Domestic Homicide Report

DHR 'F' Leeds

Report in to the death of Alison

Report produced by Ian Kennedy, Independent Chair

22nd July 2015

INTRODUCTION

This report will set out the findings of the Domestic Homicide Review carried out following the death of Alison who lived in Leeds prior to her death in [redacted] 2014. Her husband, William, was convicted of her manslaughter in October 2014. (Both parties' names have been changed to protect their identities)

Alison had moved out of their joint home in the weeks prior to her death and was looking forward to an independent life freed from what she described as a loveless relationship. However, she continued to receive regular unprompted visits from her husband to her new address, during one of which he stabbed her to death with a kitchen knife.

The review considered the interaction that Alison and her husband had with agencies prior to her death, from June 2012 onwards. The primary and fundamental purpose of the review is to learn lessons from Alison's death and the involvement which she either had with agencies, or could have had. This is the purpose of all Domestic Homicide Reviews; to learn lessons so that other preventive work can be undertaken, processes improved and understanding reinforced to prevent further similar tragedies. A better informed understanding will enable professionals to take what action is necessary to reduce the risk of further deaths occurring.

TIMESCALES

This review was initiated at the Domestic Homicide Review Sub Group meeting, in Leeds, on Wednesday, the 27th, August 2014. The first meeting of the Review Panel could not be held until Monday the 20th, October 2014, and the final draft of this report was considered and agreed at the Panel's meeting on Friday the 10th, April 2015.

The findings of this review are confidential. The details have only been made known to the professionals involved from the various statutory and voluntary agencies and their managers and supervisors.

An anonymised version of this report will be publicly available following ratification of its findings by the Home Office.

DISSEMINATION

Ian Kennedy, Independent Chair, retired Police Chief Superintendent.

Sandra McNeill, Domestic Violence Project Officer, Safer Leeds

Luke Turnbull – Designated Nurse for Safeguarding Adults for Leeds Clinical Commissioning Groups (CCGs)/NHS England (for the GP's records)

Supt Patrick Twiggs- Detective Superintendent (Head of Crime) Leeds / DI Dave Cowley – Leeds Safeguarding Unit, both West Yorkshire Police

Caroline Ablett- Lead Professional for Safeguarding Adults, Leeds Teaching Hospitals NHS Trust.

Contents

EXECUTIVE SUMMARY

1. THE REVIEW PROCESS

1.1 The Review was chaired by Ian Kennedy who is also the author of this report. The review panel was made up of representatives from West Yorkshire Police and Leeds CCGs/NHS England for the GPs' surgery, which were the only agencies to have had involvement with either Alison or her husband. Due to the meeting only being attended by the two agencies which had had dealings with either party, a representative from Leeds Teaching Hospitals NHS Trust, Caroline Ablett, attended meetings as a critical friend even though that agency had had no involvement with either party. Sandra McNeill, a project officer from Safer Leeds, also sat as a member of the group, to support its work and ensure themes identified from this review were linked in to any similar themes from other ongoing reviews in the city.

1.2 The Panel met for the first time on Monday the 20th, October 2014 to set the terms of reference for the review and agree the review process. Subsequent to this meeting and working to the terms of reference, West Yorkshire Police and Leeds CCGs/NHS England created Chronologies of their involvement with either party and conducted Individual Management Reviews (IMRs). No other agency had had dealings with either party.

1.3 There are three children from the relationship who are all adults, two of whom lived elsewhere than with the couple. They were invited to take part in the review but declined, on the basis that they said there had been no previous history of domestic abuse and they wanted to move on with their lives. Histories were obtained from Alison's friends and one of her closest friends was interviewed to assess whether there were any prior indications that agencies may have identified.

1.4 The perpetrator was also contacted in the HM Prison where he is serving his sentence, to inform him of the review and ask if he wished to involve himself with it. He declined to respond.

1.5 The Review Panel met again to consider the chronologies and IMRs and agree recommendations prior to compilation of this overview report.

