DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF VICTIM Tracey

Report produced by Peter Stride – Foundry Risk Management Consultancy

On behalf of Safer MK: Milton Keynes Community Safety Partnership

Home Office Approval: September 2021

Table of Contents

Foreword *4*

Preface *5*

1.1 Introduction **5**

1.2 Timescales **6**

1.3 Confidentiality **6**

1.4 Terms of Reference **7**

1.5 Methodology **8**

1.6 Involvement of family friends, work colleagues, neighbours and the wider community **9**

1.7 Contributors **12**

1.8 The Review Panel Membership **13**

1.9 Author and Independent Chair **13**

1.10 Parallel Reviews **14**

1.11 Equality and Diversity **15**

1.12 Dissemination **15**

2 Background information (the facts) *16*

3 Combined Chronology *17*

3.1 Background **17**

3.2 Chronology Details **18**

4 Overview *22*

5 Analysis *25*

5.1 Issue of Hindsight Bias **25**

5.2 Domestic Abuse/Violence **26**

5.3 Themes of Analysis **26**

5.3.1 Raising Awareness 26

5.3.2 Training 27

5.3.3 Reporting Pathways 27

5.4 Raising Awareness **27**

5.4.1 Policy Context 27

5.4.2 Independent Management and Chronology Review 28

5.4.3 Panel Review 30

5.4.2 Commentary 30

5.5 Training **31**

5.5.1 Policy Context 31

5.5.2. Independent Management and Chronology Review 32

5.5.3 Panel Review 34
5.5.4 Commentary 35

5.6 Reporting Pathways & Information Sharing 36
5.6.1 Policy Context 36
5.6.2 Independent Management and Chronology Review 37
5.3.2 Panel Review 38
5.3.3 Commentary 39

5.7 Additional Analysis Matters 40
5.7.1 Probation Service Risk Assessments 40
5.7.2 Isolation 41
5.7.3 The Role of the Neighbourhood Officer 42

6 Conclusions 43

7 Lessons Learned 44

8 Recommendations 46

FOREWORD

The Milton Keynes Community Safety Partnership would like to express their condolences to all those affected by the sad loss of Tracey. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening in the future. As the Independent Chair of the Domestic Homicide Review Panel, I would like to thank all agencies who contributed to the process in an open and transparent manner. This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families and friends, and to professionals. I am confident the learning points and recommendations will provide a platform to help national, regional and local agencies to implement measures designed to prevent what happened to Tracey from happening to others.

Following Tracey's death, there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect the victim and to deal effectively with the circumstances and I would urge everyone to take note and act on the findings of this Review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline and community level to help bring similar domestic homicides to an end.

PREFACE

1.1 INTRODUCTION

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

1.1.2 This report of the DHR (hereafter 'the review') examines agency responses and support given to Tracey, a Milton Keynes resident at the time of her death in June 2018.

1.1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or incidents of domestic abuse, whether support was accessed within the community 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.

1.1.4 On the morning of Tracey's death, in May 2018 Daniel called the emergency services saying he had stabbed his partner. Daniel was at Tracey's home when paramedics arrived and showed them to where Tracey's body was lying. Paramedics provided emergency care and CPR and transported Tracey to Milton Keynes hospital. Daniel admitted to stabbing Tracey and was arrested that morning. Tracey died a few days later.

1.1.5 The review considered agencies' contact/involvement with Daniel and Tracey from June 2011 until her death i.e. seven years prior to her death. However, if any agencies had information, outside of this review period, they felt was relevant, then it has also been included in any chronology/IMR. This timeframe was agreed as being appropriate to capture all the relevant circumstances which reflected:

- The relationship between Daniel and Tracey
- Significant milestones affecting their emotional state
- Any engagement with CSP agencies

1.1.6 The key purposes for undertaking Domestic Homicide Reviews is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- contribute to a better understanding of the nature of domestic violence and abuse;
- highlight good practice.

1.1.7 This review process does not take the place of the criminal or coroner's court proceedings nor does it take the form of a disciplinary process.

1.2 TIMESCALES

1.2.1 The Milton Keynes Community Safety Partnership (CSP) notified the Home Office it was commissioning a Domestic Homicide Review in June 2018.

1.2.2 Peter Stride was commissioned to be the Independent Chair (hereafter 'the chair') for this DHR on 5th August 2018. The completed report was passed to the CSP in July 2019. It was first submitted by the CSP to the Home Office Quality Assurance Panel in September 2019.

1.2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was considerably extended for a number of reasons:

- The chair was appointed in August 2018.
- The first panel meeting was held on 31st October 2018 and subsequent meetings were held on 21st January 2019, 2nd April 2019, and 5th June 2019 to ensure agencies could attend and the questions and issues raised could be addressed.
- The availability of panel members and various internal movement of staff meant that meetings had to be delayed and postponed in order that the chair could contact and brief individuals independently.

1.3 CONFIDENTIALITY

1.3.1 The findings of each review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating officers/professionals and their line managers.

1.3.2 In order to maintain anonymity, the various parties referred to in this review have been provided with alternative identities. The specific date of the death has been removed. Agencies who provided information to the review are also identified.

1.3.3 The following pseudonyms have been used for the deceased, their partner (and other parties) as appropriate, in order to protect their identities. These identities have been selected by the chair and agreed with the panel.

Name	Involvement	Ethnicity	Age (at the time of death)
Tracey	Deceased	White British	39 years
Daniel	Partner	White British	48 years
Tom	Deceased's Father	White British	N/A
Jane	Deceased's Mother	White British	N/A
Lisa	Deceased's sister	White British	N/A
John	Deceased's Ex-Partner	White British	Unknown

1.3.4 Details of confidentiality, disclosure and dissemination were discussed and agreed, between panel member agencies during the first panel meeting and all information discussed was treated as confidential and not disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

1.3.5 All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this DHR and for the secure retention and disposal in a confidential manner.

1.3.6 It was recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or gcsx. Confidential information must not be sent through any other email system. Documents may be password protected.

1.4 TERMS OF REFERENCE

1.4.1 The terms of reference are summarised below.

1.4.2 Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential, until the panel agree what should be shared in the final published report.

1.4.3 Key Lines of Enquiry

- To review the involvement of each individual agency, statutory and non-statutory, with Tracey and Daniel during the relevant period of time: June 2011 and the date of the homicide.
- To summarise agency involvement between those dates.
- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
- To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

1.4.4 To commission a suitably experienced and independent person to:

- Chair the Domestic Homicide Review Panel.
- Co-ordinate the review process.
- Quality assures the approach and challenge agencies where necessary.
- Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

1.4.5 To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

1.4.6 On completion, present the full report to the Local Community Safety Partnership.

1.5 METHODOLOGY

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

1.5.2 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

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

1.5.4 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.

1.5.5 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."

1.5.6 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.5.7 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) from all the organisations and agencies that had contact with Tracey or Daniel. Agencies were contacted to check for involvement; seven agencies returned a nil-contact. The chronologies were combined, and a narrative chronology developed.

Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the panel to analyse the contact with Tracey and Daniel and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses received. The IMRs have informed the recommendations in this report and have helpfully identified changes in practice and policies over time, as well as highlighting areas for improvement not necessarily linked to the Terms of Reference for this review.

1.5.9 The author notes the concern raised, by the Home Office QA panel, regarding the independence of the IMR authors and their role within the review process. The chair confirmed, at the commencement of the review, that there was a sterile corridor between the IMR authors/panel members and any contact with Tracey, Daniel, or any other parties. It was recognised that only two agencies had panel members who were also IMR authors. These were HM Prison and Probation Service and the Community Resolution Company, who worked alongside them. The concern was raised at the beginning of the review and reassurances sort, by the chair, that both individuals were completely 'independent'.

1.5.10 The following agencies were panel members, whilst having had no contact with either the victim of perpetrator

- Adult Social Care
- Clinical Commissioning Group
- MK Mind
- Buckinghamshire Fire and Rescue Service
- MK-Act

Their role as panel members was to support the review, consider opportunities for learning and recognise best practice.

1.5.11 Thames Valley Police were able to provide separate IMR author and panel members.

1.5.12 The CSP has confirmed that since this review was completed new Partnership arrangements have been put in place and enhanced governance procedures ensure true independence throughout future reviews in order that objectivity is maintained.

1.5.13 *Documents Reviewed:* In addition to the IMRs, and documents produced during the review process the chair has consulted other documents and policies. These have included: a published account of the Coroner's summing up. Further policy documents were also read and considered i.e.

- The Milton Keynes Needs Assessment 2018 – 2021
- HM Government Report 'Ending Violence Against Women and Girls (VAWG)'
- National Statement of Expectations for VAWG Services
- The National Institute for Health and Care Excellence: Domestic Violence and Abuse Overview
- MK-Act - Advice to Domestic Abuse Victims
- www.womensaid.org.uk
- www.smartcjs.org.uk funding until March

1.6 INVOLVEMENT OF FAMILY FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY

1.6.1 Relationship History

Details of the relationship between Tracey and Daniel have been impossible to confirm due to their individual circumstances and the private nature of their relationship. The chair has reviewed the IMRs and established that the earliest reported details of their relationship was during a meeting that Daniel had with his Probation Triage Worker (PTW) who was working alongside his Probation Offender Manager. In May 2012 Daniel disclosed his relationship with Tracey and that he intended to end it. Tracey's father confirmed that they had lived together for approximately 2-3 years until eventually Tracey asked Daniel to leave. The circumstances of this break up remain unclear but their relationship continued with Daniel moving to an address close by. They spent 2-3 nights a week together, apparently as partners. No details of their relationship have come to light during this review although there are references made by both Tom and Lisa in their accounts of the family history.

1.6.2 Family History and Background

As part of the review process the Chair contacted and visited the deceased's father and sister. Both were interviewed and permission sought and granted to share the contents of those interviews with the review panel.

Tom and Lisa were provided with Home Office DHR leaflets and offered the services of a specialist expert advocate (AAFDA). Terms of Reference were shared with each in order to understand the scope of the review. They were given the opportunity to meet with the review panel and declined but were provided with regular updates with regards to the progress of the review and at the conclusion, provided with access to the draft overview report which they were invited to consider in private and with plenty of time to do so. They were encouraged to feedback their views and comments with regards to its contents and invited to provide amendments if they so required. Tom and Lisa were offered the opportunity to liaise and contact the chair through whichever medium they preferred, they expressed their desire for a mixture of email traffic, telephone conversations and face to face meetings, these requests were accepted and dealt with by the chair directly. Details of the interviews with Tom, and Lisa are recorded below.

Tracey was brought up on the outskirts of Milton Keynes in a family including both parents and her sister 'Lisa'. Tracey was five years younger than her sister and educated at the local primary and secondary school. Shortly after leaving school Tracey moved into local authority supported accommodation five miles from the family home. Her father was a very regular visitor and provided her with money and support. Eventually she moved on and subsequently lived in council housing accommodation as an independent woman. Tracey and her mother drifted apart, however Lisa and her father remained close to Tracey and provided what support they could. Tracey had various part time jobs and was extremely popular in the area, regularly babysitting for friends, in order to subsidise her wages.

Prior to starting her relationship with Daniel, Tracey was in a relationship with John. Details of their relationship are not known to the chair and the recorded details have been drawn together from CSP agencies and Tracey's father. John was approximately 10 years older than Tracey and they lived together for several years until John was eventually diagnosed with cancer and died.

Approximately 12 months later Daniel and Tracey started their relationship. Daniel was homeless and so Tracey invited him to move in with her. Their relationship appears to have been initially stable but after 2- 3 years Daniel moved out of Tracey's flat, but they remained together, and Daniel lived nearby. The couple would normally spend 2 - 3 days a week at each other's homes and this remained the case until Tracey's murder.

1.6.3 Interviews with Family Members

<u>Deceased's Father – Tom</u>

<u>Background</u>

The family lived in the Milton Keynes area for many years. Jane and Tom brought up two daughters, Tracey and Lisa. Tracey was 5 years younger than her sister and had what Tom referred to as 'problems and issues with taking orders or instructions'. Tracey was regularly truant from school, and Tom was often called into school because of this. Tracey eventually left school and Tom feels that she had fallen in with the 'wrong crowd'. It was about this time that the family home was burgled, and this caused some resentment towards Tracey. (Tom feels that Tracey may have known the perpetrators and had been pressured into helping them.)

Eventually Jane asked her to leave. Tracey moved into a flat approximately five miles from the family home and Tom was a regular visitor. He made sure that Tracey had enough money for the essentials.

