead role in safeguarding children and protecting them from harm, everyone who comes into contact with children and families has a role to play in protecting them. Therefore, all professionals and agencies working with children and families have a responsibility to focus on children and their needs and wellbeing.

22.44 The focus on the two children of Ruth with Partner 1 was considered appropriate for Children's Services in Area A. Domestic abuse occurred in the presence of the couples' very young children resulting in assessments regarding the children's safety and wellbeing. The incidents in Area A took place over 10 years ago and the Author was assured that changes to policy and procedures have been implemented locally and nationally since then.

22.45 Known incidents of domestic abuse appeared to occur more frequently when Ruth and Partner 2 were together. The children were present and witnessed abusive incidents as records indicate they (the children) spoke about what they had seen. The impact of domestic abuse on children and the emotional harm caused was highlighted earlier. The focus on the children in terms of risk and understanding their lived experience seemed minimal from Derbyshire children's services due to the optimism shown in the capacity of Ruth and Partner 2 to change their lifestyle. The ability of Ruth herself to change whilst living with domestic abuse and poor mental health was discussed earlier. The delay in initiating a section 47 investigation supports the view that focus on the children's needs was at times secondary to the attention on the adults' needs and the challenging, chaotic issues that their lifestyle presented to professionals trying to work with them.

22.46 The domestic abuse support agencies which became involved during the period that Ruth and Partner 2 were together did attempt to focus on the two children (of Ruth and Partner 1) by offering children's counselling to address the impact of their experience. Sadly, the children's work did not take place. It does not appear that it was considered if the provision of this support could be offered in Area A, as the children around this time

returned there to live with their father.

22.47 When Ruth lived with the Perpetrator there was some evidence of focus on their children by health professionals. When their first baby together was born, six weeks after a reported domestic abuse incident, the hospital demonstrated focus on risks to the child and mother by contacting children's social care to check the current family position prior to them being discharged.

22.48 Professionals from the health visiting service during their contact with the family due to the three children born to Ruth and the Perpetrator discussed impact of domestic abuse on children with Ruth demonstrating focus on the children's needs.

22.49 However, focus on unborn children by all agencies in contact with Ruth was not a significant consideration. A pre-birth assessment was never proposed or discussed by any of the professionals involved, all of whom were aware of the historical domestic abuse suffered by Ruth and/ or had knowledge of a current risk of abuse. It is widely believed that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm. The lack of consideration to use the Pre-birth Protocol or to complete a pre-birth assessment for any of the unborn children of Ruth and the Perpetrator meant that the risks to the unborn baby were not considered exclusively even though a number of concerns were known. This demonstrates limited focus on an unborn baby's needs and in addition, shows that the impact of the arrival of a newborn child on a family where abuse was already a present risk was not considered. A plan for coordinated support and monitoring for the family was not put in place before or after any of the babies were born.

22.50 As stated earlier the local pre-birth protocol for the Derby and Derbyshire Safeguarding Children Partnership has recently been strengthened and is being re-promoted.

22.51 Routine enquiry, which is normally undertaken by health professionals, was explored earlier and found to be completed sporadically with Ruth. This was an opportunity not always taken to focus on the needs of children alongside the needs of their mother. If Ruth had been provided the safe space which routine enquiry should create for women to discuss their experiences of abuse this would in turn have given attention and focus to any risks the children, unborn or present, were facing.

22.52 A recent review, *Sowing the Seeds- Children's experience of domestic abuse and criminality, Dr Elaine Wedlock, Dr Julian Molina for the Victims' Commissioner (England and Wales), April 2020* highlights the importance of focusing on children and recommends "identifying children who live in households with domestic abuse as victims in their own right". The *Sowing the Seeds* review, and other research found there is a huge negative impact on children living in households where domestic abuse is present. The recommendation to view children in abusive households as victims in their own right hopes to lead to bespoke interventions and support programmes with appropriate funding.

11. *Was information about the family history/ experience and risks shared effectively including across geographical borders, across agencies and within agencies; and was appropriate action taken?*

22.53 There were two distinct geographical areas relevant to Ruth's life, particularly within the first half of the review's timeframe; these were Area A and Derbyshire. Sound liaison took place for the health visiting service's transfer between areas of the two elder children's information (the children of Partner 1 and Ruth). When Derbyshire children's services became aware of the family (Ruth, Partner 2 and the children) there was evidence of some communication between children's services teams in the two geographical areas with history of previous involvement and domestic abuse discussed. Whether appropriate and timely action was taken has been explored earlier.