1.6 Having circulated the report to critical friends for comment, the Panel considered it and agreed its content.

1.7 On completion the children of the victim and perpetrator were given the opportunity to read the report and discuss the findings. Whilst they were grateful for the offer they again declined to have an involvement.

2. KEY ISSUES ARISING FROM THE REVIEW

2.1 From the outset, the outstanding feature of this review was the lack of any apparent history of domestic abuse. Around the same time as Alison's death, clarity was sought by Safer Leeds from the Home Office about the need to conduct a Domestic Homicide Review in the absence of any prior indicators of abuse or agency involvement. Having received direction in that other case that one must be completed, an Independent Chair was appointed and the review conducted of this homicide.

2.2 Given the lack of any agency involvement the focus for the review was not only what interaction agencies did have (primarily the GP's surgery), but also what they may have had. That is, whether any risk factors were capable of being identified prior to Alison's death. The latter point is based on what intervention there could have been if all factors had been known or parties had understood domestic abuse more clearly and the possible risk factors which contribute to it.

2.3 The review identified that four Multi Agency Risk Assessment Conference (MARAC) risk factors were present in the relationship;

- controlling behaviour by the perpetrator,
- financial change,
- recent separation and

- regular use of alcohol by the perpetrator, above recommended levels (though alcohol abuse is not believed to have been a factor on the day of the offence).

These MARAC risk factors are used by agencies working together to identify risk and target preventative activity when abuse is identified within relationships.

2.4 In short, whilst there was initially a perceived lack of any domestic abuse history there were indications of risk factors associated with such abuse. It is recognised that this assertion is made with the benefit of hindsight and the reality is that the relationship was viewed by those close to it as 'just another' unhappy marriage with no history or expectation of violence. There was little or no agency involvement and the GP surgery appear to have dealt appropriately with both parties when they presented with health concerns.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 The review panel concluded that, based on the information available to them, agencies could not have foreseen the events that led to this domestic homicide. However, based on the identification that some MARAC risk factors had in fact been present in the relationship, a review could be carried out of educational material available locally and policies and procedures at the GP surgery to ensure that professionals fully understand the risks present in domestic abuse which can lead to escalations of violence. The following recommendations were agreed on that basis-

<u>Recommendation 1:</u>

GP practice response to domestic violence and abuse

- Surgery 1 to assess and respond to identified training and resource needs for GPs and practice staff, relating to domestic violence and abuse

- Surgery 1 to adopt a practice specific protocol for domestic violence and abuse

- Surgery 1 to ensure practitioners are aware of potential risks and links between misuse of alcohol and domestic abuse

- Practice booklet, newsletter and public areas in Surgery 1 to reflect practice responses to disclosures of domestic violence and abuse; and highlight internal and external support available

Recommendation 2:

Safeguarding responses

- Safeguarding lead in Surgery 1 to review the significant event process to ensure all significant events are reviewed. This will include unexpected death or serious injury of a patient, or where wider learning and improvements to safeguarding practice can be obtained.

3.2 Separately, NHS England agreed to conduct a review of its training material available locally to ensure that material clearly identifies domestic abuse to be broader than physical violence and that it includes controlling behaviour.

DOMESTIC HOMICIDE REVIEW PANEL FINAL REPORT

1. INTRODUCTION

1.1 The circumstances leading to this Domestic Homicide review being conducted were as follows.

1.2 West Yorkshire Police received a call on [redacted] 2014, informing them that Alison had been killed at her home in Leeds by her estranged husband, William. She had left their joint home only weeks before to escape what she described as a loveless marriage, and was looking forward to an independent life of her own. In the days immediately prior to her death Alison had made requests for financial settlement from her husband. Following police attendance after her killing, her husband was arrested and made admissions to having stabbed Alison a number of times. He was charged with murder and in October 2014 was convicted of manslaughter following a trial at Leeds Crown Court.