Relationships

Tracey's first boyfriend was John and Tom described him as the love of her life. John was older than Tracey, by approximately 10 years. When John was diagnosed with cancer Tracey assumed the role of carer and looked after John until his death. Tom describes this as being a significant moment in Tracey's life as she had never had that kind of responsibility.

It was approximately 12 months later that she met Daniel who was also older than Tracey. She allowed him to move in, as he was homeless and they co-habited for approximately 2-3 years until eventually she asked him to leave. They remained together as a couple and Daniel moved into a nearby flat allowing them to spend 2 or 3 nights a week at each other's homes.

This was their routine until Tracey's death, however a couple of weeks prior to her homicide Daniel asked to see Tom. They met at Tom 's flat, where Daniel disclosed that he thought Tracey was having affairs with other men. Tom said he thought that was very unlikely, but Daniel seemed to be convinced.

Tom didn't see Tracey as much as he would have liked, and they rarely discussed details of her relationships. Tom had no knowledge of any domestic abuse, assaults or controlling behaviour, being demonstrated by Daniel.

Employment Hobbies & Interests

Tom commented that Tracey had no real hobbies or interests but did have a number of friends in the area where she lived. He understood that she would often babysit and look after neighbours' children and that they paid her for her trouble. Tom would encourage Tracey to get regular work and he knew she'd had a couple of brief periods of employment, but they hadn't suited her, and she had left.

Deceased's Sister – Lisa

Lisa and Tracey were brought up in the family home, in the Milton Keynes area. Lisa describes their childhood as being typical of children with a small age gap. Lisa was aware that Tracey had problems at school but knew none of the details. Lisa stated that by the time Tracey had reached teenage years Lisa was building her own career and living an independent life.

Lisa still lived at home when the family was burgled, and Tracey's mother told Tracey that she must leave. Following the receipt of the insurance compensation Lisa also moved out of the family home, however remained in regular contact with her sister, visiting Tracey and doing what she could to support her younger sister. Lisa was concerned about Tracey's lifestyle but was equally aware that with Tracey's wilful nature there was little she could do to influence her.

Lisa became pregnant and gave birth to a daughter, Tracey loved to spend time with her niece however, due to Tracey's domestic circumstances Lisa took the decision to keep the contact to a minimum. Lisa saw very little of Tracey's boyfriends and Tracey never disclosed having any problems or issues relating to domestic abuse.

1.6.4 Friends and Local Community

The chair has found great difficulty in establishing an accurate picture of Tracey's position within the local community. She appears to have been a fairly private person with limited social ties, although Tom reports that she did regularly babysit for close friends and neighbours.

Interviews with local neighbours confirm that Tracey had been in a long-term relationship with John and had been his primary carer when he was diagnosed with cancer a few years ago. John subsequently died and this appears to have had a significant impact upon Tracey. There were friends who tried to support her and get her some employment however these were ineffective.

Once Tracey met Daniel it appears her lifestyle became more isolated and they often argued. Neighbours reported these could happen several times a day and appeared to be initiated by either one. On one occasion neighbours reported details to a local Police Community Support Officer. The lack of engagement with community agencies tends to support this view of Tracey as being someone who led a very private life with few friends outside of her family. The interviews and enquiries that took place during this review have tended to add further support to this assumption.

1.6.5 Attempts to contact the perpetrator

Daniel has been in prison throughout the period of this review. The chair has contacted the prisoner location services in order to request a meeting with Daniel. The chair has written to Daniel and sought support from prison authorities to ensure that letters have been delivered to him. Despite these efforts no contact has ever been granted and permission to access his medical records has never been given by Daniel.

1.7 Contributors

1.7.1 Individual Management Reviews and Chronologies were supplied by the following agencies, all of whom were invited to the panel.

Agency	Contribution
Her Majesty's Prison and Probation Service	IMR & Chronology
Thames Valley Police	IMR & Chronology
Milton Keynes Urgent Care Trust	IMR & Chronology
Milton Keynes Council, Housing and Regeneration	IMR & Chronology
The Grove Surgery	IMR & Chronology
Compass	IMR & Chronology

The following agencies were contacted but recorded no involvement with the deceased or the family during the scope of the DHR.

- Buckinghamshire Fire and Rescue Service
- Central and North West London NHS Foundation Trust
- Milton Keynes University Hospital Foundation Trust
- South Central Ambulance Service Trust
- MK ACT
- MK Adult Social Care
- MIND BLMK

1.8 THE REVIEW PANEL MEMBERSHIP

The review panel consisted of the following members:

Name	Job Title	Agency
Peter Stride	Independent chair	Foundry Risk Management Consultancy
Calum Bell	Group Commander Service Delivery Manager	Buckinghamshire Fire and Rescue Service
Sue Burke	Chief Executive Officer	MK ACT Domestic Abuse Intervention Service
Debbie Johnson	Senior Operational Support Manager	HM Prison and Probation Service
Philip Jones	Head of Assessment and Safeguarding	Milton Keynes Adult Social Care
Caroline Lewis	Community Safety Assistant	Mind, BLMK
Eleanor Nickless	Head of Homelessness Prevention	Milton Keynes Council, Housing and Regeneration
Tony O'Ceallaghan	Safeguarding Lead	UK Rehab Compass
Amanda Derbyshire	Designated Nurse Adult Safeguarding	MK CCG
Andrew Thompson	Detective Inspector	Thames Valley Police
Mark Wolski	Community Cohesion Manager	Milton Keynes Council
Lisa Lovell	Community Safety Officer	Milton Keynes Council
Caroline Duff	Emergency Planning & Community Safety Assistant	Milton Keynes Council

Each of the chronologies and IMRs were prepared by an author who was independent of this matter. They had no direct line management responsibilities or involvement with this case prior to this review being called.

An IMR is a report detailing, analysing, and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation. The IMR process is not designed for identifying gaps in the actions/activities of other organisations. Its purpose is to look openly and critically at individual and organisational practice and at the context within which people were working.

As part of the initial scoping exercise Milton Keynes CSP ensured that those selected to be panel members were independent of any involvement with the deceased or perpetrator, prior to, or during the period of this review. This position was confirmed by the chair at the beginning of the first panel meeting.

The panel met on four occasions between 31st October 2018 and 5th June 2019.

1.9 AUTHOR AND INDEPENDENT CHAIR

In August 2018 Peter Stride was appointed the chair and author of this DHR. Peter is a former Senior Detective in the Metropolitan Police, with 30 years operational service. He policed mainly within the arena of public safety, including domestic abuse and child sexual exploitation. Whilst working in Metropolitan Police he was responsible for securing the first three DVPO, in London and this success typified his passion and enthusiasm for supporting domestic abuse victims.

Since retirement he has established his own consultancy business which focuses upon chairing Domestic Homicide Reviews and Serious Case Reviews for Community Safety Partnerships across the country as well as training and mentoring those in the public safety arena.

Peter has successfully completed Home Office DHR Training including additional modules in chairing reviews, producing Overview Reports and Executive Summaries. He has received additional training provided by AAFDA (Advocacy After Fatal Domestic Abuse).

Peter has no connections, professional or personal, to Milton Keynes Community Safety Partnership.

1.10 Parallel Reviews

Inquest: The inquest was opened in June 2018 and suspended under schedule 1 of the Coroners and Justice Act 2009. Following the conclusion of the Crown Court hearing in September 2018, the coroner made the following comments: "The investigation has not been resumed. Criminal Proceedings were initiated on a charge of murder. As a result of those proceedings the defendant was convicted, life imprisonment minimum 20 years". The inquest has therefore been permanently suspended.

There were no other reviews conducted contemporaneously that impacted upon this review.

1.11 EQUALITY AND DIVERSITY

The chair of the review and the review panel considered whether the protected characteristics of age, disability, gender realignment, marriage and civil partnership, pregnancy and maternity, race, religion (or belief) and sex, where relevant to this report.

In identifying the relevant equality and diversity issues for Tracey the review panel noted that she was a heterosexual female aged 39 at the time of her death. She was a British, white woman who had been in a relationship with Daniel for approximately three years. Her religion was unknown, and she had no known or diagnosed disabilities.

The panel found no concerns over barriers to reporting and accessing services, in this case. Each agency also considered the wider issue of whether any service delivery was impacted by these characteristics, the conclusion drawn by each was that, with one exception this was not the case.

Due to domestic abuse being predominantly of violence by men towards women, gender was a relevant protected characteristic.

Analysis from the Office of National Statistics[1] record that in 74% of Domestic Homicides the victims were women and 26% were men. Also, that 7.5% of women are victims of domestic abuse, as against 3.8% of men.

Issues of the potential equality issues are referred to where appropriate in the report however this was raised to individual agencies and the collective as part of the review process and the panel felt that this was not an issue of concern with regards to services available or provided.

1.12 DISSEMINATION

The chair has consulted with local CSP officials and confirmed that as well as the MK Together Partnership, the following individuals will be in receipt of a copy of the review report.

Name	Agency
Peter Stride	Independent chair
Calum Bell	Buckinghamshire Fire and Rescue Service
Sue Burke	MK-Act
Debbie Johnson	HM Prison and Probation Service
Philip Jones	Milton Keynes Adult Social Care
Caroline Lewis	Mind, BLMK
Eleanor Nickless	Milton Keynes Council, Housing and Regeneration
Tony O'Ceallaghan	Compass
Amanda Derbyshire	MK CCG
DI Andrew Thompson	Thames Valley Police

[1]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

2. BACKGROUND INFORMATION (THE FACTS)

In May 2018 Daniel attacked Tracey and during the course of the attack he stabbed her a number of times with a screwdriver. Tracey died from her injuries in June 2018. Tracey lived alone in the Milton Keynes area and had been a relationship with the perpetrator for approximately 3 years. As was reported by Tracey's father, the couple lived together for most of this time and despite separating remained in regular contact, often staying at one another's home 2 - 3 times a week.

Tracey did not have any children.

Shortly before the homicide Daniel had indicated to a work colleague that he suspected Tracey was having an affair. There was an apparent deterioration in Daniel's behaviour in the week prior to the murder. He appeared to be drinking to excess and became somewhat 'distant'. He told the same colleague he knew who she was having an affair with and he should go and kill that man. He later claimed to have been joking.

On the morning of the murder a neighbour heard shouting from Tracey's house at around 6am. It is thought she may have been shouting for help.

At 6.31am Daniel called the Emergency Services. He said he had stabbed his partner. It was apparent he had left the house by this stage.

Upon arrival the paramedics found Daniel inside the house. He showed them to where Tracey was laid in the bedroom. She was on the floor between the bed and cupboard. She had a dressing gown on. He said to them 'It's OK she's dead, I stabbed her'.

At 6.43am the police arrested Daniel on suspicion of murder.

The post-mortem examination gave the cause of death as 'multiple stab wounds'.

In September 2018, at Oxford Crown Court, Daniel was convicted of murder and sentenced to life imprisonment. Following the conclusion of the Crown Court trial the coroner permanently suspended the inquest.

3 COMBINED CHRONOLOGY

3.1 BACKGROUND

This section summarises information known to each agency that was identified as having had contact with Tracey and Daniel in the seven years prior to her death. Feedback was also requested from services, including those who had no record of meeting or engaging with them either as a family or as individuals. The agencies documented in section 1.7 returned completed chronologies and Individual Management Reviews (IMRs).

This chronology seeks to explain the history of the deceased and her family and to record key events, contacts and involvement with agencies within the lifetime of this review and others who may have contributed.

In terms of background, prior to the review period, each agency has provided a brief outline as to what was known. With regards to Tracey there was very little involvement with partner agencies and details of family history has been referenced in Paragraph 1.6. Tracey had various engagements, including visits at the end of 2012 to the MKUCS and GP Surgery for treatment to an abscess, and what would be regarded as routine contact with the Milton Keynes Housing and Regeneration Service. There were no other contacts with agencies involved in this review.

Daniel has a recorded criminal past which has seen him engaging with Police. He has spent time in prison for various crimes of violence including Assault and Grievous Bodily Harm and this resulted in periods of supervision from the Probation and the Thames Valley Community Rehabilitation Company. These periods lasted from November 2011 to September 2013 and from June 2016 to August 2017 (available details of each appointment are recorded in the chronology below). It is noteworthy that there was no assessing for domestic abuse, however Tracey had been with Daniel during some visits and no concerns were ever identified or raised.

In 2005 there were reports to the police by Daniel's previous partner about acts of domestic abuse, including him making threats to kill her and a report of harassment. These matters were reported separately and resulted in no further action being taken in the first report and a 'Harassment Warning Notice' being issued in the second matter.