22.54 Information was also shared from Derbyshire police to Area A children's services, as well as with local key partner agencies, when reports of abuse and neglect had resulted in police attendance.

22.55 Information sharing requirements and protocols, particularly regarding safeguarding, are clear between agencies and across agencies. However, such expectations are reliant on professionals realising that risk is present and it is pertinent to share. There were instances throughout the timeframe where information was not considered relevant for disclosure to others, for example the alleged self-harm episode by Ruth when she was pregnant in spring 2015 after an "argument" with the Perpetrator. Despite the positive focus on Ruth's immediate mental health needs the wider safeguarding picture for her and the unborn child was not considered by the lack of sharing of information with children's services.

22.56 Information sharing forums such as MARAC are well embedded for multi-disciplinary partners to share information, discuss risk and develop safety plans. Unfortunately, the one recorded opportunity to utilise the MARAC process in spring 2013 was not taken despite being highlighted as an action in children's social care records. Therefore, the extensive information held by different agencies about Ruth and her family was not shared at MARAC which may have resulted in appropriate action being agreed.

22.57 Whilst accepted that the chronology of Ruth's abusive experience was long and complex, which is common for many other women, it is crucial for professionals to familiarise themselves, then share and highlight history and risk factors to colleagues, both internal and external in order that effective service can be provided to evolving circumstances. The services provided to Ruth from all involved agencies were often responses in isolation to the one presenting issue without full consideration of recent contacts and available historical information, much of which was accessible within agency records.

23 Additional points from the Terms of Reference

23.43 How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

23.1.1 The Coroner's Office was informed of the review by the Police. There are no on-going proceedings identified.

23.1.2 Liaison took place between the Panel and a police representative for the senior investigating officer throughout the investigation and criminal proceedings. As explained earlier, the first Panel meeting and subsequent request for IMRs took place expeditiously, but the next meeting of the Panel was postponed until after the conclusion of the criminal trial. This was to eliminate any risk that the DHR process may undermine the prosecution case.

23.1.3 The trial concluded in June 2019 when the Perpetrator was found guilty of the murder of Ruth. Disclosure issues were considered throughout.

23.2 *How will agencies/professionals working in other Local Authority areas with an interest in the homicide be involved, including members of the Voluntary and Community Sector (VCS) and what should their roles and responsibilities be?*

23.2.1 Agencies from Area A where Ruth spent her childhood and early life as an adult were involved in providing summary information and have responded to additional queries arising during the Review. The police and children's services are considered virtual Panel members and have been able to contribute ideas and challenge to the draft report.

23.2.2 There was no known involvement of VCS agencies in other areas but the Community Safety Partnership responsible for the Review will ensure learning themes and key points from the Review will be shared and agencies sighted as appropriate.

23.3 *Who will make the link with relevant interested parties outside the main statutory agencies, for example independent professionals and voluntary organisations?*

23.3.1 The Community Safety Partnership working closely with local voluntary agencies and supported by the local safeguarding adults board and the local safeguarding children partnership have ensured all relevant parties are included.

23.4 *How should the review process take account of previous lessons learned i.e. from research and previous DHRs?*

23.4.1 The author has accessed DHR reports with similar themes, relevant research and the *Home Office Domestic Homicide Reviews - Common Themes Identified, and Lessons to be Learned reports, November 2013 and November 2016.* Due to the involvement of children's services within the timeframe of this review and specific risk factors including alcohol, domestic abuse, mental health and pregnancy, relevant research and themes have also been explored

including the *Triennial Analysis of Serious Case Reviews 2011 to 2014, Pathways to Harm, Pathways to Protection: Final Report May 2016, Peter Sidebotham, Marian Brandon et al*.

23.4.2 Many of the panel members have now unfortunately been required to be involved in previous reviews providing them with opportunities to identify relevant learning themes. The Author is grateful for this knowledge and experience.

23.4.3 Working alongside and having the support of the advocate from AAFDA has enabled the Author to be aware of current research and lessons particularly relating to victims' families. This support has been very helpful.