1.3 Alison and her husband were both of White British ethnic origin. Alison was 61 years old at the time of her death (b. [redacted]) and her husband, William, was 62 years old when he killed her (b. [redacted]).

2. TERMS OF REFERENCE

2.1 The terms of reference for this review were set at the first meeting of the Review Group on Monday the 20th October 2014 as follows-

2.2 **Overarching aim**

The over-arching intention of this review is to increase safety for potential and actual victims by learning lessons from the death in order to change future practice. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners, and take action to make necessary changes.

2.3 **Principles of the Review**

- Objective, independent and evidence-based
- Guided by humanity, compassion and empathy, with the victim's voice at the heart of the process
- Asking questions to prevent future harm, learn lessons and not blame individuals or organisations
- Respecting equality and diversity
- Openness and transparency whilst safeguarding confidential information where possible
- Plan to effect change and disseminate lessons learned

3 SPECIFIC AREAS OF ENQUIRY

3.1 The Review Panel (and by extension, IMR authors) will consider the following:

- Each agency's involvement with Alison or her husband between 1st, June 2012 and [redacted] 2014.
- In addition, each agency should include any relevant events prior to 1st, June 2012 and a summary of any contacts prior to 1st, June 2012 that gave rise to concern. The review will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. Whether, in relation to the family members listed above, an improvement in any of the following might have led to a different outcome for Alison.
- Communication between services
    - Information sharing between services with regard to both domestic violence and to the safeguarding of children
    - Accessibility, availability and responsiveness of services
- Whether the work undertaken by services in this case was consistent with each organisation's:
    - Professional standards
    - Domestic violence policy, procedures and protocols, including MARAC (Multi-Agency Risk Assessment Conference)
    - Safeguarding adults policy, procedures and protocols

- The response of the relevant agencies to any referrals relating to either party concerning domestic abuse (including emotional abuse and controlling behaviour) or other significant harm from 1st, June 2012. In particular, the following areas will be explored:
    - Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards
    - Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective
    - Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
    - The quality of the risk assessments undertaken by each agency in respect of either party
- Whether services and agencies ensured the welfare of any vulnerable adults/adults at risk
- Whether services took account of the wishes and views of members of the family in decision making and how this was done.
- Whether thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the respective family members and whether any additional needs on the part of either of the parents or the children were explored, shared appropriately and recorded.
- Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
- Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4. CHILD'S ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

4.1 The Review Panel decided that given the age of the children in this case, i.e. that they are all adults and had been during the whole period under review, there was no need to consider any safeguarding children issues.

5. ADULTS AT RISK ELEMENT OF THE DOMESTIC HOMICIDE REVIEW.

5.1 The review panel (and by extension, IMR authors) will also consider the following:

Whether there is any learning from this case in relation to Alison which would improve safeguarding practice in relation to domestic violence and its impact on adults at risk, in particular in the areas of:

(a) communication

(b) information sharing

(c) risk assessment

6. TIME PERIOD UNDER REVIEW

6.1 The IMR covers the period 1st, June 2012 to [redacted] 2014. This period was chosen based not only on known contact with any agency (GP) for both parties, but also it was considered sufficiently far in to the past to capture everything relevant without becoming a disproportionate trawl through irrelevant records. Any item thought to be relevant to the DHR which preceded 1st June 2012 was included in the chronologies.

6.2 This review was initiated at the Domestic Homicide Review Sub Group meeting on Wednesday, the 27th August 2014. The first meeting of the Review Panel could not be held until Monday the 20th, October 2014, and the final draft of this report was considered and agreed at the Panel's meeting on Friday the 10th April 2015.

6.3 The Review panel was made up of representatives from Leeds CCGs/NHS England, West Yorkshire Police and Safer Leeds. Other statutory and voluntary agencies (Mental Health and Probation) declined to take part in the review due to the total absence of any involvement between their agencies and the victim or perpetrator. Caroline Ablett, a representative from Leeds Teaching Hospitals Trust (LTHT) joined the review at the second stage meeting and acted as critical friend in relation to the findings of the Police and NHS (England) who were the only two agencies to have had any involvement at all with Alison or her husband. In fact, the police only had involvement with Alison following her death.