Daniel reportedly had issues with drugs and alcohol. This assumption is drawn from anecdotal reporting and also his attendance at rehabilitation clinics called UK Rehab and those run locally by 'Compass'. The IMR author reports there being two 'episodes' outside the review period i.e. Between December 2008 - December 2009 and October 2010 – December 2010 both regarding alcohol abuse. No more details are available due to Data Protection Act restrictions and a lack of consent by Daniel. However, details of contact during the third episode (between January and March 2018) are recorded in the body of the chronology.

In terms of health care there are three reports of Daniel visiting the MKUCS services for minor matters that do not concern this review.

3.2 CHRONOLOGY DETAILS

	2011
3.2.1	Adult Probation Service - 1st Period of supervision **21 November 2011.** Daniel was released from prison and placed into BASS (Bail Accommodation Support Services) in Milton Keynes and subject to an HDC (Home Detection Curfew) with licence conditions. He attended seven supervision appointments including with the 'Education, Training and Employment (ETE) and Drug Agency'.
3.2.2	Adult Probation Service - **12 December 2011** Daniel attended a *Post Release Risk Assessment and Initial Sentence Plan*. He discussed his background and upbringing. He confirmed that he had been put into care at the age of 6 after setting fire to a local supermarket and that his father had spent much of his time in prison, when Daniel was young, but was now dead. He claimed that during his sentence he was diagnosed with a Personality Disorder and psychopathic or sociopathic tendencies.[2] Daniel continued to attend a variety of meetings including with his ETE worker, Offender Manager and Police Tracker Worker (PTW).

	2012
3.2.3	Adult Probation Service - **8 February 2012** Daniel discussed having contact with his daughter (from a previous marriage) and seeing a Cafcass (Children and Family Court Advisory and Support Service) report which he believed contained allegations of domestic abuse against his ex-wife, which he denied.
3.2.4	Adult Probation Service - **1 May 2012** Daniel met with his PTW. In February he had disclosed his relationship with Tracey and at this meeting stated his intention to end this relationship. This concern was flagged to the Local Neighbourhood Police.
3.2.5	TVP - **2 May 2012** Tracey and Daniel were reported to be splitting up and there was animosity as a consequence. The source of this information was anonymous.
3.2.6	Adult Probation Service - **25 May 2012** Daniel admitted that his alcohol use has now escalated and that he was now alcohol dependent. The PTW talked to Alcoholics Anonymous.
3.2.7	Adult Probation Service - **12 June 2012** *Risk Assessment and Sentence Plan Review.* The review records Daniel's on/off relationship with Tracey. She is described as a 'friend with benefits' situation. On the Self-Assessment Questionnaire, he identified that getting on with any partner was a problem area for him and the IMR author notes that "this will be explored". The outcome of the review was that Daniel was assessed as being low risk of serious harm and therefore no risk management plan was prepared.
3.2.8	Adult Probation Service - **12 July 2012** Daniel met with his probation officer and stated that he was trying to end his relationship with Tracey, however she would constantly contact him. This was evidenced during the interview with calls from Tracey which he ignored.
3.2.9	Adult Probation Service - **17 July 2012** The probation service received a call from Daniel's landlady, as she hadn't seen him for 5 days. Daniel was contacted and admitted that he had been staying with Tracey and drinking heavily.
3.2.10	Adult Probation Service - **29 November 2012** There was a visit by the Probation Trust, to an address occupied by Daniel's new girlfriend (not Tracey), as Daniel planned to move in. The visit was by way of a 'suitability check', the address was approved.

[2] The details of these diagnoses were requested by the Chair however no records have been produced.

2013

3.2.11 Adult Probation Service - **20 March 2013** Daniel reported that this relationship had now ended and that he moved in, temporarily, with Tracey. He was de-registered from the Integrated Offender Management (IOM) scheme and his reporting periods reduced to monthly appointments. Daniel was in sustained employment and there was no evidence of risk escalation.

3.2.12 Adult Probation Service - **28 September 2013** Daniel's licence was terminated, and contact ceased.

2014

3.2.13 MKUCS - On **9 October 2014** Tracey presented with a burn to her arm and the medical notes record that this had happened from the steam from the kettle.

2016

3.2.14 TVP - On **9 February 2016** Daniel was arrested for attacking another male in the street, including the use of his dog as a weapon. Subsequently he was convicted and sentenced to 6 months in prison. Tracey was not connected to this incident.

3.2.15 Adult Probation Service - 2nd Period of supervision **20 May 2016** Daniel was sentenced to 6 months imprisonment for the offence of causing actual bodily harm.

3.2.16 Adult Probation Service - **13 June 2016** There was an assessment conducted by the Thames Valley Community Rehabilitation Company (CRC) to assess its suitability as a site for HDC. During the visit domestic abuse checks were completed and no concerns were raised.

3.2.17 Adult Probation Service - **28 June 2016** Daniel was released from prison under HDC and licence conditions.

3.2.18 Adult Probation Service - **7 July 2016** Daniel attended a supervision meeting with CRC, along with Tracey. Both were anxious to apply for benefits and were provided with food vouchers. During the interview Daniel disclosed that prior to the offence (for which he was imprisoned) he felt as if his life was spiralling out of control.

3.2.19 Adult Probation Service - **12 July 2016** A 'Basic Level 1 Risk Assessment and Sentence Plan' was completed with Daniel. The two offences, for which he had previously been imprisoned were discussed and his risk of serious harm assessed as 'Medium' to those people whom Daniel perceived are deserving of revenge.

3.2.20 Adult Probation Service - **20 July 2016** During a supervision contact, the IMR author recorded "Daniel explained that Tracey had a 'heart of gold' and means well but described her as simple and slowly developed "Sometimes acts like a child".

3.2.21 Adult Probation Service - **17 August 2016** During a supervision contact meeting Daniel explained that his relationship with Tracey wasn't going well, she was stressed and was taking this out on him. He would try to get her to talk, but she just shouts. He was advised that if he felt at risk, he should move out of the address but keep his Offender Manager informed of his movement.

3.2.22 Adult Probation Service - **26 September 2016** Following a text from Tracey for the Offender Manager to call Daniel. Daniel felt he needed to apologise to the ETE worker as he didn't attend his appointment for the voluntary work. He said he had no excuse however he'd had a 'big barney' with Tracey and left

the house, went out drinking and got 'bladdered'. He said he decided he wouldn't attend whilst under the influence of alcohol.

3.2.23 Adult Probation Service - **3 October 2016.** Following the text message from Tracey the probation supervisor called Daniel. Daniel said he would report today as he couldn't last week. He said he had to go to the council and Tracey needed to be taken to the walk-in centre as she has a really swollen face which he thinks is due to an abscess.

3.2.24 MKUCS - On **3 October 2016** Tracey was treated, with antibiotics, for a dental infection and was advised to seek a dental assessment. This was the only occasion when she attended the centre with a male although their identity was not recorded.

3.2.25 Adult Probation Service - **28 October 2016** Daniel attended an intervention meeting along with Tracey, who arrived halfway through. They called the bailiffs regarding council tax which, including interest, had risen to £209. Tracey spoke to the council offices at first but struggled to understand what they were saying so gave permission for the Offender Manager to speak to them. After a number of offers, that neither Tracey nor Daniel could afford, it was explained that £10 a week was all they were able to pay at this stage; it was decided that a final offer of £11 a week was acceptable. Tracey agreed to this.

3.2.26 Adult Probation Service - **10 November 2016** Daniel's licence ended, as did his HDC and Post Sentence Supervision commenced. His reporting periods were extended to monthly meetings. The IMR author confirms that there were "no risk concerns".

3.2.27 Adult Probation Service - **8 December 2016** Daniel, along with Tracey, attended a supervision contact meeting. There was a discussion over their ability to maintain the £22.00/fortnight council tax arrears plan. They had struggled due to needing to take their dog to the vets. They were reminded that when setting up the payment plan if they fell behind, they may receive a court summons. Daniel stated that he had consumed three cans of beer that day and when asked to describe his current pattern of drinking said he drank a bottle of cider in the last two days and was currently drinking three or four times a week but more at weekends, Tracey confirmed this. Daniel said that on Sundays a co-defendant friend of his would go to their home and they would consume eight cans of lager and a bottle of cider between them. Tracey did not want them on the street together and so agreed that the co-defendant could come to the house.

2017

3.2.28 Adult Probation Service - **3 April 2017** Daniel had a supervision meeting and stated 'he has times where he feels angry and frustrated and that he does not always know how to contain and cope with these feelings. He knows when these feelings are coming but he does not know what causes them. He stated that he had a Mental Health Assessment when he was in prison but does not appear to have been given any kind of diagnosis. He also mentioned that he was smoking 2-3 cannabis pipes and drinking over 3 litres of cider each day.

3.2.29 MKUCS - Daniel's first contact is recorded as being **May 2017**, where a 'New Patient' check was completed. Daniel acknowledged that alcohol was an issue in his life but declined any support services.

3.2.30 MKUCS - In **June 2017** Daniel had blood tests and the subject of alcohol consumption was again raised. He volunteered to refer himself to Compass, however medical records indicate that he never attended this service.

3.2.31 Adult Probation Service - **12 July 2017** This was Daniel's final supervision session and the IMR author records that Daniel told the supervisor that "Throughout his lifetime he has always been involved with

professionals and he expressed some anxiety about not having that method of support". Subsequently Daniel agreed to a referral to Compass.

3.2.32 Adult Probation Service - **15 September 2017.** The assessment period with Daniel reached termination and the IMR author records that the "OM recognised risk".

3.2.33 MKUCS – There were further follow up appointments in **October 2017** where Daniel confirmed that he had been 'clean' of alcohol for some time. The GP made further referrals to Compass and the Improving Access to Psychological Treatment (IAPT) however Daniel wasn't keen, and no referral was ever accepted.

2018

3.2.34 Compass - **5 January 2018** Daniel has an initial assessment for substance abuse (alcohol).

3.2.35 Compass - **10 January 2018** Efforts made to call Daniel, which were unsuccessful.

3.2.36 Compass - **1 February 2018** A letter is sent to Daniel with the offer of an appointment.

3.2.37 Compass - **19 February 2018** Daniel failed to attend the appointment and didn't answer a subsequent call.

3.2.38 Compass - **5 March 2018** Letter sent to Daniel to confirm case closure if he failed to make contact.

3.2.39 Compass - **29 March 2018** Case sent for discharge.

3.2.40 TVP - **29 May 2018** relates to the call on the night of the assault of Tracey, leading to her death.

4 OVERVIEW

This section summarises information known to each agency that was identified as having contact with Tracey and Daniel in the 7 years prior to the homicide. The following agencies reported having no engagement at all during the scope of the DHR.

- Buckinghamshire Fire and Rescue Service
- Central and North West London NHS Foundation Trust
- MK Adult Social Care
- Milton Keynes University Hospital Foundation Trust
- South Central Ambulance Service Trust
- MK-Act
- MIND BLMK

4.1 Milton Keynes Urgent Care Services

i Milton Keynes Urgent Care Services provide telephone support and face to face assessments of minor illnesses and injuries for registered and unregistered patients. Tracey contacted the service on 12 occasions in a period from 10/4/2004 until 03/10/2106. 11 of these contacts appear to have no concerns or links to domestic abuse and related to minor illnesses. The one incident of potential concern was the report, by Tracey of a burn to her arm, caused by the kettle, in October 2014.

ii The service first met Daniel in May 2017, where a 'New Patient' check was completed. Daniel acknowledged that alcohol was an issue in his life but declined any support services. There were 3 other contacts with Daniel during the analysis period, none appear to be related to domestic abuse issues and have not raised any concerns with either the reporting agency or the chair.

4.2 MK-Act Domestic Abuse Intervention Service

A review of internal records and databases confirms that neither Tracey nor Daniel were ever in contact with this agency although the IMR author points out that it is possible that either could have done so anonymously or not provided any details when calling.

4.3 Thames Valley Police Constabulary

i The matter of reviewing police engagement with Tracey and Daniel has been completed by the Thames Valley Police Service Improvement Investigation Review Team, who reviewed internal records and national databases. Tracey had no direct engagement with the police and was only indirectly known to them following the report of her splitting up with Daniel in May 2012.

ii Engagement with Daniel can be separated into two halves.

iii <u>Matters of Domestic Violence with an ex-partner</u>
In 2005 Thames Valley Police received two complaints from Daniel's previous partner and these are mentioned previously. In the first matter the lack of evidence meant that police were unable to take any formal action against Daniel. In the second matter (harassment) he was issued with a Harassment Warning Notice.

iv <u>Additional violent incidents of note</u>
In 1987 Daniel was convicted of Grievous Bodily Harm and sentenced to 12 years in prison.

v In April 2008 Daniel was arrested for murder after he supplied class A drugs to a woman who subsequently died. No link or cause was ever proven between the two events; as a consequence, Daniel was convicted of supplying drugs and sentenced to 18 months in prison.

vi In February of 2016 Daniel was arrested for attacking another man in the street, including the use of a dog as a weapon he was subsequently convicted and sentenced to six months imprisonment, this matter was not connected to his relationship with Tracey.