23.4.4 Locally in Derbyshire a *DHR summary of learning 2014-2018* has been collated and published with many of the learning themes being applicable to the tragic case of Ruth. Some recommendations for this Review highlight similar issues and learning from other local cases. It is important for multi -disciplinary partnerships to respond robustly to the challenge of ensuring that current and future responses to domestic abuse are more effective in order that victims and families achieve more positive and safer outcomes.

23.5 *Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?*

23.5.1 There are no known legal issues but the Community Safety Partnership have sought advice as required via the Derbyshire County Council Legal Services.

23.6 *How should friends, family members and other support networks (for example, co-workers and employers, neighbours etc) and where appropriate, the perpetrator contribute to the review (including informing them of the terms of reference), and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family?*

23.6.1 The Parents of Ruth have been involved throughout the Review process and they have been able to share relevant information about the Review with other close family members and friends. It is recognised that those who knew Ruth best were actually not the statutory or voluntary agencies but her closest relatives and their contribution, facilitated by AAFDA, has been invaluable.

23.6.2 The Community Safety Partnership via the Author supported by AAFDA will make contact again with significant family members when the draft report is complete and again before publication. This is to ensure Ruth's family are given every opportunity to remain informed, to comment on accuracy of the overview report and to contribute to the final outcome of the Review.

23.6.3 After consideration of the views of the Parents and the Panel, and once agreed by the Home Office the report may be published in full on the Safer Derbyshire website and will be available to the public who access the website. If the full overview report is not published a summary of learning will be made available. The Community Safety Partnership will seek the services of the Council's Communications Team in planning for and managing any media

enquiries.

23.6.4 The Author with the Community Safety Partnership will ensure assurance is requested of the statutory agencies involved with the children of Ruth that every effort is being made to support their emotional wellbeing. Any requests from the children relating to the Review, now or in the future, should be managed sensitively and in consultation with immediate family/ carers.

24 Conclusion

24.1 Ruth was murdered by the Perpetrator in late 2018. She was 30 years old. She was a much loved mother to 5 children and a precious daughter to her Parents.

24.2 Ruth and the Perpetrator had been together for around 4 years and in that time had 3 children. Domestic abuse incidents were suspected of occurring throughout the relationship but few were formally reported. Of the suspicious incidents coming to the attention of services, 3 were during pregnancy but risks to mother and the unborn child were not considered or fully assessed. Opportunities were not taken to coordinate multi-agency information and to formulate an effective safety plan. Attempts were not consistently made, by those seeing Ruth, to professionally and sensitively enquire into her experience of domestic abuse, to develop trusting working relationships, or to create safe space and permission for abuse to be disclosed.

24.3 Prior to meeting the Perpetrator Ruth suffered domestic abuse for much of her adult life in 2 other significant relationships. Her 2 older children were born during that period. Ruth had poor mental health and at times was dependent on alcohol. Her parenting capacity with the eldest 2 children was affected by the abuse and other risk factors in her life but the harm to those children was initially not fully identified by services involved. Attention seemed focused on the lifestyle of Ruth and the abusive partner with unrealistic optimism on their ability to change and for their care of the children to improve.

24.4 Support for Ruth was attempted by specialist domestic abuse workers, housing support and by mental health professionals within the community and within acute settings. Her engagement was limited due to the cumulative toxic challenges in her life and because of the suspected control she was under. Signposting to local domestic abuse support was provided when abusive incidents were reported but Ruth was unable to engage or to benefit from this.

24.5 Reports of abuse and requests for help were responded to but mostly in isolation with opportunities not taken to link and assess patterns of behaviour and historical information.

24.6 Sadly, Ruth died during an extreme act of violence by the Perpetrator.

25 Lessons to be Learnt

25.1 A DHR will always provide an opportunity for areas for development to be identified for services involved, and for good practice to be highlighted and shared.

25.2 Some agencies providing individual management reviews as part of the DHR process have identified learning for their own agencies. The learning points are included at Appendix C and should be subject to internal quality assurance and monitoring through individual governance arrangements to ensure appropriate action has been taken to address issues identified.

25.3 Some of the learning from this case sadly reflects similar learning from other local reviews which has been summarised in five key areas in the *Derbyshire Domestic Homicide Reviews Summary of Learning 2014-2018*. This document which is helpful for both local and national learning is included at Appendix D. Considering the five themes an outline of comparable aspects from the case of Ruth is as follows:

Professional curiosity

25.4 Victims of domestic abuse often need to be given permission to disclose by asking exploratory and probing questions sensitively, but directly. Use of the routine enquiry was limited with Ruth. She, like other victims, may have been too afraid or uncomfortable to raise the issue of abuse herself.