6.4 Both the Leeds CCGs/NHS England (on behalf of both parties' GPs) and the police produced chronologies and Individual Management Reviews (IMRs). Interviews were carried out by the NHS (England) IMR author with doctors from the GP surgery where Alison and her husband both attended for medical care.

6.5 The review panel was Chaired by Ian Kennedy, a former senior police officer, who retired from West Yorkshire Police in 2012 and had had no involvement with the case or any of the parties.

7. THE FACTS

7.1 Alison and her husband William had lived together since the mid-1970s.

7.2 The couple had three adult children, two of whom lived elsewhere. William was a successful businessman with retail businesses locally. Alison did work for the business and received some pay for this though William dealt with all financial matters within their home and businesses. She had spoken with friends for years of the loveless marriage in which she found herself and the fact she and her husband lived separate lives within the same house. They ate in separate rooms and would sit in separate rooms; Alison kept company by her dog. William tended to go to the pub every night by himself and mix with other regulars there. When she moved to her new home in the weeks prior to her death, her friends say Alison did not know how to complete simple personal tasks like paying bills such had been the control William had had, over their relationship.

7.3 The couple had bought the small house close to their family home ostensibly as an investment though it may have been that Alison had seen this as her avenue for leaving the relationship as she had moved in possessions and saved some money towards a hoped for independent life. She had confided to friends that she had been unhappy for some time and also the details of them living separate lives within the same house. Some weeks prior to her death Alison had moved in to the new house though she had complained to friends that her husband kept calling and seemed to want to continue to maintain control over her life. In the days prior to her death she had instigated conversations with William about selling some financial assets and getting her share of the proceeds.

7.4 There was no history of violence within the relationship according to friends and family, though some friends do describe some verbal clashes and an unhappy relationship.

7.5 Alison was at her new home on the day of the offence. William called and whilst it is unclear specifically what occurred, neighbours reported hearing some raised voices or dispute immediately prior to her death. William was arrested for murder and made admissions to stabbing Alison a number of times with a kitchen knife belonging to the address. He was later charged with murder and, following a trial at Leeds Crown Court in October 2014, convicted of manslaughter. He maintained at his trial that he felt threatened by Alison and had lifted a knife to prevent her from picking it up and using it to offer him violence. He claimed she then fell on to it. This was at odds with expert forensic and pathological evidence in relation to the number, angle and location of her stab wounds.

7.6 Despite her husband's claims at his trial, there was no evidence that Alison ever used or threatened him with violence.

8. ANALYSIS

8.1 Prior to the completion of chronologies and IMRs, this review was characterised by the lack of any apparent history whatsoever of domestic abuse.

8.2 As a result, the review focused not just on what had been done but what may have been done, if associated risk factors were capable of being identified prior to Alison's death. The latter point being based on what intervention there could have been if all factors had been known or parties had understood domestic abuse better.

8.3 West Yorkshire Police had only become involved after the fatal stabbing and no missed opportunities or failings were identified in their practices.

8.4 Alison and her husband attended their GP's surgery during the relevant period. No incidence of domestic abuse had been disclosed by either party and the surgery dealt appropriately with the healthcare issues presented to them. The IMR author identified a need for review of practices in relation to knowledge and identification of domestic abuse

and ensuring policies and practices are in keeping with national guidelines and local policy.

8.5 The review identified that four Multi Agency Risk Assessment Conference (MARAC) risk factors were present in the relationship;

- controlling behaviour by the perpetrator
- financial change
- recent separation
- regular use of alcohol by the perpetrator above recommended levels (though this is not believed to have been a factor on the day of the offence).

A MARAC risk assessment form is available for information purposes at Appendix 1. This shows the risk factors which are used across agencies to identify the level of risk of abuse within a relationship, and thereby target an appropriate level of preventative activity and support.