4.4 Milton Keynes Council, Housing & Regeneration Service

i On 24th May 1999 Tracey was awarded tenancy of a flat in the Milton Keynes area and the service subsequently had very little contact with her, other than for rent payment matters. There was no contact with Daniel other than to confirm that he was moving into the property in July 2016.

ii Between 16th December 2016 and the date of Tracey's death there are six minor contacts between Tracey and this service with regards housing benefit issues (apparently general administration and record keeping).

4.5 Milton Keynes Council - Adult Social Care

i Adult Social Care (ASC) Case Management System records confirm they were not involved with either Tracey or Daniel during the review period.

ii Records show that Tracey was known to ASC during a period between 23rd January 1997 and 20th March 2000, however, details are not known, and records have now been destroyed.

iii Records also show that Daniel was known to ASC between 16th June and 31st July 1994. Details are also unknown for similar reasons.

4.6 Compass

i Compass is a rehabilitation service and Daniel was encouraged to attend by the Probation Service and his GP. He engaged with Compass on three occasions and as can be seen below there are no records of the first two engagements due to restrictions under the Data Protection Act and the lack of consent by Daniel. Details of the third episode of engagement are recorded within the combined chronology, however, ultimately following an initial assessment in January 2018, regarding issues of alcohol, Daniel did not engage any further despite a series of efforts that were made to contact him. As the combined chronology shows his case was discharged and closed in March of the same year.

ii There are no records of any contact between this agency and Tracey.

iii <u>December 2008 - December 2009</u>
'1st Episode' (alcohol abuse) No more details are available due to Data Protection Act restrictions.

iv <u>October 2010 – December 2010</u>
'2nd Episode' (alcohol abuse). No more details are available due to Data Protection Act restrictions.

4.7 Milton Keynes University Hospital Foundation Trust – MKUHFT

i There was only one contact with either the victim or perpetrator and the MKUHFT and this was on the day of the homicide. Tracey arrived, via ambulance and the crew confirmed that they had found the victim in full

cardiac arrest, when they attended her home. Assessment revealed multiple stab wounds to chest, back and abdomen.

ii Following a period of advanced life support the victim was transferred to the MKUHFT at 29th May 2018. Prior to arrival the ambulance crew advised the hospital of their approach and the Trauma Protocol. The protocol is led by national guidelines on the management of patients who have suffered major trauma, to maximise potential outcomes.

iii Upon arrival, at the hospital, an assessment of the victim's injuries was completed, and treatment commenced to stabilise her condition, prior to her transfer to John Radcliffe Hospital in Oxford. It was here that Tracey died.

4.8 Adult Probation Service

i This IMR regarding engagements with Daniel and Tracey was prepared jointly between the National Probation Service (NPS) and the Thames Valley Community Rehabilitation Company (CRC). Tracey was unknown to either agency (formally) other than one meeting that she attended with Daniel.

ii The two agencies were responsible for the supervision of Daniel over two separate periods whilst he was on licence from prison. These were between November 2011 until September 2013 and June 2016 until September 2017 and the details of the various engagement are recorded in the combined chronology.

iii At the beginning of Daniel's first period of supervision he was interviewed in order to understand his background and upbringing. Daniel discussed being put into care at the age of 6 and that his father spent much time in prison. Daniel claimed that during his latest period in prison he had been diagnosed with Personality Disorder and psychopathic or sociopathic tendencies.[3]. At a meeting in May 2012, he discussed his relationship with Tracey and his intention to end it. In the same month and during a subsequent meeting he admitted that his alcohol use had escalated, and he was now dependant.

iv By June 2012 it is again recorded that Daniel states that he was trying to end his relationship with Tracey and in November 2012 Daniel told his supervisor he was in a new relationship however this appears to be a short term one and subsequently Daniel moved back in with Tracey in March of 2013. His licence expired in September 2013.

v Prior to the conclusion of a 6-month prison sentence a home visit was carried out at Tracey's address, as Daniel was on the tenancy. An assessment was conducted by the Thames Valley Community Rehabilitation Company (CRC) to assess its suitability as a site for HDC. During the visit domestic abuse checks were completed and no concerns were raised.

vi Daniel attended supervision meetings with the CRC along with Tracey, he told his Offender Manager he felt life was spiralling out of control. The risk assessment and sentence plan were completed, and it was identified that the risk of serious harm presented by Daniel to other people, particularly those who Daniel perceived as deserving of revenge, was at a medium level. In August 2016 Daniel explained to his supervisor that his relationship with Tracey wasn't going well; he was unable to talk to her as she often shouted at him. His Offender Manager advised if he felt he was at risk he should move out of the address but keep his Offender Manager informed of his movements.

[3] The details of these diagnoses were requested by the chair however no records are available.

4.9 GP

i Tracey and Daniel had very little contact with the local GP surgery and appeared to rely more upon the Urgent Care Services for their medical needs.

ii Tracey visited the local surgery in October 2014 where she was prescribed anti-depressants. This course of medication was subject to regular review and appears to have been initiated following the death of her previous partner John. By March 2017 she again visited the doctors where she expressed concerns of a lack of employment and, as a result having no money, she was provided with advice and support available from more specialist agencies.

5. ANALYSIS

5.1 ISSUE OF HINDSIGHT BIAS

i As the Overview Report Author I have attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's and evaluating the quality of a decision when the outcome of that decision is already known. However, I have made every effort to avoid such approach wherever possible.

ii This section focuses upon how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not. It considers whether different decisions or actions may have led to a different course of events. This section will also seek to address the terms of reference and the key lines of inquiry within them; examples of good practice are highlighted.

iii The Chair has analysed the Individual Management Reviews provided by the agencies represented in this review and presented his thoughts and feedback. The chair has also researched a variety of policies and guidance from Milton Keynes Community Safety Partnership and local agencies who are linked to supporting Domestic Abuse victims and perpetrators, but not involved in the review, including:

- The Milton Keynes Needs Assessment 2018 – 2021
- HM Government Report 'Ending Violence Against Women and Girls (VAWG)
- National Statement of Expectations for VAWG Services
- The National Institute for Health and Care Excellence; Domestic Violence and Abuse Overview
- MK-Act - Advice to Domestic Abuse Victims
- www.womensaid.org.uk
- www.smartcjs.org.uk

iv The IMRs provided by agencies clearly show that there was very little contact between Tracey and agencies within the Community Safety Partnership, voluntary groups, or other charity organisations. This raises three key lines of enquiries:

a) Was Tracey the victim of domestic abuse or coercive control but remained unaware of the support that was available to her?

b) On the few occasions that Tracey did have contact, were opportunities recognised and maximised?

c) Were there sufficient signposted ways for those seeking support in escaping abusive relationships?

v Without more detail or factual evidence coming to light, neither the regularity nor the severity of the domestic abuse being suffered by Tracey will ever be known and therefore the chair feels that it is the responsibility of the panel to identify ways of reaching out to victims (as well as family and friends) and encouraging them to come forward and report incidents, however apparently trivial.

5.2 DOMESTIC ABUSE/VIOLENCE

i Tracey died as a result of being stabbed on multiple occasions by Daniel. The reason for this fatal assault remains unknown as the panel has never had the opportunity to discuss the motive with Daniel, despite making efforts to visit him in prison following his conviction for murder.

ii Considering the government definition of domestic violence and abuse which describes a pattern of incidents of controlling coercive or threatening behaviour the review panel has not been able to clearly determine whether there was an on-going history of abuse or a single act which caused Daniel to take this action. This conclusion is based on information gathered by this review panel. The collation of the IMRs and chronologies by individual agencies has identified there were problems and issues in the lives of Daniel and Tracey.

iii Daniel reported that, whilst in prison, he'd been diagnosed with psychopathic or sociopathic tendencies. It is clear from various engagements, particularly with the CRC and the probation service, that alcohol played a significant part in Daniel's life. There were reported incidents of domestic violence made by Daniel's former partner and reports that during a split up between Tracey and Daniel there was acrimony. Tracey had attended the hospital with a burn to her left arm which she dismissed or confirmed as being from the steam of a kettle. Daniel has a significant criminal record for violence, the level of which was a concern.

5.3 THEMES OF ANALYSIS

The themes of analysis have been recognised as:

5.3.1 RAISING AWARENESS

i The Chair believes there is benefit in the regular highlighting of issues and challenges faced by those suffering from domestic abuse and its profile needs to be constantly raised locally, regionally and nationally. With an expected rise in domestic abuse of 17%[4] in the next seven years across the UK it has never been more important to improve people's knowledge of domestic abuse including the signs, symptoms and available support.

ii The nature of raising awareness now appears to focus on a more dynamic and overt style. The asking of suitable 'framing questions' for example, should become a matter of routine for frontline practitioners, across the partnership. Suitable training and on-going support should be provided, in order that staff have the confidence to ask often difficult questions in challenging situations. Identifying potential (or actual)

[4] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018

victims should then be backed up with enhanced, clear and discrete pathways of support in order to escape the cycle of domestic abuse and coercive control.

5.3.2 Training

i Frontline practitioners and managers need to be provided with regular and relevant periods of training so that they can have the confidence to engage with victims, family, friends and perpetrators and provide information and support that is accurate and bespoke to each case. There are a wide variety of available options to support not only victims but perpetrators and families and these should be brought to the attention of all those working within the agencies represented in this review.

ii The nature and subject matter of training packages are the responsibility of the partnership and careful engagement with training providers is necessary to ensure that content meets demand.

5.3.3 Reporting Pathways

i Throughout the period of analysis, it has become apparent that the reporting or referral pathways, are areas for improvement and that frontline practitioners need to become more proactive in identifying, engaging and 'risk assessing' incidents of domestic abuse and supporting victims. A significant challenge in encouraging victims to come forward is the breaking down of 'barriers to reporting', these include:

- Being frightened of the perpetrator
- Not being believed by the authorities
- Finance
- Stigmatisation and being judged
- Uprooting of the family unit

ii These themes are echoed by feedback provided by survivors within the Milton Keynes area and professionals interviewed during the recent Milton Keynes Needs Assessment.

iii Two specific pieces of work support these as particular areas of need.

iv Professionals Survey and Stakeholders Workshop and their successful introduction will ensure a robust process, the findings of these exercises recognised several opportunities including:

- Implement clear governance and strategic delivery groups
- Need for training and awareness.
- Review/clarify pathways for securing support.

5.4 Raising Awareness

5.4.1 Policy Context

Figures provided by the British Crime Survey indicate that the amount of under reporting of domestic abuse, in Milton Keynes could be as high as 40%[5] and information provided by the 'Refuge for women and children,

[5] Milton Keynes Needs Assessment 2018-2021

against domestic violence data service'[6] indicates that as many as 30 women a week attempt to take their own lives as a result of experiencing domestic abuse. The need to raise awareness of Domestic Abuse has also been recognised in the following documents.

i Milton Keynes Needs Assessment 2018 – 2021

- Survivors of domestic abuse felt that one of the local priorities should be "an increased awareness and information on sources of support".
- 'Professionals' confirmed the need to raise awareness of domestic abuse within the community.
- Recommendation 5 "Raise awareness of domestic abuse across communities and within organisations".

ii The National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview

- "Remove obstacles to disclosure, for example by displaying information in waiting areas and other suitable places. Information should include contact details for local and national helplines. Information should be provided in languages and formats appropriate to the area".
- "Identify barriers to reporting within minority and hard to reach groups".
- "Ensure staff working in antenatal, postnatal, reproductive care, sexual health, alcohol or drugs misuse, mental health, children's and vulnerable adults ask service users whether they have suffered domestic abuse. This should be a matter of routine for a good clinical practice".

iii Violence against Women and Girls Strategy – National Statement of Expectations

- "Have a robust consultation process for identifying which services are needed locally and a forum to ensure victims and service providers can share their views and experiences to help shape services for perpetrators".
- "Identify a local champion or critical friend to drive and challenge on VAWG issues and local progress, identifying forums to bring relevant parties together to discuss VAWG and agree a local approach."
- "Local initiatives like 'Ask Me'", and whether they can they be part of a strategy to provide safe spaces where women can disclose abuse in the course of daily life to someone who will know what to do".