Data collection and risk assessments

25.5 When risk assessing, look at patterns of behaviour to see the cumulative picture, as this is the best indicator of future risk. Reports involving Ruth often focused on the presenting problem as a 'one off' incident.

25.6 Risk increases dramatically where mental health issues, substance/ alcohol misuse and domestic abuse are present within a relationship or family situation as was the case for Ruth.

25.7 Within a household where domestic abuse is present risks for children must always be considered. The lived experience of Ruth's children was not always viewed as a priority to be captured, and the risk to her unborn children whilst pregnant and living with the Perpetrator was not seen.

Importance of using historical information

25.8 Historical information alongside current issues will always inform risk assessments, analysis and action plans. Knowledge of Ruth's previous experience and family history, which was available in records and was often volunteered by Ruth, would have highlighted key areas of risk and vulnerability.

Information sharing

25.9 There is a need for better sharing of information between agencies at an earlier stage to enable a more shared understanding of the risk, including patterns of abuse and any signs of increased severity, and frequency, of domestic abuse incidents.

25.10 It is important to have a broader view as to what information is shared and who with. Thresholds and referral criteria may impact on decisions to share, as for Ruth. The opportunity to seek specialist safeguarding advice within organisations in those circumstances should always be taken.

Training and awareness raising

25.11 All professionals whatever their core business but who come into regular contact with families should understand what domestic abuse is, the signs and behaviours and how to get local support. Records of involvement with Ruth demonstrate some gaps in awareness of the complexities of controlling and coercive behaviour, and why victims fail to engage or disclose. There is also a need for improved understanding of the risks which pregnancy can increase in terms of domestic abuse.

25.12 Internal and multi-agency training including awareness of domestic abuse policy and protocols, and impact of domestic abuse on children should be widely promoted and attended.

25.13 The Author would encourage a quality framework to be developed by a working group of the Derbyshire and Derby Domestic Abuse and Sexual Violence Governance Board to monitor the five main areas of learning highlighted in the Derbyshire Domestic Homicide Reviews Summary of Learning 2014-2018 and examine if the themes are being recurrently reflected in recent and future domestic homicide reviews.

25.14 Scrutiny of practice always provides an opportunity to reflect on ways in which services can be further improved. The Author has included action already in progress in the body of the report.

25.15 Wider recommendations below have been made based on the learning from the case.

Recommendations

1. All partners will ensure the multi-agency learning from the domestic homicide review QDCNH18 is shared and implemented across the workforce as part of continuing organisational engagement with the safeguarding agenda.

2. (a) Health partners across Derbyshire should provide assurance and evidence that the requirement to make “routine enquiry” is understood, is taking place at all relevant opportunities, and responses are being recorded with follow up planned if the enquiry could not be completed

   and

   (b) All other partners in contact with pregnant women should also provide assurance that professionals are enabled to routinely enquire sensitively about women’s experience of domestic abuse in order that they can be provided with the safe space and opportunity to disclose abuse to any professional should they feel able.

3. The Derbyshire and Derby Safeguarding Children Partnership, after the re-promotion of the Pre-Birth Protocol through the briefing issued May 2020, should provide assurance and data that pre-birth assessments are being completed when risks are identified to improve outcomes for pregnant women, unborn children and their wider families.

4. The Derby and Derbyshire Safeguarding Children Partnership and the Derbyshire Safeguarding Adults Board should review relevant policies and practice guidance to ensure the need for practitioners to be alert to long term patterns of abuse and cumulative risk factors/warning signs is adequately reflected and supports the development of a shared understanding of risks within past and current relationships and within families helping to provide a focus for effective multi-agency responses to domestic abuse.

5. Assurance should be provided by partners that all domestic abuse related multi-agency and single agency training includes information regarding additional risks and triggers of domestic abuse associated with pregnancy and that agencies identify key staff requiring training and that this is delivered/completed.

6. Referral criteria and explanatory notes for the Multi Agency Risk Assessment Conference (MARAC) process should be re-examined and updated as necessary and be widely circulated to ensure professionals are supported to consider the specific circumstances, vulnerabilities and risk factors of victims in order that individuals may benefit from their case being discussed at MARAC enabling appropriate safety plans to be developed. The new MARAC+ team will provide a progress report on changes to the Derbyshire and Derby Domestic Abuse and Sexual Violence Governance Board after 6 months of implementation.