8.6 Of these four identified factors, the one believed by the Review Panel to have had the biggest influence on the offence was the controlling behaviour of the perpetrator which came to a head when separation occurred and he continued to visit Alison's new home and try to run her life. This continuing involvement in Alison's life was highlighted by one of her closest friends who was interviewed as part of the review. Alison had confided the details of his continued involvement to this friend prior to her death and also details of the conversation Alison had had with her husband in which she sought some financial settlement to support her new independent existence.

8.7 In short, whilst there was initially a perceived lack of domestic abuse history, there were identified during the course of the review, risk factors associated with such abuse. Most significant among these, in the opinion of the Review Panel, were the controlling behaviour, which was a common trait of how William chose to live his life according to friends and acquaintances, along with the recent separation and discussions over financial settlement. It is recognised that this statement of the presence of risk factors is made with the benefits of hindsight. The reality was that the relationship was viewed by those close to it as being 'just another' unhappy marriage with no history or expectation of violence. There was little or no agency involvement and the GP surgery dealt appropriately with both parties when they presented with health concerns.

9. CONCLUSIONS AND LESSONS LEARNT

9.1 The review panel concluded that, based on the information available to them, agencies could not have foreseen the events that culminated in this domestic homicide.

9.2 However, based on the identification of some MARAC risk factors in the relationship, a review could be carried out of NHS educational material available locally. Policies and procedures at the GP surgery could also be reviewed to ensure that professionals fully understand the risks present in domestic abuse which can lead to escalations of violence.

10. RECOMMENDATIONS

10.1 Recommendation 1: GP practice response to domestic violence and abuse

- Surgery 1 to assess and respond to identified training and resource needs for GPs and practice staff, relating to domestic violence and abuse
- Surgery 1 to adopt a practice specific protocol for domestic violence and abuse
    - to include a checklist of relevant interventions to offer, and current role and contact information for external specialist support agencies
    - practice response to disclosure of domestic abuse and understanding of the referral route and role of GPs in MARAC
- Surgery 1 to ensure practitioners are aware of potential risks and links between misuse of alcohol and domestic abuse
    - Information relating to external sources of support for those people misusing alcohol should be available to practitioners to make informed referrals, and accessible in public areas for patients

- Practice booklet, newsletter and public areas in Surgery 1 to reflect practice responses to disclosures of domestic violence and abuse; and highlight internal and external support available

• Measure

The practice should review their compliance with Safe Lives/IRIS (Early Intervention in Psychosis) and NICE (National Institute for Health and Care Excellence) Guidance (2014) for general practices and submit a short report to NHSE on these findings and an action plan for service improvements to be made.

10.2 Recommendation 2: safeguarding responses

- Safeguarding lead in Surgery 1 to review the significant event process to ensure all significant events are reviewed. This will include unexpected death or serious injury of a patient, or where wider learning and improvements to safeguarding practice can be obtained to ensure multi-disciplinary discussions of the learning identified in the IMR are undertaken, and learning is effectively disseminated to all practice staff

Measure

- Surgery 1 has relevant protocols and pathways for domestic violence and abuse which identifies the process for undertaking a significant event review, and practice responses to any identified safeguarding risk or risk of serious harm

- Systems are in place to effectively disseminate learning from significant event reviews to practice staff and to monitor identified actions

- Whilst Alison did not present as an adult at risk, the panel thought that practice staff need to be conversant with the domestic abuse resources and material available from www.leedsdomesticviolenceandabuse.co.uk; which include the West Yorkshire Adult policy and procedure, practice guidance and joint working protocols. Other useful sites for local information are the following and these again should be sites with which the staff should ensure they are familiar:-

Women as Victims

- http://nww.lhp.leedsth.nhs.uk/referral_info/detail.aspx?ID=186

Men as Victims

- http://nww.lhp.leedsth.nhs.uk/referral_info/detail.aspx?ID=185

Guidance for GPs

- http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

Outcomes from recommendation 1 and 2

- Increased awareness and practitioner confidence in identifying and responding to patients disclosing domestic abuse or those at risk of domestic abuse
- Reducing risk and increasing support options for those patients at risk of family violence or intimate partner violence
- Increased knowledge of specialist providers; informed referrals, increased joint planning and delivery of connected support to patients
- Improved practice responses, risk awareness and reflective practice

Timescale

The completion date for all elements of these recommendations have been set by the Review Panel to be realistic and achievable but still challenging and their completion will be monitored by an identified post holder in Safer Leeds.

