Central Bedfordshire
Community Safety
Partnership

CENTRAL BEDFORDSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Andrew

March 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date completed: July 2019

STANDING together
against domestic violence

"*Andrew was my older brother and throughout his life was very protective of me. For example, he provided great emotional and practical help when I was very ill during my first pregnancy. This caring side of his character was well known by those people close to him.*

Although Andrew could present himself as capable and able to deal with any problem and might present a little harder in manner than some people, he was actually very vulnerable to emotional hurt and felt such matters deeply. As an example, Mum and I had to provide a lot of encouragement and support when he got divorced. He was hurt deeply. He was always trying to be loyal to friends and family and felt any let down terribly.

Andrew was aware of the abuse I suffered as a child. He was not a victim like this but did suffer along with all us children in other ways. He felt guilt he could not protect me then even though only a youth himself.

Alcohol was clearly a significant factor in Andrew's death and a negative influence on his life in many ways. However, this was only a means to deal with these difficult and traumatic experiences. In his words to me to "block out the memories."

One of Andrew's most endearing qualities was his love of children. He was Godfather to the daughter of a friend of Olivia. I still have a photograph of them together. My own children J and E loved their uncle. E in particular misses his sense of humour and repeats many of his uncles' sayings and phrases. To this day E says goodnight to Andrew's photograph every night and says he loves him.

Andrew's humorous remarks and one liners are missed but somehow remain a glue that binds our family together".

Pen Portrait of Andrew by his sister, Dawn

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This report of a DHR examines agency responses and support given to Andrew[1], a resident of Central Bedfordshire prior to the point of his death at his home in March 2018. On the night of the homicide, Bedfordshire Police received a call from the East of England Ambulance Service requesting support for paramedics who were attending a male who was in cardiac arrest following a stabbing. Upon arrival, police officers found Andrew collapsed in the kitchen of the home he shared with his partner, Olivia[2]. Andrew was attended to by paramedics but was pronounced dead at the scene shortly after midnight. He had sustained a single stab wound to his chest.

1.1.3 After Andrew's death, Olivia was arrested and charged with murder, which she denied. In January 2019, Olivia was cleared of murder but was convicted of manslaughter. She received a three-year prison sentence.

1.1.4 This DHR will consider agencies contact/involvement with Andrew and Olivia from 1998 (when they are believed to have met) to March 2018 (the date of Andrew's death). In addition to agency involvement, this DHR will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

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

1.1.6 The DHR process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

[1] Not his real name.

[2] Not her real name.

1.1.7 The Review Panel expresses its sympathy to all those affected by the death of Andrew, in particular Andrew's family and friends. The Review Panel would also like to thank Dawn for the time and assistance she has given to the DHR.

1.2 Timescales

1.2.1 The Central Bedfordshire Community Safety Partnership (the CSP), in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' ('the statutory guidance') commissioned this DHR. The CSP was notified by Bedfordshire Police on the 13th March 2018 and the case was discussed at two meetings of the CSP in March and then April 2018. At the second meeting, a decision was made to commission a DHR and the Home Office were notified of the decision in writing on the 14th May 2018.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair (hereafter 'the chair') on the 4th May 2018. The completed report was handed to the CSP in July 2019. In September 2019, it was considered at a meeting of the CSP Executive Group and signed off, before being submitted to the Home Office Quality Assurance Panel in September 2019. In March 2020, the completed report was considered by the Home Office Quality Assurance Panel. In April 2020, the CSP received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2.3 The statutory guidance states that DHRs should be completed within six months of the initial decision to establish one. This timeframe was not met due to:

- The timing of the first Review Panel (held in September 2018) to enable full attendance;
- The date of the criminal trial (in January 2019, with Olivia then sentenced in February 2019);
- Engagement with Andrew's family (there was an initial delay in contacting Andrew's family due to the specific circumstances of the case. Thereafter the chair met with the family at a time of their choosing (after the trial had concluded) and ensured there was sufficient time to consider a draft report (see 1.9); and
- Attempts to engage with the perpetrator and their family (see 1.10).

1.3 Confidentiality

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

1.3.2 This DHR has been suitably anonymised in accordance with the statutory guidance. The specific date of death has been removed. Only the independent chair and Review Panel members are named.

1.3.3 The following pseudonyms have been in use in this DHR for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

- Andrew – The victim
- Olivia – The perpetrator
- Dawn – Sister of Andrew
- Noah – Brother of Andrew
- Logan – Son of Andrew
- Ethan – Son of Andrew
- Nicholas – Nephew of Andrew, son of Dawn
- Matthew – Friend of Andrew
- Neighbours 1 and 2 – Neighbours of both Andrew and Olivia
- Emma – Daughter of Olivia
- Luke – Son of Olivia
- Natalie – Daughter-in-law of Olivia, wife of Luke.

1.3.4 At the request of Andrew's sister (Dawn), the pseudonyms were chosen by the chair.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel considered the Protected Characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the DHR process.

1.4.2 *Sex* should always require special consideration. Analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators[3]. This case is therefore unusual, in that Andrew was male and Olivia is female. At the start of the DHR, the Review Panel noted that while Andrew was the victim of the homicide, there was information that indicated that the presence and nature of a wider pattern of domestic violence and abuse in the relationship was unclear. The limited previous contact with agencies suggested that there may have been issues in relation to the identification, management and assessment of domestic violence and abuse, including counter-allegations. As a result, the Review Panel has explicitly considered these issues.

1.4.3 The Review Panel also identified the following protected characteristics as being relevant to this case:

- *Age* – Andrew was 54 at the time of his death, Olivia was 73); and
- *Disability* – At the time of the first panel meeting, it was not known if Andrew had any disability. However, Olivia had a number of health needs and was listed on the 'Frailty Index' at her General Practice (GP).

1.4.4 Given these considerations, the Review Panel also considered whether either Andrew or Olivia met the 'Adult at Risk' definition in Section 42 of the Care Act 2014, as well as whether Andrew may have been her carer.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This DHR aims to identify the learning from Andrew and Olivia's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from Central Bedfordshire, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible to inform them of the DHR, their participation and the need to secure their records.

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[3] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved. Given what appeared to be the limited contact with agencies, it was agreed to extend the period of time that would be reviewed from 1998 (when Andrew and Olivia are believed to have met) to the date of the homicide. This extended time period is consistent with recent research into domestic homicides involving adults over 60 years of age, which has suggested that in a long-standing relationship a longer timescale may be required in order to identify relevant information from the more distant past[4].

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies.
- The co-operation between different agencies involved with Andrew or Olivia [and wider family].
- The opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues.
- Organisations' access to specialist domestic abuse agencies.
- Policies, procedures and training available to the agencies involved on domestic abuse issues.
- Specific consideration of the following issues:
    - Alcohol use
    - Mental health
    - Adults at Risk
    - Carer Status
    - Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom'.
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.5.5 Given the considerations in relation to Protected Characteristics, a number of agencies were invited to be part of the DHR due to their expertise even though they had not been previously aware of the individuals involved:

[4] Benbow, S.M., Bhattacharyya, S. & Kingston, P. (2018) 'Older Adults and Violence: An Analysis of Domestic Homicide Reviews in England Involving Adults over 60 Years of Age, *Ageing and Society*, pp.1–25.

- *Carers in Bedfordshire* – provides support for unpaid family carers throughout Bedfordshire[5];
- *Families First Bedfordshire* – offers one to one counselling and group support for men who have experienced sexual trauma and/or domestic abuse[6];
- *Respect* – a UK membership organisation for work with domestic violence perpetrators, male victims of domestic violence and young people's violence in close relationships[7]; and
- *SafeLives* – a national domestic abuse charity. SafeLives produced a report that highlighted that older people are often 'hidden' victims of domestic abuse and is developing training on 'responding to older people affected by domestic abuse'[8].

1.6 Methodology

1.6.1 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 new definition states that domestic violence and abuse is:

"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.

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.

[5] For more information, go to: https://www.carersinbeds.org.uk.
[6] For more information, go to: http://familiesfirstbedfordshire.org.uk.
[7] For more information, go to: http://respect.uk.net.
[8] For more information, go to: http://www.safelives.org.uk.

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

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

1.6.2 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.6.3 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 24 agencies were contacted to check for involvement. Eight agencies returned a nil-contact, four agencies submitted IMRs and chronologies, and three agencies submitted Shorts Reports only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology written by the Overview Report Writer. Additionally, two agencies submitted Thematic Reports describing local policy and provision.

1.6.4 *Independence and Quality of IMRs:* The IMRs and Short Reports considered by the Review Panel were written by authors independent of case management or delivery of the service concerned. The IMRs received from Bedfordshire Police and Central Bedfordshire Council Adult Social Care (CBC ASC) were comprehensive and enabled the panel to analyse the contact with Andrew and/or Olivia and to produce the learning for this DHR. The IMRs and short reports from other agencies were more variable, although they all met a standard which allowed the Review Panel to analyse contact with Andrew and/or Olivia and to produce the learning for this DHR. Where necessary, further questions were sent to agencies and responses were received.

1.6.5 Three IMRs and two short reports made recommendations of their own and evidenced that action had already been taken in response. These documents have informed the recommendations in this DHR. The IMRs and the Short Reports also identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this DHR.

1.6.6 *Documents Reviewed:* In addition to IMRs, Short Reports and Thematic Reports, documents reviewed during the DHR have included:

- The F750 form completed by Bedfordshire Police relating to an incident in January 2018[9], as well as the Decision-Making Tool (DMT)[10] completed by CBC ASC following a referral from Bedfordshire Police in the same month;
- Local documents, including the CBC Domestic Abuse Strategy 2016-2020, CBC ASC Carers Assessment and the local Multi-Agency Training Directory; and
- Previous DHR reports in the county.

1.6.7 The chair has also been mindful of the respective STADV and Home Office DHR Case Analysis.

1.6.8 *Interviews Undertaken:* The chair has undertaken one face to face interview in the course of this DHR, interviewing Andrew's sister (Dawn).

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Bedfordshire Clinical Commissioning Group (CCG);
- CBC Children's Services;
- Carers in Bedfordshire;
- CBC Community Safety;
- CBC Community Services;
- CBC Housing Services;
- East London NHS Foundation Trust (ELFT), provider of statutory:
  - (i) Mental Health and Wellbeing Services[11]
  - (ii) Drug and Alcohol Service – Path 2 Recovery (P2R)[12].
- Families First Bedfordshire;

[9] F750 forms are completed by a police officer when in relation to any Vulnerable Adults over 18 who they consider to be the subject of, or at risk of; neglect, physical abuse, sexual or emotional abuse, or in any other circumstances that may cause concern.

[10] The DMT is a practice tool used by CBC ASC to aid decision making. The tool has been designed to consider both the vulnerability of the adult at risk, the seriousness of the abuse that is occurring, the impact of the abuse and the risk of it recurring.

[11] Bedfordshire Mental Health and Wellbeing Service provides mental health services across Bedford Borough and Central Bedfordshire. For more information, go to: https://www.elft.nhs.uk/service/329/Bedfordshire-Mental-Health-and-Wellbeing-Service.

[12] PATH 2 RECOVERY (P2R) is a one stop service which provides drug and alcohol advice, treatment and support to adults whose lives are affected, support can include the whole family. For more information, go to: https://www.elft.nhs.uk/service/300/Path-to-Recovery-PATH 2 RECOVERY (P2R)-for-Central-Bedfordshire.

- Mind BLMK[13] (voluntary and community sector mental health service); and
- National Probation Service, Bedfordshire Local Delivery Unit.

1.7.2 The following agencies had contact with Andrew and / or Olivia and contributed as follows:

Agency	Contribution
Bedfordshire Police	Chronology and IMR
CBC ASC	Chronology and IMR
Luton & Dunstable University Hospital NHS Foundation Trust ('Luton & Dunstable Hospital')[14]	Chronology and IMR
West Street Surgery – GP for Olivia	Chronology and IMR
Bedford Hospital NHS Trust ('Bedford Hospital')	Short Report
Kirby Road Surgery – GP for Andrew	Short Report completed by the GP practice with the assistance of the Bedfordshire CCG
Victim Support – Independent Domestic Violence Advisor (IDVA) Service[15]	Short Report

1.7.3 To inform the deliberations of the Review Panel, Thematic Reports were also sought in relation to a number of areas, addressing the strategic context, evidence of local need, pathways, provision, gaps and issues as follows:

Agency	Thematic Report
CBC Children's Services	Men and domestic abuse
CBC Public Health	Drug & Alcohol Treatment Services

[13] Mind BLMK works to support positive mental health and wellbeing in Bedfordshire, Luton and Milton Keynes. For more information, go to: https://www.mind-blmk.org.uk.

[14] Located between Luton and Dunstable, Luton and Dunstable University Hospital is an acute hospital and also offers a range of community

services. For more information, go to: https://www.ldh.nhs.uk.

[15] Victim Support provide domestic abuse support services across Bedfordshire and have Independent Domestic Violence Advisor services based in Luton, Bedford and at Bedford Hospital. For more information, got to: https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/east-england/bedfordshire.

1.7.4 A third Thematic Report, relating to older people and domestic abuse, was originally due to be provided by CBC ASC, but it was subsequently agreed that this would be integrated into that agency's IMR.

1.7.5 Lastly, at the first Review Panel meeting, Respect provided a presentation on working with men. The CSP agreed to this input as it was felt important that Review Panel members had a shared understanding of the potential issues relating to the men and domestic abuse.

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name	Role	Agency
Amanda Derbyshire	Designated Nurse for Safeguarding Adults	Bedfordshire CCG
Caroline Lewis	CEO	Mind BLMK
Ippo Panteloudakis	Operations Director	Respect
T/Detective Chief Inspector Jerry Waite	Emerald Team: Domestic Crime & Serious Sexual Offence	Bedfordshire Police
Joy Leighton	Senior Operations Manager	Victim Support – IDVA Service
Joy Piper	Strategic Manager, Domestic Abuse[16]	CBC Children's Services
Leire Agirre	Principal Social Worker, Head of Safeguarding & Quality Improvement	CBC ASC
Lisa Scott	CSP & Communities Manager	CBC Community Safety Team
Lucy Giles	Consultant	Safe Lives
Marcel Coiffait	Director	CBC Community Services
Martin Westerby	Head of Public Health Programmes, Drug & Alcohol and Stop Smoking Services	CBC Public Health
Mel Gunstone	Assistant Director, Nursing and Quality	Bedfordshire CCG

[16] Located in CBC Children Services but leads on domestic violence and abuse for the council which has a Corporate Domestic Abuse Board.

Michael Howe	Chief Executive	Families First Bedfordshire
Michelle Bradley	Director	Mental Health and Wellbeing Services, ELFT
Nichola Keer	Associate Director of Nursing – Safeguarding	Bedford Hospital
Sandra Rome	Service Manager	Carers in Bedfordshire
Toni-Marie Doherty	Adult Safeguarding Lead	Luton & Dunstable Hospital
Zara Jane	Service Manager	Path 2 Recovery (P2R), ELFT

1.8.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 4th September 2018. There were further meetings on the 10th December 2018, the 25th February 2019 and the 3rd June 2019. The Overview Report and Executive Summary were agreed electronically thereafter, with Review Panel members providing comment and sign off by email in June and July 2019.

1.8.4 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and wider community.

Family

Name[17]	Relationship to victim	Means of involvement
Dawn	Sister	Interviewed Provided feedback on the report

[17] Not their real names.

Noah	Brother	Not approached
Logan	Son	Letter from chair. No response received
Ethan	Son	Letter from chair. No response received
Nicholas	Nephew (Son of Dawn)	Declined to be involved

1.9.2 It would have been normal practice for the CSP to notify the family of Andrew of their decision to undertake a DHR. However, on the advice of Bedfordshire Police, it was agreed to tailor the notification process. This was because of the potential involvement of a number of family members who had differing needs and who lived in a number of locations across the UK.

1.9.3 On the 18th July 2018, the chair, the CSP lead and representatives from Bedfordshire Police (the then Senior Investigating Officer (SIO), and a Family Liaison Officer (FLO)) spoke to discuss the best way to approach family involvement.

1.9.4 On the advice of the FLO, it was agreed that a single, combined letter would be sent by the chair and the CSP to Andrew's sister (Dawn). This letter served as notification that a DHR was being undertaken, as well as introducing the chair. It also included information on opportunities for family involvement. The Home Office leaflet for families, as well as information on Advocacy After Fatal Domestic Abuse (AAFDA)[18], were also sent with this letter.

1.9.5 The FLO made contact with Dawn on the 2nd August 2018. They discussed the DHR and passed on the letter. At the time of this contact, no specific feedback was received; Dawn's primary concern at this stage was the court process.

1.9.6 On the advice of the FLO, contact was not made with Andrew's brother (Noah) due to concerns about his health.

1.9.7 Additionally, the FLO also spoke with Andrew's two sons (Logan and Ethan). As with Dawn, they also received a copy of the letter after contact had been made by the FLO. No specific feedback was received.

1.9.8 The FLO continued to support family members through to the trial in January 2019.

[18] For more information, to: https://aafda.org.uk.

1.9.9 After the conclusion of the criminal trial, a meeting was arranged between Andrew's sister (Dawn) and the chair. The meeting was arranged via the Victim Support Homicide Service (VSHS)[19], which was supporting Dawn, and took place in February 2019.

1.9.10 A transcript of the meeting was made and shared with Dawn for her approval. Dawn confirmed she was happy with the transcript and its use in the DHR. Dawn also provided a Pen Portrait of Andrew (see page 2). During the course of the DHR, at the request of Dawn, the chair provided monthly updates by text. Information from Dawn is summarised in section 4 below.

1.9.11 In June 2019 a draft copy of the report was shared with Dawn who reviewed it with support from her VSHS caseworker. Dawn did not identify any concerns and was pleased that the Pen Portrait of Andrew had been included at the front of the report.

1.9.12 Dawn also approached her son (Andrew's nephew) (Nicholas) to ask him if he wanted to participate in the DHR. Nicholas contacted the chair by text in February 2019 to say he did not want to participate.

1.9.13 Letters were also sent from the chair to Andrew's two sons in February 2018 (Logan and Ethan). No response was received.

Friends, Work Colleagues, Neighbours and Wider Community

1.9.14 Consideration was initially given to approaching friends, work colleagues, neighbours and the wider community.

1.9.15 Bedfordshire Police provided a summary of the witness statements that had been collected during the murder enquiry. Based on this summary, the chair identified a number of individuals who could potentially contribute to the DHR. Bedfordshire Police initially contacted these individuals to confirm they were willing to share their details with the DHR. Where consent was given, a letter was sent, providing information about the DHR and inviting their involvement. The letter was accompanied by the Home Office leaflet for friends.

Name[20]	Relationship to victim	Means of involvement
Matthew	Friend of Andrew	Letter from chair. No response received
Neighbours 1 and 2	Neighbours of Andrew / Olivia	Letter from chair. No response received

[19] For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.
[20] Not their real names.

1.9.16 A former manager of Andrew was also identified. This individual had been Andrew's manager in his last substantive job in 2016 (see 2.2 below). The Review Panel discussed whether to approach this individual but agreed not to do so given that two years that had passed since Andrew had been in employment. However, the employing local authority was approached to confirm details of this employment and confirmed there had been no disclosures of domestic violence and abuse.

1.10 Involvement of Perpetrator and/or her Family:

1.10.1 In March 2019 Olivia was sent a letter from the chair via the prison governor with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. Olivia responded to confirm she was willing to be interviewed and returned a signed confidentiality form. This interview was scheduled for the start of May 2019. Between the receipt of Olivia's response and the scheduled meeting, Olivia returned a second signed confidentiality form advising that she did not understand what the (original) letter meant. The chair responded with a further letter, providing additional information. They also made attempts to contact the prison with the view to identifying someone who could speak with Olivia directly, to help clarify the purpose of request for the interview and the arrangements for the scheduled meeting. It was not possible to identify someone in the prison who could do this. Unfortunately, the scheduled meeting was itself cancelled at the last minute as Olivia was unwell. The chair wrote again to try and re-schedule a meeting and included a deadline for a response. A response was not received by this deadline and therefore Olivia has not participated in the DHR.

1.10.2 A significant challenge in approaching Olivia was the limited engagement by the prison where she was being held. The prison is a privately run, category B prison. In seeking to contact Olivia, the chair initially wrote to the prison governor. Thereafter, relevant correspondence to Olivia was copied to the prison and specific requests were made via the team that managed prison visits. This included contact attempts by both telephone and email, and a specific request for a named person with whom the chair could liaise. No response was received[21].

[21] The Home Office Quality Assurance Panel letter requested "…*clarification about what action was taken to determine whether the need for better engagement with the DHR process by prisons is a systemic issue across the prison estate*". This report details the actions taken in this case to engage with the prison. Neither the chair or the review panel have any responsibility for the wider prison estate, nor do they have the capacity to take a view as to this matter more broadly, particularly as Her Majesty's Prison and Probation Service (HMPSS) was not represented on the panel. Therefore, the chair and the review panel felt their responsibilities had been discharged by identifying this issue and making a recommendation in order that national partners could take action if appropriate. The chair and the review panel welcomed the confirmation that HMPSS would ensure that the national policy for prisons will be updated in light of this recommendation.

The statutory guidance identifies the importance of attempting to engage with the perpetrator in order to try and understand the decisions and choices they made. If convicted, this contact will need to be facilitated by the prison where they are held.

Recommendation 1: The Ministry of Justice to develop guidance for prisons in relation to their role in the DHR process, including the pro-active steps they should take to enable engagement with perpetrators.

1.10.3 Following the same process as described in 1.9.15 above, the chair sent a letter to Emma (Olivia's daughter) in April 2019. Luke (Olivia's son) and Natalie (Luke's wife and the daughter-in-law of Olivia) did not consent to their details being shared with the chair.