7. A coordinated and collaborative approach should be the aspiration of mental health services including crisis, community and hospital teams, across areas and trusts, with other relevant organisations to enable seamless continuity of care focused on the needs of individuals, with specific consideration of history and current circumstances particularly when transfer and closure of cases is proposed, and when non engagement is a reason for closure.

8. All partners must evidence their organisational focus and practice in relation to the impact of domestic abuse and its cumulative harm on children and demonstrate their continued commitment to identify children living in abusive households as victims in their own right, to listen to their voices and to enable them to receive effective support.

References

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- The Derbyshire and Derby City Safeguarding Children Procedures Multi-Agency Pre-birth Protocol
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- Domestic violence and severe psychiatric disorders: Prevalence and interventions. Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., AgnewDavies, R., & Feder, G. (2009), Psychological Medicine, 40(6), 881–893.
- The Miscarriage Association-Your Mental Health
- The Cycle of Abuse, Lenore E Walker
- A Cry for Health - Why we must invest in domestic abuse services in hospitals, SafeLives, November 2016
- World Health Organisation Intimate Partner violence and Alcohol Fact Sheet
- No Secrets, 2000
- The Care Act, 2014
- Sowing the Seeds- Children's experience of domestic abuse and criminality, Dr Elaine Wedlock, Dr Julian Molina for the Victims' Commissioner (England and Wales), April 2020
- Home Office Domestic Homicide Reviews - Common Themes Identified, and Lessons to be Learned reports, November 2013 and November 2016
- Derbyshire DHR summary of learning 2014-2018.

Appendix A

Terms of reference QDCNH-18

Review timeframe

Events in the victim's and perpetrator's life should be reviewed in detail **between 01.01.2014 to 13.12.18** to reflect the known period when the victim and perpetrator met and were involved, leading to the sad death of the victim.

Significant events in service involvement for the victim, her children and partners/ ex partners of the victim should also be reviewed between **01.03.2012 and 31.12.2013** to reflect the period when the victim moved from Area A into Derbyshire. This will provide history/ context which will assist to understand the events leading to the death.

Area A Police and Area A Children's Social Care should review their contact with the victim, her children and the victim's ex-partner and provide a summary report with analysis of significant events between **01.01.2007 and 28.02.2012.** This timeframe is to reflect the known period when the victim was in a relationship with ex- partner in Area A, resulting in two children being born, and when incidents of suspected domestic abuse occurred, prior to the move to Derbyshire.

Brief summary of agency/ description of service provided

All agencies should provide a brief description and overview of the service they provide, geographical areas covered and any relevant organizational/ strategic change(s) occurring during the identified timeframe of the review.

Issues to be considered in analysis of agency involvement

1. Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

2. Was the victim ever subject to a Multi-agency Risk Assessment Conference (MARAC)? If so, can minutes from the relevant meetings be released?

3. Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)? If so, a request may be required for the release of the minutes (subject to relevant legal considerations)?

4. Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)? If so, is there information known to professionals working with him relating to the homicide? How was risk posed by the perpetrator managed?

5. Did the victim have any contact at any time with a domestic violence and abuse organisation or helpline? If so, explain the type of support and subsequent outcomes.

6. Were all available opportunities taken by professionals to explore domestic abuse with the victim, in order that appropriate protective action could be considered? For example, use of 'routine enquiry' by health professionals.

7. Were risks of coercive and controlling behaviour considered by professionals in their contacts with the victim?

8. Was either the victim or the perpetrator a 'vulnerable adult' – a person —who is or may have care and support needs - be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation?

9. Was substance misuse (drugs and alcohol) identified as a risk factor for the victim, perpetrator and the victim's ex partners, and was appropriate support offered?

10. Was focus on the children of the victim and consideration of the children's lived experience evident through all professional contact with the family?

11. Was information about the family history/ experience and risks shared effectively including across geographical borders, across agencies and within agencies; and was appropriate action taken?

Issues for the Review Panel and Chair/Author - to be evidenced within the overview report

(not for the IMR authors)

How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process? (See section 9 for further information).

How will agencies/professionals working in other Local Authority areas with an interest in the homicide be involved, including members of the VCS and what should their roles and responsibilities be?