11. OTHER ACTION

Separately, NHS England agreed to conduct a review of its training material available locally to ensure that material clearly identifies domestic abuse to be broader than physical violence and includes controlling behaviour.

It was not thought necessary for this to be raised to a full recommendation but rather be part of the ongoing review by NHS England in relation to the material it publishes locally and is available to GPs' surgeries to inform both professionals and also the public. It is felt by the review panel that there is little understanding of the factors outside of overt violence which can be indicators of the risk to a party within a relationship.

The purpose of the recommendations and other work is to raise awareness, so that more people are able to identify risk appropriately within the relationships of those close to them and through that can understand and act on legitimate risk based concerns. Controlling behaviour in particular is often not well recognised as a risk factor, and the Panel hopes that these recommendations help address that situation so that it can be seen by the wider population in its proper context and level of risk.

APPENDICES

Appendix 1: MARAC Risk Assessment Form

Ending domestic abuse

SafeLives Dash risk checklist
Quick start guidance

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Marac meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

The Dash risk checklist should be introduced to the victim within the framework of your agency's:

- Confidentiality Policy
- Information Sharing Policy and Protocols
- Marac Referral Policies and Protocols

Before you begin to ask the questions in the Dash risk checklist:

- Establish how much time the victim has to talk to you: is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and children
- Explain why you are asking these questions and how it relates to the Marac

While you are asking the questions in the Dash risk checklist:

- Identify early on who the victim is frightened of – ex-partner/partner/family member
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

Revealing the results of the Dash risk checklist to the victim

Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to Marac and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in

future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a

Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

Resources

Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:

- **National Domestic Violence Helpline** (tel: 0808 2000 247) for assistance with refuge accommodation and advice.
- **'Honour' Helpline** (tel: 0800 5999247) for advice on forced marriage and 'honour' based violence.
- **Sexual Assault Referral Centres (**web: http://www.rapecrisis.org.uk/Referralcentres2.php) for details on SARCs and to locate your nearest centre.
- **Broken Rainbow** (tel: 08452 604460 / web: www.broken-rainbow.org.uk for advice for LGBT victims) for advice and support for LGBT victims of domestic abuse.

Asking about types of abuse and risk factors

Physical abuse

We ask about physical abuse in questions 1, 10, 11, 13, 15, 18, 19 and 23.

- Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- Sometimes violence will be used against a family pet.
- If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as a GP or A&E nurse.

Sexual abuse

We ask about whether the victim is experiencing any form of sexual abuse in question 16.

- Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

Coercion, threats and intimidation

Coercion, threats and intimidation are covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 and 24.

- It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (e.g. children/siblings). Victims usually know the abuser's behaviour better than anyone else which is why this question is significant.
- In cases of 'honour' based violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can…"
- Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home or workplace, loitering and destroying/vandalising property.

- Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

Emotional abuse and isolation

We ask about emotional abuse and isolation in questions 4, 5 and 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously.
- Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

Children and pregnancy

Questions 7, 9 and 18 refer to being pregnant and children and whether there is conflict over child contact.

- The presence of children including stepchildren can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child's life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children's Services.

Economic abuse

Economic abuse is covered in question 20.

- Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.

- The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.

We also have a library of resources and information about training for frontline practitioners at http://www.safelives.org.uk/marac/Information_about_Maracs.html

Other Marac toolkits and resources

If you or someone from your agency attends the Marac meeting, you can download a **Marac Representative's Toolkit** here: http://www.safelives.org.uk/marac/Toolkit-Marac-representative.pdf. This essential document troubleshoots practical issues around the whole Marac process.