5.4.2 INDEPENDENT MANAGEMENT AND CHRONOLOGY REVIEW

i Milton Keynes Urgent Care Service – MKUCS

Tracey had a total of 12 contacts with MKUCS, either via telephone assessment or by visiting the walk-in centre. These all appear to be opportunities for 'routine' health matters, however a visit on 9th October 2014 was due to a burn on her arm from the steam off the kettle 2 days previously. There is nothing in the IMR suggest any link with Domestic Abuse however this remains a possibility.

[6] https://www.refuge.org.uk/our-work/campaigns/more-refuge-campaigns/taking-lives/

These circumstances raise the possibility that, had there been more publicity regarding Domestic Abuse services and staff asking suitable 'framed questions', Tracey may have been willing to discuss related issues.

The IMR author comments that "*MKUCS policy on Safeguarding Adults highlights Domestic Violence as a category of abuse and the MK-Act website for further information. We do not specifically have a policy on Domestic Violence".*

ii MK-Act Domestic Abuse Intervention Service

MK-Act had no contact with either Tracey or Daniel however they raise a valid point that both the victim and the perpetrator could have made contact anonymously. Following various panel meetings and conversations with MK-Act staff it is apparent, to the chair, that they are the main service provider with regards to secondary domestic abuse support and that they could have been pro-active with providing posters, leaflets, business cards and 'barcodes' in an effort to raise awareness of their services and towards increasing domestic abuse support within the Milton Keynes community.

The chair is aware that they have been engaged in providing training to other partner agencies e.g. MKUCS and local doctor's surgeries. MK-ACT also confirmed that they release "ad-hoc' press releases" and have attended White Ribbon Day conferences.

iii Thames Valley Police Constabulary

Thames Valley Police have no planned activity to raise awareness in the area of Domestic Abuse, however they do remain proactive in supporting themed days highlighting 'Hidden Harm' issues including Domestic Abuse, Mental Health, Substance Misuse and Alcohol Abuse.

iv Milton Keynes Council, Housing & Regeneration Service

The IMR author highlights that their involvement with Tracey raised no safeguarding issues and that engagement was limited to various rent arrears matters and the two partners who either left the property or moved in. There are three dates, in particular, which raised the interest of the chair.

On 30th April 2001, 13th October 2004 and 31st December 2004 Tracey contacted the agency to inform them that her partner (no further details) was moving out from the property. There is no evidence of any professional curiosity as to why this had happened.

The chair recognises that these are rather historic events and to view them critically would indicate inappropriate hindsight bias. However, the purpose of this review is to identify opportunities to improve performance, going forward and so the chair will be raising a recommendation to encourage more proactive engagement including the asking of framing questions and offering a domestic abuse pathway in order to raise the awareness of Domestic Abuse.

v Milton Keynes University Hospital Foundation Trust – MKUHFT

The MKUHFT uses MK ACT as its support network and a weekly clinic is held to support those wishing to report matters of domestic abuse. MK ACT advertise their services in a variety of High-Risk areas including Emergency Departments, Maternity wards and Outpatient clinics. The panel discussed the volume and variety of work which is presented in these particular environments, and it was agreed that the review should

recommend that funding be found to support the recruitment of a full-time employee in an 'Awareness Raising' role.

5.4.3 PANEL REVIEW

The panel discussed current awareness protocols and it was agreed that there is a need to uplift the awareness of Domestic Abuse within the Milton Keynes community. There are a variety of examples demonstrating opportunities in this arena. MKUCS confirm that they raise domestic violence as a category but have no specific Domestic Abuse policy. Thames Valley Police investigate all Domestic Abuse allegations in accordance with the Authorised Professional Practice policy but have no plans to raise public awareness of domestic abuse through media or publicity campaigns. Similarly, there are no plans on behalf of Adult Social Care, The Housing and Regeneration Service or Compass.

MK-Act, however, have an ongoing campaign including posters leaflets, business cards and the use of barcoded products as a discreet method of raising awareness to high risk, vulnerable victims. MKUHFT employ the services of MK ACT to inform and educate service users, about domestic abuse and the available support network.

5.4.4 COMMENTARY

Local and National policies give a clear indication of the need to raise the profile of domestic abuse and this appears to be something which agencies within the CSP would find a great benefit in focusing upon. 'Refuge for women and children, against domestic violence'[7] reports that victims suffer 33 incidents of domestic abuse before coming forward to report. The chair has made extensive efforts to understand how the partnership raises awareness of domestic abuse, not only with potential victims and perpetrators, but also amongst service professionals and frontline practitioners. It is apparent that most agencies rely upon the services of MK-Act, not only on this subject but other themes within this report (see below).

MK-Act

MK-Act is the commissioned domestic abuse service for Milton Keynes CSP and the chair's perception of the role and expectation on this agency is reflected, not only by the feedback provided by the panel, but also within the Milton Keynes 'Domestic Abuse Needs Assessment'. The assessment identified that this service is responsible for a wide variety of service delivery including:

- Refuge
- IDVAs
- Perpetrator Programmes
- Domestic Abuse programmes focusing upon BME women
- GP training sessions – monthly drop-ins
- Healthy Relationship courses aimed at individuals and groups who are victims, survivors and perpetrators

The chair wishes to acknowledge the energy and professionalism of the services provided by MK-Act.

This review has highlighted that in the circumstances leading to Tracey's death neither she, nor Daniel, had much involvement with partnership agencies and so it is extremely difficult to draw many conclusions about

[7] https://www.refuge.org.uk/our-work/campaigns/more-refuge-campaigns/taking-lives/

whether a significant campaign of awareness raising would have increased the likelihood of either party coming forward to report matters of domestic abuse. However, this review has identified that, despite the efforts and functions provided by the commissioned service there remain opportunities to further raise awareness and this is highlighted by the comments made by local domestic abuse survivors i.e. the need for "an increased awareness and information on sources of support" and similarly the view of agency professionals of the need to raise awareness within the community.

The Violence Against Women and Girls strategy suggest a 'robust consultation process involving agencies and victims to shape services and that health care professionals are trained to spot the signs of domestic abuse. Both of these views support the idea of raising awareness through community engagement and supportive training. One opportunity for raising awareness is by encouraging more 'professional curiosity' amongst frontline practitioners. This more intrusive style of engagement would encourage disclosure by victims and allow for the initial layer of support to be introduced. The chair will discuss this matter further in subject '5.5 Training' but also feels that it has a role to play under this theme.

The National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview also indicates that the process of professional curiosity should be a 'matter of routine for good professional practice'.

The chair feels that Milton Keynes Community Safety Partnership Domestic Abuse forum would greatly benefit from reviewing its 'Awareness' strategy and this seems to be reflected in Recommendation 5 of its own Needs Assessment 2018-2020, "Raise Awareness of Domestic Abuse within the community".

5.5 TRAINING

5.5.1 POLICY CONTEXT

i Milton Keynes Needs Assessment 2018 – 2021

Page 4 - Survivors of domestic abuse felt there was a need to train professionals to recognise domestic abuse, support victims and work to improve understanding and trust.

Page 4 – 'Professionals' confirmed the need to embed domestic abuse training with particular focus upon coercive control and risk assessment.

Page 41 - Service Providers would welcome regular Domestic Abuse training.

Page 42 - "organisations need to ensure staff are trained and capable of asking 'framing questions' on safety".

Page 52 - NICE guidance recommends "training of antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health and vulnerable adult services ask service users (universally) whether they have experienced domestic abuse".

ii Information Sharing the National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview

Chapter 7 – Ensure frontline practitioners are suitably trained in services, policies, and procedures, relevant to local agencies.

Chapter 7 – Providing training for those who are in direct contact with domestic abuse victims.

Chapter 8 - Ensure frontline staff are trained to recognise the indicators of domestic violence and can ask relevant questions.

Chapter 14 – Those involved on Health and Social Care provide training at levels appropriate to their roles and responsibilities. "Ensuring local health professionals generally are trained to spot signs of abuse and understand the impact of trauma, and know how to recognise it, respond and refer perpetrators to appropriate services."

iii <u>Violence against Women and Girls Strategy – National Statement of Expectations</u>

Consider:

- "Whether local health professionals generally are trained to spot signs of abuse, understand the impact of trauma and make referrals to specialist VAWG services".

- "Consider how training provided to local professionals is evaluated, and how to ensure it is making a difference, increasing learning and build in the voice of victims".

5.5.2. INDEPENDENT MANAGEMENT AND CHRONOLOGY REVIEW

i Milton Keynes Urgent Care Service – MKUCS

The IMR author confirms that all nursing staff working for MKUCS have level 3 Safeguarding Adult training once every three years[8] and this appears to be entirely in keeping with professional expectation. Both MK-Act and MKUCS confirm that two training sessions were run in 2017 i.e. There was a total of 14 attendees and the training was in the form of a 2-hour working lunch. Subjects included in the session were:

- What is Domestic Abuse?
- High Risk factors
- Warning signs and disclosure
- Good Practice
- Victim Safety Planning
  - MK-Act and others for domestic abuse sufferers
  - Resources and the future

The chair wishes to acknowledge that this appears to be an excellent process that allows practitioners from various agencies to meet and discuss the subject of domestic abuse across a wide variety of subjects. This would also seem to be a suitable forum for the discussion of other matters including the raising of awareness and a more proactive approach in seeking disclosure from both victims and perpetrators.

ii MK-Act Domestic Abuse Intervention Service

It is apparent to the chair that MK-Act are the main training provider for the Community Safety Partnership and is highlighted in the feedback provided by the panel representatives from the Clinical Commissioning Group and MKUCS. The training provided constitutes six sessions each year covering the following subject matter:

[8] Based on the Intercollegiate Safeguarding Adults Guidelines published July 2018

- MARAC
- DASH Risk Assessing
- Children and the Effects of Domestic Abuse
- Honour Based Violence
- General Awareness

MK-Act records suggest that over 250 members of staff received training in the last year. They have confirmed that they also hold six monthly training sessions for the Clinical Commissioning Group as well as 'Drop In' sessions in NHS facilities.

iii **Thames Valley Police Constabulary**

Officers are provided with domestic abuse training when joining the force, as part of their basic training. They are taught how to deal with domestic incidents and complete a DASH risk assessment. Subsequently they spend two days working within the Domestic Abuse Investigation Unit (DAIU) and during their ten-week tutorship period, student officers are coached when attending incidents.

Operational guidance is also available on the police 'intranet' system.

In terms of wider safeguarding issues, officers attend a separate training course known as 'SAVE' (Safeguarding Vulnerability and Accountability). The course is designed to equip officers to respond effectively when dealing with safeguarding matters and to enhance their professional curiosity skills.

DAIU staff attend an additional specialist five-day training course.

iv **Milton Keynes Council - Adult Social Care**

The ASC panel representative raised concerns that training with Adult Social Care had been an issue for over six years and that attendance at internal training sessions was not mandatory. There is an expectation that the 'MK Together' workforce group would lead the way in resolving these concerns.
The review is keen to support the workforce group and will recommend support for its efforts in establishing a robust and successful training regime.

v **Milton Keynes University Hospital Foundation Trust – MKUHFT**

MKUHFT uses services provided by Adult Social Care. Training is provided on a monthly basis and includes both induction and mandatory training classes.

Domestic Abuse Champions

Milton Keynes CSP has a Domestic Abuse Champions framework, which has been running since 2017.

What is a Domestic Abuse Champion?

- A contact for an organisation or community
- An individual who is able to cascade awareness about domestic abuse
- Able to identify victims and refer them to local support and resources
- Be a point of contact to allow statutory and non-statutory agencies to receive and deliver information and news on the subject

In December 2017 a 'train the trainer' course was established, and three further sessions delivered, throughout the partnership in 2018, however take up was described as 'very low'.

In accordance with previous recommendations in the Milton Keynes Needs Assessment 2018 – 2021 the Community Safety Office has amalgamated services with MK-Act in order to deliver this service to a much wider audience. However, no further training has been delivered and this process appears to have stalled. The chair feels it is crucial that suitable training is delivered to volunteers who are willing to assume the role of Domestic Abuse Champion. Initial training should be enhanced with regular and on-going support as this role can involve engagement with family's enduring intimate and often extreme levels of fear and disruption.

The chair also notes that, in the case of Tracey and Daniel, there was an involvement with the local parish councillor, who has been able to provide details of their relationship. However, it has become apparent that during the interview with the Community Safety Officer, that the parish councillors have had no Domestic Abuse or Risk Assessment training and are not checked by the Disclosure and Barring Service[9], prior to 'deployment'. This places individuals and the Partnership in a very vulnerable position. Domestic Abuse Champions are often engaging with vulnerable members of the community, including children and it is crucial that only suitable individuals are selected and employed. Similarly, experience tells us that those suffering domestic abuse live their lives in volatile and often violent situations therefore, it is important that they are able assess and manage physical risk prior to visiting homes where domestic abuse may be present. There is also the matter of the changing landscape of domestic abuse legislation and best practice, it is important that Domestic Abuse Champions are provided with Continual Professional Development (CPD) in order that they can provide the best possible advice and support to domestic abuse victims.

Whilst this doesn't directly affect this review the chair feels it necessary to raise these issues and propose a recommendation to address them.

5.5.3 PANEL REVIEW

i Throughout this review the panel has considered the issue of training under two areas:

- Volume
- Content

ii As has been mentioned above, the primary provider of training has been the commissioned service, MK-Act. The IMR authors have documented the fact that in the majority of cases agencies have met training expectations in terms of regularity and attendance. Courses included induction and specific topics under the safeguarding umbrella. The panel has however recognised that in light of this review there are two particular subjects which should be explored in future training courses, i.e. professional curiosity and coercive control.

iii At the panel meeting on 21st January 2019 it was commented that there are agencies within the partnership who use framing questions when interviewing individuals and families and it has been agreed that there should be more professional curiosity and routine questioning relating to domestic abuse. The panel agreed that training of staff on the subject of domestic abuse is crucial and that the content of each session needs to be relevant and up to date and that these two subjects need to be consistent themes for upcoming and future sessions. Questions have been raised with staff at the Milton Keynes University Hospital Foundation Trust and it was confirmed that staff don't challenge the circumstances with patients when they arrive at the hospital. It was recognised that the Buckinghamshire Fire and Rescue Service do not have bespoke domestic abuse training.

[9] https://www.gov.uk/government/organisations/disclosure-and-barring-service

iv At the panel meeting on 2nd April 2019 Thames Valley Police also recognised the benefit of providing this training to Community Support Officers, particularly as they form a significant percentage of the frontline practitioners engaging with families suffering domestic abuse problems. The Housing and Regeneration Service also made commentary that they don't have a 'screening questions' process but felt that they were missing opportunities to identify and share information about domestic abuse, and they would welcome training and support on the subject.

v The panel has considered incidents where the proposed training subjects could have positively impacted upon the life of Tracey. The fact is that there was little interaction with the represented agencies however there are some examples where a more positive, intrusive approach may have encouraged Tracey to disclose any domestic abuse she was suffering.

vi On 2nd May 2012 police received intelligence that Daniel and Tracey were splitting up and there was animosity between the two. On 9th October 2014 Tracey presented herself at the Milton Keynes Urgent Care Service with a burn to her arm; the medical records reflect that the injuries were caused by a steam from a kettle. These occasions are examples of opportunities, by using more professional curiosity, to explore the relationship between Tracey and Daniel and consider whether he posed a significant risk to Tracey's safety. It was agreed by panel members that in similar circumstances in the future the opportunities should be seized and developed.

5.5.4 COMMENTARY

i The subject of training is a familiar one which runs through many Domestic Homicide Reviews. In this review it has been a theme throughout, not only the chairs research but also the opinion of the panel. Commentary from the Milton Keynes Needs Assessment, NICE Domestic Abuse Overview Report[10] and the VAWAG reports confirm that frontline practitioners need to receive regular and relevant input to ensure that their engagement with service users matches not only their primary needs but also supports those at risk of stress, emotional degradation, and violence.

ii In this case there was little interaction between the deceased and panel agencies and as a consequence it is reasonable to anticipate that opportunities for professional curiosity may have been missed. It appears to the chair that this style of intrusive, positive interaction has not been part of the front-line practitioner's culture. However, it has been identified by the panel that there is great value in encouraging a change in working practices to ensure that 'framed questions' and professional curiosity become day to day methodology, allowing those suffering (or vulnerable to) domestic abuse to reach out and obtain support.

iii The chair recognises that the amount and variety of training provided by MK-Act is wide-reaching and appears to encompass a broad range of subjects within the safeguarding arena. It is the view of the panel that there is an opportunity to enhance this training with the two subjects raised here. Certain agencies, for example the Thames Valley Police service have their own training packages with a wide variety of courses including generic sessions aimed at all staff and specific training for those who have particular roles and responsibilities in the investigation of 'Public Protection' matters. I am raising a recommendation that all training includes the subject of professional curiosity and frontline practitioners use 'framing' style questions as a matter of routine when meeting patients, clients, victims, families, and other service users.

iv There are several recommendations, within the Milton Keynes Needs Assessment 2018-2021 that support the opinion of the author and panel, including the need to ensure trained staff ask people about domestic

[10] The National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview

abuse and the need to tailor support to meet people's needs. The chair supports these recommendations and believes that they reflect the views of the panel and the learning which this review draws out.

v The issue of gender bias also causes the chair some interest. There has been little information to indicate that any domestic violence within their relationship described Tracey as the victim and Daniel as the perpetrator. As a consequence of Tracey's murder, it is natural to make this assumption, however in terms of professional fact finding and curiosity there were several occasions when those interacting with Daniel had the opportunity to have detailed discussions, with him, about his relationships and identify whether he was also the victim of any domestic abuse.

vi For example, there were opportunities in May 2014 when the Probation Service visited Tracey, prior to Daniel's release from prison. It is not recorded whether the subject of domestic violence was discussed. Similarly, in July and August 2016 Daniel was interviewed by Probation staff, he commented about "people deserving of revenge" and that his relationship with Tracey was failing. Given his recorded criminal history and documented psychotic behaviour. It would be reasonable to expect that had suitable training been provided, staff could have had discussions with Daniel and Tracey to understand the nature of their relationship and the risks presented by either to the other. There is a similar example recorded on 9th October 2014 when Tracey presented herself to the MK Urgent Care Service with burns to her arm. Any information or disclosure provided, could have been shared and raised the profile of the couple to safeguarding professionals.

vii Finally, there is commentary both in the VAWAG strategy document and the NICE overview report which indicates that frontline practitioners should receive training to recognise the signs and indicators of domestic abuse and that training packages should be subject to regular evaluations. This is a view which the chair also supports and will including in their recommendations

5.6 Reporting Pathways & Information Sharing

5.6.1 Policy Context

i **Milton Keynes Needs Assessment 2018 – 2021**

1 in 5 victims attended A&E departments (1,556 v 7,784), therefore there needs to be a clear and positive pathway including partnership support, framing/screening questions, leafleting and advocacy support.

Page 42 - The Needs Assessment recognises "the challenges of recognising or finding other organisations who offer support".

ii **The National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview**

Chapter 6 – Develop clear protocols and methods for sharing information between agencies.

Chapter 6 – Ensure there are integrated 'care pathways'.

Chapter 7 – Establish a clear referral pathway to specialist Domestic Abuse services.

Chapter 6 – Ensure there are integrated "care pathways".

iii **Violence against Women and Girls Strategy – National Statement of Expectations**

In line with the principle of placing the victim at the centre of service delivery, CSPs should:

> "Consider specialist advocates or support workers (such as the IRIS programme) in local emergency or primary healthcare and GP surgeries".
>
> "Collaborate and have protocols with other areas to allow victims easy movement from one area to another."

5.6.2 INDEPENDENT MANAGEMENT AND CHRONOLOGY REVIEW

i Milton Keynes Urgent Care Service – MKUCS

Training sessions give clear reference to services which should be offered to domestic abuse victims, however the IMR author offers no reference to referral pathways in their report. There were never any reported domestic abuse incidents disclosed by Tracey, and so there is no evidence of referral pathway being enacted or required.

ii MK-Act Domestic Abuse Intervention Service

MK-Act provides a pathway for both victims and perpetrators. They are referenced by both the Clinical Commissioning Group and Thames Valley Police as the initial point of contact and offer a range of services including:

- Independent Domestic Violence Advisors (IDVAs) and community support, including support and advice during judicial processes
- Outreach work at Milton Keynes University Hospital and Milton Keynes College
- 20 Volunteer Coordinators
- Attendance at MARAC meetings
- Refuge accommodation for 28 families
- 'Fresh Start' for perpetrators, including partner support for all current and ex-partners
- Training for Professionals, Adults, Children and Young People

Victims engaging with the program are provided with a 'Risk and Needs' Assessment, a Safety Plan, emotional support as well as other assistance including:

- Housing solutions
- Group support work
- Legal remedies
- A support plan

iii Thames Valley Police Constabulary

The pathway to the police service is traditionally by reports being made by victims or witnesses and can also be made from third parties such as doctors, voluntary organisations and support workers. Incidents are recorded on the NICHE Record Management System. Front line officers assess the risk presented by each case and further engagement is dictated by that assessment. Initial risk is placed into one of three groups,

Standard, Medium and High. The assessment is completed using a DASH Risk Assessment process[11]comprises of 27 questions requiring a Yes or No answer and the total number of yes answers allows for a level of risk to be identified i.e.

- High - 14+
- Medium - 6-13
- Low - 0-5

Thames Valley Police interpret the level of risk presented by each category as:

- High. There are identifiable risks of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm (Home Office 2002 and OASys 2006). A risk which is felt threatening and/or traumatic and from which recovery, whether physical or psychological, can be difficult or impossible.

- Medium. There are identifiable indicators of risk, serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug misuse and alcohol abuse.

- Standard. Current evidence does not indicate likelihood of causing serious harm[12].

In terms of victim engagement under these categories they are described as:

- High. The Domestic Abuse Investigation Unit (DAIU) assume ownership and suitable referrals are made.

- Medium. After initial contact by the Attending Officer/Investigating Officer, they maintain contact throughout the course of an investigation. The case is 'flagged' to the DAIU where a safety planner (provided by MK-Act) reviews and makes contact to reinforce the safety advice provided by the officer and makes necessary referrals.

- Standard. Dealt with by the attending officer, who has an option to refer to the DAIU for review and follow up calls regarding safety.

iv Milton Keynes University Hospital Foundation Trust – MKUHFT

There is a process of reporting employed by the MKUHFT and this is subject to monitoring and management by their own Safeguarding Team.

5.6.3 PANEL REVIEW

i The panel agrees with the views of the Home Office "National Statement of Expectations" and VAWAG strategy, that Community Safety Partnerships should put the victim at the centre of service delivery and that a clear focus should be placed on perpetrators. MK-Act, in their role as the commissioned service provider

11 Three definitions previously provided

12 All three definitions provided by the author of the IMR.

are the main focal point for pathways and referrals, with regards to domestic abuse. The panel recognised that they offer services for both victims and perpetrators and that demand often outweighs capacity. The panel recognised various incidents in this review where domestic abuse support services could have been offered/provided. However, due to a lack of engagement by victim or perpetrator and minimal intrusion by frontline practitioners these opportunities were not explored.

ii The use of Domestic Abuse reporting pathways is a crucial function in assisting victims out of abusive relationships as well as providing a framework which allows perpetrators to understand their problems and, through a network of supportive agencies, escape the cycle of domestic abuse and coercive controlling behaviour. The panel discussed the pathways currently available to both parties including the services provided by MK-Act and processes employed by Thames Valley Police. In terms of victim support the two agencies work in concert, with MK-Act employing a staff member to work with the Domestic Abuse investigation Unit on police premises and allows for an immediate support network to be introduced at the point at which a police investigation begins. This appears to be good practice. Although resources are often challenged, both agencies appear to be satisfied that the arrangement works well, and victims understand the relationship between these two service providers.

iii The relationship between MK-Act and GP surgeries appears to be two-fold. Doctors don't routinely ask screening questions to identify domestic abuse history or issues however, in the event of a relevant disclosure, referrals are made to MK-Act as a supporting agency. The panel also recognised that MK-Act advertise their services using various posters, stickers etc. It appears that it is the responsibility of the victim/informant to contact MK-Act following a disclosure of domestic abuse. The panel agreed that, along with the expectation placed on the GP, that staff will uplift the professional curiosity, they should become more pro-active in advertising this referral pathway.

iv Finally, the panel agreed that in order for there to be an effective pathway there needed to be a collaborative and effective Information Sharing Agreement (ISA) between each member of the Community Safety Partnership. This will be challenging in certain areas, for example the doctor-patient confidentiality agreement and the expectation that medical notes will not be disclosed without suitable agreement. The panel felt that this is a subject that should be explored by the Domestic Abuse Strategic Delivery Group.