Name[22]	Relationship to perpetrator	Means of involvement
Emma	Daughter	Letter from chair. No response received.
Luke	Son	Did not consent to being contacted.
Natalie	Daughter -in-Law (wife of Luke)	Did not consent to being contacted.

1.11 Parallel Reviews

1.11.1 *Criminal trial*: Olivia was charged with murder, which she denied. The criminal trial was in January 2019 and she was sentenced in February 2019.

1.11.2 The Bedfordshire Police Senior Investigating Officer (SIO) was invited to the first meeting of the Review Panel. It was agreed that approaches would not be made to witnesses until after the criminal trial had been concluded, with the exception of an introductory letter to Andrew's family as described in 1.9 above.

1.11.3 *The Coroner's Inquest*: The death of Andrew was referred to the HM Coroner for the Bedfordshire District. Following Olivia's conviction, it was decided no investigation was required and therefore closed the matter. Consequently, following the completion of the criminal investigation and trial, there were no parallel reviews that impacted upon this review.

[22] Not their real names.

1.11.4 *Other statutory reviews*: The chair liaised with the local Safeguarding Adults Board (SAB) for Bedford Borough and Central Bedfordshire through a Review Panel member (the Principal Social Worker, Head of Safeguarding & Quality Improvement, CBC ASC) to establish whether there would be a parallel or joint Safeguarding Adult Review (SAR). The SAB decided a SAR was not necessary as the DHR was being undertaken. It was identified that a number of SAB representatives were on the Review Panel and could act as intermediaries. It was agreed that the SAB would receive a copy of the completed Overview Report and Executive Summary.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and Author of the Review is James Rowlands, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). James Rowlands has chaired and authored five previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.12.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK to adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.12.4 *Independence:* James Rowlands has no current connection with the local area or any of the agencies involved. James has had some contact with Central Bedfordshire prior to 2013 in a former role, when he was a Multi-Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)[23]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

[23] For more information, go to: http://www.safelives.org.uk.

1.12.5 James identified a requirement of the Review Panel to include agencies with particular expertise even though they had not been previously aware of the individuals involved as described in 1.5.5 above. As James has relationships with some of the agencies that would likely meet this requirement (he is an Associate for SafeLives and is a Board Member for Respect), this was declared. The CSP made the final decision as to which agencies to invite.

1.13 Dissemination

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the CSP Executive Group for approval and thereafter will be sent to the Home Office for quality assurance.

1.13.2 Within the CBC, there is a Corporate Domestic Abuse Board and the Executive Summary and Overview Report will also be shared with this Board. Given the issues identified in relation to Adults at Risk, the Executive Summary and Overview Report will also be shared with the SAB.

1.13.3 Once agreed by Home Office, the Executive Summary and Overview Report will be published; and there will be a range of dissemination events to share learning.

1.13.4 Once published, the Executive Summary and Overview Report will be shared broadly across Bedfordshire through the Bedfordshire Domestic Abuse Partnership (BDAP)[24]. The Partnership brings together key agencies across Bedfordshire to raise awareness, to deliver services and to work together to improve the local response to domestic abuse. The Executive Summary and Overview Report will also be shared with the Police and Crime Commissioner for Bedfordshire.

1.13.5 The action plan will be monitored by the Community Safety Team on behalf of the CSP, linking to the Corporate Domestic Abuse Board, the SAB and agencies as appropriate. The Community Safety Team will be responsible for monitoring the recommendations and reporting on progress to the CSP Executive Group.

[24] For more information, go to: https://bedsdv.org.uk.

1.14 Previous learning from DHRs

1.14.1 This is the first DHR commissioned by the CSP, although other DHRs have been completed by other CSP's across the county, all of whom are represented on the BDAP.

1.14.2 Across Bedfordshire, although DHRs are shared by the BDAP, there is no mechanism to collate learning and recommendations across the county. This means that, although this DHR will be shared, there is limited capacity to ensure the learning and recommendations are progressed more broadly. This was discussed by the Review Panel and it was recognised as a potential weakness.

A key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. Given that BDAP exists to develop partnership responses to domestic violence and abuse across Bedfordshire, there is an opportunity to ensure there is a robust mechanism to share learning from DHRs commissioned across the county.

Recommendation 2: The CSP to work with partners in the BDAP to agree on a mechanism for collating and sharing findings and recommendations systematically from local DHRs.

1.14.3 Additionally, the Review Panel asked the local SAB whether there was any relevant learning or recommendations from local SARs. None was reported as being relevant.

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship**	**Age at time of Andrew's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability**
Andrew	Victim	54	White British	Unknown	UK Citizen	No
Olivia	Partner	73	White British	Unknown	UK Citizen	Physical
Dawn	Sister					
Noah	Brother					
Logan	Son					
Ethan	Son					
Nicholas	Nephew					
Matthew	Friend of Andrew					
Neighbours 1 and 2	Neighbours of Andrew / Olivia					
Emma	Daughter of Olivia					
Luke	Son of Olivia					
Natalie	Daughter-in-law of Olivia					

2.1 The Homicide

2.1.1 *Homicide:* Late one evening at the beginning of March 2018, Bedfordshire Police received a call from the East of England Ambulance Service requesting support to paramedics attending an address, where a male was reported to be in cardiac arrest following a stabbing. Upon arrival, police officers found Andrew collapsed in the kitchen of the home he shared with Olivia. Andrew was being

attended to by paramedics but was pronounced dead at the scene shortly after midnight. He had sustained a single stab wound to his chest.

2.1.2 Olivia was at the property. Members of her immediate family had also attended before the arrival of the paramedics and police officers. Olivia made a number of comments to members of her family and to the police officers at the scene indicating that she was responsible for stabbing Andrew. The attending police officer also recovered a knife.

2.1.3 *Post Mortem*: Following a Post Mortem, it was confirmed that Andrew had died as the result of sustaining a single stab wound to the heart.

2.1.4 *Criminal trial outcome*: In January 2019 Olivia was cleared of murder but was convicted of manslaughter. She was sentenced in February 2019. Olivia received a three-year prison sentence.

2.2 Background Information on Victim and Perpetrator

2.2.1 *Background Information relating to Victim:* At the time of his death, Andrew was 54 years old. He was White, British and had no known disability or religious affiliation.

2.2.2 Andrew was one of three children with a sister (Dawn) and a brother (Noah). Andrew had previously been married and had two children from that relationship (Logan and Ethan). The marriage had ended about 25 years prior to his death.

2.2.3 At the time of his death, Andrew lived with Olivia. Andrew had originally been a lodger and had moved into the property in around 1998. He remained living in Olivia's property after they began a relationship.

2.2.4 At the time of his death, Andrew was in casual employment[25]. Before this, his last job had been working for a local Town Council between March and May 2016 (he was employed through a contractor as a porter). Andrew chose to leave during his probation period after a number of informal conversations with his manager about his alcohol use. During their enquiries, Bedfordshire Police established that Andrew had previously worked for a local authority as a refuse operative for a number of years. His sister (Dawn) told the chair that Andrew had worked in that job for 30 years but had been dismissed. Bedfordshire Police established that Andrew had been dismissed following an altercation with his line manager, whom he had assaulted.

[25] It has not been possible to establish any further information about the nature of this employment.

2.2.5 *Background Information relating to Perpetrator:* Olivia was 73 at the time of Andrew's death. She is White, British and had no known religious affiliation. In relation to disability, Olivia had a number of health and mobility problems and these are discussed below.

2.2.6 Olivia had previously been married. She had two children from this relationship (Emma and Luke). Olivia had remained living in what had been the marital home, which she owned. Shortly after her divorce from her husband, Olivia took in Andrew as a lodger and their relationship developed thereafter. Although there is reference to Andrew referring to Olivia as his wife, the Review Panel has been unable to confirm whether Andrew and Olivia were married.

2.2.7 *Synopsis of relationship with the Perpetrator:* There was an age gap of some 19 years between Olivia and Andrew at the time of Andrew's death. Andrew and Olivia were not married but had lived together for a period of some 20 years.

2.2.8 *Members of the family and the household:* There were no other members of the household, although, as noted above, members of Olivia's immediate family had been present before paramedics and police officers on the night of the homicide. This is discussed further below.

3. Chronology

3.1 Background to the Chronology

3.1.1 During the course of the DHR, it became apparent that there was relatively little contact between Andrew and/or Olivia with local agencies. Most of the contact that took place was with health providers. For that reason, the Review Panel felt it appropriate to provide a summary of contact over three periods of time: before 1997; from 1998 (when Andrew and Olivia met) to the end of 2017; and in 2018 (the year of Andrew's homicide).

3.2 Before 1997

3.2.1 Andrew had been registered at the same GP (Kirby Road Surgery) from birth. He had limited contact with the practice and prior to 1997, his only contact was in 1993. During a health check, Andrew reported that he drank 30 units a week. At the time, it would have been usual practice at these types of health checks for the practice nurse to offer advice on drinking in moderation.

3.2.2 Olivia had been registered with the same GP (West Street Surgery) since 1986. Relevant contact between 1997 included a report of an overdose in 1994, although there are no other records relating to this.

3.3 From 1998 (when Andrew and Olivia met) to the end of 2017

3.3.1 From 1998 Olivia had over 20 outpatient appointments at Luton & Dunstable Hospital. As well as annual reviews, these related to appointments for a range of medical conditions including:

- Hearing loss; and
- Transient Ischaemic Attack's (TIA)[26] in 2010 and 2011.

3.3.2 Between 2001 and 2013 Olivia attended the Accident and Emergency (A&E) Department at Luton & Dunstable Hospital on five occasions for a range of medical issues. The most significant of these led to two admissions:

- The first was in November 2010. Having been admitted on the 1st November, Olivia was diagnosed with having had a TIA. She stayed in the hospital for a few days, being discharged on the 4th November 2010.

[26] A TIA or 'mini stroke' is caused by a temporary disruption in the blood supply to part of the brain. The disruption in blood supply results in a lack of oxygen to the brain. This can cause sudden symptoms similar to a stroke, such as speech and visual disturbance, and numbness or weakness in the face, arms and legs. However, a TIA doesn't last as long as a stroke. The effects often only last for a few minutes or hours and fully resolve within 24 hours. For more information, go to: https://www.nhs.uk/conditions/transient-ischaemic-attack-tia/.

- The second was in September 2013. Olivia was admitted with worsening health issue. She remained in hospital until the 5th October 2013.

3.3.3 Olivia accessed West Street Surgery in relation to her health needs when required. As noted above, the practice was aware of the TIA's and Olivia's other health issues.

3.3.4 On the 12th November 2012 Olivia attended the A&E Department at Bedford Hospital[27]. This was the first time she had attended the hospital and she was booked in as a new patient. Olivia told reception that she wanted to see a psychiatrist. Olivia left before being seen by a medical professional and prior to seeing the triage nurse. A letter was sent to her GP on the same day informing the GP that Olivia had attended but had left without being seen. There was no subsequent follow up to this discharge notification by the GP.

3.3.5 Olivia sought help from West Street Surgery in relation to her mental health. She was prescribed anti-depressants in 2014 and her dosage was monitored regularly. Olivia's medication was changed in 2015. Her medication was increased in 2016 when she reported mood swings, sleep disturbance and feeling anxious.

3.3.6 Andrew started work for a local Town Council on the 14th April 2016, where he was employed through a contractor as a porter. He was employed for a period of six weeks. He left on the 27th May 2016, during his probation period, after a number of informal conversations with his manager about his alcohol use.

3.3.7 On the 14th June 2016, Andrew attended the A&E Department at Luton & Dunstable Hospital after sustaining a fall. He had no recollection of what had happened but reported that he had been found by his wife (Olivia) on the floor near the stairs after she had heard a bang. Staff noted that Andrew smelt of alcohol. Andrew told staff that he had recently lost his job and had increased his alcohol intake over the past week. The diagnosis was that Andrew had fallen, likely due to alcohol as no other medical reasons were found. Andrew was discharged with a recommendation for a GP follow-up and advice to increase fluid and food intake, repeat blood tests via GP and seek further medical advice if needed.

3.3.8 On the same day, Kirby Road Surgery received an 'A&E discharge notification' relating to Andrew's A&E attendance. This stated that Andrew had collapsed, but that no cause could be found, and Andrew had been discharged without follow up. The discharge notification did not include any of the additional

[27] Located in Bedford, Bedford Hospital is a district general hospital providing consultant led 24-hour accident and emergency services, acute medicine, maternity, paediatrics and a range of surgical specialties. For more information, go to: https://www.bedfordhospital.nhs.uk.

information relating to the circumstances of Andrew's attendance (i.e. that he smelt of alcohol). When discharge information is received at the Kirby Road Surgery, the coding team review it and make a decision if a GP needs to be made aware. In this case, it is not clear if a GP reviewed the discharge notification. However, the IMR completed by Kirby Road Surgery noted that it is unlikely this notification would have been reviewed by a GP as the information was scanned and did not indicate a GP follow up was required.

3.3.9 On 10th August 2016 Andrew was invited by Kirby Road Surgery for an appointment. This was a routine health screening and had not been triggered by the discharge notification from A&E. He did not take up this invitation.

3.3.10 On the 16th November 2016, Andrew attended the A&E Department at Luton & Dunstable Hospital. He stated he had had a fall during manual labour and as a result sustained a blade injury to his leg. A laceration was cleaned and stitched. Andrew's account of what had happened was consistent with the injury and no concerns were identified by the staff who saw him. Andrew was discharged the same day.

3.3.11 On the same day, Kirby Road Surgery received an 'A&E discharge notification' relating to Andrew's A&E attendance. This stated Andrew had sustained a laceration to the left lower leg and described the treatment provided.

3.3.12 Andrew subsequently made an appointment to have the wound dressed at Kirby Road Surgery and came to see the practice nurse on six occasions between the 25th November and the 16th December 2016. Following these interventions, an entry was made by the practice nurse on 6th November 2016 that Andrew's wound had healed. During these attendances, there were no concerns regarding Andrew's general presentation or about alcohol consumption.

3.3.13 On the 15th May 2017, Olivia saw a practice nurse at West Street Surgery for a health check. Olivia indicated that she drank five units of alcohol per week. When she was asked as to whether she drank more than six units in one session, she replied never. Her liver function had been checked during an earlier visit on the 17th February 2017 and was normal.

3.4 2018 (the year of Andrew's homicide)

3.4.1 On the 6th January 2018, Bedfordshire Police received a 999 call. The call was abandoned by the caller before anything was said. However, the call handler could hear sounds of disturbance, including a female screaming "*stop fighting with me*" and a male who sounded intoxicated. The origin of the call was traced to a phone registered to Andrew and police officers attended Andrew and Olivia's home address. It later transpired that Andrew had made the phone call.

3.4.2 Police officers found Olivia in a distressed state, stating that she had been physically held and restrained by Andrew following an argument. She said that both she and Andrew had been drinking, although she did not appear to be intoxicated. Andrew was found asleep in a chair and had to be awoken by police officers.

3.4.3 The police officers determined that Andrew was more heavily under the influence of alcohol than Olivia. Based on this, and the circumstances of the 999 call, Andrew was arrested for common assault. He resisted his arrest, refusing to co-operate, although he was not violent.

3.4.4 Olivia declined to make a formal complaint of assault. She stated that she had no injuries and also declined a medical examination.

3.4.5 On the 7th January, a police officer visited Olivia to obtain a witness statement. The police officer noted that the house was cold, that Olivia had said that she could not put the heating on and had not eaten. Olivia again declined to make a formal complaint of assault. She provided a witness statement saying that this was the first time anything had happened, and that the incident was "*fuelled*" by [Andrew] being under the influence of alcohol. Olivia also said she was happy for Andrew to return home and would be continuing the relationship.

3.4.6 Andrew, who had been held in custody overnight, was also interviewed on the 7th January. He was unable to recall the events, saying that he had been drinking and that he was a regular drinker. He stated that he and Olivia had been drinking every day since Christmas Day[28]. Andrew said that they would usually start drinking around lunch-time and they would drink upwards of a litre of vodka [with mixers] between them daily.

3.4.7 In relation to the incident, Andrew admitted that he had taken hold of and pushed Olivia but said that this was in retaliation and that Olivia had been pushed him first.

3.4.8 When police officers explored this further, Andrew stated that Olivia had told him that "*I'll knife you then*". He said he had then gone into the kitchen, returned to the living room and handed Olivia a knife and told her to: "*knife me then*". Andrew said that he thought that Olivia had stabbed him to his side with the knife. However, he had no marks or injuries or damage to his clothing. Andrew added that threats by Olivia to "*knife*" him had happened in the past. He called these "*off the cuff*" comments.

3.4.9 Andrew described the home environment as "*always having bad moments*", but that he would frequently "*wind up*" Olivia. By this, he said he would talk about

[28] If accurate, Andrew and Olivia would have been drinking for 13 days.

Olivia's previous relationships with other men, although these relationships had happened many years in the past and before they had become a couple. He explained that he had been doing this for some 22 years, but that he meant "*nothing by it*". Andrew said that he thought such a comment was probably the catalyst to the incident. He said he had made this comment following a chance conversation that Olivia had with a former partner at a local supermarket.

3.4.10 A Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) was completed by the police officers who had originally attended the incident in relation to Olivia. This was graded as 'medium' risk[29]. Key issues identified included alcohol, as well as financial issues (Andrew had said he had been made redundant two years previously, while Olivia stated that she and Andrew only argued over money).

3.4.11 Following the interview, and after a review of the case by supervisors, it was determined that there was insufficient evidence to provide a realistic prospect of conviction. This meant that the threshold had not been met to refer the case to the Crown Prosecution Service (CPS) for a decision. Therefore, no action was taken against Andrew. He was released without charge and taken back home.

3.4.12 On the 8th January, Victim Support received a referral from Bedfordshire Police. This referral came via an automated process that transfers referrals from the Bedfordshire Police case management system directly into the Victim Support case management system. The case was referred as an assault without injury and was flagged as 'standard risk' domestic abuse. Olivia was identified as the victim. Telephone contact was made with Olivia on 9th January and an offer of support made. This was declined but Olivia did agree to a text being sent that contained the telephone number of the Victim Assessment and Referral Centre should she ever change her mind. This text was sent on 9th January and the case was subsequently closed on the 10th January[30].

3.4.13 The police officer who visited Olivia on the 7th January later also completed a Vulnerable Adult Report, using a F750 form. The F750 was marked to identify vulnerability due to Olivia's age (73), physical disability and drug / alcohol.

3.4.14 The police officer's rationale also drew attention to Olivia's apparent reliance on Andrew based on their observations of the home environment. The F750 noted that:

[29] However, at some point this risk rating was changed from 'medium' to 'standard' risk.

[30] At the time of this incident, Victim Support was commissioned by the Police and Crime Commissioner for Bedfordshire to provide support to victims of crime. Since the 5th April 2018, this service had been provided by the 'Signpost Hub'. For more information, go to: https://www.bedfordshire.pcc.police.uk/2018-04-new-service-launched-to-give-first-class-support-to-victims-of-crime.

- The report related to a domestic assault (no further details were provided)
- In relation to the domestic assault, no further action was being taken (the reasons given as the "*victim was not supportive and in the interview, the suspect informed officers that he was pushed by the victim and his actions were in retaliation*")
- Olivia had stated that "*she heavily relies on her partner Andrew to do everything for her and claimed that he is her carer. Andrew disputes this however did state that Olivia seems to be neglecting herself*"
- On attending the property, it was "*freezing*". The central heating was not on and Olivia had stated that "*she didn't know how to turn the fire on and only Andrew knows how to do this"*
- Olivia had said that she hadn't eaten as *"Andrew is responsible for this".* When asked whether she could cater for herself Olivia tried to change the subject
- That when interviewed, Andrew "*stated that* [he] *has become Olivia's carer over the years and he doesn't have any help/support in doing so but as he loves her, he expects to do everything for her*"

3.4.15 The F750 went on to conclude by setting out the following:

- Identified a concern that Andrew had said he had recently become employed and therefore Olivia would be left at home. They were concerned about this because Olivia was on various medication due to a recent stroke and Andrew had stated the couple "*drink on a daily basis*"
- Identified that: "*My main worry is that if Olivia has become so dependant* [sic] *on Andrew that she will not speak up if he abuses her as she is in fear of being alone*"
- Indicated that Olivia was aware a referral was being made and that she "*is willing to speak to services further if they make contact*"
- Under actions taken, the Police Officer noted that "*Andrew did voice that looking after Olivia is a strain"*

3.4.16 The F750 was recorded on Bedfordshire Police's Case Administration and Tracking System (CATS)[31] on the 21st January, which was 15 days after the incident (i.e. around two weeks).

3.4.17 On the same day (i.e. the 21st January), CBC ASC's Safeguarding Team received the F750 from Bedfordshire Police. The date of the incident was not recorded in the text although the Computer Aided Dispatch (CAD)[32] number indicates that the report relates to the incident on the 6th January.

3.4.18 On the 23rd January, the F750 was reviewed by a social worker in the Safeguarding Team and a DMT was completed. The DMT recommended that further enquiries and an assessment of need[33] should be considered by the relevant locality social work team. Additionally, the DMT identified that Andrew was entitled to the offer of a 'carers assessment'[34]. In making these recommendations, the DMT noted that:

- Consent for a referral to CBC ASC for a needs assessment had been gained by the Police Officer at the point of referral
- Within the relationship and home environment, there was or may be domestic abuse
- That in contact with Olivia, attempts should be made to discuss the incident on the 6th January with Olivia alone
- The incident may have occurred as a result of excess alcohol intake. However, there was also a possibility of the occurrence was due to 'carer stress' as the police officer had identified Andrew as an informal carer for Olivia (despite Andrew disputing this)

3.4.19 The DMT was sent to the relevant Older People and Physical Disability Duty locality team. It was received on the same day it was sent.

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[31] CATS is a vulnerable person case management system. The system has three core modules - Child Protection, Domestic Abuse and Vulnerable Adults

[32] CAD software is used in police control rooms as an incident response management system.

[33] If someone has any care or support needs, they can ask for a needs assessment. The assessment looks at physical, mental and emotional needs. For more information locally, go to: http://www.centralbedfordshire.gov.uk/health-social-care/support/assessment.aspx.

[34] Local authorities have a duty to assess any carer who requests one or who appears to need support. The support provided could include being offered money to pay for things that make caring easier; practical support, such as arranging for someone to step in when a carer need a short break; or being put in touch with local support groups. For more information locally, go to: http://www.centralbedfordshire.gov.uk/health-social-care/carers/assessment.aspx.

3.4.20 On the following day, the 24th January, the DMT was screened and reviewed by the locality team during the morning meeting. It was allocated for an assessment of need. The 'contact screen'[35] was printed (rather than the full DMT) and placed in the allocation folder for the assigned social worker.

3.4.21 On the 30th January, care management began. There is no evidence to indicate that the allocated social worker reviewed either the full DMT or other records.

3.4.22 A first contact attempt was made. The social worker made an initial attempt to contact Olivia by telephone without success. They entered the following note on the electronic care record: "*The mobile will not receive calls and option 1 has to be pressed for a free text to go through that is automated and not one you can type*".

3.4.23 Further contact was attempted on the 1st February and was again unsuccessful. The electronic care record was updated, although the number of attempts made is not recorded.

3.4.24 The same day a letter was sent to Olivia. The letter advised Olivia that multiple attempts had been made to contact her by telephone to arrange an assessment of need. The letter provided contact details for the social worker and requested that Olivia make contact within 14 days to arrange the assessment otherwise the request for assessment will be closed. The electronic care record was updated.

3.4.25 On the 14th February an entry was made into electronic care record by the Social Worker, headlined "*no contact*". It stated:

- "*Have telephoned- no response and not returned messages*
- *Letter sent asking to contact by 14th Feb or will close- no response*
- *Knocked on the door 14 Feb 2018- no reply*
- *Case closed on the system with no further action required*"

3.4.26 Olivia's case was then closed. There is no reference in the case record in relation to the carers assessment that had been requested for Andrew.

3.4.27 Late one evening at the beginning of March 2018, Bedfordshire Police received a call from the East of England Ambulance Service requesting support to

[35] This is the screen with summary information on the computer system used by CBC ASC.

paramedics attending an address where a male was reported to be in cardiac arrest following a stabbing.

3.4.28 During the subsequent murder inquiry, it was established that Olivia and Andrew had been drinking during the day running up to the homicide. Andrew was reported to have urinated in part of the house prior to being stabbed by Olivia.

3.4.29 Olivia was arrested for murder. Olivia appeared in court two days later and was granted bail pending trial.

Postscript

3.4.30 After Olivia's arrest, she was referred to the ELFT's Liaison and Diversion Service (L&DS). She was seen while in custody, at court and by the prison's mental health in-reach team when she was remanded. She was deemed vulnerable due to it being her first time in prison, her age, her physical health and her reported depression.

3.4.31 At the first Review Panel meeting, it was noted that Olivia was on bail and living in the community. Additionally, based on the information available from the initial scoping exercise, it was identified that Olivia may have had care and support needs. It was agreed that the ongoing support for Olivia was outside of the remit of the Review Panel but that appropriate consideration should be given to Olivia's care and support. The CBC ASC representative took an action to liaise with Bedfordshire Police and complete a needs assessment. This was duly done. The needs assessment concluded that Olivia did not have care and support needs.

4. Overview

4.1 Background to the Overview

4.1.1 Information from Andrew and / or Olivia's family and friends are included in this section.

4.1.2 As detailed in 1.9 and 1.10 above, attempts were made to contact a number of family and friends, as well as other members of Andrew and Olivia's informal networks, to inform them of the DHR and invite their participation. Unfortunately, most of those who were approached chose not to participate. Consequently, with the exception of Andrew's sister (Dawn), the following summaries are based on the witness statements provided to Bedfordshire Police as part of the murder enquiry. However, as the individuals involved chose not to participate in the DHR, their witness statements were not shared in full but are based on the summaries provided by Bedfordshire Police.

4.2 Summary of Information from Family, Friends and Other Informal Networks

Sister

4.2.1 The chair met with Dawn who provided a Pen Portrait of Andrew (which is included on page 2), and also talked about her relationship with Andrew. She described their relationship as close, reflecting their shared difficulties in childhood, and also remembered fondly the support Andrew had provided her during her early adulthood. They had remained close: Dawn was regularly in contact with Andrew, either by phone or through text.

4.2.2 Dawn said that Andrew would drink a lot, usually vodka. She felt his drinking had increased after the end of his previous marriage. Dawn said that Andrew would drink with Olivia, at a local bar or on his own. Dawn was not able to estimate how much Andrew drank. Dawn said that if Andrew was drinking his behaviour could change, saying: "*He would lose it when he was drunk*". In these circumstances, Dawn said that sometimes "*I was even scared of him*", although she was clear that he never hurt her or her sons. Dawn also said: "*I was worried about* [Andrew's] *temper and smashing things".* In relation to his alcohol use, Dawn said Andrew was "*a typical man; he didn't get help because he didn't see it as a problem*".

4.2.3 Dawn was sometimes able to visit Andrew at the home he shared with Olivia. Talking about these visits, she said that the last few times were "*awful"*. Dawn described how there was lots of shouting between Andrew and Olivia and that she "*felt like I was stepping on eggshells"*.

4.2.4 Dawn said that when she tried to discuss Andrew's relationship with Olivia, Andrew did not want to talk about it. She described Andrew as "*knocking it away*" as a topic.

4.2.5 On one occasion when Andrew did talk about the relationship, Dawn said she advised Andrew to leave. However, in response Andrew asked: "*who would want me*?". He also said he loved Olivia. Dawn remembers telling Andrew that "*if the alcohol doesn't kill you, she* [Olivia] *will*".

4.2.6 Dawn was aware that Olivia sometimes "*punched"* Andrew in the arm and "*kicked*" him on the shins. Dawn also reported that "*every day she* [Olivia] *said she's going to stab him one day, she even said it in town and in* [large supermarket]*".*

4.2.7 Dawn also said that Andrew always did the cooking and that money was tight.

4.2.8 Dawn said that in 2016, after Andrew lost his job, arguments between Andrew and Olivia were often over money.

4.2.9 Dawn also told the chair that she thought Olivia was "*jealous"* of Andrew, for example when he was around other women. When asked whether, as reported, Andrew would "*wind-up*" Olivia about seeing other men, Dawn confirmed that this happened. Dawn said that Andrew also used to tease Olivia. Summarising this, Dawn said that Andrew had told her: "*he said he can take a joke, but she* [Olivia] *can't*".

4.2.10 Talking about Olivia, Dawn she said that she had cared for Olivia at one point after she had a TIA, but that "*she could do things for herself".* The only on-going issue that Dawn identified was that Olivia was deaf in one ear. Dawn felt that sometimes this made it difficult for Olivia to hear Andrew and may have been why people would sometimes hear raised voices.

4.2.11 Dawn also said that Olivia had texted her saying Andrew was "*beating her up"*. Dawn summarised this as "*She said "Andrew is at it again, he is being mouthy", and* [that] *he had been hitting her*". However, Dawn did not take this seriously as she felt it was "*more of the other side*".

Other family members

4.2.12 Unfortunately, it has not been possible to engage any other family members of Andrew in the course of this DHR (see 1.9 above).

Friends

4.2.13 Unfortunately, it has not been possible to engage any other friends or neighbours in the course of this DHR (see 1.9 above).

4.2.14 During the murder enquiry, Bedfordshire Police interviewed Matthew, a close friend of Andrew. Matthew had known Andrew for a number of years and Andrew was regularly visited by him. Matthew explained that Andrew visited them when Olivia went to her son's home.

4.2.15 Matthew told police officers about an incident involving Andrew and Olivia. Andrew is reported to have physically taken hold of Olivia, with this described as being done "*playfully*". In response, Olivia is reported to have reacted by elbowing Andrew, rendering him dazed. Matthew and his wife were contacted by Olivia and attended the address. By the time Matthew arrived, Andrew was conscious and recovered quickly thereafter. He did not seek any medical treatment. Although there is no known date for this reported incident, it is alleged to have occurred within the previous two years. Matthew stated that he and Andrew would often "*amuse themselves*" by recounting this incident when in each other's company.

4.2.16 Matthew and his wife holidayed abroad at the same time [but not together] as Andrew and Olivia in late 2016. They were on holiday for a week but saw little of Andrew and Olivia after the first day. Matthew said that both Andrew and Olivia remained in their apartment drinking for the majority of their stay and did not socialise. Matthew also stated that Andrew and Olivia would argue regularly, however to his knowledge, he was not aware of any violence and abuse other than the incident described above.

Neighbours

4.2.17 During the murder enquiry, Bedfordshire Police identified an incident that had occurred on the 19th December 2017, although this was not reported to any agencies at the time. A neighbour, known to the couple, was asked by Andrew to help move a sideboard. They were told the sideboard had fallen over and spilled its contents across the lounge. When the neighbour attended, they found it almost incomprehensible how the sideboard could have fallen on its side or collapsed as told by both Andrew and Olivia. Other than this displaced sideboard and its contents, there was no other damage. When interviewed by Bedfordshire Police the neighbour also reported that on a number of previous occasions, he had heard a male voice 'shouting' from within the address, and although he did not know who it was, he inferred that this was Andrew.

4.2.18 As part of the murder enquiry, Bedfordshire Police conducted house to house enquiries. Apart from the information provided by one neighbour, no additional information of any note was forthcoming from neighbours. In fact, one other close neighbour believed that Andrew was in fact a lodger at the address as opposed to being Olivia's partner.

4.3 Summary of Information from Perpetrator:

4.3.1 Unfortunately, it has not been possible to interview the perpetrator as described in 1.10 above.

Daughter

4.3.2 During the murder enquiry, Bedfordshire Police interviewed Emma, the daughter of Olivia. She made a number of disclosures citing what appears to have been evidence of arguments within the relationship within the previous two years. She linked this to Andrew losing his job, as well as depression and an increase in alcohol consumption by both Andrew and her mother.

4.3.3 Emma told police officers that Andrew would "*wind-up*" her mother, suggesting that she was seeing another man, which she said was not the case.

4.3.4 Emma stated that she was not aware of Andrew striking her mother, on the other hand, she recounted an incident some three months previously when her mother reportedly knocked Andrew unconscious. Emma told police officers that an ambulance had been called but said she had no other information[36]. This is likely to have been the same incident which was referred to by Matthew above.

4.3.5 Emma stated that she was aware that her mother's health had deteriorated in more recent times and that she had become depressed, and also had various medical issues. Emma did not make any observations concerning her mother's mobility although she implied that Olivia relied on Andrew to provide her care as opposed to other members of the family.

Son

4.3.6 During the murder enquiry, Bedfordshire Police interviewed Luke, the son of Olivia. He told the police officers that, because of an alleged threat to one of his children by Andrew a number of years previously, he had very little contact with Olivia and Andrew at their home. He also did not allow Andrew to visit. As a result, other than being aware of their habitual drinking, he had little insight into their relationship, although he had told his mother on a number of occasions that she would be better ending the relationship.

[36] The East of England Ambulance Service were approached for information about this incident. They confirmed that they had only attended the home address of Andrew and Olivia on one occasion (in March 2018, the date of Andrew's death).

4.4 Summary of Information known to the Agencies and Professionals Involved

Andrew

4.4.1 Andrew had very limited contact with statutory services, with this relating to health providers and Bedfordshire Police.

4.4.2 In relation to health, Andrew had almost no contact with his GP, the Kirby Road Surgery. However, he did have contact with the A&E at Department at Luton & Dunstable Hospital on two occasions in 2016. He first presented following a fall and smelling of alcohol. He later presented with a knife blade injury to his leg. On both occasions his treatment was appropriate. Additionally, Kirby Road Surgery received a notification about his attendance. However, the Review Panel has identified issues with the quality and use of discharge notifications when sent from local hospitals to GPs. This has already been identified as an issue locally and work is underway to address this. The Review Panel has made recommendations to monitor the progress of this work.

4.4.3 The only other substantive contact with Andrew was with Bedfordshire Police when he was arrested in January 2018. Following his arrest, Andrew made a number of disclosures relating to Olivia, including her alleged use of threats with a knife. In relation to this contact, the focus was on Olivia as the victim. The Review Panel has made a recommendation because possible risk to Andrew was not considered and nor was this information shared. More broadly, the Review Panel has identified issues in relation to local practice about male victims and the identification, management and assessment of counter-allegations.

4.4.4 Although there was no contact between Andrew and CBC ASC, it is of note that when Bedfordshire Police identified concerns about Olivia, they also identified the possibility that Andrew had a caring role. These issues were considered by CBC ASC when Olivia and Andrew came to attention during an initial review of the referral from Bedfordshire Police. However, the Review Panel has identified that when the case, and accompanying recommendations, were passed to a locality team for action it was treated as a routine request for an assessment. This meant concerns around both possible domestic violence by Andrew, as well as issues around Andrew's possible carer status, were not addressed. A number of recommendations have been made by CBC ASC's IMR to improve policy, practice and case management systems as a result.

4.4.5 Based on the information available to the Review Panel, Andrew may have had an alcohol use issue. However, there is no evidence that he sought help for this. The Review Panel has considered local alcohol services as part of the DHR and made some recommendations in relation to the identification and offer of brief advice by professionals in relation to alcohol use.

Olivia

4.4.6 Olivia also had limited contact with statutory services, although this was more extensive than Andrew. Like Andrew, the contact Olivia did have was principally with health providers and Bedfordshire Police.

4.4.7 Olivia had significant contact with both her GP, West Street Surgery, as well as contact with Luton & Dunstable Hospital. This contact related to a range of issues, principally relating to her physical health. Based on the information available to the Review Panel, Olivia may have had an alcohol use issue, however this was not apparent to any professional during any of these health contacts.

4.4.8 A further contact is of note: In 2012 Olivia attended the A&E Department at Bedford Hospital and said she wanted to see a psychiatrist. Olivia left before seeing a medical professional and West Street Surgery thereafter received a discharge notification. Olivia also had other contacts with West Street Surgery around her mental health treatment. However, at no point was she offered a referral to other mental health support. As a result, West Street Surgery has identified some learning around the support offered to patients and their access to counselling.

4.4.9 The only other substantive contact with Olivia was with Bedfordshire Police, when they attended an incident in January 2018. Following the arrest of Andrew, Olivia said she would not support any charges but did speak with a police officer. This incident triggered contact by Victim Support, although Olivia declined further support.

4.4.10 Following this incident, a police officer identified a number of contacts and made a referral to CBC ASC in January 2018. The Review Panel has identified some differences between the approach by Bedfordshire Police and CBC ASC but was satisfied that this referral was appropriate. It also led to a thorough assessment being completed by CBC ASC, with a range of recommendations being made that addressed potential concerns about domestic violence and abuse. However, as noted in relation to Andrew above, when this information was passed to the locality team for action, the case was treated as a routine request for an assessment. This meant concerns were not addressed and, when Olivia did not respond to contact attempts, the case was closed. A number of recommendations have been made by CBC ASC's IMR to improve policy, practice and case management systems as a result. Additionally, the Review Panel has made recommendations in relation to local referral pathways. This is because of the potential for the duplication of support offers that were identified in this case. The Review Panel has also recommended that guidance be developed in relation to raising concerns about abuse and neglect.

4.5 Any other Relevant Facts or Information:

4.5.1 No additional information was shared with the Review Panel.

5. Analysis

5.1 Domestic Violence and Abuse

5.1.1 The cross-government definition of domestic violence and abuse refers to "*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*".

5.1.2 In relation to the first part of this definition ("*any incident*"), Andrew was clearly the victim of a fatal act of domestic violence and abuse. He died from a stab wound inflicted by Olivia; his death is the reason that this DHR was initiated and Olivia has since been found guilty of manslaughter.

5.1.3 However, when considering the definition in its broader sense ("*pattern of incidents*"), the picture is less clear. The information available to the Review Panel (some known at the time, some with the benefit of hindsight) is both limited and contradictory.

5.1.4 There is information that could suggest that either Andrew or Olivia were experiencing domestic violence and abuse:

- For Andrew – after the incident on the 6th January 2018, Andrew told the police that Olivia had said to him that: "*I'll knife you then*". Andrew also said that threats by Olivia to "*knife*" him had happened in the past although he described these as "*off the cuff*" comments.
- Additionally, Andrew attended the A&E Department at Luton & Dunstable Hospital for treatment after a fall in June 2016, and then for a blade injury to his leg after a fall in November 2016. While there is no information available that would indicate domestic violence and abuse was a cause for concern at the time, and Andrew provided a plausible account for the blade injury, it is of note that one of these incidents involved a knife.
- For Olivia – During a 999 call to Bedfordshire Police on the 6th January 2018, the call handler could hear sounds of disturbance and a female screaming in the background. Olivia later told police officers that she had been physically held and restrained by Andrew following an argument.
- Additionally, after the incident on the 6th January 2018, Andrew told the police officers during an interview that he would frequently "*wind up*" Olivia. Andrew stated he had been doing this for some 22 years, and from his account, this related to Olivia's former relationships. As part of the murder enquiry, Olivia's daughter told police officers that Andrew would "*wind-up*" her mother. Meanwhile, there was a single report that Andrew was not welcome to see Olivia's son, because he had once made a threat to his child.

5.1.5 This conflicting information is also reflected in the account given by Andrew's sister (Dawn). Dawn told the chair about hearing lots of shouting between

Andrew and Olivia and feeling like she was "*stepping on eggshells"* when she visited. Dawn said that Olivia would punch and kick Andrew and threaten to stab him. She also remembers telling Andrew: "*if the alcohol doesn't kill you, she* [Olivia] *will*". However, Dawn also told the chair that Andrew could "*lose it when he was drunk",* including "*smashing things".* She also said that Olivia told her that Andrew would hit her, although she felt this was "*more of the other side*".

5.1.6 There was at least one incident where either Andrew or Olivia could have been described as the 'victim'. A friend (Matthew) told Bedfordshire Police after the homicide that at some point in the last two years that Andrew had physically taken hold of Olivia (the nature of this hold, including its force, is unclear). In response, Olivia is reported to have reached behind and elbowed Andrew, rendering him dazed. Olivia's daughter was also aware of an incident when Olivia had knocked Andrew unconscious (whether this was the same incident recounted by Matthew is unclear). Matthew additionally informed Bedfordshire Police that during a holiday in 2016 Andrew and Olivia regularly argued, although he said that he saw no evidence or suggestion of violence.

5.1.7 There were also some incidents where there is simply not enough information to know what happened. For example, a neighbour told Bedfordshire Police after the homicide that they were once asked by Andrew to help move a sideboard which had fallen over. The same neighbour also reported that on a number of previous occasions, he had heard a male voice 'shouting' from within the address and he inferred that this was Andrew.

5.1.8 Finally, two further issues were noted:

- Clearly money was an issue. Andrew had lost his job in 2016, although he had some casual employment thereafter, while Olivia did not work. Additionally, the home that Andrew and Olivia shared was owned by Olivia. Consequently, the Review Panel considered whether there was any evidence of financial abuse. While there were possible indicators, the Review Panel felt it had insufficient information available to reach a determination; and
- The F750 completed by Bedfordshire Police included a report that the property was "*freezing*", and that Olivia had said that she hadn't eaten as *"Andrew is responsible for this".* These issues are explored further in relation to vulnerability and adult safeguarding below.

5.1.9 Given these factors, the Review Panel was unable to reach a determination as to the presence of a broader pattern of domestic violence and abuse in the relationship. This is because:

- Andrew may have been a victim of domestic abuse from Olivia, particularly given reports that Olivia had threatened to use a knife in the past, and this could have been the cause of an injury on a previous occasion. Andrew was also knocked unconscious at least once. Finally, his sister (Dawn)

reported that he was punched and kicked by Olivia and was fearful that Olivia would kill Andrew; but alternatively,

- Olivia may have been a victim of domestic violence and abuse from Andrew. Dawn said that Olivia told her that Andrew was beating her up. Additionally, there are reports that Andrew would make comments about past relationships (jealousy is a risk indicator in domestic abuse[37]) and that a male was heard shouting at the property (although Andrew told Bedfordshire Police that this was because Olivia found it hard to hear). The significant age gap, as well as her long-term illness and possible concerns relating to vulnerability, may have also increased Olivia's risk of experiencing domestic violence and abuse[38]. In this context, it is possible that Olivia may have used 'violent resistance' (i.e. violence utilised in response to domestic abuse) against Andrew.

5.1.10 However, it is also possible that both Andrew and Olivia had experienced violence and abuse, with the pattern of abuse changing over time. Alternatively, the relationship may have consistently featured bi-directional violence which would mean the relationship was marked by 'situational couple violence' (i.e. violence that is not embedded in a general pattern of power and control but is a function of the escalation of a specific conflict or series of conflicts). These definitions for 'typologies' of intimate partner violence are most commonly ascribed to the work of Michael Johnson[39].

5.1.11 Whatever the nature of the relationship, it is also likely that alcohol use was an issue, featuring in the accounts given to Bedfordshire Police by family and friends.

5.1.12 Because the Review Panel was unable to reach a determination as to the presence of a broader pattern of domestic violence and abuse in the relationship, it agreed to use the learning from this case to explore practice more broadly. The Review Panel agreed to consider three areas:

- Male victims of domestic violence and abuse;
- Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom and with what effect'; and
- Older people and domestic violence and abuse.

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[37] Campbell, C., Glass, N., Sharps, P., Laughon, K and Bloom, T. (2007) Intimate Partner Homicide: Review and Implications of Research and Policy, Trauma, Violence and Abuse, 8(3), pp. 246-269.

[38] Smith, K (ed) (2014) *Homicides, Firearm Offences and Intimate Violence 2009/10*: Supplementary Volume 2 to Crime in England and Wales 2009/10. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/116512/hosb0111.pdf (Accessed 30th January 2019).

[39] Johnson, M. P. (2008) *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence*. Boston: Northeastern University Press.

Male victims of domestic violence and abuse

5.1.13 There has been an increasing awareness that men can experience domestic violence and abuse in both heterosexual and same sex relationships. The latest data from the Office for National Statistics (ONS)[40] reported that an estimated 695,000 male victims (or 4.2% of men) experienced domestic abuse in the year ending March 2018, as opposed to an estimated 1.3 million female victims (or 7.9% of women). However, these figures need to be treated with some caution: the same report noted that when coercive and controlling behaviour is taken into account, there are differences between the experiences of male and female victims. Recent research into men's experience of domestic abuse in GP settings has summarised these issues, drawing attention to the need to understand the abuse being reported by men, including its severity, the presence of coercive control and also reports by men who are actually being abusive[41].

5.1.14 Nonetheless, for men who do experience domestic abuse, there can be barriers to seeking help. The Men's Advice Line's booklet, '*Talk it Over'* describes some myths that can act as barriers, including:

- Domestic violence does not happen to men;
- Men who experience abuse are weak or not 'real' men; and
- The law only protects women who experience domestic violence but does nothing to help men[42].

5.1.15 The impact of these myths can be significant, with a recent study drawing together findings about men's experience of help seeking and service provision. The study noted that a key issue for male victims is a fear of disclosure, with this being influenced by assumptions about masculinity that can be held by both a victim and wider society. This research made a number of recommendations for policy and practice, specifically:

- "*Service provision for male victims needs to be more publicly advertised;*
- *Images and wording of publicity need to represent different types of masculinity and sexuality;*

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[40] ONS (2018) *Domestic abuse: findings from the* Crime *Survey for England and Wales: year ending March 2018*, Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018 (Accessed: 30th January 2019).

[41] Hester, M., Jones, C., Williamson, E., Fahmy, E., & Feder, G. (2017) 'Is it coercive controlling violence? A cross-sectional domestic violence and abuse survey of men attending general practice in England', *Psychology of Violence*, 7(3), pp. 417-427.

[42] Respect (n.d.) *Talk it Over*: *Help and support for male victims of domestic violence and abuse*. Available at http://www.mensadviceline.org.uk/wp-content/uploads/2017/01/Mens-Advice-Line-booklet-for-male-victims-1.pdf (Accessed: 30th January 2019).

- *Service provision needs to be more inclusive and better tailored more to effectively address the needs of different sociodemographic groups;*
- *Ensuring confidentiality and building trust in service provision is essential for male victims of domestic violence;*
- *Continuity of contact (care) is an essential feature of services for male victims; and*
- *Services should aim to give all people seeking support for domestic violence and abuse a choice of professional personnel in terms of gender or sexuality*"[43].

5.1.16 To help understand policy and provision relating to male victims and survivors locally, the Review Panel drew on the Thematic Report on men and domestic violence and abuse provided by CBC.

5.1.17 CBC's Domestic Abuse Strategy, which runs from 2016 – 2020 and is overseen by a Corporate Domestic Abuse Board, includes an aspiration that women, children and men in Central Bedfordshire will be kept safe from domestic abuse and have the opportunity to lead healthy and happy lives[44].

5.1.18 The estimated male population of Central Bedfordshire in 2017 was 280,000. Of these, 138,200 (49%) were males and 141,800 (51%) were females. Using ONS data to estimate the number of male victims, that would equate to around 5,804 males who experience domestic abuse in the year (as opposed to 11,202 females), albeit with the caveat as to differences in experience as noticed in 5.1.13 above. Looking at local data, in the same year (i.e. the year ending March 2018):

- 3,504 domestic abuse crimes were reported to Bedfordshire Police; and
- Of these, 826 (24%) were male, with 2678 (86%) being female.

5.1.19 The Thematic Report also outlined a number of public or professional awareness raising activities that were undertaken in 2017 and 2018. These included activities relating to men and domestic violence and abuse.

5.1.20 Male victims and survivors can access help locally, for example the Review Panel were provided with the following data for 2017/18 by CBC's Strategic Manager, Domestic Abuse:

- Victim Support received 1000 domestic abuse referrals. Of these, 253 (25%) were male, with 747 (75%) being female;

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[43] Huntley, A.L., Potter L, Williamson, E., Malpass, A., Szilassy, E. & Feder, G. (2019) Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis, BMJ Open 9(6), p. e021960

[44] Central Bedfordshire Council (2016) Domestic Abuse Strategy 2016 – 2020, Available at: http://www.centralbedfordshire.gov.uk/Images/domestic-abuse-strategy_tcm3-19094.pdf (Accessed: 30th January 2019).

- The Victim Support IDVA service worked with 199 high risk victims. Of these, 30 (15%) were male, with 169 (85%) being female;
- 293 victims were referred to the monthly Multi-Agency Risk Assessment Conference (MARAC). Of these, 9 (or 3%) were male, with 284 (97%) being female; and
- There is also a recently launched support specifically for male victims, with Families First providing counselling and group support for men who have experienced sexual trauma and/or domestic abuse.

5.1.21 Additionally, the Review Panel were informed that a new Domestic Abuse Needs Assessment has been commissioned, with this due to report in Summer 2019. The Needs Assessment is intended to ensure that the local area has a clear picture of domestic abuse, including the needs of the local community, as well as identifying gaps in service and emerging trends or themes. The Review Panel were assured that this would include consideration of male victims.

5.1.22 The Review Panel felt that, taken together, there was much that was positive about the local response to male victims. In this case, it has not been possible to reach a conclusion on a presence of a pattern of domestic violence and abuse. Nonetheless, if Andrew had been experiencing domestic violence and abuse and had felt able to seek help, he could have potentially accessed a range of services, including provision specifically for men.

5.1.23 Tragically, it is not possible to ask Andrew if he would have felt able to access such services. However, it is relevant to note that Andrew's sister (Dawn) told the chair that Andrew was "*a typical man; he didn't get help because he didn't see it as a problem*". Although this statement was made about his alcohol use, this might have meant Andrew would have been unlikely to seek help more generally.

5.1.24 Additionally, while Andrew was appropriately arrested on the 6th January, when he was interviewed the following day, he disclosed that Olivia had threatened him with a knife. He also said she had done so in the past. This disclosure does not seem to have been considered. For example, a DASH RIC was not completed, there was no recognition that counter-allegations had been made by Olivia and Andrew, and nor was this information passed onto other agencies. It is possible that stereotypes about the gender of victims of domestic abuse may have meant that the possibility that Andrew was at risk affected how this disclosure was handled. This is discussed further in relation to the Bedfordshire Police response below.

5.1.25 As a result, the Review Panel identified two areas where local approach could be further strengthened.

5.1.26 The first area relates to how domestic violence and abuse is framed and managed:

5.1.27 Nationally, domestic violence and abuse are included under the umbrella of Violence Against Women and Girls (VAWG) Strategy[45]. This reflects the gendered nature of these forms of violence and abuse, in particular the disproportionate impact on women and girls. This is not articulated explicitly in CBC's domestic abuse strategy, which reads as 'gender neutral'.

5.1.28 As well as being inconsistent with the national strategy, this has implications for male victims. This is because, by not naming the gendered nature of violence and abuse, it also means it is not possible to explicitly consider the issues facing male victims. For example, it is not possible to set out how provision for male victims will be developed in a gender informed and proportionate way (taking account of men's experiences, risks and needs, as well as help seeking, and how these can be the same or different). This will have practical implications: in the absence of a gender informed approach, it is challenging to think about the best way to reach men and women respectively, for example, by developing targeted publicity material. As Dawn's description of Andrew as a "*typical man*", and the myths identified by Respect demonstrate, men may face particular barriers to help seeking. This underscores the importance of targeted raising awareness among male victims of domestic violence and abuse.

5.1.29 Adopting a gendered approach would also be consistent with the UK Government's approach, which is set out in a recently published position statement relating to male victims. This sits alongside the national VAWG Strategy as a complementary and connected piece of work[46].

It is important to have a strategic approach that articulates the needs of male victims and the proportionate actions that will be taken to respond to this need.

Recommendation 3: The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy takes a gender informed approach, and that the revised strategy identifies the specific actions that will be taken, proportionally to need, to support male victims.

[45] HM Government (2016) Ending Violence against Women and Girls Strategy 2016 – 2020, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FIEmmaL_PUBLICATION_MASNatalieR_vRB.PDF (Accessed: 30th January 2019).

[46] HM Government (2019) Position statement on male victims of crimes considered in the cross-Government strategy on ending Violence Against Women and Girls (VAWG), Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783996/Male_Victims_Position_Paper_Web_Accessible.pdf (Accessed: 18th April 2019).

5.1.30 During Review Panel discussions, an issue with the management of the response to domestic violence and abuse was also identified. Specifically, the CBC has a Corporate Domestic Abuse Board and Strategy (see 5.1.17 above). While this addresses some aspects of multi-agency work, there is no external strategy, partnership or action plan for the multi-agency response to domestic violence and abuse. This led to a number of discussions at the Review Panel as to what this meant for the wider multi-agency response and the delivery of a CCR[47]. A number of issues where identified. In relation to local partners, there is understandably no voluntary or community sector representation on the Corporate Domestic Board, but this does mean that there is no single multi-agency space where issues can be raised. In relation to victims, some might not 'fit' within these current arrangements, for example, a victim who neither has children nor meets the threshold for adult safeguarding. Additional issues relating to adult safeguarding are also noted below (see 5.1.38 below). While multi-agency arrangements are a matter for partners locally, the current arrangements may curtail aspects of multi-agency work.

The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that local statutory and voluntary / community sector agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

Recommendation 4: The CSP should review existing strategic arrangements with local partners to ensure that these can support a robust multi-agency CCR locally.

5.1.31 The second issue builds on the proceeding point, specifically relating to publicity material. The BDAP has a website that brings together a range of resources for residents, as well as professionals. CBC Children Services are responsible for maintaining this website[48]. The 'Get Help' page lists support services alphabetically, including both specialist domestic and sexual abuse services, as

[47] The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. A CCR is delivered by by agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

[48] Bedfordshire Domestic Abuse Partnership (2017) *Get Help,* Available at: https://bedsdv.org.uk/get-help/ [Accessed: 30th January 2019].

well as other more generic services. While this is a useful resource, for a victim or survivor, the quantity of information may be overwhelming. Moreover, victims and survivors from communities where the awareness of domestic violence and abuse may be low, or there are barriers to seeking help, may struggle to find information that 'speaks' to them. It may be useful to consider offering a simpler route to sources of local and national support. One way of doing this would be to have a 'tab' for different cohorts of victims (such as men), so an individual user of the website could choose what route most suits their needs.

It is important that victims and survivors can find information on sources of help and support in an accessible format.

Recommendation 5: CBC Children Services to ensure that the 'get help' section of the BDAP website is reviewed to make it more easily navigable.

Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom and with what effect'*'*

5.1.32 There are specific tools available to manage counter-allegations or concerns about bi-directional violence and to establish 'who does what to whom and with what effect' (although it is of note that such tools are most commonly used by specialist domestic abuse services; they are not for example used by Bedfordshire Police). The most well-known version of this tool has been published by Respect and is part of a toolkit that has been designed to support and inform work with male victims of domestic violence[49]. In this toolkit (updated in summer 2019), the issue is summarised as follows:

"In some couples, both parties are using violence. However, it is often the case that one is using violence to defend themselves or the children, or as a means of resistance. In any case, there are risks for both adults and for children witnessing the violence. The appropriate responses will be more effective if the practitioners understand who is doing what to whom and with what consequences. For example, responding to a victim who has used violence in self-defence will not be the same as responding to someone who is the perpetrator. It is therefore very important, when both parties are using violence,

[49] Respect (2019) *Toolkit for work with male victims of domestic violence*, Available at: http://respect.uk.net/wp-content/uploads/2019/06/Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf (Accessed: 9th July 2019).

to assess clearly who is the perpetrator and who is the victim using violent resistance, self-defence or some other form of violence, in the interests of all adults and children involved".

5.1.33 The toolkit includes resources to help practitioners listen to what someone says about their experiences and identify what is going on, to provide the most appropriate help and to make the best use of scarce resources. It also enables practitioners to identify any behaviours that someone may themselves be using, which may include identifying if they are in fact a perpetrator.

5.1.34 In the guidance for the toolkit, the following categories of client following an assessment are identified:

- Victim/survivor of domestic abuse;
- Perpetrator of domestic abuse;
- Victim who has used violent resistance against the perpetrator or perpetrator whose victim has used violent resistance;
- Mutual violence; and
- Unhappy relationship with no abuse or violence.

5.1.35 In this case, it has not been possible to reach a conclusion as to the presence of a pattern of domestic violence and abuse. This is in part because of reports that both Andrew and Olivia may have experienced behaviours that could be indicative of domestic violence and abuse. This underlines the importance of professionals being able to identify and assess such circumstances in practice.

5.1.36 Consequently, the Review Panel identified the importance of ensuring that professional training includes information on the typologies of domestic violence, as well as the identification and assessment of counter-allegations and bi- directional violence. For more specialist practitioners, the Review Panel also considered the ability to undertake an assessment of 'who does what to whom and with what effect'.

5.1.37 This is discussed further in relation to partnership later in the analysis (from 5.2.107 below). However, the Review Panel also felt it important to consider the capacity of the providers of domestic abuse services in Central Bedfordshire in relation to this issue. Unfortunately, this capacity appears limited:

Domestic Abuse Service	Training	Policy / Procedure
Victim Support – IDVA Service	Access IDVA training from SafeLives which includes male victims	Uses a perpetrator screening tool, a desk aide to assist with assessment. This is

		taken from a manual dated '2008'
Signpost Hub	Covered as part of training in relation to non-molestation orders	None

Best practice would be to ensure that there is a robust policy and procedure for the identification, management and assessment of counter-allegations particularly where there are two services that may be receiving domestic abuse referrals.

Recommendation 6: The CSP and the relevant commissioners to work with Victim Support and the Signpost Hub to develop shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services locally.

Older people and domestic violence and abuse

5.1.38 The issue of older adults and domestic violence and abuse has become a subject of increased attention in recent years. Guidance has been issued by the Local Government Association and Association Directors of Adult Social Service[50], while the National Institute for Clinical Excellence (NICE) has issued guidance for health and social care organisations to support best practice around domestic abuse[51].

5.1.39 A report by SafeLives has also identified that, while many of the problems facing older victims are common to all of those experiencing domestic violence and abuse, older victims' experiences may be exacerbated by social, cultural and physical factors. These can include:

- Systematic invisibility;
- Long term abuse and dependency issues;
- Generational attitudes about abuse may make it hard to identify;

[50] Local Government Association and Association Directors of Adult Social Service (2015) *Adult safeguarding and domestic abuse: a guide to support practitioners and managers: Second edition,* Available at: https://www.local.gov.uk/adult-safeguarding-and-domestic-abuse-guide-support-practitioners-and-managers-second-edition [Accessed 30th January 2019].

[51] NICE (2014) *Domestic violence and abuse: multi-agency working*, Available at: https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621 [Accessed 30th January 2019].

- Increased risk of adult family abuse;
- Services are not effectively targeted at older victims and do not always meet their needs; and
- Need for more coordination between services[52].

5.1.40 These issues were echoed in recent research into DHRs involving adults over the 60 years of age. This research identified learning for health and social care practitioners working with older adults, in particular:

- The need to consider the myths and stereotypes about older adults that can influence both health and social care assessments and the interventions offered; and
- The risk of confusion between different terminology, including domestic violence and abuse but also terms like 'elder abuse'[53].

5.1.41 In this case, it has not been possible to reach a conclusion as to the presence of a pattern of domestic violence and abuse. Nonetheless, Andrew was 54 at the time of his death, while Olivia was 73. It is important to consider whether, if either were a victim of violence and abuse and had sought help, they would have been able to access it. This has already been recognised as a potential gap locally, with the 2017 Joints Strategic Needs Assessment identifying that older victims in Central Bedfordshire are not being identified and supported[54].

5.1.42 The Review Panel discussed this at some length and identified that there are some gaps in the local response. For example, older victims and survivors are not explicitly identified in the CBC Domestic Abuse Strategy. This absence may reflect an issue identified in recent research, which suggested that there is a disconnect between the legislation, policy and practice approaches regarding domestic abuse and safeguarding in the context of older people[55]. Additionally, during the Review Panel discussion it was confirmed that the SAB had not identified domestic abuse as a priority. The wider strategic response is discussed in 5.1.24 above.

5.1.43 The Review Panel were informed that a new Domestic Abuse Needs Assessment has been commissioned, with this due to report in Summer 2019.

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[52] SafeLives (2016) Safe Later Lives: Older people and domestic abuse, Available at: http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf [Accessed 30th January 2019].

[53] Benbow, S.M., Bhattacharyya, S. & Kingston, P. (2018) 'Older Adults and Violence: An Analysis of Domestic Homicide Reviews in England Involving Adults over 60 Years of Age', *Ageing and Society*, pp.1–25.

[54] Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group (2017) Domestic Abuse: What are the unmet needs / service gaps? Available at: https://www.jsna.centralbedfordshire.gov.uk/info/4/developing_well/123/domestic_abuse/6 (Accessed: 30th January 2019).

[55] Bows, H. (2018) 'Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK', *The British Journal of Social Work*, bcy108.

The Needs Assessment is intended to ensure that the local area has a clear picture of domestic abuse, including the needs on the local community, as well as identifying gaps in service and emerging trends or themes. The Review Panel were assured that this would include consideration of older victims.

It is important to have a strategic approach that articulates the needs of older victims and the proportionate actions that will be taken to respond to this need.

Recommendation 7: The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy identifies the specific actions that will be taken to support older victims.

5.2 Analysis of Agency Involvement:

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference.

Analyse the communication, procedures and discussions, which took place within and between agencies.

Bedfordshire Police

5.2.2 Bedfordshire Police had one contact with Andrew and Olivia before the homicide on the 6th January 2018. The Bedfordshire Police IMR included a detailed analysis of this incident and concluded that the response was robust and accorded with the positive action policy for matters of domestic violence and abuse, as well as safeguarding priorities. Key issues included:

- Dispatching Police Officers, despite the call being 'silent';
- The completion of a DASH RIC in relation to Olivia, with this graded as 'medium risk' (although, as will be explored below, this was subsequently downgraded to 'standard', and no DASH was completed for Andrew;
- The completion of an F750, which triggered an onward referral to CBC ASC. This issued Olivia's vulnerability identified due to her age, the alcohol misuse by Andrew and the allegation that Andrew had been verbally abusing her for a "*number of years".* The content of this form, and the implications for co-operation with ASC, is discussed in more detail from 5.2.8 below; and

- A gatekeeping decision[56] not to prosecute Andrew. This was on the basis that the threshold test was not met because there was a lack of a complaint. The IMR notes that a charge can be made even when it is not supported by a victim, but in this case, there was a lack of other supporting evidence (for example a statement or a medical examination, both of which the victim had declined).

5.2.3 The Bedfordshire Police IMR made no recommendations. However, the Review Panel identified two areas of concern.

5.2.4 The first area relates to the identification of domestic abuse risk, its management and supervision. When Andrew was interviewed on the 7th January 2018, he disclosed that Olivia had threatened him with a knife and had done so in the past. This disclosure does not seem to have been considered further by police officers. For example, a DASH RIC was not completed, nor was this information passed onto other agencies. This is significant, in particular in relation to the response by CBC ASC. Communication between Bedfordshire Police and ASC is discussed further in 5.2.32 below.

5.2.5 The Review Panel concluded that there should have been specific consideration of the disclosures made by Andrew. As a minimum, that should have included: considering the possibility that Andrew was at risk and the completion of a DASH RIC; recognising the counter-allegations made by Olivia and Andrew; and passing this information onto other agencies (e.g. CBC ASC given the referral that had been made, as well as Victim Support). While this was not possible on the day of the incident itself, it could have been done after the interview with Andrew the following day. Furthermore, given the case was subject to supervisory oversight, there was the opportunity to consider these issues as part of that process.

5.2.6 In addition, the DASH RIC completed in relation to Olivia was downgraded from 'medium' to 'standard' risk. The Review Panel was unable to establish a timeline for when and why the risk rating was changed. However, it concluded that this change was likely to have been made internally by Bedfordshire Police, probably as part of the review of the case by supervisors.

5.2.7 Sadly, issues in relation to supervision are not uncommon. In 2016, her Majesty's Inspectorate of Constabulary (HMIC) commissioned a research project to investigate risk-led policing of domestic abuse across England and Wales. Of relevance to this case were the findings that noted:

- The DASH RIC was not applied consistently at the frontline;

[56] Files are reviewed by a supervisory officer to see if they meet the threshold test for the Crown Prosecution Service to be contacted for charging advice.

- Police officers and staff appeared to prioritise criminal offences and especially physical violence and injury at the current incident at both the initial and secondary stages of risk assessment; and
- A more thorough risk/needs assessment is best undertaken by those with specialist training[57].

5.2.8 It is clearly not possible to say if a different response could have prevented Andrew's death. However, it is clear that there was a missed opportunity to consider the circumstances of the case. While Bedfordshire Police may not have been able to complete a 'who does what to whom and with what effect' assessment, it could have identified the potential risks to both Andrew and Olivia, and the presence of counter-allegations, and then shared this information with partner agencies.

Secondary subversion, by appropriately training staff, is critical to ensure that domestic abuse risk is appropriately identified. In this case, it appears likely that secondary did not identify potential risk to Andrew.

Recommendation 8: Bedfordshire Police to ensure there is a consistent and robust process for the subversion all of domestic abuse incidents / crimes, with this supported by a training package that ensures that police officers and their supervisors are confident in the use of risk tools.

5.2.9 The second concern relates to the timelines of the F750 referral, which was not recorded on the CATS database until the 21st January 2018. This was some two weeks following the incident. Why this took some two weeks is not clear, although this may be due to the backlog of recording incidents that the Review Panel was informed frequently arises following the Christmas and New Year period. This delay also affected the timeliness of a referral to CBC ASC, as the F750 was not sent on until the 21st January 2018.

5.2.10 The Review Panel discussed the delay in the F750 referral. Bedfordshire Police have recently employed 'Vulnerability Engagement Officers' to support victims of domestic abuse crimes. If this case occurred in the future, this would mean that there would, in theory, be capacity to undertake targeted engagement with

[57] Robinson, A., Myhill, A., Wire, J., Roberts, J., and Tilley, N. (2015) Risk-led policing of domestic abuse and the DASH RIC model. Available at: https://www.college.police.uk/News/College-news/Documents/Risk-led_policing_of_domestic_abuse_and_the_DASH_risk_model.pdf [Accessed: 26th April 2019].

Olivia. However, in the same discussion, while it was noted that there is ongoing work to ensure that referrals are progressed as quickly as possible, there continue to be delays at certain times e.g. over the Christmas and New Year period.

5.2.11 Additionally, a copy of the DASH RIC was not sent to CBC ASC on this occasion. Bedfordshire Police were unable to account for why this had not happened, although the Review Panel was assured that a copy of the DASH RIC would normally be sent.

5.2.12 The issue of capacity and timeliness of the response to incidents involving all vulnerable adults who require protection, particularly victims of domestic abuse, was identified as an area of improvement in the most recently published PEEL (Police Effectiveness, Efficiency and Legitimacy Programme) inspection for Bedfordshire Police[58]. The next PEEL inspection is scheduled for July 2019.

Although it is positive that a F750 was completed, the F750 was not entered on the CATS database promptly and this also meant onward referral to CBC ASC was delayed. It is not possible to determine what impact this delay might have had, but such a delay is clearly problematic.

Recommendation 9: Bedfordshire Police to audit the timeframes for referrals made at periods of peak demands and identify mitigating actions to ensure prompt onward referral to partner agencies.

CBC ASC

5.2.13 Neither Andrew nor Olivia where known to CBC ASC prior to 2018, when a F750 form was received from Bedfordshire Police. A number of issues have been identified in relation to the CBC ASC response. This section of the analysis relates solely to internal issues and content of F750.

5.2.14 Having received the F750 on the 21st January 2018, a social worker within the Safeguarding Team reviewed the information and completed a DMT on the 23rd January 2018 (this was within two working days, as the incident occurred on a Sunday). The social worker, based on the information provided in the F750

[58] HMICFRS (2017) *NoahEL: Police effectiveness 2017: An inspection of Bedfordshire Police*, Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-effectiveness-2017-bedfordshire.pdf (Accessed: 18th April 2019).

report, concluded that the incident did not meet the 3-stage test threshold for safeguarding in accordance with the Care Act 2014[59]. Consequently, the DMT advised that, based on the limited information within the referral, a Section 42 safeguarding enquiry[60] was not the proportionate response. Instead, they recommended that an assessment of need should be completed in relation to Olivia and that a carer's assessment should be offered to Andrew.

5.2.15 The DMT:

- Highlighted relevant information, including alcohol use, but also the possibility of 'carer stress' as the police officer had identified Andrew as an informal carer for Olivia;
- Identified that an assessment of need should be completed; and
- Recommended that attempts should be made to discuss the incident with Olivia alone.

5.2.16 The DMT appears to have identified the key issues as set out in the F750 and made reasonable proposals for the next steps to be taken. However, as discussed previously, there was no information included in the F750 that a knife had been used or allegations made by Andrew about Olivia. This is discussed further in relation to communication between Bedfordshire Police and ASC (see 5.2.32 below).

5.2.17 However, at this point there was a breakdown of internal communication. This meant that ultimately neither Olivia nor Andrew were assessed. There are a number of reasons for this breakdown, which are set out below by issue, alongside any contextual information and the learning identified.

Case allocation

5.2.18 The referral was sent onto the relevant Locality Team (the Community Older People and Physical Disability Duty Team) on the 24th January 2018. It was reviewed and allocated on the 25th January 2018. However, in subsequent case management, the social worker to whom the case was allocated was not aware of the DMT. This meant that their approach to Olivia was not informed by the issues identified in the DMT and no carer's assessment was offered to Andrew.

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[59] The eligibility threshold is based on identifying: whether a person's needs are due to a physical or mental impairment or illness; to what extent a person's needs affect their ability to achieve two or more specified outcomes; and to what extent this impacts on their wellbeing. For more information locally, go to: http://www.centralbedfordshire.gov.uk/health-social-care/support/assessment.aspx#EligibilityCriteria.

[60] Safeguarding enquiries are carried out on behalf of adults who fit the criteria outlined in Section 42 of the Care Act 2014. The criteria is: an adult who is believed to: Be experiencing, or at risk of, abuse or neglect; AND Have needs for care AND support (whether or not the local authority is meeting any of those needs); AND As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect. For more information locally, go to: http://www.centralbedfordshire.gov.uk/Images/multi-agency-policy-practice-procedures-sept-2016_tcm3-19861.pdf.

Practice issue	Context	Learning
The DMT was not reviewed at the allocation meeting	It was not the practice of the team to print the entire DMT from the safeguarding team Instead, the 'contact information only' was printed	Reliance on a manual system that is open to error and omission Highlights the limitations of the current client database in its absence of automated workflow, allocation, case monitoring and follow-up
The DMT was not reviewed by the allocated Social Worker	There was an expectation that, as the DMT and other case information were available within the customers record, they would be accessed by the Social Worker The Social Worker, based on the allocation meeting, assumed the case to be a routine request for an assessment of need for Olivia The recommendation for a separate carer's assessment for Andrew was missed	

5.2.19 The CBC ASC IMR noted that there was no rationale for the social worker to not review the DMT and information within the customer record. While accepting this, and the implication that this was a human error by the social worker, the Review Panel felt it was important to contextualise the social worker's response. While the DMT was sent to the Community Older People and Physical Disability Duty Team, and was available electronically, it was not used at the team meeting and was therefore not discussed. This would have provided an important opportunity for information from the DMT to be communicated to the social worker as part of the allocation process.

Care management

5.2.20 Having been allocated, the social worker attempted to make contact on the 30th January 2018, with follow up attempted on the 1st February 2018. A letter was drafted and sent advising that multiple attempts have been made to contact by

telephone to arrange an assessment of need. The letter provides contact details for the social worker and requests that Olivia make contact within 14 days to arrange the assessment otherwise the request for assessment will be closed on the system.

5.2.21 No attempts were made to contact Andrew to explore his needs, in particular whether there may be an issue relating to his being a carer as identified by Bedfordshire Police.

Practice issue	Context	Learning
Quality of the letter – not person-centred and did not take into consideration the sensitivities and risks associated with potential domestic abuse	The letter was drafted by the Social Worker. The electronic client database does not have this capability and available corporate templates did not address this scenario	Staff need to be competent in drafting letters that are person-centred Highlights the limitations of the current client database as there is no capacity to generate template letters Corporate templates are not sufficient Where engagement with people, regardless of purpose, has been repeatedly unsuccessful a discussion should be held with the relevant manager prior to case closure

Case Closure

5.2.22 On the 14th February, the social worker recorded that there had been no contact by email or telephone by Olivia within the requested 14-day period. As there had been multiple attempts to contact with no response, Olivia's case was closed.

Practice issue	Context	Learning
Case does not contain a robust summary of risk and rationale for case closure Likewise, there is no recorded evidence to support that management oversight was sought prior to closure. (This was not evidenced as being discussed either during supervision or in an ad hoc manner, although the Social Worker recalled a discussion with peers and a senior within the team. However, no record exists so this cannot be confirmed).	Due to the limitations of the client electronic database, no automatically generated prompt to revisit or review the case without a new request or further information being received from partners Case closures, particularly in relation to non-engagement, do not have to be sanctioned by a manager	Highlights the limitations of the current client database in its absence of automated workflow, allocation, case monitoring and follow-up Case discussions should be a key part of individual supervision sessions providing support, guidance and also management oversight A discussion should be held with the relevant manager, prior to case closure, where there has been non-engagement

5.2.23 The CBC ASC IMR acknowledged that the database being used is outdated, cumbersome to navigate and does not assist and enable people to work effectively. These limitations and weaknesses have resulted in teams and practitioners creating 'work arounds'. For example, having to adopt a manual system to allocate work to social workers. This inevitably heightens the risk of human error.

5.2.24 The Review Panel also identified three further issues.

5.2.25 First, there was (at first sight) an example of good practice in this period, with the social worker visiting Olivia's address and knocking on the door in a final attempt to make contact. As it happens, nobody was home at the time of visit. However, the Review Panel noted that there does not appear to have been any risk assessment in relation to this visit. While the social worker would not have been aware of this fact, because Bedfordshire Police had not shared this information, there were reports that a knife had been used. There could therefore have been a potential risk to the social worker.

5.2.26 Second, it was reported in the CBC ASC IMR that: "*The social worker said at interview that Olivia's lack of response to contact attempts was interpreted as an indication that the needs assessment and social services involvement were*

being declined by Olivia." The Review Panel felt this was concerning. This suggests that an assumption had been made about the outcome of the contact attempts. Where assumptions are made, there may also be an increased risk of confirmation bias i.e. the tendency to search for or interpret information in a way that confirms one's preconceptions, leading to errors. In this case, non-engagement was inappropriately interpreted as Olivia having declined a service offer.

5.2.27 Third, the Review Panel were informed that currently the training for ASC staff consists of a basic e-learning customer database training module undertaken during the induction period. As a result, staff skills are therefore developed primarily from work experience, their peers and champions. This means there is a risk of inconsistent practice.

5.2.28 Additionally, while ASC does have existing policies and procedures in relation to safeguarding and domestic abuse, training in relation to these areas differs. Safeguarding training is mandatory, with the level of training depending on a practitioner's role and responsibility. In contrast, while domestic abuse training can be accessed by practitioners, and is encouraged as part of safeguarding training, it is not mandatory. The IMR noted that access to domestic abuse training is usually instigated either through development needs identified as part of an annual appraisal or by practitioners themselves.

5.2.29 The Review Panel were informed that a number of different workstreams are underway that are relevant to this learning:

- A new customer database system is currently being commissioned. Learning from this incident will be used in the 'user testing stage' of the implementation to verify how effectively the new system both operates case allocation and closure of cases with a specific focus on risk and managerial oversight;
- Operational policy is under review, in particular areas relating to allocation and risk assessment practices. In the future, all allocations arising from a safeguarding alert will be subject to discussion, allocation and professional oversight by the team manager or delegated senior practitioner; and
- Going forward, it is the intention to identify a Domestic Abuse 'champion' in every team so that knowledge and expertise can be developed, and peer support provided in an accessible manner.

5.2.30 The ASC IMR made the following single agency recommendations relating to case allocation and the existing customer database, which were accepted by the Review Panel:

- *"Case allocation and case closure sections within the operational policy will be updated by Integrated Services to reflect any revisions/improvements made within the system.*

- *When practitioner/ supervisor case closure discussions occur narrative, risk assessment and outcome will be recorded on the customer database. Team managers will highlight this expectation to all practitioners via individual team meetings to aid reflection and learning and ensure that practitioners are not reliant of systems and processes and are using mechanisms such as peer discussions, reflective practice, auditing and reflective case supervision and utilising available managerial support in their day to day practice.*
- *A corporate letter template will be drafted by Integrated Services and sanctioned for use when corresponding with the public around engagement/contact obstacles.*
- *The current customer database training will be reviewed by learning and development with practitioner involvement to ensure training modules are available to the workforce until the replacement system is in situ. Locality teams will identify system champions who can offer assistance to less experienced practitioners when required.*
- *The programme that is overseeing the procurement of a new electronic client database will ensure that robust training and operational guidance is available to the workforce prior to introduction of the new customer database system".*

5.2.31 The ASC IMR also made recommendations relating to the scope of the current staff training offer, as well as supervision and practice issues. The IMR included the following single agency recommendations, which were accepted by the Review Panel:

- *"Manager within Integrated Services will present this and other similar cases as a reflective case study so that team discussions can take place and assist in developing confidence and competence in this area of social work practice. The Practice surgeries and the Practice Forum will be used for further learning and to inform how we approach cases where there are indications of domestic abuse.*
- *Policies and procedures relevant to safeguarding and domestic abuse will be highlighted to all practitioners via practice surgeries.*
- *To ensure all workers are equipped and supported to have conversations about domestic abuse it is recommended that the learning needs analysis captures and is agreed as a priority for this topic.*
- *All practitioners undertaking safeguarding activity to continue to have access via the domestic abuse partnership to a variety of domestic abuse training modules, including training relating to male victims.*
- *'Research in Practice for Adults' have been commissioned to deliver Safeguarding-Coercive and Controlling Behaviour training in March 2019. This subject was the 'topic of the month' in July 2018 following practitioner interest in additional learning in this area".*

Analyse the co-operation between different agencies involved with Andrew or Olivia [and wider family].

Cooperation between Bedfordshire Police and CBC ASC

5.2.32 The issue around cooperation between Bedfordshire Police and CBC ASC can be summarised as follows. First, a specific issue in that Bedfordshire Police did not share information disclosed by Andrew about a knife and threats by Olivia. Second, a broader issue with the overall quality of the F750.

5.2.33 In relation to the first issue, Bedfordshire Police did not undertake a DASH RIC and did not share any information regarding Andrew's disclosures about a weapon (the knife) and previous threats. CBC ASC have indicated that, if this information had been shared, it is likely that the incident on the 6th January 2018 would have met the 3-stage test threshold for safeguarding and therefore a Section 42 safeguarding enquiry would have been completed.

5.2.34 The Review Panel has not made a further recommendation, as it felt that this issue was addressed by recommendation 8.

5.2.35 In relation to the second issue, regarding the quality of the F750, the Review Panel was presented with two different perspectives. Bedfordshire Police believe that the F750 was good practice and appropriately signposted Olivia for access to services, drawing out a number of issues that related to her vulnerability, and also identifying Andrew as a possible carer. In contrast, CBC ASC believe that initial information received did not provide key information or sufficient detail in relation to the actual domestic incident. CBC ASC were also concerned about the delay to receipt of the F750 (which is discussed above).

5.2.36 After the second Review Panel meeting, the CBC ASC representative was asked to identify what they would have wanted the F750 to include. They provided a summary response which highlighted the following factors to consider when assessing seriousness, which they suggested should be addressed in any referral:

- The capacity and wishes of the adult – do they want you to intervene?
- Is there an overriding public concern, are others at risk?
- The nature and extent of the abuse and whether it constitutes criminal activity and a police officer has been consulted, previous convictions, previous reports (this is to include information on the type of abuse and details of events, e.g. if household items and or weapons previously used, this should be included in the referral. Also, information on any historical abuse if known). The length of time it has been occurring;
- The impact on the individual and the risk of repeated or increasingly serious acts;

- The contact the alleged person causing harm may have with other people with care and support needs or children;
- Are there acts and/or level of coercion, threats or manipulation?
- The risk that it may present significant harm to the adult and to others;
- Are there counter-allegations, where both parties allege that the other is abusive; and
- What does the person alleging abuse feel should happen – what was the intended purpose of the allegation?

5.2.37 Additionally, the CBC ASC representative noted that referrals should include a range of other case information (like the name, address and date of birth, etc), as well as a copy of the DASH RIC.

5.2.38 The Review Panel discussed this at some length. The Review Panel ultimately concluded that while the factors that the CBC ASC representative had identified were desirable, they would not always be achievable and that this was dependent on the nature of the incident and the information available to police officers at the time. Moreover, the quality of the F750 that was submitted was reasonable. In reaching this decision, the Review Panel also noted that when the F750 was reviewed on the 21st January 2018 it was good enough to enable a social worker to complete a DMT.

5.2.39 The Review Panel felt there was no simple solution to the issues identified in relation to inter-agency community but felt that the learning identified did underline the importance of clear and robust lines of communication. The Review Panel was therefore pleased to learn that, since the homicide, a number of changes have taken place:

- In April 2018, the CBC ASC Safeguarding Team began regular outreach work with the Bedfordshire Police Public Protection Unit (PPU) to review and make joint decisions on a proportion of backlogged referrals. Since then, the Head of Safeguarding has delivered training to the PPU and the Safeguarding team to recognise the need to share expertise and further support from agencies in relation to raising appropriately informed referrals and safeguarding best practice;
- Outreach support and more frequent conversations have resulted in improved practice in relation to reporting and signposting where information or a required response would be more appropriately and swiftly acted upon by other departments, agencies or partners within Mental Health or Health Services;
- The Pan Bedfordshire Safeguarding Policies and Procedures are due to be strengthened to highlight the need for ASC to contact the PPU requesting additional information where the reason for arrest is not clear on the referral; and

- Safeguarding policies and procedures are being updated to ensure strengthened information around referral and seeking information when missing.

5.2.40 Reflecting these activities, the CBC ASC IMR made the following single agency recommendations, which were accepted by the Review Panel:

- *"Where referrals are received from the Police relating to a domestic incident arrest and information and detail is sparse, the Safeguarding Team will make attempts to contact the PPU. The PPU will receive an email requesting urgent contact and further detail be shared with the safeguarding team and relevant locality team.*
- *The Head of Safeguarding will review the Pan Bedfordshire Safeguarding Policies and Procedures by end of December 2018 and the Operational subgroup of the board will ratify the proposed changes".*

5.2.41 In addition to accepting these single agency recommendations, the Review Panel also identified some additional concerns.

5.2.42 First, there are clearly some differences of understanding as to what constitutes vulnerability locally. In this case, as described in the chronology, Bedfordshire Police and ELFT's Liaison and Diversion Service (L&DS) felt that Olivia was vulnerable in their contact with her in January 2018 and after her arrest in March 2018. Her GP (West Street Surgery) also placed her on their Frailty Index. In contrast, when ASC had contact with Olivia when she was on bail, they determined she had no care and support needs. While the Review Panel accepted that ASC's determination will be informed by its statutory duties under the Care Act 2014, these differences are stark. The Review Panel felt it was reasonable to suggest that such differences could lead to confusion or a lack of confidence among those either making or receiving referrals.

5.2.43 Locally, there are '*Multi-Agency Adult Safeguarding Policy, Practice and Procedures*'[61]. The purpose of this document is to enable all agencies to achieve consistent and robust arrangements for safeguarding adults at risk and to implement effective protection plans which minimise risks of harm and adopt a zero-tolerance approach to abuse, maltreatment and neglect. It would be out of scope to review the document during this DHR, but it is relevant to note that it is 131 pages long. The document does not include a complete definition of domestic abuse, although it does include a short summary of what domestic abuse may involve and a list of possible indicators (p. 22), and it also addresses the purpose of the MARAC (p.50).

[61] Central Bedfordshire Council (n.d.) *Multi-Agency Adult Safeguarding Policy, Practice and Procedures*, Available at: http://www.centralbedfordshire.gov.uk/Images/multi-agency-policy-practice-procedures-jan-2018_tcm3-19861.pdf (Accessed: 18th April 2019).

5.2.44 Alongside this document, there is a shorter '*Guide for Alerters: What to consider before making a safeguarding alert*'[62]. This provides basic guidance for a referrer to consider and poses key questions to help make a decision about a safeguarding referral. However, the guide does not provide an example of different concerns (e.g. neglect, physical abuse, etc) or provide a readily accessible framework for decision making (e.g. non-reportable, consult with CBC ASC or make a safeguarding alert).

5.2.45 Despite these issues, it is positive that CBC ASC regularly receives referrals to its Safeguarding Team. For example, in the first three quarters of 2018/19 there were 812 safeguarding concerns raised. Of these:

- Converted to S42: 123 (15%);
- Assessment and review: 389 (48%);
- Information / advice provided: 106 (13%);
- Inappropriate referral: 73 (9%); and
- Information sharing only: 121 (15%).

5.2.46 However, in the Review Panel's discussion there was a recognition that there was clearly some disparity between different agencies understanding of vulnerability in this case.

While there is a local Adult Safeguarding Policy, Practice and Procedures document, with an associated guidance document, there is a need for greater confidence and consistency in deciding when an issue is a safeguarding concern or not. This could include providing a more explicit threshold document or framework for multi-agency partners to assist in decision making (including whether to contact CBC ASC Services for advice or to make a safeguarding referral).

Recommendation 10: The SAB to develop guidance on raising concerns about abuse and neglect.

[62] Central Bedfordshire Council (n.d.) *Guide for Alerters: What to consider before making a safeguarding alert*, Available at: http://www.centralbedfordshire.gov.uk/Images/alerters-guide_tcm3-21253.pdf (Accessed: 18th April 2019).

5.2.47 Second, this case illustrates the potential for parallel pathways where there is both a safeguarding adult and domestic abuse concern. When Bedfordshire Police identified a concern about Olivia's vulnerability, this triggered a referral to CBC ASC via the F750. Separately, a domestic abuse referral was made (in this case, to Victim Support, although since April 2018 this would be either to the Signpost Hub or Victim Support depending on the level of risk).

5.2.48 This means that there were two different attempts at contact with Olivia relating to the same incident, while Olivia also had contact with Bedfordshire Police. As it happens, CBC ASC were not able to make contact with Olivia, while Victim Support were albeit this was brief. In neither of these contacts by CBC ASC or Victim Support was there any consideration of the potential support needs of Andrew.

5.2.49 Additionally, there is no mechanism currently by which ASC or the Signpost Hub / Victim Support would be automatically aware of these parallel referrals. That would be dependent on either Bedfordshire Police noting that a referral had been made and/or one or other agency identifying this and making contact. Either way, this leaves a considerable amount to chance.

5.2.50 The Review Panel considered whether to make a recommendation that an Adult Multi-Agency Safeguarding Hub (MASH) should be established. A MASH is a single point of contact for all safeguarding concerns. The model was originally developed to manage safeguarding concerns relating to children and young people, although in some areas the MASH also manages either adult domestic abuse or all adult safeguarding concerns. However, there is no single model for the establishment of an adult MASH[63].

5.2.51 The Review Panel was informed that the local area has considered whether to establish an adult MASH and has no intention to do so at this time. Given this, the Review Panel decided not to make a recommendation that an adult MASH be established. This was because it felt the substantive learning in this case was addressed by the single agency IMR recommendations described above. However, the Review Panel felt that further actions were necessary.

5.2.52 In relation to this issue, the Review Panel noted that various models have been developed to try and address this issue. For example, SafeLives have developed guidance relating to an older persons' care pathway. This is included as an example in Appendix 4.

[63] For more information, go to: https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/collaborative-working-and-partnership/multi-agency-safeguarding-hubs.asp.

Referral pathways for adults should be clear and enable agencies to work together to safeguarding victims and survivors.

Recommendation 11: The SAB to audit local referral pathways for adults who are victims of domestic abuse, and for whom there may be vulnerability or safeguarding concerns, to ensure these offer a robust response regardless of whether someone meets the level for statutory intervention.

Analyse the opportunity for agencies to identify and assess domestic abuse risk.

Bedford Hospital

5.2.53 There is no record of Andrew having attended Bedford Hospital.

5.2.54 Olivia attended the A&E department at Bedford Hospital once in November 2012. When she attended, she was booked at reception as a new patient because she had not been to the hospital previously. Olivia told reception staff that she wanted to see a psychiatrist. However, she left A&E before being seen by a medical professional and prior to seeing the triage nurse. A letter was sent to Olivia's GP, informing them that Olivia had attended but had left without being seen. This is good practice and is aligned with trust policy.

5.2.55 Since this contact, the psychiatric services have been re-commissioned and re-designed. At A&E, all patients are now seen by a registered practitioner (this commenced in October 2018) when booking. They are then referred to the most appropriate service, whether that be the Urgent Treatment Centre or Accident and Emergency, and then to the Psychiatric Team. The Psychiatric Service is available within the A&E department 24 hours a day, 7 days a week.

5.2.56 The benefit of being seen by a registered practitioner at the point of booking is to expedite referrals to other services, but also for clinical questions to be asked which would help form any assessment of need.

5.2.57 As an example of good practice, the Review Panel were informed that there has been a Health IDVA (HIDVA) at Bedford Hospital since 1st May 2017. They are employed by Victim Support. They are funded through the Better Care Fund Plan for Central Bedfordshire, although funding has to be applied for annually.

5.2.58 Staff have access to Safeguarding Training. The level of subject detail depends on the role of staff within the organisation; with clinical staff such as registered nurses/doctors/allied health care professionals receiving more in-depth training

as part of Level 3 training. Additionally, Bedford Hospital has a Domestic Abuse Policy (not assessed as part of this DHR). However, Bedford Hospital NHS Trust's short report identified a number of single agency recommendations that were accepted by the Review Panel:

- *"Continue with awareness raising through structured training, and team training events of Domestic Violence*
- *Development of an e-learning package.*
- *Aide Memoire being developed for nursing and medical professionals in regard to identifying signs of domestic violence".*

5.2.59 As the issue of discharge notifications was raised by one of the two GP surgeries in this case (Kirby Road Surgery), both hospital trusts were asked about their current approach. The Review Panel was informed that the quality of content in regard to discharge letters and their timeliness in being sent from the hospital to GPs is an area of work that is currently being reviewed. A new IT system (called 'Symphony') is being implemented in A&E in July 2019. This will support improvement plans in regard to both the content and delivery of discharge letters. As a result, the Review Panel did not make any recommendations in relation to this issue.

Luton and Dunstable Hospital

5.2.60 Based on the chronology, Andrew had minimal involvement with Luton and Dunstable Hospital. The exception to this was two A&E attendances in June and November 2006. On both occasions, he presented having fallen (and on the second visit, he had also sustained a blade injury to his leg).

5.2.61 Concerning the medical interventions provided in response to these two attendances, discussions appear to have taken place with Andrew and appropriate monitoring and surveillance also took place. However, during these contacts, no enquiry was made about domestic violence and abuse. This may have been reasonable; there were no reports from other agencies or disclosures made by Andrew that might have indicated he was experiencing domestic violence and abuse. Additionally, he provided a plausible account for his injuries. It is not possible to say without the risk of hindsight bias whether an enquiry should have been made, however, the issue of Luton and Dunstable Hospital's Domestic Violence and Abuse Policy is discussed below and barriers for male victims are explored elsewhere in this report.

5.2.62 The only other issue was Andrew's alcohol intake, which was noted at his first admission. Andrew told staff that he increased his alcohol intake. This was discussed with Andrew. The records relating to this contact were reviewed during the course of the DHR, but they are limited. This means it is possible to

see that advice was given, but not to clarify any further details about Andrew's disclosure.

5.2.63 Olivia had significantly more contact, but these contacts were within an outpatient setting. Medical interventions were appropriate and there is no evidence that Olivia disclosed any information that would have led staff to believe violence and abuse was an issue.

5.2.64 During all these contacts, discharge notifications were sent to the relevant GP surgeries. The issue of notifications is discussed further below (from 5.2.83 below).

5.2.65 During some of the time period reviewed, Luton and Dunstable Hospital did not have a standalone policy for Domestic Violence and Abuse; however normal safeguarding procedures and protocols were clearly outlined within the Adult Safeguarding policy available at that time. This would have included Domestic Violence and Abuse. A Domestic Violence and Abuse Policy was completed and published in December 2016. It is due to be reviewed in June 2019 (not assessed as part of this DHR).

5.2.66 All staff receive training in relation to Adult Safeguarding, whereby Domestic Violence and Abuse is discussed. Currently, this includes Level 1, 2 and 3 Adult Safeguarding training. The level 3 Adult Safeguarding training is a one-day course and discusses Domestic Violence and abuse in detail. This commenced in October 2016.

5.2.67 The Luton and Dunstable University Hospital IMR made two recommendations, which were accepted by the Review Panel:

- *"The DHR findings will be shared with trust staff via departmental meetings and clinical governance*
- *A summary of the findings of this investigation will be discussed within Children's and Adults Safeguarding training sessions provided by the Trust".*

5.2.68 As noted above, both hospital trusts were asked about their current approach to discharge notification. This is particularly relevant to Luton and Dunstable Hospital, given Kirby Road Surgery raised issues specifically regarding a discharge notification it received relating to Andrew in 2016. As with the Bedford Hospital, a new IT system (called 'Symphony') has been implemented. There is an implementation plan in place that will enable improvements in the content and delivery of discharge letters. As a result, the Review Panel did not make any recommendations in relation to this issue.

5.2.69 The Review Panel found a discrepancy between the two hospital trusts. Specifically, Bedford Hospital has a HIDVA. This is positive and reflects the value of a specialist domestic abuse staff within a hospital, which have been

evidenced by a recent SafeLives report[64]. However, there is no HIDVA at Luton and Dunstable Hospital. As both Andrew and Olivia accessed A&E at various points, it is reasonable to suggest that there should be equitable provision in respect of HIDVA's locally. This would ensure that should similar circumstances occur in the future and a disclosure is made, there is a consistent service offer.

It is best practice to have specialist domestic abuse staff co-located within a hospital setting, as is the case in Bedford Hospital. However, HIDVA provision is not consistent locally.

Recommendation 12: Within the Better Care Fund Plan for Central Bedfordshire, the Bedfordshire CCG and CBC review funding for local HIDVA services to ensure that there is a consistent and equitable service offer.

West Street Surgery – GP for Olivia

5.2.70 Staff at the GP surgery have access to Safeguarding Training, which incorporates Safeguarding, Domestic Abuse and Vulnerable Adults. Nonetheless, the West Street Surgery IMR had the following recommendation, which was accepted by the Review Panel:

- *"Refresher Domestic Abuse training as incorporated in the Level 3 Safeguarding Training for all Clinical staff".*

5.2.71 Olivia had been registered with the GP surgery since 1986. She accessed the GP surgery in relation to her health needs when required, which equated to six appointments with a GP and four appointments with a practice nurse in the past 4 years. Olivia did not see her Named GP but was seen by the same Partner GP with regard to her depression.

5.2.72 While Olivia was reported as having taken an overdose in 1994, there were no other safeguarding concerns of this nature. However, she had a number of health issues. In 2010 Olivia had a small stroke (a TIA) which resulted in her having left sided weakness where she had to use a stick. She also had

[64] SafeLives (2017) *A Cry for Health: Why we must invest in domestic abuse services in hospitals*, Available at: http://safelives.org.uk/node/935 (Accessed: 18th April 2019).

longstanding high blood pressure, depression and took appropriate medication for this. The GP surgery was aware that Olivia had a range of health needs, including placing her appropriately on the 'Frailty Index'[65].

5.2.73 It appears that the health care provided to Olivia was appropriate. Olivia had a health check with a practice nurse in May 2017 when she indicated that she drank five units of alcohol per week. She was asked as to whether she drank more than six units in one session, she replied never. Her liver function was checked in February 2017 and was normal. The issue of alcohol use is addressed below (from 5.2.92 below).

5.2.74 The only issue identified in the IMR was in relation to Olivia's mental health. She was prescribed anti-depressants in 2014, with the dosage monitored regularly and then changed medication in 2015. The dose was increased in 2016 when she reported as having mood swings, sleep disturbance and feeling anxious. During this time, Olivia was not referred to the Mental Health Link worker. This was because there were no concerns relating to her coping with everyday life, she was not showing any signs of mental health deterioration and she did not disclose any information that suggested she was a danger to herself or other. The Review Panel felt that there was evidence of discussions with Olivia about her circumstances, and, without the risk of bias, it is not possible to say whether an enquiry should have been made about domestic violence and abuse.

5.2.75 In reviewing the case, the GP surgery has recognised that patients may benefit from counselling when on anti-depressants for any length of time. Consequently, West Street Surgery made the following recommendation. The Review Panel accepted this recommendation because it felt that access to talking therapies may have provided Olivia with a space where she may have felt able to talk about any concerns or be asked about issues at home.

- *"Review Mental Health/Counselling Pathway"*.

Kirby Road Surgery – GP for Andrew

5.2.76 Staff at the GP surgery have access to Safeguarding Training, which incorporates Safeguarding, Domestic Abuse and Vulnerable Adults.

5.2.77 Andrew registered at Kirby Road Surgery from birth. He remained in good health and was not a regular attendee at the GP practice. His limited contact

[65] A Frailty Index is a tool used by GP's to identify, assessment and case manage older people living with frailty.

was for medical matters and appears appropriate. No disclosures of domestic violence were made nor were there any safeguarding concerns identified.

5.2.78 The IMR noted that two discharge notifications were received in relation to Andrew. The first, following his fall in June 2006, is of note. This was very brief and did not include any information in relation to Andrew's disclosures around alcohol.

5.2.79 On 10th August 2016 Andrew was invited for a routine health check. He did not take up this invitation. The invitation was generated automatically based on Andrew's age, although if Andrew had taken it up, this check would have taken place relatively soon after his attendance at Luton and Dunstable University Hospital.

5.2.80 On the 16th November another A&E discharge notification was received. This stated Andrew had sustained a laceration to left lower leg, and described the medical treatment provided. Andrew made an appointment to have the wound dressed at the practice and came to see the practice nurse on six occasions between 25th November and 16th December 2016 for wound dressings. There were no concerns about a smell of alcohol, Andrew being inebriated or his general presentation.

5.2.81 It is reasonable to assume that if the GP practice had been made aware of the alcohol issue identified at Andrew's June 2016 A&E attendance, this information would have been entered on Andrew's health record and health staff may have undertaken further enquiries during contact.

5.2.82 The GP surgery IMR noted that this illustrates an issue with the quality of information contained in discharge notifications and suggested that this be considered further. The Review Panel considered this but did not make any further recommendations as it was advised about the work locally regarding discharge notifications (discussed above in relation to both Bedford Hospital and Luton and General Hospital).

5.2.83 However, the Review Panel did note that there were occasions when both Olivia (after her attendance at Bedford Hospital in November 2012) and Andrew (after his attendance at Luton & Dunstable Hospital in June 2016) were subject of discharge notifications that did not lead to any follow up by their respective GPs.

While it is encouraging that the quality of discharge notifications will be improved, this will also mean that it is important to ensure GPs respond appropriately to notifications.

Recommendation 13: Bedfordshire CCG to work with GPs to evaluate the impact of the changes to the discharge notifications from local hospitals and ensure that this GPs take follow up action if required.

5.2.84 The Review Panel were informed by the Bedfordshire CCG that a new pathway has been developed with the CBC (including Children Social Care and ASC) where the first point of referral for GPs is to Signpost Hub for support for the victim. A referral to the (Children) MASH is automatically made if children are involved. This is good practice.

Analyse agency responses to any identification of domestic abuse issues.

5.2.85 These issues are discussed elsewhere in the report, with the exception of Victim Support.

5.2.86 Victim Support was the service commissioned by the Bedfordshire Police and Crime Commissioner to provide support to victims of crime until March 2018. Referrals were principally received directly from Bedfordshire Police via an automated process, although victims could also self-refer or be referred by any other agency.

5.2.87 Following the incident on 6th January 2018, an automatic referral was received by Victim Support on the 8th January 2018 directly from Bedfordshire Police. The case was referred as an 'assault without injury' and carried a flag for 'standard risk' domestic abuse. The referral related to Olivia as the victim and did not include the information disclosed by Andrew regarding allegations of knife use. The domestic abuse flag made the case eligible for an enhanced service, and the Review Panel were informed that the same offer would have been made if the referral had (as originally graded by Bedfordshire Police) been 'medium' risk. Telephone contact was made on the 9th January 2018 and this included an offer of support. Olivia declined the offer of support but did agree to a text being sent that contained the telephone number of the Victim Assessment and Referral Centre should she ever change her mind. This text was sent on the same day and the case was subsequently closed on the 10th January 2018.

5.2.88 As there was no information provided by Bedfordshire Police regarding Andrew as a potential victim, or the use of a knife by Olivia, Victim Support did not make any attempt to contact him.

5.2.89 As all processes were correctly completed in line with internal policy and contractual requirements, no recommendations were made.

Analyse organisations' access to specialist domestic abuse agencies.

5.2.90 These issues are discussed elsewhere in the report.

Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

5.2.91 These issues are discussed elsewhere in the report.

Specific consideration to the following issues:

- ***Alcohol use***
- ***Mental health***
- ***Adults at Risk***
- ***Carer Status***
- ***Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom'.***

Alcohol Use

5.2.92 The evidence available to the Review Panel has identified the potential for alcohol use to have been an issue for both Andrew and Olivia:

- At an early health contact with Kirby Road Surgery, Andrew reported drinking 30 units a week. His subsequent contacts with health services were very limited. Alcohol was identified as an issue at the first of Andrew's two attendances at A&E at Department at Luton & Dunstable Hospital (following a fall, in June 2016) when he disclosed that he had recently lost his job and that his alcohol intake had increased. However, there were no issues identified at his second attendance at A&E at Department at Luton & Dunstable (for a blade injury, in November 2016). Thereafter Andrew attended his Kirby Road Surgery for ongoing care of this wound. During this contact, no issues were identified around alcohol use. There was one other event of note in relation to alcohol, with Andrew leaving a job in May 2016 due to his drinking; and
- In contrast, Olivia does not appear to have been identified as having any alcohol issues in her contact with any agency. At her last contact with West Street Surgery (in May 2017), Olivia told the practice nurse that she drank

five units of alcohol per week and her liver function had been checked at an earlier visit (in February 2017) and was normal.

5.2.93 However, on the 6th January 2017, when Bedfordshire Police attended their home both Andrew and Olivia were intoxicated. During an interview the following day, Andrew told the Police that he and Olivia had been drinking heavily since Christmas Day. Police officers identified alcohol as a key issue, with this also being included in the F750 form that was sent onto CBC ASC. Olivia also told the police officers that she and Andrew had been drinking. A friend (Matthew) also told Bedfordshire Police after the homicide that, on a holiday in 2016, Andrew and Olivia drank throughout. Lastly, during the murder enquiry, it became apparent that both Andrew and Olivia were intoxicated on the day of the homicide.

5.2.94 As part of the thematic report relating to Drug & Alcohol Treatment Services, it was noted that anecdotal evidence suggests that alcohol misuse is a growing concern amongst the local population aged 50 plus. For example, the Review Panel were informed that over 40% of Path 2 Recovery (P2R) clients are aged 50 or older:

Age Group	% accessing alcohol treatment in 2016/17	% of local population by age group, 2015[66]
50-59	26%	14%
60-69	13%	11%
70-79	2%	7%

5.2.95 This is clearly relevant to Andrew (who was aged 54 at the time of his death), and Olivia's (aged 73 at the time of Andrew's death).

5.2.96 Because there was limited contact with agencies in relation to these issues, the Review Panel did not feel able to make any specific recommendations. However, it did conclude that both Andrew and Olivia were each almost certainly drinking more than the recommended units per week and were probably misusing alcohol. However, in the absence of further information, it is not possible to determine definitively whether Andrew and / or Olivia were alcohol dependent. Nor is it possible to determine when and how their alcohol use (individually and together) developed. This means it is not possible to

[66] Central Bedfordshire Council (2018) *Population: Central Bedfordshire population by age group, 2015,* Available at: https://www.jsna.centralbedfordshire.gov.uk/info/8/demography/48/population/2 (Accessed: 30th January 2019).

consider in any detail the interaction between alcohol use and the relationship dynamics, including domestic abuse.

5.2.97 However, to maximise the opportunity to use the learning from this case, the Review Panel agreed to reflect on local provision and consider the extent to which agencies would be able to identify and respond to alcohol use issues. The Review Panel agreed that each agency providing direct services would provide information on their training, policy and procedure in relation to:

- Identification – identifying whether a client/patient is drinking at risk/harmful/dependent levels;
- Brief advice – providing solutions or strategies or information to reduce harmful drinking levels where appropriate; and
- Pathways - referral to the local Alcohol Service where it is clear that the client/patient requires more in-depth treatment and drinking may be dependent.

5.2.98 A summary of responses is included in **Appendix 2**. There is considerable variation across local agencies in relation to identification and brief advice.

Clearly, this exercise is limited in scope but, given that both Olivia and Andrew had alcohol use issues and had contact with some services regarding this, the Review Panel felt this was an area that should be considered further.

Recommendation 14: Public Health Commissioners to develop a programme to raise awareness of best practice in relation to the identification and offer of brief advice by local services in relation to alcohol use.

5.2.99 While there was variation across local agencies in relation to identification and brief advice, it is positive that the majority of agencies were aware of and would signpost or refer to Path 2 Recovery (P2R).

5.2.100 Additionally, the Review Panel was informed that future service plans locally include:

- On-line Service Provision: Commissioners are working to develop an on-line platform, which is planned to allow residents experiencing drug and alcohol harms to access information, support and treatment virtually, reducing the need to access physical hubs;

- Alcohol CLeaR: Commissioners have recently undertaken an Alcohol CLear Assessment, Public Health England[67] assessment tool, an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective collaborative working. This will help assess work around vision, governance, partnership, planning and commissioning, communications, primary, secondary and tertiary prevention, children and young people, data and innovation. This mechanism will support strategy development; and
- Health Needs Assessment & Strategic Action Plan: Public Health have recently produced a Health Needs Assessment (HNA) to identify local needs, provision and gaps in services, in order to underpin a new Drug and Alcohol Strategic Action Plan, with recommendations to reduce the harms caused by alcohol misuse, which will promote collaboration to improve outcomes.

5.2.101 The Review Panel sought assurance that these future service plans would take into specific consideration the needs of older residents. Assurances were provided that this was the case. It was also noted that, as a proportion of the local population, the age category of Andrew (50-59) was over-represented in services. Therefore, the Review Panel did not make any further recommendations.

Mental health

5.2.102 There was no information available to the Review Panel to indicate that Andrew had any needs in relation to his mental health.

5.2.103 Issues in relation to Olivia's mental health are discussed elsewhere in the report.

Adults at Risk and Carer Status

5.2.104 These issues of 'Adult at Risk' (including whether a Section 42 enquiry should have been triggered) are discussed above.

5.2.105 The Review Panel sought further information from CBC ASC about the process for assessing carer status, and whether this included consideration of issues around domestic violence and abuse. In this context, it was noted that someone can be assessed as a carer in their own right, and this is not dependent on an assessment of the cared-for person. Although CBC ASC did identify a potential issue around Andrew being a carer (based on the information in the F750), he

[67] For more information, go to: https://www.gov.uk/government/publications/local-alcohol-services-and-systems-improvement-tool.

was not offered a carer's assessment. The reasons for this are discussed in the analysis of CBC ASC's response above.

5.2.106 A copy of the local carer's assessment, as well as the 'prompts' that are provided to practitioners as guidance, was shared with the chair. In the assessment conclusion the latter includes a specific reference to domestic abuse, asking: "*Are there any safeguarding considerations including dynamics of domestic abuse within the household, risks to either party, how to respond to allegations and counter allegations where divulged*." This is good practice.

Identification, management and assessment of domestic abuse, including counter-allegations and 'Who Does What To Whom'.

5.2.107 The dynamics of Andrew and Olivia's relationship are discussed above in 5.1, which identified the potential of counter-allegations. As noted in the discussion of contact by Bedfordshire Police, the presence of counter-allegations was not identified. While CBC ASC did initially identify the potential for domestic abuse in the DMT, it is not clear if and how professionals would have managed such a concern.

5.2.108 To maximise the opportunity to use the learning from this case to reflect on local provision and consider provision for male victims, as well as the extent to which agencies would be able to identify and respond to counter-allegations, the Review Panel agreed that each agency providing direct services would provide information on their training in relation to:

- Male victims of domestic violence and abuse;
- The identification and resolution of counter-allegations; and
- Access to relevant external training programmes.

5.2.109 A summary of responses is included in **Appendix 3**. While most agencies appear to have training that covers men, this was not universal. Additionally, there is variation in the extent to which this training explicitly addresses men and / or issues of counter-allegations. However, it was positive, and reflects the established partnerships locally, that most agencies were aware of the BDAP Training Programme.

5.2.110 The BDAP Training Programme training is available through the 'Learning Academy', which is delivered by the Pan Bedfordshire Training Unit. The

Academy supports safeguarding training across Bedfordshire[68]. This training programme has an extensive domestic violence and abuse offer, including:

- Domestic Abuse – Advanced;
- Domestic Abuse – DASH Risk Assessment Training Domestic Abuse & the Legal Framework;
- Domestic Abuse and the Lesbian, Gay, Bisexual and Trans (LGBT) Community;
- Domestic Abuse Awareness;
- Domestic Abuse in the Digital World;
- Engaging with Perpetrators; and
- Perpetrators - Moving Towards Change.

5.2.111 Assurances were provided to the Review Panel that issues for male victims are explored generally across these courses, and are specifically addressed in:

- The 'Domestic Abuse – Advanced' course, which includes a learning outcome for participants to be able to 'Respond to male victims'; and
- The 'Domestic Abuse and the LGBT Community' course, which addresses the needs of GBT men.

5.2.112 Assurances were also provided that issues relating to counter-allegations and 'who does what to whom and with what effect' are addressed in the 'Engaging with Perpetrators' course.

5.2.113 While this training activity is positive, the Review Panel noted that there is no intermediate and advanced training content in relation to heterosexual male victims of domestic abuse. Additionally, while it may be appropriate to address issues relating to counter-allegations and 'who does what to whom and with what effect' in perpetrator training, it is important to ensure that staff can access key messages relating to these issues across training content. This is particularly important given that these issues may present in contexts outside of a 'perpetrator' response, which would have been the case for Olivia and Andrew if services had engaged with them more substantively.

[68] For more information, go to: https://www.centralbedscpd.co.uk/safeguarding/Default.asp.

There is a local training offer which could be further developed to address issues for male victims, as well as considerations in relation to 'who does what to whom and with what effect'.

Recommendation 15: The Pan Bedfordshire Learning Academy to review the current training available in relation to male victims of domestic abuse and ensure that:

(a) Key messages are integrated across all introductory training

(b) Staff can access intermediary and advanced level training.

Recommendation 16: The Pan Bedfordshire Learning Academy to ensure that domestic abuse training content addresses typologies of domestic violence and abuse.

Recommendation 17: The Pan Bedfordshire Learning Academy to review the current training available locally and ensure it addresses the identification, management and assessment of counter-allegations. This should include integrating key messages across training content and also developing bespoke training content.

Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

5.2.114 Issues around help seeking are discussed elsewhere in the report.

5.3 Equality and Diversity:

5.3.1 The Review Panel identified the following protected characteristics of Andrew and Olivia as requiring specific consideration for this case; age, sex and disability.

5.3.2 *Age:* While no information was presented specifically in relation to age in this case, given that Andrew was in his 50s and Olivia was in her 70s, the Review Panel has considered this Protected Characteristic. Looking beyond this case, the Review Panel has identified the potential challenges for older people in terms of identifying their experiences as abusive and / or seeking help. Conversely, there may be barriers to professionals and services identifying domestic abuse among older people, particularly if stereotypes mean that the potential for victimisation or perpetration are not considered. In this case, despite CBC ASC's initial response identifying domestic abuse as a possible

issue, a breakdown in internal communication meant domestic abuse was not considered. This meant the referral from Bedfordshire Police was assumed to be a routine request for assessment. Moreover, the fact that Olivia did not respond to contact attempts was inappropriately assumed to mean that she was declining support.

5.3.3 Issues in relation to age have also been noted in respect of access to alcohol treatment services.

5.3.4 *Sex:* As discussed above (see 1.4), sex is a risk factor in domestic violence, with females being disproportionality affected by domestic homicide. However, in this case, the victim of the homicide was male. The Review Panel has considered the information available and, while recognising Andrew was clearly the victim of a fatal act of domestic violence, has been unable to reach a determination as to the wider presence and nature of domestic violence and abuse in Andrew and Olivia's relationship. While an initial concern was considered in relation to Olivia, the Review Panel has established that potential risk to Andrew was not identified. Additionally, information about this potential risk was not shared. This may have reflected stereotypes about male victims, and also about the likelihood of (older) female perpetrators. Regardless of the cause, this meant that there were missed opportunities to assess risk. While a more holistic assessment may have clarified whether either Olivia or Andrew were the primary victim, it may have also identified counter-allegations or bi-directional violence. The Review Panel has therefore considered the importance of having the appropriate pathways, training and tools to identify potential concerns about the use of violence and abuse in relationships, in particular where victim and perpetrator status are unclear (otherwise referred to as an assessment of 'who does what to whom and with what effect'). Looking beyond this case, the Review Panel has also considered issues around provision for male victims, as well as the importance of taking a gendered informed approach.

5.3.5 *Disability*: No information was presented to suggest that Andrew had a disability, however the Review Panel identified differences in the perspective of local services as to whether Olivia had a vulnerability. Olivia also appears to have had a physical disability with some issues with mobility. Given both Andrew and Olivia used alcohol, it is of note that an addiction to alcohol is not itself considered a disability. However, if someone has liver disease or depression caused by alcohol dependency, that may be considered an impairment if that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities and therefore constitute a disability. Given the limited engagement of agencies with Andrew and Olivia, there were no opportunities to make such an assessment. However, agencies did identify concerns around alcohol use for Andrew and, after the homicide, for Olivia.

5.3.6 *Race*: Both Andrew and Olivia were White British. No information was presented that raised issues around this Protected Characteristic. However, although it is impossible to know, it is likely that both Andrew and Olivia's cultural context affected both their perception, and also the help and support they might have felt they could access.

5.3.7 The Review Panel noted that, taken together, these issues may have affected how Andrew and / or Olivia were seen by agencies, and the extent to which they may have felt help and support were available. For example, if Andrew had been experiencing domestic abuse, he may have faced barriers in identifying or disclosing this, as well as in securing an appropriate response. This could also have been affected by stereotypes about Olivia and whether she could have been a perpetrator. Conversely, Olivia if Olivia had been experiencing domestic abuse, her age may have been a barrier to accessing help and support.

5.3.8 No information was presented that raised any issues regarding other Protected Characteristics, including: Religion *and Belief; Sexual orientation; Gender reassignment; Marriage / civil partnership; or Pregnancy and maternity.*

6. Conclusions and Lessons to be Learnt

6.1 Conclusions:

6.1.1 Andrew's death was a tragedy. He was a dearly loved brother, and his death has affected his family deeply. Andrew had limited contact with services, and the lessons to be learnt from this contact are discussed below. The Review Panel is grateful to Dawn for her contribution to the DHR, as it has allowed this DHR to have a picture of Andrew as a person – for example his sense of humour, as well as his affection for his nephews.

6.1.2 However, this DHR has been complicated by the limited information available to the Review Panel about the relationship between Andrew and Olivia. What's more, the information that is available is open to a range of different interpretations. Although Andrew was clearly the victim of a fatal act of domestic violence, looking beyond this, it has not been able to determine whether he experienced domestic violence and abuse in the broader sense of an ongoing pattern of behaviour. It is possible he did so. However, as discussed in the analysis, it is also possible that Olivia was the victim of violence and abuse. If Olivia had experienced violence and abuse from Andrew prior to the homicide, this has significant implications for the lessons to be learnt in this DHR. As a final consideration, it is also possible that both Andrew and Olivia may have been using violence and abuse. Acknowledging the complexity of this case, as well as these different possible scenarios, does not however diminish Olivia's responsibility for the fatal act of violence that killed Andrew, an act which led to her conviction for manslaughter.

6.1.3 There is lastly the wider context of Andrew and Olivia's lived experience, which included issues such as alcohol use, but also concerns around possible vulnerability and / or care and support needs.

6.1.4 Given these issues, the Review Panel has sought to try and understand what happened and consider the issues in Andrew and Olivia's lives that might help explain the circumstances of the homicide.

6.1.5 The Review Panel extends its sympathy to all those affected by Andrew's death and thanks all those who have participated in the DHR.

6.2 Lessons To Be Learnt:

6.2.1 The learning in this case includes learning which is related specifically to agencies and their interactions with Andrew and / or Olivia. There has also been

broader learning that has come about by using this tragic case to reflect on issues in relation to male and older victims, as well as alcohol use.

6.2.2 In relation to this specific case, the most substantive learning relates to Bedfordshire Police and CBC ASC. In relation to the former, the Review Panel has identified a specific issue with the timeliness of onward referrals once a case has come to the attention of Bedfordshire Police. The good practice demonstrated by Bedfordshire Police in identifying concerns relating to Olivia following the incident on the 6th January 2018 could have been compromised by the length of time it took for their referral to reach CBC ASC. More concerningly, although Andrew made disclosures about possible risk, these were not addressed. This meant no DASH RIC was completed, counter-allegations were not considered, and this information was not shared. In relation to CBC ASC, while the Review Panel has identified examples of good practice in the initial assessment, a breakdown of internal communication meant that ultimately neither Olivia nor Andrew were assessed. CBC ASC is to be commended for making a significant number of single agency recommendations to address policy, practice and case management systems as a result of its participation in this DHR. There has also been learning for health providers, including hospitals and GPs, particularly in relation to the quality and response to discharge notifications.

6.2.3 The Review Panel was mindful that, even if agencies had responded differently to this case, Andrew and Olivia had limited engagement with services. This could have presented considerable challenges to agency involvement. As a result, while different responses (including a carer's assessment or a Section 42 assessment) could have created opportunities for engagement, they may not have led to a different outcome. However, this is not to suggest that Andrew and Olivia could not have been helped. Professionals and agencies must be able to identify, and take pro-active steps to respond to, concerns. Even if someone is not able to take up offers of support, agencies should be seeking ways to ensure that people are aware of what help and support is available and take, where possible, measures to provide a 'safety net' should they seek help in the future.

6.2.4 Considering broader learning, the Review Panel has made recommendations relating to the importance of a gendered approach to domestic violence and abuse as this allows for the specific consideration of the needs of male victims. In this context, while it is positive that CBC has a Corporate Domestic Abuse Board, the Review Panel has recommended that local strategic arrangements are reviewed to ensure these can support the delivery of a robust CCR.

6.2.5 Additionally, the Review Panel has identified learning around a range of other issues. This case illustrates how different agencies can have a very different

understanding of vulnerability, and a recommendation has been made to ensure that there is a good understanding of how local agencies raise concerns about abuse and neglect.

6.2.6 In relation to specialist domestic abuse service, the Review Panel has recommended that local providers (and their commissioners) address a gap locally by developing shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services. A disparity in HIDVA provision was also the subject of a recommendation. While neither Andrew nor Olivia engaged with a HIDVA, both attended A&E departments at different times, which is an important reminder of the opportunity that a HIDVA service may represent.

6.2.7 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Many of the recommendations made in this DHIR will help develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

7. Recommendations:

7.1 IMR Recommendations (Single Agency):

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section three following the analysis of contact by each agency and are also presented collectively in **Appendix 5**. These are as follows:

CBC ASC

7.1.2 Case allocation and case closure sections within the operational policy will be updated by Integrated Services to reflect any revisions/improvements made within the system.

7.1.3 When practitioner/ supervisor case closure discussions occur narrative, risk assessment and outcome will be recorded on the customer database. Team managers will highlight this expectation to all practitioners via individual team meetings to aid reflection and learning and ensure that practitioners are not reliant of systems and processes and are using mechanisms such as peer discussions, reflective practice, auditing and reflective case supervision and utilising available managerial support in their day to day practice.

7.1.4 A corporate letter template will be drafted by Integrated Services and sanctioned for use when corresponding with the public around engagement/contact obstacles.

7.1.5 The current customer database training will be reviewed by learning and development with practitioner involvement to ensure training modules are available to the workforce until the replacement system is in situ. Locality teams will identify system champions who can offer assistance to less experienced practitioners when required.

7.1.6 The programme that is overseeing the procurement of a new electronic client database will ensure that robust training and operational guidance is available to the workforce prior to introduction of the new customer database system.

7.1.7 Manager within Integrated Services will present this and other similar cases as a reflective case study so that team discussions can take place and assist in developing confidence and competence in this area of social work practice. The Practice surgeries and the Practice Forum will be used for further learning and to inform how we approach cases where there are indications of domestic abuse.

7.1.8 Policies and procedures relevant to safeguarding and domestic abuse will be highlighted to all practitioners via practice surgeries.

7.1.9 To ensure all workers are equipped and supported to have conversations about domestic abuse it is recommended that the learning needs analysis captures and is agreed as a priority for this topic.

7.1.10 All practitioners undertaking safeguarding activity to continue to have access via the domestic abuse partnership to a variety of domestic abuse training modules, including training relating to male victims.

7.1.11 'Research in Practice for Adults' have been commissioned to deliver Safeguarding- Coercive and Controlling Behaviour training in March 2019. This subject was the 'topic of the month' in July 2018 following practitioner interest in additional learning in this area".

7.1.12 Where referrals are received from the Police relating to a domestic incident arrest and information and detail is sparse, the Safeguarding Team will make attempts to contact the PPU. The PPU will receive an email requesting urgent contact and further detail be shared with the safeguarding team and relevant locality team.

7.1.13 The Head of safeguarding will review the Pan Bedfordshire Safeguarding Policies and Procedures by end of December 2018 and the Operational subgroup of the board will ratify the proposed changes.

Bedford Hospital

7.1.14 Continue with awareness raising through structured training, and team training events of Domestic Violence

7.1.15 Development of an e-learning package.

7.1.16 Aide Memoire being developed for nursing and medical professionals in regard to identifying signs of domestic violence".

Luton and Dunstable Hospital

7.1.17 The DHR findings will be shared with trust staff via departmental meetings and clinical governance

7.1.18 A summary of the findings of this investigation will be discussed within Children's and Adults Safeguarding training sessions provided by the Trust".

West Street Surgery

7.1.19 Refresher Domestic Abuse training as incorporated in the Level 3 Safeguarding Training for all Clinical staff

7.1.20 Review Mental Health/Counselling Pathway

7.2 DHR Recommendations:

7.2.1 The Review Panel has made the following recommendations, which are also described in section three as part of the analysis and are also presented collectively in **Appendix 6**.

These recommendations should be acted on through the development of an action plan, with progress reported on to the CSP within six months of the review being approved.

7.2.2 **Recommendation 1:** The Ministry of Justice to develop guidance for prisons in relation to their role in the DHR process, including the pro-active steps they should take to enable engagement with perpetrators.

7.2.3 **Recommendation 2:** The CSP to work with partners in the BDAP to agree a mechanism for collating and sharing findings and recommendations systematically from local DHRs.

7.2.4 **Recommendation 3:** The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy takes a gender informed approach, and that the revised strategy identifies the specific actions that will be taken, proportionally to need, to support male victims.

7.2.5 **Recommendation 4:** The CSP should review existing strategic arrangements with local partners to ensure that these can support a robust multi-agency CCR locally.

7.2.6 **Recommendation 5:** CBC Children Services to ensure that the 'get help' section of the BDAP website is reviewed to make it more easily navigable**.**

7.2.7 **Recommendation 6:** The CSP and the relevant commissioners to work with Victim Support and the Signpost Hub to develop shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services locally.

7.2.8 **Recommendation 7:** The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy identifies the specific actions that will be taken to support older victims.

7.2.9 **Recommendation 8:** Bedfordshire Police to ensure there is a consistent and robust process for the subversion all of domestic abuse incidents / crimes, with this supported by a training package that ensures that Police Officers and their supervisors are confident in the use of risk tools.

7.2.10 **Recommendation 9:** Bedfordshire Police to audit the timeframes for referrals made at periods of peak demands and identify mitigating actions to ensure prompt onward referral to partner agencies.

7.2.11 **Recommendation 10:** The SAB to develop guidance on raising concerns about abuse and neglect.

7.2.12 **Recommendation 11:** The SAB to audit local referral pathways for adults who are victims of domestic abuse, and for whom there may be vulnerability or safeguarding concerns, to ensure these offer a robust response regardless of whether someone meets the level for statutory intervention.

7.2.13 **Recommendation 12:** Within the Better Care Fund Plan for Central Bedfordshire, the Bedfordshire CCG and CBC review funding for local HIDVA services to ensure that there is a consistent and equitable service offer.

7.2.14 **Recommendation 13:** Bedfordshire CCG to work with GPs to monitor the impact of the changes to the discharge notifications from local hospitals and ensure that this GPs take follow up action if required.

7.2.15 **Recommendation 14:** Public Health Commissioners to develop a programme to raise awareness of best practice in relation to the identification and offer of brief advice by local services in relation to alcohol use

7.2.16 **Recommendation 15:** The Pan Bedfordshire Learning Academy to review the current training available in relation to male victims of domestic abuse and ensure that:

(a) Key messages are integrated across all introductory training

(b) Staff can access intermediary and advanced level training.

7.2.17 **Recommendation 16:** The Pan Bedfordshire Learning Academy to ensure that domestic abuse training content addresses typologies of domestic violence and abuse.

7.2.18 **Recommendation 17:** The Pan Bedfordshire Learning Academy to review the current training available locally and ensure it addresses the identification, management and assessment of counter-allegations. This should include integrating key messages across training content and also developing bespoke training content.

Appendix 1: Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Andrew and Olivia following the death of Andrew in March 2018. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with:

    - Andrew and Olivia from 1998 (when they are believed to have met) to March 2018 (the date of the homicide) (inclusive)
    - Andrew and / or Olivia and any other parties where it is relevant, including any history of domestic violence and abuse in previous relationships.

2. 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.
3. To 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.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To 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.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Role of the Independent Chair, the Review Panel and the Central Bedfordshire Community Safety Partnership (the CSP)

8. *The Independent Chair will:*

    a) Chair the Review Panel.

b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. *The Review Panel will:*

a) Agree robust Terms of Reference (ToR).
b) Ensure appropriate representation of their agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by their organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the CSP
j) Implement your agency's actions from the Overview Report Action Plan.

The CSP will:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and STADV.

d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will reference 'domestic violence' and 'coercive control'. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

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

Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Andrew and Olivia (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities.

12. The Review Panel identified the following protected characteristics of Andrew and Olivia as requiring specific consideration in this case:
    - Age (Andrew was 54 at the time of his death, Olivia was 73)
    - Disability (At the time of the first panel meeting, it was not known if Andrew had any disability. Olivia had a number of health needs and was listed on her General Practice's 'Frailty Index')
    - Sex (Andrew was male, Olivia is female).
13. The following issues have also been identified as particularly pertinent to this homicide:
    - Alcohol use
    - Mental health
    - Carer status.
14. Additionally, the Review Panel noted that while Andrew was the victim of the homicide, the presence or nature of a wider pattern of domestic violence and abuse in the relationship is unclear. The limited previous contact with agencies also indicates that there may be issues in relation to the identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom'.
15. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."
    - Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.
    - If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as ASC, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.
    - The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on

any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

16. The conclusion of the Review Panel is that Olivia may have been an Adult at Risk, while Andrew may have been her carer. During the course of its deliberations the Review Panel will also consider if Andrew may have been an Adult at Risk in his own right.
17. *Expertise:* The Independent Chair will invite services with expertise in relation to men and domestic abuse, as well as older people, to be on the Review Panel to provide appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide:
    - Carers in Bedfordshire – provides support for unpaid family carers throughout Bedfordshire
    - Families First Bedfordshire – offers one to one counselling and group support for men who have experienced sexual trauma and/or domestic abuse
    - Respect – a UK membership organisation for work with domestic violence perpetrators, male victims of domestic violence and young people's violence in close relationships
    - SafeLives – a national domestic abuse charity, which has recently produced a report that highlighted that older people are often 'hidden' victims of domestic abuse and which is developing training on 'responding to older people affected by domestic abuse'.
18. If Andrew and Olivia have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
19. The Review Panel agrees it is important to have an intersectional framework to review Andrew and Olivia's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

20. There is an inquest into the death Andrew and the panel will ensure the DHR process dovetails with the Coroner Inquest.
21. As the DHR will consider issues in relation to Adults at Risk and Carer Status, the Review Panel noted that issues may be identified that relate to how agencies work together to

safeguard and promote the wellbeing of adults. The Review Panel agreed that it was important that a link is made to the Local Safeguarding Board (SAB) for Bedford Borough and Central Bedfordshire.