Other **frontline Practitioner Toolkits** are also available from http://www.safelives.org.uk/marac/Resources_for_people_who_refer_to_Marac.html. These offer a practical introduction to Marac within the context of a professional role. Please signpost colleagues and other agency staff to these toolkits where relevant:

A&E
Ambulance Service
BAMER Services
Children and Young People's Services
Drug and Alcohol
Education
Fire and Rescue Services
Family Intervention Projects
Health Visitors, School Nurses & Community Midwives
Housing
Independent Domestic Violence Advisors
LGBT Services
Marac Chair
Marac Coordinator
Mental Health Services for Adults
Police Officer
Probation
Social Care Services for Adults
Sexual Violence Services
Specialist Domestic Violence Services
Victim Support
Women's Safety Officer

For additional information and materials on Multi Agency Risk Assessment Conferences (Maracs), please see the http://www.safelives.org.uk/marac/10_Principles_Oct_2011_full.doc. This provides guidance on the Marac process and forms the basis of the Marac Quality Assurance process and national standards for Marac.

Ending domestic abuse

SafeLives Dash risk checklist

Aim of the form

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to Marac and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the Marac[1] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form

Before completing the form for the first time we recommend that you read the full practice guidance and FAQs. These can be downloaded from: http://www.safelives.org.uk/marac/RIC_for_Marac.html. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to MARAC

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.

3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but **this will need to be reviewed** depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

What this form is not

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

[1] For further information about MARAC please refer to the 10 Principles of an Effective MARAC: http://www.safelives.org.uk/marac/10_Principles_Oct_2011_full.doc

Name of victim: Date: Restricted when complete

SafeLives Dash risk checklist for use by Idvas and other non-police agencies[2] for identification of risks when domestic abuse, 'honour'- based violence and/or stalking are disclosed

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is not the case, please indicate in the right hand column	YES	NO	DON'T KNOW	State source of info if not the victim (eg police officer)
1. **Has the current incident resulted in injury?** Please state what and whether this is the first injury.	☐	☐	☐	
2. **Are you very frightened?** Comment:	☐	☐	☐	
3. **What are you afraid of? Is it further injury or violence?** Please give an indication of what you think [name of abuser(s)] might do and to whom, including children. Comment:	☐	☐	☐	
4. **Do you feel isolated from family/friends?** I.e., does [name of abuser(s)] try to stop you from seeing friends/family/doctor or others? Comment:	☐	☐	☐	
5. **Are you feeling depressed or having suicidal thoughts?**	☐	☐	☐	
6. **Have you separated or tried to separate from [name of abuser(s)] within the past year?**	☐	☐	☐	
7. **Is there conflict over child contact?**	☐	☐	☐	
8. **Does [name of abuser(s)] constantly text, call, contact, follow, stalk or harass you?** Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.	☐	☐	☐	
9. **Are you pregnant or have you recently had a baby (within the last 18 months)?**	☐	☐	☐	
10. **Is the abuse happening more often?**	☐	☐	☐	
11. **Is the abuse getting worse?**	☐	☐	☐	
12. **Does [name of abuser(s)] try to control everything you do and/or are they excessively jealous?** For example: in terms of relationships; who you see; being 'policed' at home; telling you what to wear. Consider 'honour'-based violence (HBV) and specify behaviour.				
13. **Has [name of abuser(s)] ever used weapons or objects to hurt you?**	☐	☐	☐	
14. **Has [name of abuser(s)] ever threatened to kill you or someone else and you believed them?** If yes, tick who: You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	

[2] Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	YES	NO	DON'T KNOW	State source of info
15. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	☐	☐	☐	
16. Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	☐	☐	☐	
18. Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
19. Has [name of abuser(s)] ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. Drugs ☐ Alcohol ☐ Mental health ☐				
22. Has [name of abuser(s)] ever threatened or attempted suicide?				
23. Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. Bail conditions ☐ Non Molestation/Occupation Order ☐ Child contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐				
24. Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: Domestic abuse ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional

Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural / language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe.	
Consider abuser's occupation / interests. Could this give them unique access to weapons? Describe.	
What are the victim's greatest priorities to address their safety?	