Who will make the link with relevant interested parties outside the main statutory agencies, for example independent professionals and voluntary organisations?

How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

How should friends, family members and other support networks (for example, co-workers and employers, neighbours etc) and where appropriate, the perpetrator contribute to the review (including informing them of the terms of reference), and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of possible conflicting views within the family?

How should matters concerning family and friends, the public and media be managed before, during and after the review, and who should take responsibility for this?

Appendix B

Combined agency chronology

QDCNH-18
Combined Chronolc

Appendix C

Single agency learning as identified in Individual Management Reviews

Constabulary A

None

Children's Services Area A

None

Derbyshire County Council Children's Services

Previous assessments must be reviewed in cases where domestic abuse is a factor to ensure that the analysis is comprehensive and factors in what is already known.

More than three referrals concerning the "toxic trio"[30] should result in a manager's oversight being recorded regarding rationale to remain outside of a Section 47 enquiry, alongside a MARAC Referral being made.

Derbyshire Constabulary

None

Derbyshire Healthcare NHS Foundation Trust

The DHCFT Safeguarding Unit should review the current Trust Transfer and Discharge Policy and revisit standards.

The DHCFT Safeguarding Unit should meet with Pathfinder/Single Point of Access teams to examine the referral pathway and transfers in and access to the new community perinatal service.

Sherwood Forest Hospitals Trust

None

Derbyshire Community Health Services NHS Foundation Trust (DCHS)

DCHS People Resources Team should ensure staff employed on a bank contract have access to their required level of safeguarding training which is monitored and recorded within DCHS NHS FT electronic staff records.

DCHS 0-19 Children's Service and DCHS Safeguarding Service should embed the learning relating to professional curiosity and hidden fathers in practice through training and supervision.

[30] The toxic trio is now often referred to as the "cumulative risk of harm" (domestic abuse, mental ill health and substance misuse)

DCHS 0-19 Children's Service and the DCHS Safeguarding Service should work together to ensure the updated 0-19 Children's Service Best Practice Domestic Abuse Aide memoire guidance is embedded into practice.

NHS Derby and Derbyshire Clinical Commissioning Group

None

East Midlands Ambulance Service (EMAS)

EMAS should continue to work with staff in promoting the importance of recording the names of other individuals on scene at attendances.

The Elm Foundation (previously known as Derbyshire Domestic Violence and Sexual Abuse Service/ North Derbyshire Women's Aid)

Elm Foundation staff and volunteers should take all possible steps to follow up and action known changes to circumstances in order that current contact details, including phone numbers and addresses are on record within the service.

Action Housing and Support

None

North East Derbyshire District Council

None

Bolsover District Council

None

Appendix D (follows on next page)

DERBYSHIRE DOMESTIC HOMICIDE REVIEWS SUMMARY OF LEARNING 2014 - 2018

A 'Domestic Homicide Review' (DHR) is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a relative, someone they had been in an intimate personal relationship with or who was a member of the same household. DHRs are held to identify any lessons to be learnt from the death. Between 2014 and 2018 there have been six DHRs within Derbyshire.

This summary is designed to promote awareness of the latest learning to come out of both national and Derbyshire domestic homicide reviews. It covers five main areas of learning:

1. **Professional curiosity**
2. **Data collection and risk assessments**
3. **Importance of using historical information**
4. **Information sharing**
5. **Training & awareness, including:**
    - Domestic abuse awareness training
    - Coercion and control
    - 'toxic trio'
    - Hidden men

Please ensure that you read this document and pass the information on to your colleagues. Follow the hyperlinks for more information.

1. Professional curiosity

This is the capacity and communication skill to explore and understand what is happening within a family or relationship, rather than making assumptions or accepting things at face value. Sometimes known as 'respectful uncertainty'.

Curious professionals will spend time engaging with individuals and families, observing body language and verbal interactions and considering the implications. Do not presume you know what is happening – ask questions and seek clarity if you are not certain. If the victim is not alone, you might observe the following:

- the victim waits for their partner to speak first or glances at them each time they speak, checking their reaction
- the victim smooths over any conflict
- the suspected perpetrator speaks for the victim most of the time
- the suspected perpetrator sends clear signals to the victim, by eye/body movement, facial expression or verbally, to warn them
- the suspected perpetrator has a range of complaints about the victim, which they do not defend

If any of these signals are present, you should find a way of seeing the suspected victim alone. Victims of domestic abuse are often too afraid or uncomfortable to raise the issue of abuse themselves. Give them permission to disclose by asking exploratory and probing questions sensitively, but directly. For example:

- How are things at home? Do you feel safe there?
- Do you ever feel frightened by your partner or other people at home?

2. Data collection and risk assessments

If domestic abuse is disclosed, you should 'risk assess' the individual using the 'Derbyshire Risk Assessment DASH' and refer to the Derbyshire domestic abuse services if there is standard or medium risk, or Multi-Agency Risk Assessment Conference (MARAC) if high risk. You can find the relevant forms here. If you need advice please call the helpline number: 08000 198 668.

Consider risks for children and any vulnerable adults within the household and refer to Safeguarding, where appropriate.

When risk assessing, look at patterns of behaviour, to see the cumulative picture, rather than only focusing on the presenting problem as a 'one off' incident…..this is the best indicator of future risk.

Recognise the risk increases dramatically where the "toxic trio" (mental health issues, substance misuse and domestic abuse) are present within a relationship or family situation. (See training section)

All agencies should ensure they keep accurate and up to date records. Make sure your systems are flagged and tagged to show victims and perpetrators who have been to MARAC. Ensure you know how to access archived data and use it to inform practice, where appropriate.

Ensure you capture the lived experience of any children within the family. You should speak to the children separately where possible, to enable them to disclose.

To seek advice, or to access specialist domestic abuse services contact the **The Derbyshire Domestic Abuse Support Line:**

08000 198 668 **IN AN EMERGENCY CALL 999**

3. Importance of using historical information

It's important to use historical information alongside current issues to inform risk assessments, analysis and action plans. Knowledge of the family history can highlight key areas of risk and vulnerability.

Look for patterns of behaviour – are there signs of escalation or increasing severity? If so, consider referral to MARAC. If your agency does not hold full information on the victim or the family, liaise with other agencies, so that together, you can arrive at a full assessment of the risks.

4. Information sharing

The DHR learning highlights the need for us to get better at sharing information between agencies at an earlier stage. This will allow us all to have a better shared understanding of the risk, including patterns of abuse and any signs of increased severity, and frequency, of domestic abuse incidents.

We should also have a broader view as to who we share information with. Think about which organisations have contact with the victim and what they might know which could help, both in terms of identifying risk and in any support they can offer.

5. Training and awareness raising

Domestic abuse awareness training
We need to ensure staff understand what domestic abuse is, the signs and behaviours and how to get support in Derbyshire.

Many organisations run their own training, but multi-agency training is also available. Make sure you and your colleagues know what to look out for and where to access support.

The DHRs also highlighted the need to understand the impact of coercion and control, the 'toxic trio' and hidden men.

Coercion and control
Many of the cases seen in DHRs nationally and locally involved coercion and control. Often victims don't realise they are experiencing domestic abuse because it isn't physical or sexual in nature. Professionals can also miss the signs and behaviours if they are not aware.

Controlling behaviour is defined as; a range of acts designed to make a person subordinate, and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

> "An act, or a pattern of acts, of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

Example behaviours a perpetrator may exhibit include:

- Isolating the victim from family and friends
- Taking control of their everyday life – e.g. controlling what someone wears, what they eat, where and when they sleep, where they can go, what they are allowed to do etc.
- Threatening to hurt or kill the victim, their children or family pets if they don't comply.
- Enforcing rules and activities which humiliate, degrade or dehumanise the victim.
- Controlling access to, and/or monitoring mobile phones, social media, email etc.
- Depriving someone of access to support services and medical services.
- Threatening to withhold medication or personal care.
- Controlling them with drugs and/or alcohol.
- Controlling access to finances, work opportunities, transport etc.

It's important to note that controlling and coercive behaviour is now defined in law and is a criminal offence which can carry a maximum prison sentence of up to five years.

Also be aware that perpetrators are often very adept at coercion and control. They may seek to manipulate and control professionals, including you. It's important to remain neutral and not endorse their behaviour through your language and actions, as you may inadvertently reinforce the control the victim is experiencing.

To seek advice, or to access specialist domestic abuse services contact the **The Derbyshire Domestic Abuse Support Line:**

08000 198 668 **IN AN EMERGENCY CALL 999**