5.6.4 COMMENTARY

i The reporting pathways are a crucial stage of supporting those suffering or engaging in domestic abuse. During the circumstances which led to this review there was minimal involvement between Tracey or Daniel and CSP agencies and no direct reporting of domestic abuse by either party. Earlier in this report various incidents have been highlighted where Tracey and Daniel were engaging for reasons seemingly unrelated to domestic abuse. The statistics, which have been researched by the Milton Keynes Needs Assessment, suggest that the true level of domestic abuse within the Milton Keynes district remains unknown and it is anticipated that it is significantly higher than currently recorded. A positive, well-publicised reporting pathway is one tactical option towards encouraging victims, family and friends.

ii When there is limited contact in circumstances such as Tracey and Daniel it is critical that every opportunity is taken to provide all parties with a clear route for reporting matters of domestic abuse which are safe, secure and supportive. This requires suitable protocols and ISAs, and this has been recognised and agreed by the review panel. The research documents used by the chair also support this view and it seems entirely reasonable that a recommendation is made for the Domestic Abuse Strategic Delivery Group to ensure that Information Sharing Agreements and local protocols reflect this need.

iii There is a second matter raised within the analysis, which is that of assessing and dealing with information received regarding domestic abuse matters. In May 2012 there was an anonymous report to the police about

Daniel and Tracey splitting up and there being animosity between them. An assessment of this information resulted in police taking no further action. However, as mentioned above Daniel had made threats towards a previous partner and had been issued a Harassment Warning Notice.

iv The police IMR author confirms that there was no domestic abuse history between the victim and perpetrator known to the police at the time of this report. The panel reviewed this process and the fact that police took no action following receipt of this report. The process of assessment is carried out by intelligence officers, who assess the content and provenance of the information provided. The apparent vague nature of the information and lack of previous history of domestic abuse meant that no apparent risk was present.

v It seems that further information was available to the IMR author and so presumably was available to the intelligence team who assessed this initial report. Had Daniel and Tracey's details been researched, the previous information about Daniel's criminal history (for violence, drug supplying and domestic abuse) would have been revealed and should have influenced subsequent decision-making. This could have included a potential referral to front line staff, for example the local neighbourhood policing team who could have visited both parties and assessed current risk via a DASH risk assessment. Consideration could have been given to a disclosure under the Domestic Violence Disclosure Scheme[13] to Tracey. This report will be creating a recommendation that upon receipt of information relating to domestic abuse which references potential risk, victims and perpetrators should be subject to research using the Police National Database (PND), Police National Computer (PNC), the Multi Agency Safeguarding Hub and other local databases in order that historical information and criminal history can be identified and used to inform subsequent risk assessments.

vi The details from the chronology and IMR indicates that the source of this information was the Probation service, and this suggests another issue over information sharing and questions the need for agencies to report things anonymously. This has been raised by the chair and reassurances provided that this has been an issue which has previously been recognised and levels of provenance and governance are routinely checked to ensure that information is passed appropriately to agencies who may be able to impact on this type of intelligence.

5.7 ADDITIONAL ANALYSIS MATTERS

5.7.1 PROBATION SERVICE RISK ASSESSMENTS

i The review has recognised that in June 2012 following a 13-year sentence for violent crime Daniel was assessed by the Probation Service and graded as low risk. Efforts have been made to understand how this decision came about. Particularly with regards to the fact that Daniel had disclosed problems in getting on with previous partners, the fact that his drinking had escalated to the point where he declared himself alcohol dependent (only two weeks earlier the PTW had made contact with Alcoholics Anonymous on behalf of Daniel) and with due regard to his criminal history. Efforts have been made by the IMR author for the Probation service to understand how this assessment of risk was reached.

ii The analysis presented to this review indicates that none of the assessments carried out on Daniel gave any consideration to previous psychotherapy diagnosis/therapy or previous domestic abuse. It appears to be the case that these assessment processes considered only Daniel's situation and relationship at the end of his licence period from prison. He appeared to have achieved significant stability, was working, and living in suitable housing. He declared himself drug-free and was managing his alcohol intake.

[13] https://www.thamesvalley.police.uk/advice/advice-and-information/daa/domestic-abuse/af/clares-law/

iii The IMR author notes that the assessments of Daniel tended to focus on his immediate presenting needs and did not pay sufficient attention to historic offending, previous behaviour of concern or therapeutic treatment whilst in prison. The absence of any evidence of domestic abuse in his relationship with Tracey led to a false reassurance about the level of risk posed by Daniel towards her or any other partner. However, it is the author's assessment that the risk posed by Daniel towards Tracey did not explicitly relate to domestic violence but rather the risk he posed to any individual he was in contact with due to his callous lack of concern for the feelings towards anyone as a consequence of his apparent personality disorder.

iv There were a number of meetings during the second period of licence during which Tracey was in attendance; the CRC assessments at this time did not probe into the relationship between the two and simply recorded that due to the co-dependent nature of their relationship, and the absence of any apparent risk indicators it was felt (at the time) that the supervision was managed appropriately. What is not recorded is whether any specific questions were asked in relation to their relationship and of any particular issues around domestic violence. There were a number of potential triggers which could have generated such questions, for example Daniel's disclosure regarding financial problems, his admissions over having difficulty in managing relationships in the past, his problems with alcohol and previous mental health issues. It would have been a benefit for the case worker to have carried out a formal assessment with regards to the relationship between the two.

v Therefore this report will recommend that a series of domestic abuse questions or inquiries are made should similar circumstances arise again i.e. perpetrators under licence and their partners attend similar meetings in the future.

vi It is noted that this review has attempted, several times, to gain access to the mental health assessments carried out at HMP Grendon, however it is our understanding these reports are unavailable or have been destroyed. In the Lessons Learned Section the National Probation Service and Community Rehabilitation Company recognised the opportunity to improve performance in this area.

vii The IMR author, in completing the analysis, has identified that there was an opportunity for learning with regards to completion of PSRs[14] and that overall the reports that they had read were poor. Instructions and guidance is provided in Probation Instruction 04/2016[15]. The chair discussed this with the author and recognised that the training provided in this area wasn't adequate. Therefore, it was agreed that the NPS should be allowed to use this Domestic Homicide Review to recommend that training should be provided to all those completing PSRs in order that the quality of the reports be improved and courts better informed when deciding sentences for convicted offenders

5.7.2 Isolation

i The review has considered the issue of Tracey living a very private life and whether this was of her own free will, or due to issues of domestic abuse or coercive control that she may have been suffering. Research[16] suggests that those who seek to isolate a partner demonstrate various themes or characteristics e.g.

- separating from family and community
- taking control of the handling of the victim's resources and property

[14] Pre-Sentence Report - A pre-sentence report (PSR) is an expert assessment of the nature and causes of an offender's behaviour, the risk they pose and to whom, as well as an independent recommendation of the sentencing option(s) available to the court.
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/996771/pi-04-2016-determining-psr_.doc
[16] http://www.familysurvivaltrust.org/info.php?page=how_cults_operate
http://www.criminaljusticedegreesguide.com/features/9-ways-groups-become-cults.html
https://sites.google.com/site/cultmindcontroltechniques/isolation

- undoing (mind control)
- physical isolation
- extortion/dependency tactics
- controlling victim's access to necessities

ii The purpose of isolating a victim is to increase the perpetrator's ability to control and to weaken the victim's connections with family and friends making it difficult to seek support. Perpetrators try to reduce a victim's contact with the outside world and prevent them from realising that the perpetrator's behaviour is abusive and wrong. Isolation leads to victims becoming dependent on their controlling partner.

iii The Chair interviewed Tracey's father and he described her as someone who rarely discussed her relationships and he said he didn't see his daughter as much as he would have liked. He described the events of being visited by Daniel who expressed concerns that Tracey was having affairs with other men, as something which he found very difficult to accept. This could be interpreted as another tactic of the domestic abuser i.e. grooming the community, so that the victim is not believed.

iv Tracey and Daniel lived together for several years and it was Tracey's decision that they separate, although it appears that they remained in a relationship, spending 2-3 days a week together. The fact that Daniel moved out upon Tracey's request weakens the argument that she was being isolated as part of a coercive controlling relationship. Anecdotal reports suggest that during their relationship there were regular arguments, and it seems that these were initiated by either Daniel or Tracey. There is an alternative explanation that Daniel could have maintained his control, over Tracey, by still expecting her to have him stay with her 2 or 3 days a week. Whilst this could have been a condition of his moving out, this review has found nothing to suggest that this was the case.

v Tracey's father described her previous partner John as 'the love of her life' and it is reasonable to assume that his death had a profound effect upon her and potentially made her vulnerable. This vulnerability may have been apparent to Daniel, when he met Tracey as it had been less than 12 months since John had died. Daniel had previously been arrested for threatening to kill a partner, who had engaged in a course of harassment, which had led to formal warning notice being issued. Tracey's circle of friends appeared to fade away when she met Daniel and it could be argued that this may have been due to some element of control which he began to have over her.

vi In conclusion, the lack of information available to this review makes it impossible to say with any confidence whether or not Tracey was the victim of any coercive controlling behaviour. As mentioned above there are isolated incidents which suggest that this was the case, equally other reported elements of their relationship which suggest that this was not. The recommendations regarding Professional Curiosity and Domestic Abuse training should include matters of coercive control and isolating behaviours.

5.7.3 THE ROLE OF THE NEIGHBOURHOOD OFFICER

i The review has considered the role of the Housing and Regeneration service and their relationship with Tracey during the period. As has been recorded several times there were no apparent issues with regards to tenancy, rent or any other matters. However, when dealing with matters of information sharing it could be argued that the housing officer responsible for Tracey's property would have benefitted from being provided with more details, particularly when Daniel moved into the property and with regards to his criminal past, mental health and alcohol issues.

ii There have been reports from neighbours that Daniel and Tracey had been heard arguing on several occasions however these reports were anecdotal and only came to light during the homicide investigation. It is noted that the Milton Keynes Council 'Help with Housing' website provide details for those subjected to

domestic abuse or violence. These include advice and support options, guidance for those wishing to stay at home as well as those wishing to move away to a safe place and details of emergency and temporary accommodation.

iii The role of neighbourhood officers is a resource which is often under-used by the wider partnership and yet regularly they are the frontline staff with most access to domestic abuse victims. In this case Tracey had very little contact with agencies, however, was potentially vulnerable. Once Daniel moved into the address it may have been an opportunity to the neighbourhood officer to have made an application under Clare's Law to disclose, to Tracey, the history and risk presented by Daniel as a domestic abuser. This report will be raising a recommendation that the Community Safety Partnership reviews the role of Housing and the Neighbourhood Officer within their Domestic Abuse Strategy.

6. Conclusions

6.1 This review was generated following the homicide of a female by her ex-partner. Its purpose has been to identify lessons which can be learned to prevent a similar set of circumstances from happening again. The review has taken several forms, including panel meetings with Community Safety Partnership agencies and police experts, the preparation and assessment of chronologies and Individual Management Reviews and research into current local policies and methodology.

6.2 This process has generated several questions and challenges along three themes i.e. Raising Awareness, Training and Reporting Pathways. Subsequent recommendations have been prepared to address these matters and agreed with the panel members as being both proportionate and practical.

6.3 This review does not seek to blame any agency or individual but rather focuses on identifying good practice and opportunities to improve services to those in similar circumstances. Recommendations and proposed actions seek to enhance the service provision to victims and their families as well as raising awareness of the various issues which were subject of the analysis.

6.4 Tracey had previously been in a long-term relationship with a partner who had passed away. Daniel has, reportedly, had previous partners and spent time in prison for violent offences. The relationship between the pair appeared to be volatile with various reports of arguments and disputes. Details of the relationship have been extremely difficult to establish with many reports being anecdotal and unconfirmed. Tracey had moved from her parents' home whilst a teenager and after living in supported accommodation, moved into rented property. She shared this flat with her partner John until he died and approximately 12 months later Daniel moved in, having previously been homeless. Tracey and Daniel lived together for approximately 2-3 years until eventually Tracey asked Daniel to leave. The circumstances of this break up remain unclear but their relationship continued with Daniel moving to an address close by. They spent 2-3 nights a week together, apparently as partners.

6.5 In terms of family life, the couple did not have any children and whilst Tracey had occasional employment, it seems that nothing was ever permanent. Her father describes Tracey as a popular person who loved children and many of her friends would pay her to child mind for them. Research and interviews have painted a picture of the couple as being private with few, if any, mutual friends. Background research into Daniel has been a significant issue for the chair and panel. He is known to have spent lengthy periods of time in prison and that he was homeless when he met Tracey.

6.6 Tracey had few engagements with CSP agencies and those that did occur could be considered routine and would not cause any concern. The panel can only find one incident of possible relevance when, on 9th October 2014 Tracey was treated for a burn to her arm. Although apparently innocent it was possible that more

professional curiosity may have identified a link to domestic abuse, which could have led Tracey being provided with access to support services. The chair has not identified any link or effect, with these circumstances and purely uses this as an example of possible opportunities in the future.

6.7 Having had two periods of imprisonment Daniel had extended periods of time under the supervision of the Probation and Rehabilitation services. He claims to have been diagnosed with a psychotic illness, although no records of this have ever been found and during several interviews, he discussed his relationship with Tracey and the fact that it was breaking down. He discussed his life spiralling out of control and expressed several anger managements issues. There may have been opportunities to discuss the likelihood of Daniel being the victim of domestic abuse, in a similar fashion to the incident involving Tracey, above, the chair has not identified any link or effect, with these circumstances and uses this simply as an example of possible opportunities in the future. The chair has also recognised a thread of non-engagement between victim, perpetrator and panel member agencies. Whilst there is no reason why any of the agencies need, necessarily to have known of Tracey or Daniel it appears that this review provides an opportunity for the CSP to raise community awareness about the subject of domestic abuse and encourage not only victims to come forward but also families, neighbours and communities. It is for these reasons that the first theme in this review is 'Raising Awareness'.

6.8 During the period of review the panel has considered its position with regards to domestic abuse training and it's apparent that the situation is sound, however the chair has questions which are common to many Domestic Homicide Reviews and that is with regards to Professional Curiosity. The chair believes that increased intrusion by frontline practitioners could lead to:

- Increased reporting
- Victims feeling more comfortable to come forward and confident that agencies will be equally dynamic in providing support networks

6.9 Domestic abuse and coercive control rely upon secrecy and confidentiality to succeed and therefore in order to conquer this problem the chair feels that national and local services need to become more open and intrusive in tackling the problem and that staff should be suitably trained and supported to discuss this challenging subject with service users. The Chair feels that this will encourage victims to become more empowered to come forward and disclose their suffering. It is for this reason that the second theme of this review is, 'Training'.

6.8 As has been previously mentioned there was limited contact between the Community Safety Partnership and either Tracey or Daniel. Very few of those contacts could be interpreted as relating to domestic abuse and it is for this reason that all proportionate efforts should be made to ensure that reporting pathways are clear and easily accessible. The Chair's research, along with the recommendations from the Violence Against Women and Girls Strategy and The National Institute for Health and Care Excellence – Domestic Violence and Abuse Overview support this view. The panel agrees that the services provided by the main providers, Thames Valley Police and MK-Act offer victims and perpetrators the opportunity to engage with support services and programmes. It seems appropriate for the recently formed Domestic Abuse Strategic Delivery Group to review these pathways and ensure that all suitable avenues and opportunities are explored and that services also include friends and families, and information is shared in a timely, proportionate manner. It is for this reason that that the third theme of this review is, 'Reporting Pathways and Information Sharing'.

7. Lessons Learned

7.1 Several early learning opportunities have been identified and documented by the IMR authors and recorded in their reports. They have been collated and recorded in the table below:

Agency	Learning	Action
MK Urgent Care Service	MK-Act have delivered ‘Lunch and Learn’ training sessions	Posters now located in female toilets. Use of Urine sample bottles providing contact number for MK-Act
MK Urgent Care Service	All nursing staff now receive Level 3 safeguarding adult training every three years.	This training is led by the services safeguarding lead nurse internal records report 100% compliance in this training. All staff have subsequently been sent the NICE guidance on domestic abuse and regular meetings with safeguarding leads at the CCG provide support advice and guidance. One to one sessions are also available to staff at all times. There are online mandatory training modules which had been implemented.
MK Urgent Care Service	Women attending the urgent care service accompanied by a third party we're not having the details of that third party recorded.	Women attending the service in the company of a partner now have the partner details recorded upon attendance and more professional curiosity to understand the need for that person to be present during consultations
National Probation Service	Staff focused too much on immediate presented risk, there was not sufficient assessment of historic offending or of previous therapeutic treatment in prison, leading to false reassurance of his level of risk.	This issue has now been addressed with enhanced training to all relevant staff.
National Probation Service	Provide Court Reporting writers with refresher training regarding probation Instruction 04/2016	Training Events On-line Presentations Ensured Supervision processes
National Probation Service and Community Rehabilitation Company	To ensure all responsible staff are trained in working with personality disordered service users	The National Probation Service and Community Rehabilitation Company to run training events on the subjects of: • Personality Disorder, • Information Sharing • Professional Curiosity

8. Recommendations

	Overarching Recommendations	
	Pathways – Ensure that pathways for victims, communities and the professionals who provide support is clear	
	Training – Ensure that training, for all those engaging Domestic Abuse sufferers or pursuing perpetrators is up to date and relevant	
	Raising Awareness – Ensure that Domestic Abuse is presented, across all communities, as a significant and under-reported crime.	
	Recommendation	**Actions to be taken**
1	All panel members to review their own responses to the three themes i.e. Raising Awareness, Training and Domestic Abuse referral pathways	Complete a formal assessment, forward outcomes to the Domestic Abuse Strategic Delivery Group for onward reporting to the Community Safety Board. **Update July 21** – this was completed as part of the new Domestic Abuse Strategy published in 2020. Impact to be reviewed by Assurance Board in early 2022.
2	Introduce an enhanced policy with regards to Domestic Abuse, into the Urgent Care Services Safeguarding Adult Policy	Milton Keynes Urgent Care Service to review current safeguarding policy and strategy documents with a review to introducing a dedicated 'chapter' on Domestic Abuse. **Update July 21** – Action to be carried out by Assurance Board by end of 2021
3	Improve awareness raising of Domestic Abuse across the Community Safety Partnership.	The Domestic Abuse Strategic Delivery Group to review current activities by the service provider (MK ACT) and ensure support in uplifting their current profile-raising strategy across all partnership agencies. **Update July 21** – New strategy launched in 2020. Training continues across the partnership monitored by the DA operational group
4	University Hospital Foundation Trust to expand current awareness raising process to include all available service user site, both physical and virtual	The UHFT should review current MK ACT activities and ensure that they are shared across all hospital sites, internet webpages and other avenues used to advertise UHFT services **Update July 21** - MKUH has now launched its Hospital Navigator Scheme which is a scheme supported by Thames Valley Police specifically to reduce violent crime. MKUH is one of five hospitals across Thames Valley that are taking part in this project. The agency who are co-ordinating this scheme for MK is the YMCA. There are is an allocated coordinator/lead from both YMCA and TVP.
5	Develop a culture of 'Professional Curiosity' within frontline practitioners and line managers, through on-going training and internal publicity	Ensure that the Milton Keynes Domestic Abuse Strategic Delivery Group monitors and supports the uptake of training by professionals

		Update July 21 – monitored by operational group and fed back to strategic group
6	Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions	Training for CCG staff including all frontline staff, GPs and other practice staff. **Update July 21** – Completed and ongoing training overseen by Bedford, Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG)
7	Develop and uplift the role of Domestic Abuse Champion	Re-introduce a campaign to recruit champions from all areas with particular focus upon high risk and underrepresented communities and workplaces. **Update July 21** -This is overseen by the Domestic Abuse Operational Group. Several champions have now been trained within healthcare settings with many other members of staff signed up to undertake the training.
8	All those being recruited in the role of Domestic Abuse Champion should be subject to DBS checks, prior to selection into the position	The MK Together Partnership to ensure that all applicants for the role of Domestic Abuse Champion are subjected to initial DBS checks and subsequently annual checking to ensure continued suitability for the role. **Discussed in July Review Board**, this will not be realistic for the partnership to enforce/ monitor.
9	Safer MK CSP should produce and initial training packages and provide a system of CPD for Domestic Abuse Champions	Include initial and on-going training and a mentoring network. Further training including DASH risk assessments and coercive control. Domestic Abuse Champions should be provided with personal protection and first aid training, to ensure that safeguarding issues are addressed. **Discussed in July Review Board**, each agency is responsible for providing training regarding personal safety, first aid and safeguarding to staff. This can be monitored via the operational and strategic group.
10	Training for Local Parish Councillors relating to safeguarding and personal protection	Local Parish Councillors involved in visiting vulnerable couples and families should be provided with similar training to that recommended for Domestic Abuse champions. **Update Aug 21** - all the Councillors have access to our online platform Smarter Learning where there is training on Safeguarding, Personal Safety and Domestic Abuse Awareness
11	Security checking for Local Parish Councillors relating to safeguarding and personal protection	Local Parish Councillors and those involved in visiting vulnerable families must have successfully completed the Disclosure and Barring Service process

		Update Aug 21 – Councillors do not put themselves in a position that would necessitate a DBS check, and on that basis none of the councillors have/need DBS checks.
12	Develop and deliver training, for all staff regarding professional curiosity and coercive control.	Ensure that the Milton Keynes Domestic Abuse Strategic Delivery Group monitors and supports the uptake of training by professionals **As recommendation 5**
13	Uplift training of Domestic Abuse issues within Adult Social Care	The MK together workforce should be supported in reviewing and revising domestic abuse training. Particular focus to be placed upon attendance at sessions and consideration given to making attendance mandatory and not voluntary. **As recommendation 5**
14	All agencies represented on the panel should ensure that there are suitable Information Sharing Agreements within all domestic abuse policies and strategies.	The Domestic Abuse Strategic Delivery Group to support panel agencies in the development of these ISAs **Discussed in July Review Board,** there are ISAs already in place across agencies such as the MARAC agreement.
15	All reports to Thames Valley Police, relating to domestic abuse, should be subject to thorough research, including PNC, PND and local databases	Thames Valley Police to ensure that all staff involved in the assessment of intelligence and information reports, related to domestic abuse complete thorough checks and research as suggested. **Update July 21 -** This is already in place, used to inform the DASH risk grading**.**
16	The pathway of sharing intelligence and information between Thames Valley Police and the Probation Service staff needs to have concise lines of provenance and governance	Thames Valley Police and the Probation Service to review their Information Sharing protocols to avoid anonymous information sharing creating missing safeguarding opportunities **Update Aug 21 from Probation -** 1. There are established information sharing practices in place between Thames Valley Police and the local Probation Service, which are based on named rather than anonymous sharing of information. Specific safeguarding requests are routinely made and supplied for police domestic abuse call out information. 2. During 2019, Thames Valley Police revised it partnership intelligence sharing protocol, and this has been shared with staff. Again, not anonymous. 3. Re: Governance. This is done at a national level between HMPPS and Police Service. Locally,

		our Head of Public Protection is cited on this and the awaiting the final position on how the exact process for requests for Domestic Abuse checks & Call outs should work. In the meantime, she has been in contact with Thames Valley Police to look at our current process to determine how to streamline process for requests (to reduce current demand on police). In short, once we have national direction, local protocols and ISAs will be created. In the meantime, the process of requests is working, although cannot be sustained in its current design and there is clear governance via the national Police Service Domestic Abuse Reference Group.
17	The Probation/Community Rehabilitation Company to introduce a series of routine enquiries or questions in circumstances where supervision meetings are attended by both the perpetrator and their partner.	**Update Aug 21** from Probation – The Community Rehabilitation Company ceased to exist as of 26th June 2021. Its interests and operating frameworks were transferred to the “The Probation Service”. What TV-CRC did from 2019 onwards was a lot of work on professional curiosity, reflective practice, reflective supervision and completely refreshed and improved the domestic abuse training and ensured that this was delivered to all practitioners. TV-CRC’s rating by HMIP went from “insufficient” in 2018/19 to “good” in 2019/2020 as evidence that the efforts we made yielded improvements in practice. The Probation Service will continue to oversee this and ensure it is embedded into practice.
18	Procedures to share information legally and appropriately between housing officers and neighbourhood officers should be reviewed to ensure that risk to tenants can be assessed and protective measures taken where appropriate	The MK Domestic Abuse operational group to assess previous actions and activities of these officers and ensure they are trained and aware of domestic abuse issues and be aware of current or potential victims with their geographic region **Update July 21 -** A new Domestic Abuse (DA) Hub was created. The officers within the DA Hub have the expertise to support all Housing Solutions Officers, noting urgent, high risk cases, and supporting those victims themselves. All Housing Solutions Officers within the service will have awareness of Domestic Abuse and will access support where required from DA Hub, MK ACT and senior colleagues, noting our duties under both Part VII of the 1996 Housing Act as amended (Homelessness Legislation) and the Domestic Abuse Act.