22. It will be the responsibility of the Independent Chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

[Criminal trial disclosure dealt with in disclosure as set out in paragraph 50 - 52]

Membership

23. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Review Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
24. The following agencies are to be on the Review Panel:
    - Bedford Hospital NHS Trust
    - Bedfordshire Clinical Commissioning Group (who will support the involvement of Street Surgery – related to Olivia and Kirby Road Medical Practice – related to Andrew)
    - Bedfordshire Police – Senior Investigating Officer (for first meeting only), Family Liaison Officer, Head of Emerald Team (Domestic Crime & Serious Sexual Offences)
    - CBC ASC Services
    - CBC Children Social Care Services (Strategic Manager, Domestic Abuse)
    - CBC Community Safety Partnership
    - East London Foundation Trust (ELFT) – Mental Health
    - East London Foundation Trust (ELFT) – Path 2 Recovery (Substance Misuse)
    - Luton & Dunstable University Hospital
    - Mind Bedfordshire, Luton and Milton Keynes
    - Victim Support (domestic violence specialist service provider).

25. As set out in paragraph 17 the following organisations bring additional expertise:
    - Carers in Bedfordshire
    - Families First Bedfordshire
    - Respect
    - SafeLives.

26. The Principal Social Worker, Head of Safeguarding & Quality Improvement, (ASC, Central Bedfordshire Council), who is a Review Panel member, will be the panel member to ensure good cross communication with the SAB (see paragraph 21).

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

27. Standing Together have been commissioned by the CSP to independently chair this DHR. Standing Together have in turn appointed their DHR James Rowlands to chair the DHR. The DHR team consists of two Support Officers and a DHR Manager. The DHR Support Officer (Helene Berhane) will be the main point of contact for the DHR and the DHR Team Manager (Gemma Snowball) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

28. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
29. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Andrew and / or Olivia during the relevant time period:
    - Bedfordshire Police
    - CBC ASC Services
    - Luton & Dunstable University Hospital NHS Foundation Trust
    - West Street Surgery – related to Olivia.
30. Given their limited contact with Andrew and / Olivia, the following organisations will provide a short report:
    - Bedford Hospital NHS Trust
    - Kirby Road Medical Practice – related to Andrew (short report)
    - Victim Support – IDVA Service.
31. Each IMR / short report should:
    - Set out the facts of their involvement with Andrew and/or Olivia;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;

- Consider issues of agency activity in other areas and review the impact in this specific case.

32. Further agencies may be asked to completed chronologies and IMRs if their involvement with Andrew and Olivia becomes apparent through the information received as part of the review.
33. To inform the deliberations of the Review Panel, reports are also sought in relation to three thematic areas. These reports should address the strategic context, evidence of local need, pathways, provision, gaps and issues in relation to:
    a) Men and domestic abuse (to be provided by the CSP and Central Bedfordshire Children Services, Central Bedfordshire Council)
    b) Older people and domestic abuse (to be provided by ASC, Central Bedfordshire Council))
    c) Substance misuse (to be provided by the Public Health Commissioning, ASC, Central Bedfordshire Council)

Key Lines of Inquiry

34. In order to critically analyse the incident and the agencies' responses to Andrew and/or Olivia, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Andrew or Olivia [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Specific consideration to the following issues:
        - Alcohol use
        - Mental health
        - Adults at Risk
        - Carer Status
        - Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom'.

h) Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

35. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the CSP on their action plans within six months of the Review being completed.
36. The CSP to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

37. The review will sensitively attempt to involve the family of Andrew in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Bedfordshire Police Family Liaison Officer (FLO) and / or the relevant support service (e.g. Victim Support Homicide Service or Advocacy After Fatal Domestic Abuse) as appropriate
38. The review will sensitively attempt to involve the family of Olivia in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Bedfordshire Police Contact Officer.
39. Olivia will be invited to participate in the review, following the completion of the criminal trial.
40. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
41. The Review Panel discussed involvement of other informal networks of the Andrew or Olivia. Based on the information available, it was agreed it to seek the involvement of Andrew's employer, as well as the neighbours of Andrew and Olivia.

Media handling

42. Any enquiries from the media and family should be forwarded to the CSP who will liaise with the chair. Panel members are asked not to comment if requested. The CSP will make no comment apart from stating that a review is underway and will report in due course.
43. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

44. All information discussed is strictly confidential and must not be 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.
45. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
46. It is 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. Documents will be password protected.
47. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.
48. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
49. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

50. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

51. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
        - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
        - partial redaction of record content.
    c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
    d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime

ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

e) As part of the police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.

f) The Independent Chair will discuss the issues of disclosure in this case with the Senior Investigating Officer / Disclosure Officer as appropriate.

g) The Independent Chair, the CPS and the police will consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 2: Summary of Responses (Alcohol)

Agencies providing direct services were asked to complete a short template, describing their training, policy and procedure in relation to alcohol use considering:

- ***Identification*** – identifying whether a client/patient is drinking at risk/harmful/dependent levels
- ***Brief advice*** – providing solutions or strategies or information to reduce harmful drinking levels where appropriate
- ***Pathways*** - referral to the local Alcohol Service where it is clear that the client/patient requires more in-depth treatment and drinking may be dependent

Agency	Identification	Brief advice	Pathways
Bedford Hospital NHS Trust	Questions about alcohol use is incorporated into Medical Assessments on presentation to the hospital. However, there is no template to ensure that this is asked which would aid consistency of approach	Patient information available-'Alcohol Fact Sheet'. Information provided about Pathway 2 Recovery Services	Signpost (or refer with consent) to Path 2 Recovery (P2R). Pathway 2 Recovery (P2R) staff will attend the hospital to see patients
Bedfordshire Police	All officers receive training when the join the organization in recognizing these who drink, behaviours, signs of intoxication and management of drunk persons.	Officers will supply members of the public with leaflets, information and advice on how they can seek help with their alcohol abuse.	No direct referrals are sent by Response Officers. Issues flagged to Public Protection Unit who are then responsible for making necessary referrals.
Carers in Bedfordshire	No specific training policy	No specific training policy	Signpost to Path 2 Recovery (P2R)
Central Bedfordshire Council – ASC Services	This is not a specific question but where it is identified by another professional this would be explored and identified in assessments	We would ask person about the impact of alcohol in their life and try to understand if they are seeking to change this	Signpost to Path 2 Recovery (P2R)

Central Bedfordshire Council – Children's Social Care Services	Confirmed Staff can access training courses: 'Parental Substance Misuse and its Impact on the family' (Class room based) and 'The effects of parental problem substance use on children' (e-learning). No specific information submitted on identification.	No specific information submitted on brief advice	No specific information submitted on pathways.
ELFT (includes Mental Health and Wellbeing Services and Path 2 Recovery (P2R))	Not specifically identified within Adult Safeguarding training and guidance	Not specifically identified within Adult Safeguarding training and guidance	Signpost to drug and alcohol services (Path 2 Recovery (P2R)); Dual Diagnosis group in place, overseeing development of pathways for people with mental health and drug and alcohol services
Families First Bedfordshire	Staff are not provided with specific training around alcohol use. Covered in general safeguarding training/ policy	Counselling services would provide this, but it is not something day to day services would provide	We would signpost to the GP or Path 2 Recovery (P2R)
Kirby Road Surgery	All new patients aged 16 and above are asked to complete the attached questionnaire; this includes questions on alcohol consumption. Ad hoc intervention during consultations	No information provided	Path 2 Recovery (P2R)is our local service and if patients agree they are referred.
Luton & Dunstable University Hospital	Staff are informed via various routes regarding substance misuse and the referral pathways to the Resolutions team	Upon referral and assessment by the onsite Resolutions team, solutions, strategies and information to reduce	The Trust have 2 permanent staff (Liaison workers) provided by Resolutions that are

	available within the trust to support patients with substance misuse. Alcohol is discussed within various training sessions including the Adult and Children's Safeguarding Training. The referral pathway to the Hospital Liaison Team from Resolutions is also discussed during these training sessions	harmful drinking levels would be the discussed by this particular team and in some cases alongside the medical team responsible for that particular patients care. Hospital staff also give advice were necessary regarding support available etc	on site 9-5 Mon to Friday
Mind BLMK for Mental Health	In initial assessment the clients drinking habits are identified through using the Recovery star as an assessment tool	If drinking levels are at level where more support is required, the support worker will provide information and help the client goal plan to reduce drinking	Clients are referred with permission to: Path 2 Recovery (P2R
Victim Support – IDVA Service	Access IDVA training from SafeLives which includes work with clients with substance misuse	Access IDVA training from SafeLives which includes work with clients with substance misuse	Signpost to Path 2 Recovery (P2R))
West Street Surgery	All patients are asked about their alcohol consumption during GP consultations.	Patients with alcohol consumption above recommended units are provided with signposting information/leaflets. Those patients with excessive consumption and worrying symptoms are referred to alcohol support groups when it is felt necessary.	Signpost to Path 2 Recovery (P2R))

Appendix 3: Summary of Responses (Domestic Violence and Abuse)

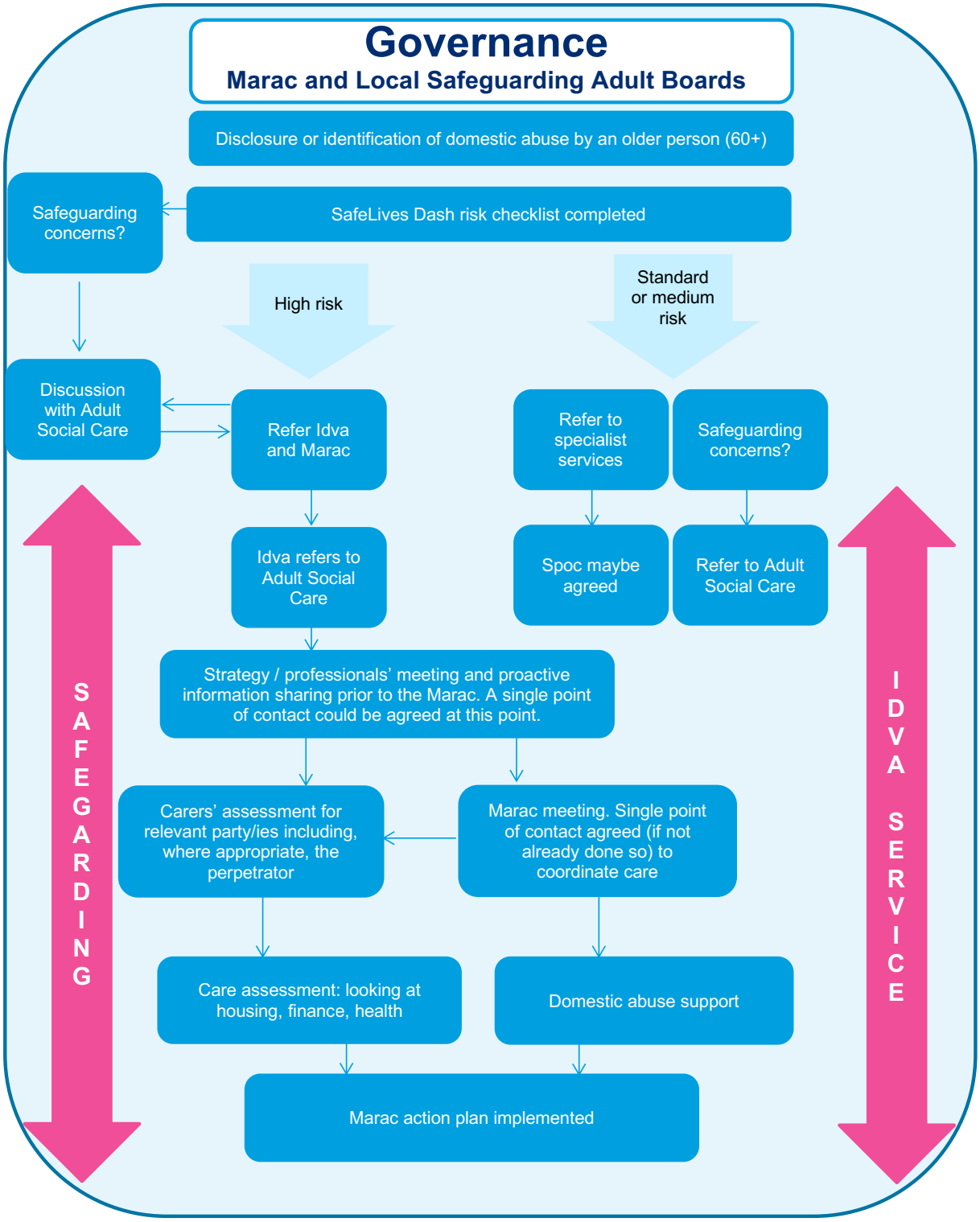
Agencies providing direct services were asked to complete a short template, describing their domestic violence and abuse training offer for staff, specifically whether:

- The training addresses **male victim**s of domestic violence and abuse
- The training specifically addresses the **identification and resolution of counter-allegations**
- Staff accessed any relevant **external training** programme

Agency	Men as victims	Counter allegations	External training
Bedford Hospital NHS Trust	Level 1, 2 and 3 Adult and Child Safeguarding Training HIDVA provides bespoke training to relevant departments (e.g. A&E and Maternity staff). Training includes case studies where male victims have attended the hospital and discusses support services available.	Training includes case studies identifying counter allegations and resolution examples	Staff have the ability to access external training regarding Domestic Abuse training (e.g. BDAP)
Bedfordshire Police	Have access to SafeLives DA Matters training. This is a recognised training Programme that covers all elements of domestic abuse, including male victims	Contains elements of the type of abuse male victim will suffer and how male victims will try to hide they are victims of abuse	n/a
Carers in Bedfordshire	No	No	Staff are signposted to the BDAP Training Programme
Central Bedfordshire Council – ASC Services	Yes	Yes	Staff are signposted to the BDAP Training Programme
Central Bedfordshire Council –	Yes	Yes	Staff are signposted to the

Children's Social Care Services			BDAP Training Programme
ELFT (includes Mental Health and Wellbeing Services and Path 2 Recovery (P2R)	No	No	Staff are signposted to the BDAP Training Programme
Families First Bedfordshire	Training coves all victims of domestic abuse and additional activity around male victims	Being implemented	Staff are signposted to the BDAP Training Programme
Kirby Road Surgery	Safeguarding Training, which incorporates Safeguarding, Domestic Abuse and Vulnerable Adults	n/a	All staff can access the online training portal e-Learning
Luton & Dunstable University Hospital	Level 1, 2 and 3 Adult and Child Safeguarding Training.	Counter allegations discussed on Level 3 Safeguarding Adults training	Staff have the ability to access external training regarding Domestic Abuse training (e.g. BDAP)
Mind BLMK for Mental Health	N	N	Source training through the CVS and Local Authorities
Victim Support – IDVA Service	Access IDVA training from SafeLives which includes male victims	SafeLives training covers, gathering information, interview questions, presentation of victims and perpetrators, key indicators. Staff also use a desk aid as an aide memoire	n/a
West Street Surgery	Safeguarding Training, which incorporates Safeguarding, Domestic Abuse and Vulnerable Adults	n/a	All staff can access the online training portal e-Learning

Appendix 4: SafeLives Older Persons' Care Pathway



Appendix 5: Single Agency Recommendations and Template Action Plan

CBC ASC

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Case allocation and case closure sections within the operational policy will be updated by Integrated Services to reflect any revisions/improvements made within the system.						
When practitioner/ supervisor case closure discussions occur narrative, risk assessment and outcome will be recorded on the customer database. Team managers will highlight this expectation to all practitioners via individual team meetings to aid reflection and learning and ensure that practitioners are not reliant of systems and processes and are using mechanisms such as peer discussions, reflective practice, auditing and reflective case supervision and utilising available managerial support in their day to day practice.						
A corporate letter template will be drafted by Integrated Services and sanctioned for use when corresponding with the public around engagement/contact obstacles.						
The current customer database training will be reviewed by learning and development with practitioner involvement to ensure training modules						

are available to the workforce until the replacement system is in situ. Locality teams will identify system champions who can offer assistance to less experienced practitioners when required.						
The programme that is overseeing the procurement of a new electronic client database will ensure that robust training and operational guidance is available to the workforce prior to introduction of the new customer database system".						
Manager within Integrated Services will present this and other similar cases as a reflective case study so that team discussions can take place and assist in developing confidence and competence in this area of social work practice. The Practice surgeries and the Practice Forum will be used for further learning and to inform how we approach cases where there are indications of domestic abuse.						
Policies and procedures relevant to safeguarding and domestic abuse will be highlighted to all practitioners via practice surgeries.						
To ensure all workers are equipped and supported to have conversations about domestic abuse it is recommended that the learning needs analysis captures and is agreed as a priority for this topic.						
All practitioners undertaking safeguarding						

activity to continue to have access via the domestic abuse partnership to a variety of domestic abuse training modules, including training relating to male victims.						
'Research in Practice for Adults' have been commissioned to deliver Safeguarding- Coercive and Controlling Behaviour training in March 2019. This subject was the 'topic of the month' in July 2018 following practitioner interest in additional learning in this area".						
Where referrals are received from the Police relating to a domestic incident arrest and information and detail is sparse, the Safeguarding Team will make attempts to contact the PPU. The PPU will receive an email requesting urgent contact and further detail be shared with the safeguarding team and relevant locality team.						
The Head of safeguarding will review the Pan Bedfordshire Safeguarding Policies and Procedures by end of December 2018 and the Operational subgroup of the board will ratify the proposed changes.						

Bedford Hospital

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Continue with awareness raising through structured training, and team training events of Domestic Violence.						
Development of an e-learning package.						
Aide Memoire being developed for nursing and medical professionals in regard to identifying signs of domestic violence.						

Luton and Dunstable Hospital

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
The DHR findings will be shared with trust staff via departmental meetings and clinical governance.						
A summary of the findings of this investigation will be discussed within Children's and Adults Safeguarding training sessions provided by the Trust.						

West Street Surgery

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Refresher Domestic Abuse training as incorporated in the Level 3 Safeguarding Training for all Clinical staff.						
Review Mental Health/Counselling Pathway.						

Appendix 6: DHR Recommendations and Template Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1: The Ministry of Justice to develop guidance for prisons in relation to their role in the DHR process, including the pro-active steps they should take to enable engagement with perpetrators.						
Recommendation 2: The CSP to work with partners in the BDAP to agree a mechanism for collating and sharing findings and recommendations systematically from local DHRs.						
Recommendation 3: The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy takes a gender informed approach, and that the revised strategy identifies the specific actions that will be taken, proportionally to need, to support male victims.						
Recommendation 4: The CSP should review existing strategic arrangements with local partners to ensure that these can support a robust multi-agency CCR locally.						
Recommendation 5: CBC Children Services to ensure that the 'get help' section of the BDAP website is reviewed to make it more easily navigable						
Recommendation 6: The CSP and the						

relevant commissioners to work with Victim Support and the Signpost Hub to develop shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services locally						
Recommendation 7: Bedfordshire Police to ensure there is a consistent and robust process for the subversion all of domestic abuse incidents / crimes, with this supported by a training package that ensures that Police Officers and their supervisors are confident in the use of risk tools						
Recommendation 8: The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy identifies the specific actions that will be taken to support older victims.						
Recommendation 9: Bedfordshire Police to audit the timeframes for referrals made at periods of peak demands and identify mitigating actions to ensure prompt onward referral to partner agencies.						
Recommendation 10: The SAB to develop guidance on raising concerns about abuse and neglect.						
Recommendation 11: The SAB to audit local referral pathways for adults who are victims of domestic abuse, and for whom there may be vulnerability or safeguarding concerns, to ensure these						

offer a robust response regardless of whether someone meets the level for statutory intervention.						
Recommendation 12: Within the Better Care Fund Plan for Central Bedfordshire, the Bedfordshire CCG and CBC review funding for local HIDVA services to ensure that there is a consistent and equitable service offer.						
Recommendation 13: Bedfordshire CCG to work with GPs to monitor the impact of the changes to the discharge notifications from local hospitals and ensure that this GPs take follow up action if required.						
Recommendation 14: Public Health Commissioners to develop a programme to raise awareness of best practice in relation to the identification and offer of brief advice by local services in relation to alcohol use						
Recommendation 15: The Pan Bedfordshire Learning Academy to review the current training available in relation to male victims of domestic abuse and ensure that: (a) Key messages are integrated across all introductory training (b) Staff can access intermediary and advanced level training.						
Recommendation 16: The Pan						

Bedfordshire Learning Academy to ensure that domestic abuse training content addresses typologies of domestic violence and abuse.						
Recommendation 17: The Pan Bedfordshire Learning Academy to review the current training available locally and ensure it addresses the identification, management and assessment of counter-allegations. This should include integrating key messages across training content and also developing bespoke training content.						

Appendix 7: Glossary of Terms

AAFDA	Advocacy After Fatal Domestic Abuse
A&E	Accident and Emergency
BDAP	Bedfordshire Domestic Abuse Partnership
DMT	(ASC) Decision Making Tool
CAD	(Bedfordshire Police) Computer Aided Dispatch
CATS	(Bedfordshire Police) Case Administration and Tracking System
CBC	Central Bedfordshire Council
CBC ASC	Central Bedfordshire Council Adult Social Care
CCR	Coordinated Community Response
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist
DHR	Domestic Homicide Review
DMT	(CBC ASC) Decision Making Tool
ELFT	East London NHS Foundation Trust
F750	(Bedfordshire Police) Vulnerable Adult Report
FLO	(Bedfordshire Police) Family Liaison Officer
GP	General Practice
HIDVA	Health IDVA
HMPSS	Her Majesty's Prison and Probation Service
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IT	Information Technology
L&DS	(ELFT) Liaison and Diversion Service
LGBT	Lesbian, Gay, Bisexual and Trans
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
NICE	National Institute for Clinical Excellence
ONS	Office for National Statistics
PEEL	Police Effectiveness, Efficiency and Legitimacy Programme
P2R	(ELFT) Path 2 Recovery
PPU	(Bedfordshire Police) Public Protection Unit
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SIO	(Bedfordshire Police) Senior Investigating Officer
STADV	Standing Together Against Domestic Violence
TIA	Transient Ischaemic Attack
VAWG	Violence against Women and Girls
VSHS	Victim Support Homicide Service