Do you believe that there are reasonable grounds for referring this case to Marac?		Yes ☐ No ☐	
If yes, have you made a referral?		Yes ☐ No ☐	
Signed		Date	
Do you believe that there are risks facing the children in the family?		Yes ☐ No ☐	
If yes, please confirm if you have made a referral to safeguard the children?	Yes ☐ No ☐	Date referral made	
Signed		Date	
Name			

Practitioner's notes

This document reflects work undertaken by SafeLives in partnership wi h Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool Marac for their contribu ion in piloting the revised checklist without which we could not have amended the original SafeLives risk identification checklist. We are very grateful to Elizabeth Hall of CAFCASS and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson and Jasvinder Sanghera.

Appendix 2: Acronyms used in this report

CCG	Clinical Commissioning Group
DHR	Domestic Homicide Review
DV	Domestic Violence
GP	General Practitioner
IMR	Individual Management Review
LTHT	Leeds Teaching Hospitals Trust
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
WYP	West Yorkshire Police

Appendix 3: Action Plan

DHR12					
Surgery 1 to assess and respond to identified training and resource needs for GPs and practice staff, relating to domestic violence and abuse	Meeting with safeguarding lead at practice to discuss findings and agree actions		Visit to practice TBA By Designated Nurse Safeguarding Adults (	Aug 15	
Surgery 1 to adopt a practice specific protocol for domestic violence and abuse	to include a checklist of relevant intervention to offer, and current role and contact information for external specialist support agencies practice response to disclosure of domestic abuse and understanding of the referral route and role of GPs in MARAC	Practice	Visit to practice TBA By Designated Nurse Safeguarding Adults	Dec 15	
Surgery 1 to ensure practitioners are aware of potential risks and links between misuse of alcohol and domestic abuse	Information relating to external sources of support for those people misusing alcohol should be available to practitioners to make informed referrals, and accessible in public areas for patients Practice booklet, newsletter and public areas in Surgery 1 to reflect practice responses to disclosures of domestic violence and abuse; and highlight internal and external support available	NHSE / CCG	Practice visit to be arranged to communicate requirements of recommendations Designated Nurse Safeguarding Adults	Nov 15	

	The practice should review their compliance NICE (National Institute for Health and Care Excellence) Guidance (2014) for general practices and submit a short report to NHSE on these findings and an action plan for service improvements to be made.				
Safeguarding lead in Surgery 1 to review the significant event process to ensure all significant events are reviewed. This will include unexpected death or serious injury of a patient, or where wider learning and improvements to safeguarding practice can be obtained to ensure multi-disciplinary discussions of the learning identified in the IMR are undertaken, and learning is effectively disseminated to all practice staff	Surgery 1 has relevant protocols and pathways for domestic violence and abuse which identifies the process for undertaking a significant event review, and practice responses to any identified safeguarding risk or risk of serious harm Systems are in place to effectively disseminate learning from significant event re-views to practice staff and to monitor identified actions Practice staff need to be conversant with the domestic abuse resources and material available from www.leedsdomesticviolenceandabuse.co.uk; which include the West Yorkshire Adult policy and procedure,	Practice reporting to NHSE	Practice visit to be arranged to communicate requirements of recommendations Patients Experience Manager NHS England (	Nov '15	

	practice guidance and joint working protocols. Other useful sites for local information are the following and these again should be sites with which the staff should ensure they are familiar:- Women as Victims • http://www.lhp.leedsth.nhs.uk/referral_info/detail.aspx?ID=186 Men as Victims • http://www.lhp.leedsth.nhs.uk/referral_info/detail.aspx?ID=185 Guidance for GPs • http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx				