CONFIDENTIAL

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

DHR10

Deceased February 2016

Age 30 years

Steve Baumber

April 2017

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INTRODUCTION

1. Domestic Homicide Reviews

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: -

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

1.4 The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to policies and procedures as appropriate; and
- prevent domestic violence homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

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[1] www.homeoffice.gov.uk.

[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2. Summary of Circumstances Leading to the Review

2.1 The victim (E) and perpetrator (F) were intimate partners and lived together in Stoke-on-Trent with their two children (G and H). In February 2016, the emergency services were called to their address by the couple's eldest child (G), who reported that their mother had been stabbed. The victim was found to have sustained stab wounds from which she had died.

2.2 The perpetrator had left the scene but returned a short time later and was arrested. He was subsequently charged with the murder of the victim.

2.3 On 22 March 2016, a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a DHR were met. A recommendation to commission a DHR was endorsed by the Chair of the Responsible Authorities Group.

2.4 As agreed by the Scoping Panel, the Stoke-on-Trent Safeguarding Children Board were consulted on the Domestic Homicide Review Terms of Reference and engaged with the Review.

2.5 In June 2016 F pleaded guilty to manslaughter on the grounds of diminished responsibility and he was subsequently sentenced to life imprisonment, initially to be served within a secure psychiatric unit.

3. Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 The Review considered in detail the period from 21 May 2009 (when F was provided with services following his referral to Harplands Hospital) until the time of the fatal incident. Summary information regarding significant events outside of this period was also considered.

3.3 The focus of the Review was on the following individuals:

Name	E	F	G	H
Relationship	Victim	Perpetrator	Child	Child
Gender	Female	Male	-	-
Age (February 2016)	30yrs	31yrs	11yrs	8yrs
Ethnicity	White British	White British	White British	White British
Address:	Stoke-on-Trent			

3.4 In conjunction with the areas for consideration outlined at section 4 of the statutory guidance specific issues considered by the Review were:

- Domestic abuse and the effectiveness of support services.
- Impact of the toxic trio (domestic abuse, drug and alcohol misuse, and mental ill health) on the children and how agencies responded to this.
- Mental health of the victim and perpetrator and the effectiveness of support services.
- Substance misuse and access to support services.
- The employment of the victim as a carer (in a home).
- The victim as a carer for the perpetrator.

3.5 Issues around equality and diversity (in particular race, gender, age and religion) were considered during the course of the review and these are reflected on where relevant.

4. Review Panel Chair and Independent Overview Report Author

4.1 The Review Panel was chaired by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

4.2 The Overview Report author was Steve Baumber, an Independent Consultant with experience in safeguarding, public protection and the conduct of case reviews. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

5. Review Panel Members

5.1 The Review Panel comprised the following:

- David Giles - Senior Investigating Officer, Staffordshire Police.
- Mark Harrison - Major Crime Policy and Review Investigator and Detective Sergeant Mark Tolley, Staffordshire Police.
- Nathan Dawkins - Commissioning Officer for Community Safety, Safer City Partnership, Stoke-on-Trent City Council.
- Vicki Baxendale – Safeguarding Lead and Maegan Hepher - Adult Safeguarding Nurse, North Staffordshire Combined Healthcare NHS Trust.
- Janice Johnson - Senior Nurse Safeguarding, University Hospital of North Midlands.
- Rachael Fitton - Adult Safeguarding Nurse Specialist, Stoke-on-Trent CCG on behalf of NHS England North Midlands (in respect of primary care services).

[3] Under the Children Act (2004) and its associated statutory guidance.

- Dot Thomas, Named Nurse Safeguarding Children, Staffordshire and Stoke-on-Trent Partnership NHS Trust.
- Amanda Owen, Strategic Manager Safeguarding and Quality Assurance, Stoke-on-Trent City Council Children's Social Care.
- Alex Spragg - Strategic Manager, Rachael Holdcroft - Temporary Operational Lead Central Locality and Tracey Bagnall - Operational Lead Central Locality, Stoke-on-Trent City Council Housing / Cooperative Working.
- Clare Hope - Named Nurse Safeguarding Children, Birmingham Community Healthcare NHS Trust.
- School Principal, School 1.
- Safeguarding Officer and Inclusions Manager, School 2.
- Nicola Lowry - Head of Business Development and Operations and Paula Brogan - Domestic Violence Victims/Survivors Coordinator, Arch North Staffordshire.
- Ros Negrycz - Chair of the Stoke-on-Trent Safeguarding Children Board Serious Case Review Sub-Committee (as advisor to the Panel).

6. Review Process

6.1 The Review Panel met on three occasions to consider contributions to and emerging findings of the Review:

- 6 June 2016
- 8 September 2016
- 15 December 2016.

6.2 This Overview Report was endorsed by the Review Panel on 15 December 2016 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. On 6 April 2017, it was presented to and endorsed by the Responsible Authorities Group.

7. Contributions to the Review

7.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review Reports.

7.2 Management Review Reports were submitted by:

- Staffordshire Police
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- University Hospital of North Midlands (UHNM)
- NHS England North Midlands (in respect of primary care services)

- Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)
- Stoke-on-Trent City Council Children's Social Care (SOTCSC)
- Stoke-on-Trent City Council Cooperative Working
- Birmingham Community Healthcare NHS Trust
- School 1
- School 2

7.3 Other sources of information accessed to inform the Review included:

- Summary Report from Arch North Staffordshire (including involvement with North Staffordshire Mind)
- Summary Report from Victim Support (including policy and practice guidance on contact with victims in domestic abuse cases)

7.4 The Panel considered access to information from GP records relating to F, G and H should be made available to the Review and were advised that there was no authority to access these records without the consent of F. This was not granted.

8. Parallel Processes

8.1 North Staffordshire Combined Healthcare Trust undertook a Serious Incident Investigation, which informed the contribution of that Trust to the Review during Panel meetings and through the submission of the Trust Management Review Report.

8.2 The criminal investigation concluded in June 2016 following a guilty plea by F to manslaughter on the grounds of diminished responsibility.

8.3 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

9. Family Engagement

9.1 The most appropriate contacts for the families of E and F were identified at the initial meeting of the Review Panel. They were informed that a review was being undertaken at the start of the process and arrangements for disseminating relevant information to other family members were agreed.

9.2 Members of the families were subsequently invited to contribute to the Review. The Overview Report Author and police Family Liaison Officer met with the mother of E, father of E and father's partner on 13 March 2017. An explanation of how and why the Review was being undertaken was provided and a summary of the draft findings was given. The family were invited to ask any questions they had about the Review and share their knowledge of the events and views on why they happened and these have been included within this report at relevant points. The family of E were asked if they wished for a pseudonym to be used for E but preferred the report to be anonymised through the use of letters, they also declined to provide any written statement of impact preferring instead to talk about events.

9.3 During the course of the Review the Review Panel were updated regarding the wellbeing of G and H and the arrangements for their care and support. It was agreed that it would not be in the interests of G and H to approach them at this time for a contribution to the Review.

9.4 The family of F were contacted by the Family Liaison Officer but decided that they did not wish to be involved with the Review and declined the offer of a meeting with the Overview Report Author.

9.5 The final report was shared with contributing family members prior to its submission to the Home Office.

10. Local Context

10.1 The unitary authority of the City of Stoke-on-Trent lies within the county of Staffordshire. It became a unitary authority in 1997.

10.2 The Stoke-on-Trent City Council Strategic Plan 2016-2020 "Stronger Together" sets out the Council's vision 'Working together to create a stronger city we can all be proud of'. Provision of services for high risk victims of domestic violence and abuse contributes to this vision.

10.3 Stoke-on-Trent's Safer City Partnership delivers the national crime, disorder and substance misuse strategies at a local level. The Safer City Partnership Plan 2014-17 identifies violent crime, including domestic abuse as a priority for the City.

10.4 The Stoke-on-Trent Domestic Abuse Partnership has been in place since 2008 and reports directly to the Safer City Partnership's Responsible Authorities Group, the Local Safeguarding Children Board and the Children and Young People's Strategic Partnership Board. Membership consists of statutory sector, third sector and community group representatives.

10.5 Staffordshire Criminal Justice Board Victims and Witnesses sub-group receives performance information concerning, inter alia, domestic violence and abuse, with actions identified and implemented for service improvements. This group, together with the Domestic Abuse Partnership, receives feedback from victims of domestic violence and abuse regarding Criminal Justice Services to inform the identification and implementation of service improvements.

10.6 Stoke-on-Trent City Council currently contracts Arch (North Staffs Ltd.) to provide a range of domestic violence and abuse services for men, women and children. These include:

- A purpose built refuge for women and children who have been subject to, or are at risk of, domestic abuse.
- A local telephone helpline.
- An outreach service, including one to one practical and emotional support.
- Counselling.
- Personal safety advice and support.
- A school based educational project (Relationships Without Fear).
- A domestic abuse recovery programme (RISE).
- An accredited perpetrator programme and tailored support for spouses attending the programme.

THE FACTS

11. Family Background

11.1 F has a history of contact with the police related to minor incidents/criminal offences dating back to 1998 and these include convictions for assault and criminal damage.

11.2 E met F whilst at school when she was fourteen or fifteen years of age. Their first child (G) was born in 2004 when E was nineteen years of age. In August 2005, the family moved to a council owned property, E held the tenancy for the property and the family remained there until her death. In 2007 their second child (H) was born. E also had a number of pregnancy terminations which her mother suggested were due to F not wishing to have further children.

11.3 E worked for some of the period covered by this Review as a carer for elderly people at several different locations. Her family explained that her employment had not been continuous during this time and that she had stopped working altogether approximately 12 months before her death due to concerns about travelling to and from work during the night. F was apparently unwilling to pick her up from work. F worked as a painter and decorator although E's family reported that this was not full time work and that money problems were an issue for most of the time covered by the Review with E's father often offering to help them out with loans.

11.4 The family of E were aware of the difficulties that E and F had in their relationship including some of the episodes involving violence, however they were not fully aware of the extent of the problems. E was described as a 'bubbly' person who would often paint a rosy picture of the situation and the family now felt this was a front and that she had only told them what she wanted them to know. E often visited her mother in the evening and had a drink of wine which was described by her mother as social drinking rather than being problematic. Her mother explained that E had stopped drinking vodka as they both had acknowledged it was not good for her. Sometimes E would visit her mother to get out of the house at times of difficulty between herself and F (not necessarily violence) and E's father had offered her use of his property to live in as he often worked away.

11.5 The family of E said that everything thing was good between E and F when they had money and that she loved him and would never leave him. The care of the children was reported by the family of E as often being split between the couple with E having care of H and F looking after G. The family of E said that she kept the house very clean and tidy. When they visited, it was often apparent that F was upstairs as he could be heard moving around but he did not come downstairs to see them. The family of E described the behaviour of F towards E as controlling at times with E making phone calls to her father at the bottom of her garden to be out of the earshot of F.

11.6 F visited his father most weekends, sometimes taking the children with him, E had been estranged from F's family for the last three years and her family thought this was due to them 'pulling her down' and E feeling on tenterhooks in their company. E did have some social contact with F's brother and there was a history of disputes between E, F's brother and his partner.

12. Summary of Events

Issues around parental mental health and alcohol misuse first emerge – May 2009

12.1 In May 2009 E contacted the police to report F as a missing person. E explained that following some unusual behaviour F had run away from the family home with their youngest child (H) who he then dropped off at his father's address.

12.2 The police undertook a missing person investigation in accordance with policies and procedures in place at that time. F was located a short time later having returned to his father's address. The police conducted a safe and well check but did not contact any other agencies in relation to potential support needs for the family and advised F to seek help from his GP the following morning.

12.3 The same day F attended the Emergency Department (University Hospitals of North Midlands NHS Trust[4] - UHNM), he initially left without being triaged but returned later with his father and step mother. F provided a history of unusual behaviour for the past week, he reported feeling drained with repetitive questioning behaviour and was not sleeping. F was agitated and aggressive and at one point threw himself at a window. A staff nurse contacted the police stating F was beyond their control and they feared for the safety of their staff. The police attended and restrained F remaining with him at the hospital for some time until he was appropriately accommodated. Medical investigations were undertaken and an organic cause for the presenting symptoms was ruled out, F was therefore admitted to the Harplands Hospital (North Staffordshire Combined Healthcare NHS Trust - NSCHT) for psychiatric assessment.

12.4 After a three-day stay at Harplands Hospital F was discharged, his psychosis appeared to have mostly resolved in that time. NSCHT Early Intervention Team were then engaged and their assessment concluded that there had been a brief psychotic episode which had resolved without treatment. Rather than immediately discharging F from their care the Early Intervention Team offered a three-month period during which F and his family could contact the team if symptoms appeared. In the event, no further contact was made and F was subsequently discharged.

12.5 F had no further contact with mental health services until a self-referral in September 2013 (described in more detail later within this report) led to sustained involvement with mental health services which continued up to the point where E died.

12.6 In June 2009 E attended a reception interview with the School Nurse for G (School 1). E raised concerns regarding the behaviour of G and acknowledged that she shouted a lot and was inconsistent in the management of her child. A referral was made to the Triple P Positive Parenting Group. The first session of the Triple P Group was not attended by the family and in line with the operational policy an attempt was made to establish whether E and F still required the service before they were discharged.

12.7 Later in the year (August 2009) H was referred to speech and language therapy by a Health Visitor following concerns regarding delayed speech.

[4] Formerly University Hospital of North Staffordshire NHS Trust.

12.8 In August 2009 E underwent her third pregnancy termination.

12.9 In September 2009, the police received information from the ambulance service, via adult social services, concerning an allegation that E had financially exploited an elderly female neighbour. The police and social services made enquiries, it emerged that a previously good relationship between E and her neighbour had recently soured and doubts emerged about the reliability of the complainant. E denied any wrongdoing and stated she had carried out some shopping on behalf of the neighbour. The allegation was found to be unsubstantiated and the police took no further action on the basis that the complainant did not wish to pursue the matter and there was no evidence of dishonesty on the part of E.

12.10 In October 2009 E was taken to the Emergency Department (UHNM) following an overdose of Xenical (diet tablets) and Brufen (anti-inflammatory pain killers) she was also reported to have consumed a bottle of vodka. It was noted in the hospital records, although it is not clear if this was self-reported or from other sources, that E had a history of self-harm, had domestic problems and that her children were with their father. E said she was not suicidal and self-discharged after being provided with a general advice sheet for alcohol/drug addiction. This was a short 45 minute stay in hospital and although E explained she was going home to her mother's there is no recorded evidence[5] of any consideration being given to the potential impact of her alcohol/drug abuse on her children or response to the domestic 'problems'.

Domestic violence and abuse incidents reported to the police – November 2009 onwards

12.11 In November 2009, the police were contacted by F's brother to complain about people being drunk in his house and causing problems. The police attended and found E apparently under the influence of alcohol, no offences were apparent and E left the scene. This was the first incident within the scope of this Review where the police became aware of alcohol abuse apparently affecting the behaviour of E.

12.12 During the period between 2009 and 2015 Staffordshire Police were called to a total of 21 incidents at the home address of E and F, including 13 domestic incidents, further details of these contacts is provided within the following sections of this report.

12.13 The first call to the police regarding a domestic incident was in December 2009. E reported that she had been 'thrown out of the house' by F. The police attended and it was noted that both had been drinking and a verbal argument had taken place. It was assessed by the police that E and F were not intoxicated to a level that would impact on their care of G and H who were in bed at the time - the police did not see G or H. There is no record of a Domestic Incident Assessment Log (DIAL)[6] being completed by officers attending this incident. E was taken to her mother's address and no further action was taken.

[5] Since 2015 Emergency Department records have been updated to prompt staff to ask if they are responsible for caring for children; if the patient has children then staff are prompted to consider if they have any safeguarding concerns.

[6] The DIAL form is the means by which Staffordshire Police assess the level of risk to a victim of domestic abuse, they are also used to record additional information and professional judgement. The risk score on the DIAL form is used to determine the level of response to the incident. Policy in place at the time of this incident did not require the completion of

12.14 In April 2010 E applied for a position as a care assistant. Information checks were carried out by the police under the Disclosure and Barring Scheme (DBS) and three potentially relevant pieces of information were identified for consideration of disclosure. The first piece of information related to an alleged assault by E on a similarly aged girl when she was 15 years old, no further police action was taken at the time due to there being insufficient evidence. The second piece of information was linked to E but as a result of enquiries carried out for this Review, it was established actually related to another woman with the same name as E and should not have been part of the disclosure considerations[7]. The third piece of information concerned the unsubstantiated report of financial exploitation of an elderly neighbour in September 2009. A decision was made that none of the information was relevant to an assessment of the risk that E may pose to children or vulnerable persons.

12.15 In June 2010 E contacted the police to report that she had been assaulted by F. E was at a neighbour's house and said her children were at home with their father. Both E and F were said to have been drinking and E stated that F had dragged her around by her hair, slapped and kicked her, the children were apparently asleep in bed at this time. The police attended and arrested F for common assault. There is no record of the children being seen to check on their welfare or of a DIAL form being completed. During interview F denied the assault although he admitted that he had drunk 12 cans of lager. E had not sustained any injuries and subsequently refused to support a prosecution. F was released with no further action being taken.

12.16 In September 2010 E attended her GP surgery concerned about her increasing weight which she felt was 'really affecting her, including her sex life'. The Practice Nurse advised E about her diet, exercise and alcohol intake. An Alcohol Use Disorder Identification Test Consumption questionnaire was completed and indicated a low risk.

12.17 A further domestic incident was reported to the police in November 2010. On this occasion E reported that she had been 'beaten up' by F in front of her children. E said that she had told the children off and then F had pinned her to the floor and told the children to stamp on her, F had also punched her head several times. It was noted that E had a bloody nose and she complained her head hurt however she declined an ambulance. F had already left the address and E was described as 'too drunk' to make a statement. There is no record of a DIAL form being completed or of any engagement by the police with the children to either check on their welfare or as a possible source of evidence. Despite E being described as being 'too drunk' to make a statement the children were left in her sole care.

12.18 Officers returned the following morning but E altered her account and said that her injuries were self-inflicted and that she had lied about F assaulting her. The incident was finalised as a non-crime domestic. A safeguarding referral regarding the children was not made to partner agencies concerning domestic abuse/violence issues in the family.

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a DIAL provided no offences were disclosed and there were no concerns – current policy requires a DIAL to be submitted for all domestic incidents.

[7] The manager and supervisor of the Disclosure and Barring Service has been advised regarding the accuracy of checks.

12.19 A further domestic incident was reported to the police in March 2011 by F and by members of the public who witnessed the dispute which was taking place in a supermarket car park. F stated that E had been drinking and wouldn't get out of his car. The member of the public reported that E had been calling out to them and looked scared of F. The police attended and confirmed that E had been drinking, the children were not present at the time, and the incident was described as a verbal argument. A DIAL form was not completed and the incident was finalised as a non-crime domestic.

12.20 In August 2011 E contacted the police to complain that she had been hit over the head with a bottle earlier that night whilst at a public house. The police visited her at her home address and noted that she had a small cut to her head, E said that the incident had occurred at a family function but refused to identify who had assaulted her. The police arranged to see her later when she was 'sober' however when she was revisited later the following day E stated she wished to withdraw her allegation and the incident was closed with no further police action. A crime report was not completed in relation to this alleged assault.

12.21 In October 2011 E contacted her GP surgery concerned that she was not losing weight and requested a thyroid function test. However, she failed to attend the appointment that was made for blood tests the following month.

12.22 In February 2012 E attended the Emergency Department (UHNM) via ambulance, stating she had consumed a bottle of vodka. It was recorded that she was experiencing self-harm thoughts and very low mood. The reviewing doctor determined that there had not been an overdose or deliberate self-harm. E said that she would not self-harm if she went home and it was agreed that she was medically fit for discharge and should go to her mothers and the GP would be asked to follow up. No record was made of G or H or any safeguarding considerations in relation to them[8].

12.23 Later in February 2012 E contacted her GP surgery for contraceptive counselling saying that she 'cannot carry on like this'. E said that she had two children and had seven pregnancies and wanted to discuss sterilisation.

12.24 There is no record of an appointment being made at that time for E to discuss with her GP the issue of sterilisation however in March 2012 E contacted her GP surgery again requesting an appointment. E attended the appointment and complained of mood swings and feeling very low and weepy before her periods. A Patient Health Questionnaire (PHQ-9[9]) was completed with a score of 14/27 and E was prescribed anti-depressant medication for anxiety disorders. It appears at this point that E was not attending work.

Domestic incident prompts referral by the police to children's social care - August 2012

12.25 In August 2012 E contacted the police to complain that she had been kicked in the stomach by F and was not prepared to take anymore. E said that her children were now asleep upstairs

[8] As noted earlier recording systems have changed in the Emergency Department and now include prompts to consider children being cared for and safeguarding concerns.

[9] PHQ-9 is a tool used for screening, diagnosing, monitoring and measuring depression – a score of 10-14 indicates minor depression.

and were safe although they had witnessed the assault. F had apparently left the address before E called and she was advised by the police to lock her doors and call 999 if F returned. The police attended the address almost 2 hours later and F opened the door, he was apparently sober and claimed that E had returned home very drunk in the early hours of the morning with the children. A police supervisor attended and spoke to E alone who said she had no injuries and did not want to make a complaint. E claimed to have made up the allegation and only called the police so that F would leave the house whilst she got the children to bed although she did admit that they had argued. F agreed to leave the house and additional support (not specified) was offered to E but declined. The children were said to be 'fine and would not come to any harm' although it is not clear if they were seen or on what basis this assessment had been made. A DIAL form was not completed.

12.26 The police finalised the incident as a verbal domestic argument and contacted the Advice and Referral Team (ART) of Stoke-on-Trent Children's Social Care (SOTCSC). This was the first notification of a domestic incident made by Staffordshire Police to SOTCSC regarding F and E.

12.27 After confirming that there had been no previous contact between SOTCSC and E no further action was taken by the ART and the notification was dealt with as information only. A Multi-Agency Safeguarding Hub (MASH) meeting[10] took place between the police and children's social care a few days later during which the police provided further information including F's convictions (for assault and criminal damage) and details of domestic incidents during 2010 and 2011 where it was thought alcohol had been a factor. In response to the further information received an ART Senior Social Worker contacted E by telephone, however E declined to meet with SOTCSC.

12.28 In October 2012 E attended an appointment with her GP and complained of a low mood. E said that she was struggling again and had stopped taking anti-depressant medication of her own accord as she was not sure it was helping. E said that she had a significant problem with binge drinking every week consuming 2-3 bottles of wine at a time. An Alcohol Use Disorder Test Consumption questionnaire was carried out again with a score of 7/12[11]. A PHQ was repeated with a score of 17/27[12]. The GP discussed referral to Aquarius for support however a referral was not made[13] and E was prescribed anti-depressants with a follow up scheduled in four weeks.

12.29 In early November 2012 E had telephone contact with her GP. E reported low mood and disturbed sleep but was much improved on the medication prescribed. A repeat prescription

[10] MASH operating processes have evolved during the time period covered by this Review, they essentially provide a mechanism to share information between organisations and details of the current process for dealing with information about domestic abuse are outlined later in this report.

[11] Alcohol Use Disorder Identification Test questionnaire score of 7/12 indicated an increasing risk.

[12] PHQ score of 17/27 indicates major depression.

[13] Aquarius held the contract for drug and alcohol services until November 2015 – enquiries made as part of this Review have established that a referral would only be made with the consent of the patient and it is assumed that as a referral was not made consent was not forthcoming.

was made with the intention that an appointment be made the following week although this did not take place.

12.30 An appointment was made in February 2013 for E to see her GP however she did not attend. The next time E saw her GP was in March 2013 when E again reported mood swings, feeling low, and not sleeping well. E said that her partner was not very supportive. The GP prescribed medication for depression and a follow up appointment was made although there is no record of E attending and it was not until October 2013 that E had contact with her GP again.

G injured during domestic incident leading to a second referral by the police to children's social care and a child in need assessment – March 2013

12.31 In March 2013, the ambulance service attended the home address of E in response to an incident initially reported as a child falling on a bottle. On arrival at the address, F explained to ambulance staff that he had thrown a bottle at E which actually hit G causing a small cut to the top of the child's head. The injury was treated by ambulance staff who described it as a superficial 1" cut which did not require further medical treatment. The ambulance service contacted the police to report the domestic incident.

12.32 The police attended by which time F had left the address, E initially refused to say what happened but later confirmed that she had been involved in a domestic dispute with F when he threw the bottle as described. E was adamant that F would not deliberately harm his children and that the bottle was aimed at her.

12.33 The Force Duty Officer, responsible for supervising the Force Control Room, recorded on the log the need for officers to take positive action in line with the domestic abuse policy and safeguard E and G. Officers took immediate safeguarding action by conveying E and her children to E's mother's address and were reassured that the grandparents then had care of the children. The incident was 'tagged' on the system by Force Control Room staff to ensure that it was brought to the attention of the MASH in the morning. A DIAL form was not completed on the night of the incident in accordance with procedures however a record was made on the police 'Guardian' database.

12.34 The following morning a police sergeant took responsibility for managing the incident. A police child protection team supervisor was consulted and advised that the SOTCSC Emergency Duty Service (EDS) should be contacted as SOTCSC staff were not in the MASH at that time. The police sergeant attempted to contact response officers to clarify the details of G's injury but was unable to do so. The police log was updated some time later to the effect that staff at the MASH had made contact with EDS (SOTCSC) and that the Social Worker had raised concerns that this was the second domestic incident where alcohol was thought to be a factor, referencing an assessment undertaken the previous December[14]. Consideration was given to a medical assessment being undertaken but it was agreed that a Social Worker should visit and assess the situation as the trauma of an examination could have been worse than the

[14] The record made at the time states that the previous incident referred to was in December however the Review has concluded that this was a recording error and that it should read August.

injury. The MASH identified that a DIAL form was required and requested the police complete one.

12.35 A joint visit by police and a Social Worker took place during which E declined to support an investigation or allow an account to be obtained from G through an Achieving Best Evidence (ABE) video interview. E stated that the injury resulted from an accident and that F held her responsible for causing it. SOTCSC decided that the case should be dealt with as a child in need (CIN)[15] and an assessment under s.17 Children Act 1989 was commenced. A medical assessment of G was not undertaken.

12.36 E disclosed that she had been suffering from depression and had been drinking. A written agreement was signed by E to the effect that F should not reside at the property while social care assessments were carried out. The agreement was used as a means of providing clarity for E around the expectations of SOTCSC and was not made with F

12.37 F was detained the day after the alleged assault and interviewed. He provided a different account of the dispute claiming that E had attacked him and was seen to have scratch marks to his back and neck. F claimed that they were all sat on the sofa with G between them when E lunged at him, he raised his hand (in which he was holding a beer bottle) to protect himself and the bottle made contact with G's head.

12.38 A file was submitted by the police to the Crown Prosecution Service (CPS) that included a 'Joint CPS and ACPO Evidence Checklist – for use by police forces and CPS in cases of domestic abuse'. The checklist contained inaccurate information about previous domestic abuse incidents referring to only three previous verbal incidents in 2009/2010 and 2012 when in fact there had been five known previous incidents including three allegations of violence. No comment was provided on the police view of future relationship and likelihood of recurrence/any threats.

12.39 The CPS decision was for no further action to be taken on the grounds of there being no realistic prospect of conviction of F for the injury to G and that E declined to support a prosecution for the alleged assault on herself.

Child in need (CIN) meeting – decision for SOTCSC to close the case April 2013

12.40 A Child in Need (CIN) meeting was convened by SOTCSC in April 2013, following the domestic incident in March 2013. The meeting took place at School 1 and involved SOTCSC, the Deputy Head of School 1 and the School Nurse. E and F did not attend having apparently already been informed by the Social Worker that the CIN plan would be closed.

[15] A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

12.41 A number of actions were agreed at the CIN meeting. Referrals would be made to the Bridge Centre for E and F to receive relationship counselling and to mental health 'changes'[16] for E to receive support. It was also identified that H should undergo a hearing test.

12.42 The decision taken at the meeting was for SOTCSC to close the case on the basis that they had attempted to work with the family for a period of five weeks following the referral in March 2013 but neither E nor F had made themselves available. As the case was deemed to be 'child in need' the parent's consent was required for any work to be undertaken by Social Workers and this did not appear forthcoming. There was no step down to early help services and it was recorded that parents were accessing support and there were no outstanding concerns for the wellbeing of G.

12.43 In August 2013 E applied for a new job as a care assistant and information checks were again carried out by the police under the Disclosure and Barring Scheme (DBS). The three pieces of information identified as part of the previous check in April 2010 were again considered and the error regarding incorrectly linking the second of those to E was not recognised. The relevancy test for disclosure was again not met and no disclosure was made.

F self-referred to services with concerns about mental health and alcohol consumption – September 2013

12.44 In September 2013, F self-referred to NSCHT Access Team[17] reporting that he was not sleeping, had excessive energy and was concerned about his consumption of alcohol. He also reported some paranoia regarding E although no details were provided. An appointment was made for a full assessment a few days later.

12.45 F attended the appointment for an assessment and provided further details of his paranoia which concerned thoughts that E was trying to poison him and that travellers were trying to harm him. The outcome of the assessment was unclear and F attended the Access Team again a few days later, this time in company with E, and a further appointment for assessment was made however F failed to attend.

E arrested for common assault on F and receives a police caution – referral made to SOTCSC - September 2013

12.46 Towards the end of September 2013 Staffordshire Police received a call during the night from F complaining that E was drunk, that he could not control her and that she had bitten him. The police attended and F stated that they (F, E, G and H) had been to a family function during which E had become abusive and aggressive resulting in him taking her home. Once at home E had become aggressive towards her neighbours before assaulting F who had then stayed in the lounge until the police arrived.

12.47 The police arrested E for common assault and she was conveyed to a custody centre. No specific reference was made by the attending officers to the children. The investigation was

[16] Further information about the referral to the Bridge Centre was not available to the review, 'Changes' was an independent sector provider for mental health services and E declined this offer of support.

[17] NSCHT front door service.

picked up by a team based in the custody centre. E admitted drinking heavily, becoming abusive towards a neighbour and causing minor injuries to F (bite to thumb and scratch to face). Although F stated he did not wish to pursue the matter it was decided that E should receive a caution for the offence in light of the admission she had made. A disclosure to E's employer under the Notifiable Occupations Scheme[18] was not made.

12.48 Stoke-on-Trent City Council Housing (later part of Cooperative Working) became aware of the incident following a complaint to them by a neighbour. MASH information sharing also led to school nursing (Staffordshire and Stoke-on-Trent Partnership NHS trust - SSOTP) being informed of the incident. They noted that the children were reported to have been asleep at the time of the incident and that there was no specific action for them to take.

12.49 SOTCSC received a referral the day after the incident and visited E who was initially resistant to their involvement saying she didn't understand why they were involved as the children were in bed at the time. The Social Worker explained that there had been previous domestic abuse incidents and a visit was required to see if any support could be provided to reduce the risks of any further incidents. SOTCSC kept the case open as a CIN whilst an assessment was undertaken.

12.50 At the beginning of October 2013 E attended her GP stating she was struggling to sleep, had stopped taking anti-depressants as they made her feel high and that she was still drinking at weekends. E also said she had lost her job and requested sleeping tablets. The GP declined to prescribe sleeping tablets and discussed lifestyle measures with E and referred her for health coaching.

12.51 During early October 2013 F contacted the NSCHT Access Team on two occasions. F said that he was concerned about E's emotional health and referred to her becoming intoxicated and attacking him. F was described as having some paranoid thinking about his wife being unfaithful and his food being poisoned. The main issue according to F was his relationship with E and he was initially advised to see 'Relate' and continue with anti-depressant medication and then on the second visit he was referred to the Community Mental Health Team (CMHT).

12.52 A few days later E contacted the duty professional at the CMHT stating F was displaying evidence of psychosis, she said that he seemed to be unaware of his behaviour and was 'not keen' on his medication. A medical review was requested by the duty professional and E was advised to re-contact if more support was required.

12.53 The CMHT referred F to the Early Intervention Team (NSCHT) and he remained under the care of that team for three years during which he had regular contact and visits from a Community Psychiatric Nurse (CPN). At the start of this period of care he was seen promptly by a Consultant Psychiatrist and a diagnosis of stress induced psychosis was made. A care plan was subsequently put in place and this is commented on in the analysis section of this report.

[18] This scheme was designed to protect vulnerable people by disclosing certain information about persons in particular occupations to their employers – further detail is provided in the analysis section.

12.54 In late November 2013 SOTCSC closed the cases of G and H. It was noted that F was accessing services to address his mental health issues and that E was aware that her actions carried consequences and that she was also making a conscious effort to reduce the potential for further conflict and prevent the children from being exposed to this.

12.55 In early December 2013 E attended her GP surgery and was described as being 'very stressed'. E believed she was pregnant and had pregnancy tests which were positive and then negative. A further test was arranged due to her anxiety and E was referred to the hospital Gynaecology Department (UHNM) regarding sterilisation, however E did not attend the appointment. At this point E had four previous pregnancies terminated and one still birth.

12.56 In February 2014 E contacted the Early Intervention Team (NSCHT) and said that she felt unable to cope with F. E reported that F had stopped taking his medication and had no motivation to do anything. The CPN visited and F reported difficulties in his relationship with E, he agreed to think about taking his medication again. The CPN and F discussed E using illicit substances and drugs and during this conversation E entered the room and was verbally abusive towards F. The CPN suggested that E and F needed to consider their wellbeing and the wellbeing of their children. The CPN assisted F and E to spend some time apart in the short term by helping F draw out some money for E and then conveying E to her mother's address to stay there.

12.57 A referral was made to the Carers Team (NSCHT) for E to have a carers assessment. E was subsequently informed by letter that there may be a delay in completing the assessment and was advised to contact the Carers Team if the circumstances became more urgent. In the event the assessment was never completed as E did not engage with the process despite several attempts to contact her for this purpose.

12.58 In February 2014 School 1 (attended at that time by G and H) was involved in discussions with the MASH regarding historic and current domestic abuse issues in the family home[19]. It was noted that G was displaying some behavioural difficulties and school staff attempted to speak to G however he declined. Social Workers subsequently spoke to G and H at school and nurture support for G and H was provided from class teachers and the Learning Mentor. A referral was made to the Family Support Worker service, linked to the school, to offer support to E however despite several attempts E did not engage.

E contacted the police to report being kicked in the mouth by F – March 2014

12.59 In early March 2014 E contacted Staffordshire Police to report an assault. The call was ended by E before full details could be obtained however E called back a short time later and said F had kicked her in the mouth. E said that F had now left the house and that the children were next door. Police patrols were initially directed to attend as the call was graded by the control room as 'priority' however before they attended the incident was re-graded without explanation to 'appointment'.

[19] It was not clear to the Review what prompted this discussion or under which framework action was being taken. School 1 reported some recording issues regarding their earlier involvement which gave the incorrect impression that this was the first knowledge they had of domestic abuse affecting G and H.

12.60 Later that evening the police contacted E by telephone, apologised for the delay in responding and arranged to attend the following day. E said she did not think F would return that night and the police advised her to contact them if there were any problems. Later that evening F did return to the house and E contacted the police who attended and arrested F. The injury to E was noted by the officer to be a small mark or blood blister to the inside of her mouth.

12.61 After conveying F to the custody centre the police returned to obtain a statement of evidence from E but she refused to provide one. The officer discussed with E at length the Staffordshire Police policy on domestic related incidents however E was adamant that she did not wish to pursue the allegation of assault. Details of the National Centre for Domestic Violence (NCDV)[20] were provided to E after she said that she did not want the police to make a referral to them but would get in touch herself.

12.62 F was interviewed, denied the allegation and was released with no further action on the basis that the injured party refused to support a prosecution and there were no other witnesses. A domestic abuse leaflet was given to F and he was taken back to the family address where he collected his car and then left to stay with his brother. A DIAL form was submitted with an assessment of 'Standard Risk'.

12.63 The following afternoon E contacted the police on three occasions within an hour. E reported that she had returned home to find F at the address, she did not want him there and he was refusing to leave. E said she had an injunction preventing F from being at the home. The police attended and established that an injunction was not in place, F and E informed the police that they were joint tenants[21]. E said that she had contacted the NCDV and she believed they were in the process of obtaining an injunction, she had also been assigned a solicitor. E was leaving to go to work and said she would not be returning until 7am and the police therefore reached the conclusion that there was no potential for further dispute. No record was made of any engagement by the police with the children. It was noted by the police that E had incorrectly believed they could make F leave and that both parties were fine and that no offences were apparent.

12.64 Three days after the report of E being kicked in the mouth by F the GP received a letter stating E attended the fracture clinic at UHNS with an injury to her right hand caused at work. The injury was apparently caused through lifting up a woman and led to E receiving compensation.

12.65 MASH information sharing arrangements led to the School Nurse service subsequently being made aware of the incident where E reported being kicked in the mouth. No specific action was required of the service other than to record the information on the School Nurse child health records. The information sharing did not extend to notifying the school on this occasion.

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[20] The National Centre for Domestic Violence (NCDV) provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances, race, gender or sexual orientation. The service allows anyone to apply for an injunction within 24 hours of first contact (in most circumstances) and works in close partnership with the police, local firms of solicitors and other support agencies (Refuge, Women's Aid etc.) to help survivors obtain speedy protection.

[21] The property was in fact under a single tenancy agreement with E

12.66 In April 2014 SOTCSC received notification from the police of the incident in March 2014 where E reported being kicked in the mouth. This prompted an unannounced home visit by a Social Worker and Social Work Assistant. E was initially not happy with them visiting stating she was not prepared, however, she declined a planned visit the following day and instead agreed to speak to them at that point in time. F joined them a short while later and had a similar response to the visit. It was noted that:-

- F was being seen fortnightly by his CPN and had received advice on how to respond to issues at home which included leaving the house to prevent any potentially volatile situation escalating
- relationship counselling had also been considered and whilst F was agreeable, E was reluctant to engage
- a review of F's mental health support was scheduled for May 2014 with a psychiatrist but it was unlikely that F would be discharged.

12.67 F spoke to his CPN shortly after the visit by SOTCSC expressing concern about the Social Worker's view of his mental health problems. As a result, the CPN contacted the Social Worker who informed the CPN that there had been four contacts with SOTCSC in the last 12 months. The CPN advised the Social Worker that there were no current concerns regarding any deterioration in F's mental state.

F reported being attacked by E with a knife – April 2014

12.68 Later in April 2014, F contacted the police reporting that he had been assaulted twice by E including her attacking him with a kitchen knife and causing a cut to his side. The incident was apparently still ongoing and two children were in the house, the eldest (G) had apparently witnessed the attack. The police attended and found all was quiet – F was described as calm however E was clearly upset. Both parties said they had not been getting on for some time and each stated that the other had mental health/emotional problems. The police records of the incident (based on the information provided by E and F) stated that E had no record of depression or mental ill health but F had two break downs, the most recent being in September 2013, and that he was still receiving counselling for this. The injury was described by the police as a superficial 1½ inch cut to the right side of his waist. Both children were seen to check on their welfare and were described as being calm, happy, playing with each other and almost oblivious to what was going on.

12.69 F did not want to provide a statement of evidence or support a prosecution. E was arrested but denied the allegation. Following a review of the case by a police inspector a decision was taken for no further police action[22] due to F not supporting the investigation and there being no other witnesses.

12.70 A DIAL form was completed and it was recorded that F was not a vulnerable person. This was despite the form including 'mental health' in a list of vulnerability factors for consideration and reference being made in another part of the form to him suffering 'two mental breakdowns, the last one being Sept 2013, seeing counsellor but takes no medication'. It was also noted that F was stating his intention was to leave E when he had saved sufficient money.

[22] CSC records incorrectly state that E received a caution regarding this incident.

12.71 In early May 2014, the Social Worker and Social Work Assistant undertook a further home visit to discuss the outcome of their assessment with E and F. During the visit F and E started arguing and informed the Social Worker and Social Work Assistant that a further domestic abuse incident had taken place and went on to describe the incident with the knife reported on in April 2014. It does not appear that SOTCSC were aware of the incident prior to their visit. E and F were advised that the case would stay open and be managed on a CIN plan to provide support and services to reduce the risk of further incidents in the future. E said that she was engaging with the Family Support Service at School 1 however this was not the case.

12.72 There was further contact between E and the Social Worker by telephone in May 2014 during which E spoke about her home life and relationship with F. E said that F had attacked her that morning, that her fingers were cut and that she was now sleeping on the settee. E also said that F had taken photos of her which he said he would show to the Social Worker. During the conversation E said she would leave F but wanted advice on whether she could take her children with her. E told the Social Worker that G had said to her that he didn't know how she was not reacting to F. General advice was given but further discussion was deferred until the next CIN meeting.

12.73 In early June 2014, following an unsuccessful home visit, SOTCSC informed E and F by letter that the case was closed. The reason given for the decision was that the parents had failed to engage with the CIN plan and made no effort to be available despite being advised of a home visit. The letter advised E and F that further referrals of reported domestic incidents could instigate statutory involvement. Between the referral to SOTCSC in April 2014 and June 2014 the case was managed by SOTCSC through a CIN plan and although there are references to further discussions at a CIN meeting there were no CIN meetings during this period.

12.74 In July 2014, the police received several calls about a dispute between neighbours which included E and F. Consumption of alcohol was a factor in the incidents and the outcome was that all parties involved were advised about their behaviour. Cooperative Working (housing) were also made aware of the dispute although no further action was taken due to lack of evidence and the situation having calmed down.

12.75 During August 2014 E attended her GP's surgery complaining of low mood and being under stress at work and home. E reported having relationship problems and was still suffering pain in her wrist. The GP referred her to Healthy Minds[23] for cognitive behavioural therapy and advised her to return to the surgery in two weeks or sooner if needed. E missed an appointment that had been made for an MRI scan of her wrist, revisited her GP later that month and was prescribed medication for her wrist injury. In early September, the GP received notification from Healthy Minds that E had not attended her appointment for therapy and there would be no further follow up. An assessment of E's mental health was not made at this time.

12.76 In September 2014 E had several contacts with a trainee Social Worker from the Carers Team (NSCHT). The initial contact was made by the Social Worker to arrange for a carers assessment to be completed (following the referral earlier in the year). Two days later E telephoned the Social Worker and said that F had been verbally and physically abusive

[23] Healthy Minds is the Stoke on Trent offer for Improving Access to Psychological Therapies.

towards her over the past few weeks. E was tearful and said she did not feel safe and was unwilling to leave her home, E said that she did not want to inform the police as she did not want social services involved again. E requested that the carers assessment be brought forward.

12.77 The Social Worker from the Carers Team sought advice and as a result contacted F's CPN who confirmed she was aware of the domestic abuse and would offer an appointment to F that afternoon. The CPN agreed to update the Carers Team before the carers assessment was undertaken. The Social Worker from the Carers Team re-contacted E to let her know that she had spoken to the CPN. E said that she felt better having told someone and agreed to speak further to the CPN. The arrangements for the carers assessment were left as originally planned.

12.78 The CPN then contacted E to discuss the issues she had raised with the Carers Team. E told the CPN that F had been making faces so she had taken a photograph of him he had responded by touching her breast in front of her children, showing her underwear to her children, spitting at her and filming her in the bedroom. The CPN then visited F and he admitted spitting at E but denied touching her breast and said that he had only pretended to record her. The CPN concluded that there was no evidence of psychosis and noted that F was considering the detrimental effect of the current situation on the children.

12.79 At this point the CPN was aware that the CIN plan had ended and contacted SOTCSC to explore what support was available to the family and shared the information about the recent disclosures by E with School 1. The police were not contacted by either the CPN or the Social Worker from the Carers Team regarding the allegations made by E – the Social Worker had discussed informing the police with E but she did not want them involved.

Adult safeguarding referral following alleged assault of F - October 2014

12.80 In October 2014, the CPN visited F who reported that E had assaulted him a few days earlier by squeezing his testicles and scratching his face. E was present at the time of the visit and became verbally abusive towards the CPN and said she wished to complain about her.

12.81 The CPN made an adult safeguarding referral, having received the complaint from F, on the basis that there had been an allegation that a vulnerable person had been physically abused. F was deemed vulnerable because of his mental health and E was identified as the perpetrator. A CAADA DASH risk assessment[24] was completed with F and the score did not reach the MARAC threshold.

12.82 Over the next few days in addition to the contact by the CPN several other services had contact with E and F.

[24] CAADA DASH risk assessment is a checklist primarily for use by professionals (specialist or mainstream) to enable the level of risk from domestic abuse, stalking and honour based violence to be assessed – it is recommended that a score of 14 or more should lead to a MARAC however professional judgement and/or an escalation in the number of police callouts should also be taken into account.

12.83 E had a telephone consultation with her GP regarding her wrist injury. The Early Intervention Team (NSCHT) contacted E and F by phone and noted the situation appeared more amicable, consideration was given to early identification of signs of relapse for F.

12.84 The police received a complaint from E that F had been aggressive towards her and was drunk, no offences were identified and the incident was closed as a no crime domestic. At this point the police were unaware of the incident that had been reported to the CPN the day before where F alleged he had been assaulted by E. A DIAL form was not completed although the log recorded in response to a set of automated questions that one had been completed[25].

12.85 A few days later a manager from the Early Intervention Team (NSCHT) met with E and F, neither of them agreed that F was showing early signs of relapse, although it was also commented that they didn't appear to know what early signs of relapse for F would be. However, F did agree to a short-term prescription of medication. The CPN visited F at home the following day and noted concerning behaviour by F, including a preoccupation with gypsies and making connections that were not apparent, which were thought to be possible signs of relapse. F agreed to take the medication but declined Home Treatment Team support[26].

12.86 On receipt of the adult safeguarding referral police within the MASH undertook a risk assessment using the completed Adult Protection Form (AP1). It was noted by the police that the incident had apparently taken place when E was trying to recover her phone from F. A further incident, where E hit F with a metal bar causing swelling to his arm, had also been alleged by F. The police record states that steps were being taken to rehouse[27] F at the weekend to safeguard him and that F had said that he did not want the police to be involved.

12.87 A review of the referral within the MASH led to a strategy discussion taking place under the Staffordshire and Stoke on Trent Adult Protection Procedures. The strategy discussion involved a police supervisor and a mental health professional and they agreed that NSCHT should continue to provide support to F on a single agency basis. The police recorded the incident as a crime and an investigation review meeting (under the vulnerable adult process) was scheduled for early November 2014. The new Domestic Violence Protection Notices and Protection Orders (DVPN/DVPO) that had become available to Staffordshire Police in June 2014 were not used.

[25] The police IMR has identified that practice in the control room was to complete the automated questions in this way so that control room operators could quickly return to resourcing the incident – the use of an automated set of questions has ceased following a recent review of procedures.

[26] Home Treatment Team support people in their own homes providing packages of care as an alternative to hospital admission as well as assistance following discharge.

[27] The reference to 'rehousing' is thought to relate to F staying at his mother's in the short term as there is no evidence of housing providers being contacted to formally rehouse F.

Referral to SOTCSC by mental health team following concerns about the impact on the children - October 2014

12.88 In late October 2014, SOTCSC received another referral from the mental health team on behalf of F's CPN, who was concerned about the impact of domestic abuse on the children. It is recorded that the CPN had completed a home visit that day and found home conditions to be extremely volatile – the CPN was concerned that physical violence towards F was escalating although it was not yet affecting his mental health and E was not addressing her own mental health issues. The CPN was shaken up by the visit and there was a discussion about the risks of lone working although the outcome was not clear. Information on previous SOTCSC involvement was provided and it was noted that there had been a reluctance to engage with the CIN plan and progression to child protection was likely. The outcome of the referral was however for a further child and family assessment to be undertaken and another CIN plan to be put in place.

12.89 A CIN meeting involving the Social Worker, CPN and Learning Mentor took place in early November 2014 at School 1. Both E and F were in attendance. Notes taken by the CPN indicate that triggers for domestic abuse were identified and included F being concerned about E visiting her mother frequently and E stating that F drank to excess once a week. E said that she needed her mother's support and that she had addressed her own excessive drinking by spreading out her alcohol intake over the week. It was noted that both G and H had shown signs of distress at school in October 2014 and that G did approach a teacher at times to talk. A plan was agreed for F and E to be referred by SOTCSC to Arch for a 'Freedom Project' course[28], The Social Worker agreed to speak to G about accessing support through 'Younger Mind'[29] and make a referral if he agreed. E was given the telephone number of the Carers Team to access support and the CPN agreed to feedback the outcome of the forthcoming adult protection investigation review meeting to the Social Worker who was unable to attend.

12.90 Following the CIN meeting the Social Worker contacted Arch and found that the next course would start in January 2015. Arch agreed to email the referral forms to the Social Worker and contact everyone when the date had been agreed[30]. There is no record of a referral to Younger Mind.

12.91 The adult protection investigation review meeting took place as planned in early November 2014. The meeting was chaired by the Adult Safeguarding Nurse (NSCHT) and attended by the CPN, Caseload Manager (Area Intervention Team), F and E. Apologies were given by SOTCSC and the police[31] (who were unable to attend due to late notice and shift patterns).

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[28] The Review noted that it was unlikely that Arch North Staffs would have worked with E and F over the same period as both were perpetrators and victims of domestic abuse.

[29] Younger Mind is a registered charity (part of Mind) which offers emotional support to young people.

[30] The Review found that there was considerable uncertainty around referrals to Arch, in this instance the Freedom Project is a 12-week course aimed at women (not couples) and no record was found by Arch of a referral which may be explained by individual risk assessments not being completed with E and F.

[31] Having been unable to attend the meeting it does not appear that the police were engaged in any other way regarding the decision made at the adult protection investigation review meeting.

The meeting discussed the original concerns and progress being made. It was confirmed that the CIN process was in place. F and E stated that they wanted to make their relationship work and felt that the involvement of services had made them reflect and put actions in place to prevent further difficulties in the home. No further incidents were reported or known and it was agreed that the vulnerable adult process should be closed and that the concerns should be managed through CIN and Care Programme Approach (CPA)[32]. It was noted that should further concerns arise consideration should be given again to managing them through vulnerable adult and safeguarding processes.

12.92 A care plan was developed under the CPA and this acknowledged F's approach to his medication which was to initially accept treatment to manage his brief episodes of psychosis but then stop taking medication without consulting staff. The care plan included options of how F could access medication if he began to feel unwell or notice any early signs of relapse although the plan did not detail what those signs were[33]. The CPA was not fully implemented in that not all professionals were involved, such as the Social Worker, however the CPN linked in through the CIN and later child protection processes.

12.93 The CPN continued to visit F and understood from E that she was accessing support from the carers team. However, E did not attend her appointment for a carers assessment in November 2014, numerous attempts were then made to arrange another appointment with E however this was unsuccessful and the Carers Team therefore closed the case.

12.94 SOTCSC contacted E by telephone later in November 2014 and explained that to access Arch support services a risk assessment needed to be completed individually. E objected saying that they (E & F) had discussed it and decided to complete the assessment together. E said that she felt there was an expectation on them to exaggerate the situation. Although both E and F did subsequently complete individual assessments SOTCSC records note E often delayed situations to prevent support and was not willing to engage with services.

12.95 In December 2014 E had a telephone consultation with her GP and was diagnosed with depression and a Med 3[34] was issued. The GP noted that E had been referred for counselling but did not attend and apparently did not want counselling services. The GP prescribed a month's course of anti-depressants. E had a history of stopping her medication of her own accord and this was a re-prescription of the same medication with a follow up medication review appointment with her GP in four weeks' time.

12.96 A month or so later E attended the GP surgery stating she was not coping well and was under stress from work having been off for more than 6 months. E said her partner was self-employed and had mental health issues and that money was low. Cognitive behavioural therapy and self-help methods were discussed, E again declined counselling services and was prescribed further medication.

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[32] Care Programme Approach is a system of delivering community mental health services to individuals diagnosed with mental illness. It is a multi-disciplinary approach that requires an assessment of need and the development of a care plan coordinated by a named person and reviewed with key stakeholders.

[33] Early signs of relapse were included in F's clinical notes.

[34] Med 3 is a Statement of Fitness for Work completed by GPs and other doctors.

12.97 During a telephone consultation with her GP in February 2015 E reported feeling much better and was advised to consider returning to work although she seemed anxious about the prospect.

F arrested for common assault on E – February 2015

12.98 In February 2015 E contacted the police. The initial call was cut short and a disturbance could be heard in the background. A second call was made a short time later during which E provided further details. E said that F had been spitting in her face all day and had been bullying her for a while, assaulting her on a number of occasions. E said that she had been stamped on and spat at by her ex-partner (F) following an incident when F kicked the dog and tried to whip it with a leash but hit himself instead. E said that she didn't need an ambulance and thought F was having a psychotic episode. The children were not at the address at the time.

12.99 A location comment on the police system, appended to the address provided by E, indicated that there was a connection to a vulnerable adult currently open to the Early Intervention Team with early psychosis, along with a warning that it was a volatile household.

12.100 The police attended, F had already left the address and E explained there had been an argument about the dog and F had spat at her, rubbed it in her face and then pushed her to the floor and stood on her. E had no visible injuries and declined to support a prosecution. F was arrested for common assault later that evening and denied the alleged offence disputing E's version of events. Following a review of the case by a Police Inspector F was released in the early hours of the morning with no further police action due to insufficient evidence. The rationale for this decision was that 'there is no history of violence as an issue in the relationship', indicating a lack of research. The Inspector recorded that the DVPN process had been considered but not used.

12.101 A DIAL form was completed and a referral recorded on the public protection database GUARDIAN. The record made on the GUARDIAN database noted *"both parties had a history of Domestic Violence both as IP and Offender. The IP (E) was not reporting all incidents to the police in order to avoid social services involvement. She refused to cooperate in pursuing any formal complaint and refused emergency injunction, Independent Domestic Violence Adviser (IDVA) or a Domestic Violence Protection Notice (DVPN). With a DIAL score of 7 it was not deemed suitable for a MARAC".*

12.102 The following day E contacted the police requesting they attend as F was at the address and there were conditions requiring him not to be there. The police attended and established that the call related to the incident the previous day and confirmed that F had been released without further action and was not under any bail conditions. E was concerned that their dispute would escalate and F left the address of his own accord. A DIAL form was completed and the subsequent assessment at the MASH recorded a 'Standard Risk' for the relationship and the threshold for MARAC was not met.

12.103 The CPN then visited F at home, the previous three appointments having been cancelled by F. F reported that his relationship with E was volatile again and that he had been arrested (for common assault) the night before. It was noted that F was very distressed about his grandfather who was very poorly in hospital. The CPN discussed with F and E making a referral to SOTCSC due to her concerns about the impact of domestic abuse on the children.

At this point G and H were already under a CIN plan which had been revised the previous October and it appears that the CPN was not aware that the CIN plan was still in place at this time and that CSC were therefore already working with the family.

12.104 The CPN subsequently contacted SOTCSC to raise the concerns about the children. Information was also provided to SOTCSC by the police about the incident reported to them by E earlier that month. SOTCSC made contact with School 1 to check on the welfare of the children and it emerged that G appeared to be withdrawn.

12.105 A copy of the DIAL risk assessment in the children's records confirmed that E had stated the following; that the children had witnessed the previous incidents, F controls their money, has been violent to the dog, damages property, is acutely jealous and suffers from stress psychosis. E stated that she suffers from depression, is under medication and wishes to separate. Details of the support offered by the police were included in the assessment.

12.106 A CIN meeting took place in March 2015, but neither E nor F attended. The incident reported to the police by E in February 2015 was discussed, it was recorded that G appeared well at school. The meeting noted that F had missed appointments with mental health services and it was felt he was disengaging although the CPN had been able to contact him that day through an unannounced visit and he appeared reasonably well. School 1 identified that F and E were disengaging from SOTCSC. The following actions were agreed;

- mental health services to arrange an appointment with F in two weeks' time
- School 1 to discuss the outcome of the CIN meeting with E and arrange for E and F to meet with SOTCSC at the school
- the case should be escalated from CIN to child protection (s.47 enquiries).

Details of the CIN meeting were recorded in school nursing and School 1 systems however SOTCSC have no record of any minutes for a CIN meeting on this day.

12.107 A child protection strategy discussion between the police and SOTCSC[35] (March 2015) confirmed the decision to initiate s.47 enquiries under the Children Act 1989 and convene an Initial Child Protection Conference. A child and family assessment was subsequently completed.

G and H made subjects of Child Protection Plans – April 2015 to December 2015

12.108 The Initial Child Protection Conference took place in April 2015 within the required time period[36] and G and H were made subject of a Child Protection Plan under the category of emotional abuse. The conference identified the risk of significant harm to G and H through

[35] Working Together to Safeguard Children 2015 (and its predecessor published in 2013) states that strategy discussions should involve children's social care, police, health and other bodies. It was noted by the DHR panel that in the past health were not routinely involved in strategy discussions but this had changed more recently and in this case the strategy discussion was formalising the agreement made at the CIN meeting.

[36] The timing of an initial child protection conference should depend on the urgency of the case and respond to the needs of the child and the nature and severity of the harm they may be facing. The initial child protection conference should take place within **15 working days** of a strategy discussion, or the strategy discussion at which section 47 enquiries were initiated if more than one has been held

witnessing further domestic abuse and the aim of the plan was to improve the relationship between parents and to minimise the risk of further domestic abuse which may lead to emotional harm to G and H. The health and educational attainment needs of G and H were also identified. The conference heard that G and H had been aggressive and violent towards other children, G and H had said that they had not witnessed anything between their parents other than swearing. F did not attend the conference and E arrived as the Chair was summing up. The police agreed to update their systems to show that the children were subject of a plan.

12.109 The family of E reported to the Overview Report Author that the involvement of children's social care at this point had a real impact on her. E told her mother that she was scared of losing the children and that she 'had to get her act together' in order to avoid this.

12.110 The first Core Group took place later in April 2015 and both E and F attended. Specific actions were agreed at the meeting in response to the risks and needs identified at the child protection conference: -

- F should take part in a perpetrators programme on a one to one basis at home organised by SOTCSC
- a referral should be made by SOTCSC for E to receive counselling through Arch
- a referral should be made for G and H to attend 'Relationships Without Fear'[37]
- SOTCSC would carry out announced and unannounced visits every 4 weeks
- the CPN should continue to work with F through fortnightly sessions
- the school should continue to build positive relationships with G and H
- F and E were required to offer healthy food options for G and H and to take them both to the opticians and dentist.

12.111 In the event of F and E not cooperating with the plan it was recorded that legal advice would be sought. The plan did not include the views of G and H, it is recorded they had told their parents that they did not wish to have a Social Worker visit them at school as they felt embarrassed by it. A copy of the plan was not provided to G and H or discussed with them. A copy of the plan was given to F and E and discussed with them.

12.112 A Core Group meeting took place in May 2015 and it was confirmed that the 'Relationships Without Fear' referral would be submitted on that day[38], a perpetrators course referral for F would be completed with the Social Worker and E was to be asked to self-refer to Arch.

12.113 Core group meetings also took place on two occasions in June 2015. The actions were reviewed during those meetings and it was agreed that the Learning Mentor (School 1) should complete a risk assessment for G and H. It was noted that issues still remained

[37] The 'Relationships Without Fear' programme aims to encourage healthy relationships and is delivered in schools between Year 4 and Year 11, it is provided by Arch. The Review established that this reference to the programme and all subsequent references were as a result of the professionals involved having an incorrect understanding of the programme – G and H were actually referred to Arch for 1:1 sessions with the Arch Children and Young Persons worker.

[38] The referral to Arch (mistakenly referred to as 'Relationships Without Fear') was emailed to an incorrect named email address and was therefore not received until 20/10/15 when it was hand delivered to Arch.

between G and another pupil. Although E and F did not attend the second of these meetings, it was recorded that there had been positive engagement with services.

12.114 In June 2015 Court action was commenced in relation to rent arrears concerning the tenancy held by E. Over the next few days both E and F had separate contact with Cooperative Working in relation to housing and support. Initially contact was made with E regarding the rent arrears, the following day F was spoken to when E did not attend an appointment and F explained that E was suffering with her mental health and that the children were on a Child Protection Plan. Later that day E attended a local centre and explained that she was leaving F due to him inflicting mental abuse on her and turning her children against her, however she then changed her mind and focussed on resolving housing benefit issues. Cooperative Working offered support which was accepted and a referral was made to the Service Coordinator for support regarding housing benefit and mental health.

12.115 When the Housing Officer becoming aware of the wider issues affecting the family the court action in relation to the rent arrears was paused. The Service Coordinator (Cooperative Working) contacted the Social Worker and agreed to support E to resolve her benefit issues and to access mental health services.

12.116 During this period E had further contact with her GP about her anxiety/depression and her prescribed medication continued and she was advised regarding her absence from work. E attended the surgery and informed the GP that social services were involved with the children and that her partner was going through a mental breakdown. There is nothing in the GP records (relating to E) to indicate that the GP had been contacted by other agencies about the child protection processes or that there had been input into them by the GP surgery at any time during the period covered by this Review. SOTCSC did however send a copy of the minutes from the Initial Child Protection Conference in April 2015 to the GP surgery.

12.117 SOTCSC also undertook a number of home visits during this period and it is recorded that the Social Worker spoke to G and H.

12.118 A Child Protection Review Conference took place in early July 2015 and it was agreed unanimously that the Child Protection Plan should continue under the category of emotional harm. The objective of the plan was to promote the safety and welfare of the children and it was recorded that if the parents failed to cooperate with the plan SOTCSC would seek legal advice that may result in G and H being moved to alternative accommodation.

12.119 Attendees at the conference included; the children's Social Worker (SOTCSC), CPN (NSCHT), and School Nurse (for G and H). Apologies were received from Staffordshire Police (who confirmed prior to the meeting that there was no new information), a number of named/designated health professionals. E attended however F was not present. It was noted during the conference that there had been much positive progress since the plan was put in place but the parents now needed to demonstrate they could sustain the changes and continue to engage with professionals. SOTCSC records show that G and H were consulted prior to the conference and that their views would be made known via attendees at the conference. G and H were not able to attend the conference due to being at school.

12.120 In addition to the actions identified at the Core Group meeting in April 2015 further actions were detailed including;

- an appointment for H to see a GP (following E raising concerns about the child's gait)
- arrangements to provide support regarding housing and financial matters
- support for G during the transition to a new school in September (via parents and school staff).

Reference was made again to 'Relationships without Fear' the purpose of the referral being to enable G and H to discuss what concerns they may have.

12.121 The day after the conference E contacted Arch domestic abuse outreach service requesting a referral for counselling. In response, a referral was made to Mind and a worker made contact with E to arrange a counselling appointment in approximately six weeks.

12.122 SOTCSC continued to undertake visits including a joint visit with Cooperative Working later in July 2015. During a follow-up visit to discuss housing benefit, the Service Coordinator (Cooperative Working) was informed by E that she was not taking her anti-depressant medication and then passed on this information to SOTCSC.

12.123 Further Core Group meetings took place in July 2015 and August 2015. At the latter meeting it was noted that there were no concerns expressed regarding G and H at the last visit, the children had been on holiday with paternal grandparents and E and F were getting on much better. It was also recorded that the housing issue had been resolved and assistance for E to change GP had been agreed. E was attending[39] counselling and requesting a mental health assessment.

12.124 Between the Core Group meeting in August and mid-September 2015 E disengaged from Cooperative Working and SOTCSC were informed of the missed appointments. Towards the end of August 2015, E attended her GP surgery having been contacted by them a few days earlier for an interim review of her depression and medication, E reported that her mood was still up and down but had no thoughts of harming herself. E said that social services were reviewing her and they had referred her to mental health. A further PHQ– 9 assessment was undertaken and the score was 17/27[40], the GP diagnosed that E had depression and a Med 3 was issued for a two-month period.

12.125 In September 2015 G started attending School 2. The child health record for G was transferred between the school nursing teams although there is no record of any discussion between the teams or verbal handover. The school record[41] for G was transferred from School 1 to School 2.

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[39] Although it was recorded at the meeting that E was attending counselling this was not the case. E had self-referred to Arch (North Staffs) for counselling which led to a referral to Mind however E did not attend the two sessions that she was offered.

[40] A score of 17/27 indicates a major depression that is moderately severe.

[41] School 1 IMR identified some record keeping issues including; incomplete dates and the incorrect storage of staff notes/diary entries, which left gaps in knowledge that potentially could impact on the identification of patterns and provision of support mechanisms. School 2 also highlighted the need to review their recording systems.

12.126 In mid-September 2015 E did not attend two pre-arranged appointments for counselling with Mind and as a consequence the service was ended in line with Mind procedures. E was contacted and informed but was assured that she could take the service up anytime in the future if she needed to.

12.127 A Core Group meeting took place in September 2015 attended by the Social Worker (SOTCSC), CPN, Learning Mentor (School 1), Service Coordinator (Cooperative Working) and E. School 2 were not invited to the meeting. The meeting heard that the children had settled into school well and that the housing financial issues had been resolved. A response was awaited from 'Relationships without Fear'[42]. F was still engaging with his CPN and E was having a mental health assessment the following week. As yet there had been no engagement with the perpetrators programme. E attended the meeting and said she was overwhelmed by the people currently engaged, the Service Coordinator (Cooperative Working) agreed to be available when E was more able to access the support on offer.

12.128 A few days later G contacted the police to report an assault on them by children at a local park. Whilst the call was in progress E intervened and terminated the call. Following further contacts between the police and E an officer attended and it was established that three older children had made offensive comments to G and H about their family before causing a minor injury to G. The insults were believed to relate to how E was being treated by F. As a result of the injury G attended the Emergency Department (UHNM) and was discharged home with advice. A Health Visitor referral form was completed and G's Social Worker was informed the following day of his attendance at the hospital.

12.129 Arrangements between the police and E to resolve this incident were problematic with both parties unable to attend agreed appointments. The police recorded the incident as a crime complaint and it was agreed that E would contact the police when they had decided if they wished to pursue the matter. In the event 57 days after the initial report of the incident the police recorded that E had stated that G had decided not to make a complaint and she supported the decision. No further action was taken by the police[43].

12.130 At some point around October 2015 E received several thousand pounds' compensation related to the injury that she had received at work. Her family describe how she was very happy around this time with money difficulties having been temporarily resolved although it is understood that the money had gone by December.

12.131 In October 2015 E contacted the Service Coordinator (Cooperative Working) and requested support to attend a mental health assessment with the Access Team[44] scheduled for a few days' time. The Service Coordinator subsequently supported E to attend the appointment on that day as well as two further appointments the following day. The GP was updated by letter

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[42] Arch had not received a referral at this point due to an incorrect email address being used.

[43] The issues around how this incident was responded to by the police have been highlighted with relevant police supervisors to address.

[44] According to NSCHT E was referred to the Access Team by her GP although GP records do not have a record of this but do note receipt of a letter confirming that the Access Team had closed the referral as E had been referred on by them to the CMHT Centre.

that E had been referred to the CMHT Centre following assessment by the Access Team who were therefore now closing the referral to them but had provided E with a telephone number if she wished to contact them again.

12.132 A further Core Group meeting took place in October 2015 attended by the Social Worker (SOTCSC), CPN, School Mentor (School 1), School Nurse, Service Coordinator (Cooperative Working) and E. School 2 did not attend the meeting due to only receiving the invitation on the afternoon of the previous day. During the meeting, the Social Worker explained to E that it was hoped to reduce the case to a CIN at the next child protection conference but progress must be seen against the actions. The incident where G was assaulted at the local park was discussed. E was reportedly struggling with her mental health and had not attended her first appointment with the Arch domestic abuse support service[45]. It was agreed that the School Nurse should develop a health care plan to include dental health, attendance at the opticians and emotional health input.

12.133 During early November 2015, the Service Coordinator (Cooperative Working) had contact with E on several occasions in an effort to support her attendance for a mental health appointment at the CMHT Centre (following completion of an assessment and referral by the Access Team). E was reluctant to attend stating she would attend but then changing her mind several times. However, E did eventually attend the CMHT Centre and saw the Duty Professional Practitioner. E said that she had sleeping difficulties and had stopped taking her prescribed anti-depressants and sleeping tablets, E said that her GP had accused her of only attending appointments to get a sick note. The Duty Professional Practitioner contacted the GP surgery and arranged an appointment for E with an alternative GP and then advised E to attend, rectify her medication and sick note problems, and then recommence claiming benefits in order to reduce her stress.

12.134 A Core Group meeting took place in November 2015 involving the Social Worker (SOTCSC), CPN, School Mentor (School 1), School Nurse, Service Coordinator (Cooperative Working) and F. School 2 were not aware of the meeting and consequently did not attend. The CPN described how she had visited F at home earlier in the month, at that time an argument was taking place between F and E, the CPN had attempted to calm the situation but had been unable to and left. It was agreed that F would take H for an appointment with the GP and that the 'Relationships without Fear' for H would start in January. Relationship counselling was suggested for E and F although this did not translate into an action on the Child Protection Plan.

12.135 The Service Coordinator (Cooperative Working) continued to support E, accompanying her to an appointment with the GP the day after the Core Group meeting. E told the GP that she was not consuming alcohol at that time and an Alcohol Use Disorder Identification Test Consumption questionnaire was completed with a score of 0 (indicating low risk). The GP provided advice regarding long term contraception and reviewed E's medication. A backdated Med 3 for employment support allowance purposes was provided and a new prescription issued.

[45] This is believed to refer to the appointments made with Mind following E self-referring to Arch in July 2015 in which case Mind had closed the service by this time due to non-attendance.

12.136 The Service Coordinator also tried to facilitate a meeting with the housing benefit assessor but E cancelled. In early December 2015, the Service Coordinator made an unannounced visit to see E due to disengagement. E stated that she had made an appointment to attend the CMHT Centre and requested support from the Service Coordinator to attend.

Child Protection Review Conference – step down to CIN plan – December 2015

12.137 In December 2015, a Child Protection Review Conference was convened. E attended the conference however F gave his apologies. Professionals attending the conference included; the children's Social Worker (SOTCSC), CPN (NSCHT), School Nurse (for G), Safeguarding Officer (School 2), and Service Coordinator (Cooperative Working). Apologies were received from; School Mentor (School 1) who provided a verbal update ahead of the meeting, School Nurse (for H), Staffordshire Police, GP surgery (for E) and a number of named/designated health professionals.

12.138 The conference unanimously agreed that G and H no longer needed a Child Protection Plan. It was recorded that E '*accepts the impact of the parental relationship on the children and real progress has been made. Both parents are seeking support for their mental health needs and now have strategies and techniques in place to diffuse any disagreements. G and H both feel that their parents' relationship has improved and are awaiting 'Relationships without Fear' through Arch. Both G and H are doing well at school. There have been no further incidents of domestic violence and considerable progress has been made"*

12.139 The conference agreed that the needs of G and H could now be supported via a CIN plan and the following actions were identified: -

- G and H to be referred to Relationships Without Fear
- Service Coordinator (Cooperative Working) to support E with her mental health needs and appointments
- G and H to attend all health appointments and H's appointment regarding feet to be made and kept
- G and H are to be supported and encouraged to maintain appropriate levels of attainment and attendance at school
- F to continue to address his mental health needs and engage with CPN
- F to complete perpetrator work around domestic abuse
- regular visits to the family home by the Social Worker.

12.140 The outcome of the conference was communicated to agencies involved and records updated with the exception of the GP surgery, School 1 and School 2 which did not receive a copy of the minutes. E and F were sent a copy of the minutes through the post.

12.141 The Service Coordinator (Cooperative Working) visited E later in December 2015 to convey her to a prearranged appointment at the CMHT Centre. E requested that the appointment be cancelled as there was no one to pick up H from school. During the visit E told the Service Coordinator that her relationship with F had significantly improved and she acknowledged that alcohol was a major factor that caused a lot of conflict.

12.142 The GP recorded in late December 2015 that the Jobcentre plus had assessed E as suitable for work from that date forward.

12.143 The CPN visited F in December 2015 and January 2016. The visits provided some reassurance regarding F's mental health and his relationship with E. No evidence of psychosis was apparent and F reported that he and E had not argued as much recently.

12.144 The Service Coordinator (Cooperative Working) supported E to attend an appointment at the CMHT Centre in mid-January 2016. A mental health review was undertaken by a Psychiatrist during which E complained of mood swings, anxiety symptoms, visual, auditory and tactile hallucinations. E stated that she was aware that F was having some mental health problems but was not aware of his diagnosis, she discussed a physical fight with her partner 8 months ago which resulted in the police attending and social services becoming involved because of the children. E disclosed recent physical and emotional abuse by her partner (F) and admitted excess alcohol and drugs use in the past, she also said that her partner (F) had accused her of assaulting him twice in the past. E said that she was not taking any prescribed medication. E was anxious that confidential information about her would be shared and reassurance was given that the main purpose of the meeting was only regarding her mental health.

12.145 A diagnosis was made that E had an emotionally unstable personality disorder and generalised anxiety disorder, she was prescribed a course of anti-psychotic medication for two weeks. A review was scheduled for 3 months' time and a referral was made to the Early Intervention Team. A request was also made for a Care Coordinator to be allocated. The GP received a letter from NSCHT which provided details of the mental health review, the diagnosis and treatment. The Service Coordinator (Cooperative Working) also recorded E's diagnosis.

12.146 A few days later, E contacted the duty professional at the CMHT Centre and said that the medication she had been prescribed was helping her to manage her mental health although she was experiencing side effects which she felt were affecting her family life. The Duty Professional left a copy of E's last clinic appointment, along with information about the side effects of the medication she was taking, at the CMHT Centre reception for collection by her partner.

12.147 The referral to the Early Intervention Team was declined by them later in January 2016. The reason given by them was that the team had a long-standing knowledge of E, she had an open relationship with them and had discussed her mental health but never disclosed any hallucinatory experiences. It was believed by the Early Intervention Team that E's experiences would be in the context of the diagnosed emotionally unstable personality disorder.

12.148 The School Nurse attended two CIN meetings in January 2016 however on both occasions the meetings had been cancelled by SOTCSC without the School Nurse being made aware.

12.149 Later in January 2016 E had a telephone consultation with her GP and a Med 3 was completed advising that E was not fit to work for the next two months due to emotionally unstable personality disorder. E said that she was starting to feel better and in the long term wanted to return to work.

12.150 SOTCSC visited G and H at home in January 2016 and then called around again the following day to see E and provide financial support. H attended the first one to one session

with an Arch worker in late January 2016 and an arrangement was made for G and H to attend a future session at School1 in February 2016 (after school).

12.151 In early February 2016, the CPN visited F at home and discovered that F's grandfather had passed away the previous Friday. F spoke of his feelings of loss and recognised he needed to take measures to keep himself well including taking exercise and avoiding drinking alcohol.

CIN meeting agrees that SOTCSC should close the case and the service coordinator takes lead responsibility for Early Help – February 2016

12.152 A CIN meeting held the day after the visit by the CPN agreed that the case should be stepped down to early help[46] with support being offered to the family without social services involvement. The Service Coordinator (Cooperative Working) was identified as the Lead Worker and it was agreed that an early help plan should be formulated and an early help meeting arranged.

12.153 The following professionals attended the CIN meeting; the children's Social Worker (SOTCSC), Service Coordinator (Cooperative Working), Learning Mentor (School 1), CPN, housing and Arch. Neither E or F attended the meeting and this was thought to be due to F's grandfather passing away,

12.154 The CIN meeting was informed by the Social Worker that G and H had been seen and appeared to be getting on well with no concerns being raised about them during the visit. The Service Coordinator (Cooperative Working) reported that she had supported E to attend the CMHT Centre for a mental health assessment and that she now had a diagnosis and was on medication. The Social Worker said that E seemed well and much more relaxed on her last visit. The CPN informed the group about F losing his grandfather and said the risk of relapse had been recognised by E and F who were both avoiding alcohol. The Arch worker informed the meeting that she was now working with G and H around understanding what is acceptable in relationships and safety plans, H had been seen twice and was engaging really well and G had requested that the sessions take place after school at School 1. The housing representative stated that E was in arrears and a warrant for eviction was in existence – the housing representative and Service Coordinator (Cooperative Working) planned to visit E after the meeting to try and support E to clear the debt and prevent further action.

12.155 The Social Worker informed the meeting that she was leaving and a discussion followed during which the possible detrimental effects of a new Social Worker starting to work with the family were considered. It was agreed that the CPN would continue to work with F and support his completion of the perpetrator work around domestic abuse and the Service

[46] Early help is defined by SOT LSCB as: - 1. Preventing, or minimising the risk, of problems arising-usually through universal services such as school, children's centres, youth work and health provision. 2. Early intervention by targeting individuals, groups at high risk or those showing early signs of a particular problem to try to stop it occurring or escalating. 3. Providing early help services that respond effectively to needs, to redress the situation, stop problems getting worse and improve outcomes.

Coordinator (Cooperative Working) would continue to support E regarding her mental health needs and appointments. In the event of E and F not engaging with services in the future and there being further concerns raised then a discussion would be held with the Practice Manager (Cooperative Working).

12.156 SOTCSC closed the case later that day and the Service Coordinator (Cooperative Working) took the early help lead with responsibility for arranging future meetings and recording actions. Other services in contact with the family retained responsibility for their own areas of specialism. The views of G and H about the step down to early help are not recorded although it is noted that H had thanked the Social Worker for the support they'd had. Similarly, it is not clear what E or F's views were about the step down to early help.

12.157 Over the next 9 days the Service Coordinator (Cooperative Working) attempted to make an appointment with E to discuss a housing benefit application without success.

12.158 The CPN visited F at home mid-February 2016 – both F and E were present and discussed how they were arguing less about parenting issues and feel more able to talk to each other. The CPN noted that there was no evidence that F was suffering any psychosis, F stated that he had felt slightly uncomfortable during a visit to a fair, however this had not developed into paranoid thinking.

12.159 Later in February 2016, the Service Coordinator (Cooperative Working) visited E at home however no one was in. The Service Coordinator contacted E by telephone and she reported that she had gone out to lunch with F but they had a disagreement and he had dropped her off so she was waiting for a friend at the pub. E said she was worried that F may be becoming unwell and the Service Coordinator advised her to contact the CPN however E said she did not want to go behind F's back. It was agreed that E would speak to F and that the Service Coordinator would follow up with a visit next day.

12.160 The Service Coordinator visited E the following day as planned and E said that G and H had stayed at her mother's because she had feared that she and F may argue and she didn't want them to witness it. E said she could have 'ripped F's head off' and then shouted to F who was upstairs. An argument began between E and F – E became upset but F remained calm and said he would pick the children up from school. The Service Coordinator left the property due to E and F trying to include her in the argument and was therefore unable to follow up E's comment on the telephone the previous day that she was worried F may be becoming unwell. The Service Coordinator planned to visit the following week.

12.161 Two days after this G contacted the police via 999 to report that their mother had been stabbed by their father.

ANALYSIS

13. Domestic abuse and the effectiveness of support services

13.1 The majority (8) of the 13 domestic incidents that are known about in the period covered by this Review came to the attention of services as a result of E contacting the police. On three occasions F initiated contact with the police and F reported a further incident to his CPN. The ambulance service contacted the police about another incident having attended the address, following a report of G being injured after falling on a bottle, when it was found that the injury was actually as a result of G being caught up in a domestic incident between F and E.

13.2 The incidents followed a similar course often starting with a complaint to the police of assault and a request for attendance, followed by a police response which led to the separation of the couple sometimes through the arrest of one or the other, and typically ending with a prosecution not being supported. The incidents increased in severity with the first incident being reported as an argument, progressing to complaints by E of being kicked and stamped on through to allegations of weapons including bottles and knives being used. In one case, it was reported that the children had been encouraged to join in the assault on their mother.

13.3 The DIAL form is the means by which Staffordshire Police assess the level of risk to a victim of domestic abuse, they are also used to record additional information and professional judgement. DIAL forms were not completed consistently by the police attending the domestic incidents. In some instances, this was due to the policy at the time not requiring one to be completed unless offences were disclosed or other concerns apparent, however there were occasions when it was clear a DIAL form should have been completed and was not.

13.4 The completion of a DIAL form is an important aspect of the Staffordshire Police response to a domestic incident. It is the means by which the level of risk to a victim is assessed and it provides a consistent format for additional information and professional judgement to be recorded. The form is also used as a mechanism for highlighting when there are children in the household.

13.5 The policy guiding when DIAL forms should be completed and how they inform the response of services to domestic incidents has evolved over the period covered by this Review. The current Staffordshire Police policy[47] requires the completion of DIAL forms for every domestic incident between intimate partners[48] and this provides much clearer direction to frontline officers than previous policies. The initial risk score on the DIAL form is now used to determine if a risk assessment is undertaken at a local 'vulnerability hub' or lead to a referral to the MASH where information can be exchanged with other agencies and consideration be

[47] Multi-agency guidance provided by SOT LSCB has not kept pace with the changes to policy on the use of DIAL forms and requires updating – as a result of the Review SOT LSCB policy and procedures sub-committee have been alerted of the need to review their guidance.

[48] The policy in SOT on the use of DIAL forms for domestic incidents involving other family members (e.g. father and son) is now at the discretion of the attending officer due to resource issues. Although this issue is not relevant to this DHR the Review Panel agreed that the change in policy be reported to the Responsible Authorities Group for consideration of the implications.

given to a MARAC and/or specialist support from an independent domestic violence advisor (IDVA).

13.6 During a HMIC Inspection in 2014, the force identified that DIAL forms had not been completed for 38% of the domestic incidents (where submission of a DIAL form was required) and were therefore non-compliant with the policy in place at that time. The force undertook a review where recorded domestic abuse crimes were cross referenced against DIAL form submissions and daily management activity was introduced to identify the reasons for poor compliance and to instruct officers to retrospectively complete DIAL forms. Of the domestic incidents attended by the police during 2014/15 within the scope of this review, a DIAL form was submitted on four occasions (with a 'Standard Risk' outcome in all cases), of the two incidents where a DIAL form was not completed one of the events was connected to an incident the previous day. The incident reported during this period retrospectively via the CPN did not have a DIAL form completed as the information was already known within the MASH and would have been duplicative.

13.7 None of the incidents identified during this review led to the case being referred to a MARAC. The author of the police IMR has reviewed the completed DIAL forms relevant to this Review with the MASH Team Leader and sought advice from the senior manager of the MARAC process. The DIAL forms were deemed to have been completed effectively although they relied heavily on the complainant's responses. The latest version of the DIAL form includes questions that prompt the person completing the form to research and confirm the accuracy of the information provided by the complainant. The senior manager of the MARAC concluded that the incident in March 2013, where G received an injury, met the threshold for a MARAC referral. This suggests that whilst the forms were completed according to the guidance at the time they did not result in an appropriate assessment of the level of risk – potentially due to Officers not applying professional judgement.

13.8 The assessment of risk of domestic abuse not only rests with the police. Local multi-agency guidance in place at the time advises professionals to refer to the SafeLives Risk Assessment (previously known as the CAADA DASH Risk assessment) to help inform a dynamic assessment of the level of need and/or risk faced by a child or non-abusing partner. The review found that the DASH risk assessment had been used by the CPN in October 2014 and this was in response to a complaint by F that he had been assaulted. A similar scoring system to the DIAL form is applied to DASH risk assessment and in this case the threshold for referral to the MARAC was also not met.

13.9 The multi-agency response to the risk posed to the children at that time (March 2013) was to consider them to be Children In Need. Following the incident in March 2013 the level of violence involving F and E continued to escalate and included an allegation of E attacking F with a knife in April 2014. The increased risk to the children was also recognised when both G and H were assessed as suffering significant harm or likely to suffer significant harm in April 2015 and made subject of a Child Protection Plan. The assessments completed by SOTCSC as part of the child protection processes therefore provided an appropriate dynamic assessment under which the full circumstances of the family could be recorded, analysed and risk assessed. However, it should be noted that the DIAL form and DASH risk assessments are the means by which a level of risk of domestic abuse is defined and that is the basis on which referrals to the MARAC are made.

13.10 The criteria for referral to a MARAC is when a victim of domestic abuse is assessed as being at a high risk of harm. The information available to services in contact with the family suggests that this was the position in March 2013 and from that point on the situation deteriorated further, the use of a weapon (April 2014) does not appear to have been given sufficient weight when assessing the increasing level of risk[49]. It should be noted that referrals into the MARAC can be made by any partner agency and it is possible that if other professionals had taken the opportunity to utilise the DASH risk assessment then a referral to the MARAC may have been triggered.

13.11 MARACs are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA[50], a risk focused, coordinated safety plan can be drawn up to support the victim[51]. In this case the coordination of services took place primarily through CIN meetings and child protection processes where the focus is on responding to the needs of the children and protecting them from significant harm. Whilst some of the support provided clearly had a dual function of protecting the children and reducing the risk of harm to the adults in the household there was not a coordinated safety plan for either E or F.

13.12 Stoke-on-Trent City Council provide a good range of domestic violence and abuse services which could have been accessed by E, F, G or H (see paragraph 10.5 for details). The Review has identified numerous examples of E being offered support services but then not accessing them and it was not until June 2015 when the Service Coordinator (Cooperative Working) became involved (triggered by housing problems) that E received the level of personal support she apparently needed to access services. Referral to the MARAC and the appointment of an IDVA may have provided that emotional and practical support - which could have led to E accessing support services at an earlier point. Intensive support (frequent contact) from an IDVA has been shown to significantly increase the safety of victims of domestic abuse[52]. Involvement of the MARAC may also have led to support services, in particular counselling, being prioritised for G and H.

13.13 Investigations by the police into the reported assaults sometimes lacked rigor with opportunities to seek out information from potential witnesses not taken (August 2011 & April 2014) or decisions around further action being based on incomplete information (February 2015). Where supervisory input took place at an early stage there was evidence of more

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[49] Staffordshire Police now provide more intensive domestic abuse training (DART) where it is made clear that the use of a weapon is a high-risk behaviour which increases the risk of homicide.

[50] The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. (safelives.org.uk).

[51] Staffordshire Police's approach to tackling domestic abuse (HMIC 2014).

[52] Studies have shown that when high risk clients engage with an IDVA, there are clear and measurable improvements in safety, including a reduction in the escalation and severity of abuse and a reduction or even cessation in repeat incidents of abuse Safety in Numbers (www.safelives.org.uk).

thorough investigations with examples of good practice including a first line supervisor ensuring E was seen alone to try and ensure she was making decisions freely and other cases where supervisors reinforced the need to take positive action. Conversely the lack of supervisory oversight led to the decision to delay attendance at one incident (March 2014) not being corrected. On one occasion (August 2012) E contacted the police and said she 'wouldn't take anymore' however police did not respond immediately and when they did attend she retracted, there potentially would have been a greater chance of taking positive action had the police attended more promptly.

13.14 There were challenges for the police, who attended incidents, to successfully pursue criminal prosecutions in relation to reports of assault due to the non-availability of witness statements or other corroborating evidence. The Out of Court Disposals policy, described in detail later in this report, provides additional options for the police to deal with cases where a victim does not wish to support the prosecution of a domestic abuse perpetrator.

13.15 During 2006 North Staffordshire (Newcastle-under-Lyme) Magistrates Court became one of 64 areas[53] to be accredited with specialist domestic violence court (SDVC) status. Cases are heard from Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands.

13.16 These court systems are part of the Government's efforts to improve the support and care provided for victims of domestic violence and abuse. The specialist domestic violence court programme promotes a combined approach to tackling domestic abuse by the Police, the Crown Prosecution Service (CPS), Magistrates, Courts and Probation together with specialist support services for victims as part of a community-wide response to domestic abuse. During 2010/11 there were 726 domestic abuse cases heard at Newcastle-under-Lyme Magistrates Court. This nearly doubled to 1318 in 2011/12 and 1250 in 2012/13. The conviction rate for prosecuted offences was 65% for 2010/11, 73% for 2011/12 and 70% in 2012/13.

13.17 Each SDVC should have Independent Domestic Violence Advisors (IDVA) who have attended accredited training to provide support for service users and whose goal is the safety of their service users and their children. There are currently three Independent Domestic Violence Advisors (IDVA) in Stoke-on-Trent. Domestic abuse services across Stoke-on-Trent and Staffordshire are in the process of being recommissioned, and it is expected that IDVA capacity will increase as a result.

13.18 In 2014 Staffordshire Police took steps to improve domestic abuse investigations by focussing on evidence led prosecutions, victimless processes and Out of Court Disposals (OoCD) to achieve positive outcomes. A pilot scheme procedure concerning the use of OoCD for offences involving Domestic Abuse was introduced in November 2014 and was subsequently adopted as policy on 31st August 2016.

13.19 The importance of "positive action" is strongly expressed within the OoCD policy as is the objective to focus investigative efforts on gathering sufficient evidence to be able to build a prosecution case that does not rely entirely on the victim's statement. OoCD are only suitable for low level offences and a set of overarching principles must be adhered to when considering dealing with a case through the policy. The principles require that the victim's informed wishes

[53] There are now over 100 specialist courts nationally.

be met by following the OoCD approach, that there should be no evidence of coercive/controlling behaviour by the suspect which might influence the victim's views and that a DIAL risk assessment indicates that the risk to the safety of the victim and/or family is no higher than the 'standard' classification.

13.20 Under the OoCD policy a case may be dealt with by issuing a 'Conditional Caution' (which requires an unambiguous admission to have been made by the suspect) or through 'Community Resolution' (not suitable for violence between intimate partners/ ex intimate partners). Staffordshire Police have special dispensation to use OoCD for domestic abuse and hate crime cases and the disposal options that are available under the policy require specific authorisation. Where the victim does not support a prosecution and the available evidence would only support charging a very minor offence, an OoCD can be considered in preference to a decision to take no further action.

13.21 The OoCD policy recognises the need for a positive action approach by Staffordshire Police to ensure the safety and protection of victims and children whilst allowing the Criminal Justice System to hold the offender to account.

13.22 E had significant contact with her GP surgery during the period covered by this Review and provided a history at times of low mood, excessive alcohol consumption, anxiety around pregnancies, concerns about weight, disturbed sleep as well as an injury to her wrist suffered whilst at work. In consultations with her GP E said that her partner was not very supportive and had mental health issues and that social care were involved with the family regarding the children. There is no indication that the GP proactively sought out further information having been made aware of social care involvement by E and E did not specifically disclose suffering from domestic abuse.

13.23 Domestic abuse was not identified as an issue during attendances by E at the GP surgery and therefore referral to support services were not considered. The GP did however discuss with E options to provide support for her alcohol use and depression and made referrals to such services.

13.24 Stoke-on-Trent is currently implementing enhanced arrangements to promote the referral by GPs of their patients as either victim or perpetrator to relevant domestic abuse services. To this end, Stoke-on-Trent City Council has introduced a Primary Care Domestic Abuse Awareness Programme, delivered by Arch (North Staffs Ltd.). It is an early intervention and referral programme for primary care staff based in Dental Practices and General Practices within Stoke-on-Trent and is a targeted intervention for patients experiencing domestic abuse or violence from a partner, ex-partner or family member. Practices are supported through training for GPs, dentists and practice staff, on-going support and advice to practices, a dedicated referral pathway and named contact for referrals of patients, and resources/materials for surgeries

13.25 Support was offered to E and F to address the domestic abuse in their relationship: -

Relationship Counselling - A referral was made for E and F to receive relationship counselling at the Bridge Centre in April 2013 and this was offered again in April 2014. In November 2014, a CIN meeting agreed that E and F should be referred to Arch however, it was not possible to complete the required individual risk assessments with F and E and a referral to Arch was not made. In April 2015, a Core Group meeting agreed that a referral should be

made to Arch for E to receive counselling and E contacted the Arch Domestic Violence Outreach Service in July 2015 and was referred to Mind however E did not attend the appointments. Relationship Counselling was again suggested for E and F in November 2015 but not taken up.

Offering relationship counselling is not normally recommended in cases of domestic abuse. In this particular case E and F indicated independently to professionals that they wished to make their relationship work and the family of E stated that she loved F and would never leave him. The context of the violence in the relationship included diagnosed mental illness, alcohol abuse, depression and bereavement and attempts by professionals to reduce the risk to E and F and their children by improving their relationship and attempting to address other needs seemed to be an appropriate response. It should be noted that the service to which E and F were referred is no longer commissioned and it is not current practice to offer relationship counselling in domestic abuse cases.

Perpetrators programme - A Core Group meeting in April 2015 agreed that F should undertake a perpetrators programme on a one to one basis at home with the Social Worker. At the point the case was stepped down to a Child in Need in December 2015 it was recorded that F still needed to complete this work and in February 2016 when children's social care closed the case it was agreed that the CPN would support F to complete the perpetrator work. It was not clear why the plan was for the Social Worker to deliver the perpetrators programme on a one to one basis rather than a referral being made to the perpetrators programme provided by Arch which includes tailored support for spouses.

13.26 The effectiveness of support services offered to address mental health and alcohol abuse issues, which were also factors related to the domestic abuse in the relationship, is commented on in more detail later within this report. The ability of services to engage effectively and provide a range of support services, particularly with E, was limited. Initial positive indications from E about seeking support often did not result in her accessing services. There appear to be a number of factors that impacted on E seeking support. E was a vulnerable person suffering at times with depression and alcohol difficulties who was later diagnosed with an emotionally unstable personality disorder and generalised anxiety disorder. She was concerned about the involvement of services with her family and the possibility of having her children removed due to the risk of harm. The family of E described her personality as 'bubbly' and inclined to 'paint a rosy picture' therefore acknowledging the need for help may also have been difficult for her. The Social Worker explored in supervision sessions the barriers to E seeking support although it remained an issue throughout E's contact with SOTCSC. The Cooperative Working Team were able to develop a generally positive relationship with E and were able to provide practical support to help resolve difficulties and access services. The CPN was also able to support F to manage his mental health over an extended period of time. There were also examples of services recording that E was accessing a support service when in fact that was not the case and E had not followed through referrals made on her behalf or initial contacts for help made by her.

14. Impact of the toxic trio (domestic abuse, drug and alcohol misuse, and mental ill health) on the children and how agencies responded to this

14.1 High levels of fear and trauma are experienced by children exposed to domestic abuse. Children who live with domestic abuse are at increased risk of behavioural problems, emotional trauma, and mental health difficulties in adult life[54]. Even when children do not actually observe the physical or verbal attack they often witness the aftermath which can be highly distressing (Stanley 2010). Studies of the impact of domestic abuse on children have found that; a loss of self-confidence, feelings of being different, a sense of burden (related to secretiveness), anger and depression are all potential consequences for children living with domestic abuse. Young people's friendships and social networks can also be negatively affected (Gorin 2004; Buckley et al 2007).

14.2 The extent to which mental health difficulties and or substance misuse problems affect parenting capacity varies considerably[55]. It is recognised that the impact of such issues can be mitigated through involvement of extended family and early community support but without this there may be a risk of neglect, emotional harm and physical abuse.

14.3 It is clear from the information gathered that G and H suffered significant harm as a result of the environment they were living in. Both witnessed numerous incidents of domestic abuse involving their parents, including one incident where they were instructed to join in the assault on their mother (November 2010). G was physically injured during the course of another dispute (March 2013) and ultimately both G and F were present in the house when the fatal attack on their mother took place. Mental health difficulties and alcohol misuse affected the ability of both parents to provide adequate care. G and H both suffered emotionally as a consequence and this was evident through behavioural difficulties, delayed speech, weight gain and poor relationships with their peers, for example.

14.4 The recognition by services of the impact that domestic abuse, parental mental health problems and/or alcohol misuse was having on G and H improved over the period covered by this Review.

14.5 In 2009 and 2012 when F and E both had contact with health staff (Mental Health Services and Emergency Department attendances) there did not appear to be any consideration of the impact on G and H of parental mental health difficulties.

14.6 Despite several domestic incidents already having taking place, including one in November 2010 where G and H were told to join in the assault on their mother, it was not until August 2012 that a safeguarding referral was made by the police to SOTCSC. The incident leading to the referral involved a physical injury to G and it appears that the risk of emotional harm to G and H when previous domestic incidents were responded to was not recognised. G and H were also left in the care of E when she was described as being 'too drunk' to make a statement indicating a lack of consideration of safeguarding issues. In response to the referral in August 2012, a Senior Social Worker contacted E by phone but E declined to meet. There

[54] Women's Aid 2007 citing, Kolbo, et al., 1996; Morley and Mullender, 1994; Hester et al., 2000

[55] What about the children? (Ofsted, 2013)

is no evidence that the children were seen at this time by either the police or SOTCSC to understand their situation and the impact of the violence in the home was having on them and no further action was taken at that point.

14.7 Following the domestic incident in March 2013 when G was injured with a bottle, a second referral was made by the police to SOTCSC which led to a CIN plan for G and H. E refused to allow the police and SOTCSC to obtain an account of the incident. A joint decision by the police and SOTCSC was also taken not to arrange for a medical assessment of G the reason being given that the trauma of an examination could have been worse than the injury. This suggests that professionals had not fully appreciated the potential value of a holistic paediatric assessment which assesses the child's wellbeing, including mental health, development and cognitive ability. Rather than being viewed as a traumatic experience a medical assessment may have provided an opportunity for a professional to develop a greater understanding of the experience of G.

14.8 In response to the incident in March 2013 a written agreement was made with E by SOTCSC that F should not reside at the house whilst an assessment was carried out. The Review examined the purpose of the written agreement and the reason why it was only made with E and it was explained that the agreement was to provide clarity around SOTCSC expectations. Written agreements can be a useful way of specifying the actions needed to safeguard children, however local guidance requires such agreements to be signed by all parties to which they relate and the failure to follow that guidance in this instance put the onus on E keeping F away which was unreasonable given the risk of violence to her. The police and SOTCSC worked together to respond to this incident and F was arrested the following day which would have provided an opportunity to directly address the need for F to stay away from the family home whilst SOTCSC completed an assessment.

14.9 From 2013 onwards, it is evident that Staffordshire Police communicated better with SOTCSC over the risks to G and H from domestic abuse by referring cases more appropriately.

14.10 After G and H had been identified as Children In Need and information about domestic abuse in the home shared with other agencies, School 1 provided nurture support to G and H through class teachers and the Learning Mentor. Incidents where G and H were involved in disputes with other children at the school, including aggressive behaviour and teasing, were dealt with sensitively by the school, anti-bullying and behaviour policies were implemented and both G and H were provided time to talk about their feelings as a consequence of the incidents and more generally. A Family Support Worker was also offered by the school but this was declined by E.

14.11 It is clear that the CPN was considering the impact of F's mental health on G and H at an early point in her work with the family when in February 2014 she spoke with F and E about the need to consider the wellbeing of their children. The CPN initiated contact with SOTCSC and exchanged information about the mental health of F (April 2014). When concerns increased the CPN contacted SOTCSC to explore what support was available to the family (September 2014). An appropriate referral was made by F's mental health team following concerns raised by the CPN about the impact of domestic abuse on the children leading to a CIN plan.

14.12 A CIN meeting in November 2014 considered making a referral for G to receive support through Younger Minds however this was not followed through.

14.13 SOTCSC worked with the family over an extended period of time. E and F were resistant to contact with Social Workers and this limited the effectiveness of their work to support the children, particularly during the periods when G and H were subjects of CIN plans and parental consent was required. SOTCSC were able to gather information about the impact of domestic abuse on G and H through communications with other agencies (e.g. School 1, CPN). Much of the work of SOTCSC was around trying to improve the understanding of F and E about the impact domestic abuse was having on their children and there are indications that both E and F acknowledged this over time, there was little contact with G and H whilst they were subjects of a CIN plan.

14.14 In April 2015, following E and F disengaging from the CIN process an Initial Child Protection Conference was held and G and H were made subject of a Child Protection Plan under the category of emotional abuse. Further information about the possible impact domestic abuse was having on the children was evident, it was noted at the conference that G and H had been aggressive and violent towards other children and concerns were raised about their health in particular H being overweight.

14.15 At the Core Group meeting that followed actions were identified to address the health needs of G and H and to seek one to one support for them. Unfortunately, the professionals involved incorrectly believed that one to one support could be accessed via a referral to the 'Relationships Without Fear' programme. A further delay occurred as a result of an incorrect email address being used when SOTCSC submitted the referral to Arch. It was not until October 2015 that SOTCSC received an email from Arch indicating that there were capacity issues in relation to providing one to one support and that it may not be possible to prioritise providing support for G and H over high risk MARAC cases. Assurance was given by Arch that their cases would be allocated as soon as possible. It was not until 9 months after the action was first raised that G and H started to receive one to one support and shortly after that E was killed and the need for much more intensive and specialist counselling for G and H became necessary.

14.16 Social Workers regularly visited the family home on announced and unannounced visits during the period that G and H were subjects of a Child Protection Plan[56]. This direct work with the family allowed the Social Worker to observe G and H at home and provided opportunities for them to speak with them about their family and school life. The Social Worker created opportunities for G and H to disclose any worries they may have, including visits to the park, playing games and helping with homework. Health professionals and school staff also had numerous contacts with G and H providing opportunities for them to talk. Throughout this time G and H did not directly speak about the impact the circumstances they were living in were having on them which is unsurprising given the secretiveness around domestic abuse and the pressures they were under.

14.17 E and F were often resistant towards SOTCSC involvement, E refused to meet a Senior Social Worker (August 2012), CIN plans were closed due to lack of parental engagement (April 2013, June 2014) and E and F expressed concerns about SOTCSC involvement at different times and were worried about their children being removed. The decision to take the case to an

[56] At least 13 home visits were undertaken which exceeded the minimum frequency of visits required for children on a child protection plan (monthly).

Initial Child Protection Conference and make the children subject to a child protection plan was an appropriate response to the information that was known at that time about the risks to G and H and the response by their parents. The move into child protection processes provided the statutory footing for SOTCSC, in particular, to work with the family and overcome some of the resistance by E and F. Social Workers were able to regularly visit the family and in July 2015 it was made clear during a Child Protection Review Conference that legal advice would be sought about finding alternative accommodation for G and H if the parents failed to cooperate with the plan.

14.18 In December 2015, the decision to step down the case from child protection to CIN appears to have been premature as there was little evidence of real progress having been made. E was not attending counselling, F had not completed a perpetrators course, G and H had been involved in an incident at the local park and one to one support for G and H had not started. It is noted that G and H felt their parent's relationship had improved although this should be seen in the context of them having been previously reluctant (understandably) to acknowledge the full extent of the domestic abuse in the home. Although there had not been any further reports of domestic incidents to the police[57] the CPN had attended the home in November 2015 and found an argument taking place between E and F which she had been unable to calm down. The Service Coordinator (Cooperative Working) had also had to make an unannounced visit due to disengagement by E. Whilst the actions were carried forward into the CIN plan and SOTCSC did visit the home on a further three occasions, the decision to step down to a CIN plan may have sent the wrong message to E and F and agencies again became reliant on parental consent.

14.19 The decision, in February 2016, to close the CIN plan again appears premature with actions remaining outstanding and a further diagnosis by a Psychiatrist of E's mental health having been made (January 2015) that E was suffering from emotionally unstable personality disorder and generalised anxiety disorder. It is clear that the decision was influenced by the fact that the Social Worker who had been working with the family was leaving and if the case was left open to SOTCSC a different Social Worker would have to be assigned to work with them which potentially could have been problematic. However, children's social care is the lead agency in child protection and the closure of the case meant they were no longer able to exert influence over E and F's engagement with services.

14.20 Throughout the contact that services had with G and H there are examples of their views being sought, however what is not apparent is an analysis of what their verbal responses actually meant or a triangulation against other sources of information such as their behaviour and the known circumstances of particular domestic incidents. In some cases, the non-disclosure of abuse or a negative impact on their wellbeing seems to have provided reassurance to the professional involved (e.g. April 2014 when F was stabbed and the children were described as happy and apparently oblivious). There is little evidence that the views of G and H were taken into account when decisions were made affecting them such as; the decision not to arrange a medical assessment for G (March 2013) on the basis of causing greater trauma without actually seeking G's thoughts or the decision for SOTCSC to close the

[57] E and F were aware of the consequences of reporting domestic incidents to the police at this stage and this may have influenced their contact with the police during this period.

case in February 2015 when H had indicated he was appreciative of the support the Social Worker had provided.

14.21 The family of E were asked about their understanding at the time of the impact the family circumstances were having on the two children. The family said that they did not hear much from G and H during 2015 – the boys had mentioned arguments involving their parents but the family were not aware of any particular impact on them.

15. Mental health of the victim and perpetrator and the effectiveness of support services

Mental health of E

15.1 At several points during the period covered by this Review it is apparent that E was struggling with her mental health. The first indication to services involved was in October 2009 when E attended the Emergency Department (UHNM) following an overdose of tablets. There was a further attendance at the Emergency Department in 2012 when E had consumed a bottle of vodka and was described as having a very low mood with thoughts of self-harm. By the time E was 24yrs old she had undergone three pregnancy terminations and presented to her GP on more than one occasion as being very anxious when she believed she might be pregnant[58]. In March 2012 E was diagnosed by her GP as suffering from depression, the first assessment indicated minor depression with further assessments over time indicating major depression. In March 2013 E disclosed to the police and SOTCSC (who were responding to a domestic incident where G received an injury) that she was suffering from depression. Mental health services initially had contact with E in the context of her being a carer for F and later had involvement as a result of E being referred for services. A psychiatric assessment in January 2016 led to a diagnosis that E had an emotionally unstable personality disorder and generalised anxiety disorder.

Effectiveness of support services for E

15.2 The support offered to E following her attendances at the Emergency Department (UHNM) in October 2009 and February 2012 was minimal and took the form of the provision of a general advice sheet for alcohol/drug addiction on the first attendance and advice to go to her GP for follow up on the second occasion. The opportunity to offer more support was limited in that both attendances were brief (an hour or less) and on the first occasion E did not stay long

[58] Evidence of the risks to mental health of multiple pregnancy terminations is uncertain http://www.nhs.uk/news/2008/08August/Pages/Mentalhealthafterabortion.aspx. The review panel considered whether the repeated pregnancy terminations were relevant to the issues being considered and if there were further sources of information available to assist with this analysis. It was established that the only information known to the review was held by the GP and SSOTP sexual health services had not had contact with E. The review panel concluded that E was anxious about becoming pregnant again but there was no evidence that her anxiety about becoming pregnant was connected to domestic abuse.

enough to see a Doctor. On the second occasion the Doctor did not feel that it was an overdose or act of self-harm.

15.3 Whilst usual practice would have been for a letter to be sent by UHNM to the GP informing them of an attendance at the Emergency Department there is no record of letters being received by the GP regarding these two incidents and it appears that the GP was unaware of the events.

15.4 Had letters been sent to the GP this would have provided a potential pathway to further support being offered, particularly following the first attendance, and would have provided information that was relevant to the contacts E subsequently had with her GP regarding low mood and anxiety. Letters were sent by the Emergency Department to E's GP following attendances for other matters (e.g. wrist injury) and this appears to have been an anomaly with the system in place at that time.

15.5 The process for UHNM sending letters to GPs has been strengthened following the introduction of an IT system, Patient First (MSS), in November 2011. Since September 2013 GPs who are signed up to the system receive an electronic copy of the letter within 24 hours. Those GPs not signed up to the electronic process receive a printed copy.

15.6 The GP treated E for depression and monitored her condition over several years. Anti-depressant medication was prescribed and reviewed although it is recorded that E stopped taking them of her own accord on at least two occasions. E was also referred by her GP (with her consent) to Healthy Minds although she did not attend the appointment and later denied agreeing to the referral. On another occasion, the GP discussed self-help and cognitive behavioural therapy with E but she declined any counselling.

15.7 The CIN plans and Child Protection Plans put in place at various times included appropriate actions to access support for E including referrals to mental health 'Changes' and counselling services, however E did not engage with the services offered. Following the involvement of the Service Coordinator (Cooperative Working) during the period when G and H were on a Child Protection Plan in 2015, support was provided for E to engage with services with some success.

15.8 E directly contacted the Arch Domestic Violence Outreach Service requesting counselling and an appropriate and timely referral was made by Arch to Mind. Unfortunately, E did not attend the appointments made with Mind and the service was ended in line with their procedures although it was made clear to E that she could take up the offer of support anytime in the future.

15.9 Cooperative Working initially became involved with E due to housing problems however when they became aware of the wider issues affecting her they offered the support of a Service Coordinator to help with housing benefit and mental health and this was accepted by E. The Service Coordinator provided a significant amount of support to E and, despite periods when E disengaged, was able to build up a relationship with E and successfully supported her engagement with CMHT services and attendance for a mental health review in January 2016. This in turn led to a further diagnosis and treatment by a Psychiatrist along with a referral to the Early Intervention Team and the suggestion a Care Coordinator from the CMHT should be involved. The Early Intervention Team subsequently declined the referral on the basis of their

existing knowledge and ongoing relationship with her. E was awaiting allocation to a Care Coordinator at the time of her death in February 2016.

Mental health of F

15.10 F's mental health problems first emerged when he attended the Emergency Department (UHNM) in 2009 and provided a history of unusual behaviour during the previous week, he was agitated and aggressive. Medical investigations ruled out an organic cause and he was admitted to hospital where he underwent a psychiatric assessment before being discharged three days later, the conclusion being that there had been a brief psychotic episode which had resolved without treatment. F then came to the attention of police and SOTCSC in connection with incidents of domestic abuse but it was not until he self-referred to the NSCHT Access Team in September 2013 that his mental health featured in contact with services again. F reported paranoid thoughts about E trying to poison him and was concerned about his and her consumption of alcohol. As a result, F was referred to the CMHT and was diagnosed with Stress Induced Psychosis. F remained under the care of the Early Intervention Team for three years and during that time there were several further brief episodes of psychotic symptoms which were responded to appropriately.

Effectiveness of support services for F

15.11 Following F's discharge from hospital the Early Intervention Team kept the case open for three months to enable either F or his family to contact them in the event of any further incidents.

15.12 When F self-referred to NSCHT Access Team he was dealt with promptly and saw a Consultant Psychiatrist within 12 days. For three years F was under the care of the Early Intervention Team. During this period, brief episodes of psychosis were treated with medication which typically F initially accepted but then stopped taking without consulting staff. F's approach to his medication was acknowledged in his care plan which included options to access medication if he began to feel unwell or notice any early signs of relapse. F's staying well plan[59] was minimal and did not detail early signs of relapse that were identified with him and recorded in his clinical notes.

15.13 The CPN provided regular contact and support for F and demonstrated a strong commitment to multi-agency working. Whilst F did not see a Consultant Psychiatrist after May 2014 this was considered appropriate given that for the majority of time he remained well and the CPN would have been able to quickly access a Psychiatrist if needed.

15.14 The Service Coordinator (Cooperative Working) became involved with the family in June 2015 providing support to E and following the closure of the case by SOTCSC the Service Coordinator took on the responsibility of the early help lead. Whilst no specific agreement was made about what action the Service Coordinator should take in response to signs of relapse in relation to F the Service Coordinator had been trained appropriately and knew how to access support and/or make a referral if it was thought necessary. Specialist support continued to be available and the care plan made it clear that either F or his family could contact the Early

[59] The main purpose of a staying well plan is for the service user to understand signs of relapse and what they and others can do to support them at each stage – this is important if people are not taking medication and may need to do so in the future. The NSCHT IMR identified this as an issue and have included a recommendation in the report to address it.

Intervention Team or CMHT Centre in office hours or the Access Team out of hours if they were concerned about any deterioration in F's mental health (relevant contact numbers were included in the plan).

15.15 Bereavement was recognised as a risk of relapse and when the CPN visited F in February 2016 and became aware that his Grandfather had passed away, measures to keep himself well were explored and discussed with him.

16. Substance misuse and access to support services

16.1 Misuse of alcohol featured in at least 11 of the incidents attended by the police during the period covered by this Review. In some cases, the police observed E was under the influence of alcohol and in other cases either F or E accused the other of being drunk at the time an incident occurred.

16.2 Health professionals also had contact with both F and E when concerns were raised about their level of alcohol consumption.

16.3 E attended the Emergency Department on two occasions after she had apparently consumed a bottle of vodka (October 2009 & February 2012) and on the first occasion she was provided with an information leaflet on alcohol and substance addiction.

16.4 Alcohol consumption was also discussed during a number of contacts E had with her GP surgery. A questionnaire was used by the surgery to assess E's level of alcohol consumption and this was carried out on three occasions; September 2010 (low risk), October 2012 (increasing risk) and November 2015 (low risk). In October 2012, the GP discussed with E making a referral to Aquarius (drug and alcohol services) although a referral was not made and it is believed this was due to E not consenting.

16.5 Information about F's contact with his GP was not available and therefore cannot be commented upon. However, F did disclose that he was worried about his own alcohol consumption when he self-referred to mental health services in September 2013 and it was also acknowledged that part of F's plan to stay well, following the death of his grandfather in February 2016, was to avoid alcohol.

16.6 Whilst there was no indication of recent alcohol misuse by either E or F, there was a history of concerns about alcohol misuse. Services, including the police and SOTCSC, recognised it as a factor which contributed to the violence in E and F's relationship. At the CIN meeting in November 2014 E raised F's alcohol misuse as a trigger for domestic abuse. Some concerns were raised during the Review that using terminology such as 'alcohol fuelled' domestic incidents may have an impact on the way incidents were viewed and on the perspective taken by different agencies and consequently their practice.

16.7 There was little evidence of substance use by either E or F being assessed by the services in contact with them, other than the GP. Support services for alcohol misuse were not specifically addressed within the CIN plans or Child Protection Plans developed. Information provided to the Review suggests that during 2015 alcohol misuse became less of a problem for both E and F. During this period, Social Workers visiting the home during the daytime did

not encounter evidence of alcohol consumption by either party and no other professionals raised concerns. E reported to her GP in November 2015 that she was not consuming alcohol at that time and information provided to the panel suggests that F was not consuming alcohol at all from January 2016 and that alcohol misuse played no part in the fatal incident.

17. The employment of the victim as a carer (in a home)

17.1 Disclosure and barring scheme (DBS) requests were received by Staffordshire Police in April 2010 and August 2013 in relation to E seeking employment as a Care Assistant. On receipt of the DBS requests the relevant team in Staffordshire Police carried out searches of their databases and identified three pieces of information that they believed related to E. On both occasions the information was reviewed and a decision was made not to disclose. The decision not to disclose was based on the assessment that either the information was not considered to be true, lacked substance, was not relevant to the job being sought and/or it would be disproportionate to disclose. An error in relation to one of the pieces of information that was incorrectly linked to E was identified during the Review and this has been addressed with the manager of the unit.

17.2 The Notifiable Occupations Scheme was in place for the majority of the time covered by this Review and its purpose was the protection of the vulnerable, including children; national security and probity in the administration of justice. Application of the scheme was guided by The Notifiable Occupations Scheme: revised guidance for Police Force (circ.6/2006). The guidance included two lists of the occupations where notification to the employer was to be considered, there was a presumption to notify in relation to occupations on the Category 1 list and the Category 2 list of less sensitive occupations where the police would decide on the relevance before disclosing what had happened.

17.3 The employment status of E varied over the period covered by the review. According to information provided by E to her GP, E lost her job at the beginning of October 2013. In May 2014 E attended UHNM with a wrist injury apparently sustained whilst at work (E stated she worked with people who have a learning disability and a patient had tried to bite her). In July 2014 E visited her GP and stated that she is a Care Worker for adults with learning disabilities, the GP issued a Med 3 form (Statement of Fitness to Work). The GP continued to issue Med 3 forms up to October 2015 during which time it does not appear E was working. In December 2015, there is reference in the GP records to the Jobcentre stating that they have assessed E as ‘fit to work’ however E had a mental health review shortly after and a further Med 3 was issued.

17.4 The caution received by E in September 2013 was considered under the notifiable occupations scheme and deemed not to meet the threshold for disclosure. This decision has been examined by the Review and supported on the basis that E was the complainant in the majority of the preceding domestic incidents. In addition, E stated to the police at the time that her occupation was a care worker with the elderly but was unemployed at that time.

17.5 On 25th March 2015 Common Law Police Disclosure replaced circ.6/2006, the new arrangements focus on disclosure where there is a public protection risk, with the threshold for

disclosure being that of 'pressing social need'[60]. Staffordshire Police implemented a new policy in September 2015 as follows; *"All disclosure considerations are now to be made by Chief Officers / delegates who consider disclosing relevant information to a third party when, in the course of an investigation or other policing activity, a serious and urgent risk is identified which requires a pressing social need to be addressed"*.

18. The victim as carer for the perpetrator

18.1 The role of E as a carer for F was made more challenging by her own mental health needs and the violence in their relationship. In February 2014, E sought help and contacted the Early Intervention Team stating she was unable to cope with F. The CPN met with F and E and a timely referral was made to the Carers Team (NSCHT).

18.2 The Carers Team were unable to complete an assessment at the time of referral due to capacity issues and as the referral was not assessed as being urgent, E was provided contact details for E to get in touch if the situation became more urgent.

18.3 Following E's request for help in caring for F the situation deteriorated. In March 2014 E alleged that F had kicked her in the mouth and in April 2014 F alleged that he had been attacked by E with a knife. The case was being managed through a CIN plan during this period but was then closed in June 2014 due to non-engagement by parents. E contacted her GP in August 2014 reporting being stressed at home and saying she couldn't cope.

18.4 The Carers Team then sent a letter to E to arrange an appointment and E contacted them in a distressed state, E said she didn't feel safe in the home but did not want the police informing as she did not want social services involved again. Despite several further attempts to make an appointment with E for an assessment one was never completed.

18.5 The delay in responding to E's request for help in her role as carer for F and her subsequent lack of engagement was very regrettable. There were very few occasions when E initiated requests for support, other than calls to the police to respond to immediate incidents, and the escalation of events that followed E's initial contact for support merited a joint response by agencies involved at the time to prioritise an assessment of her needs as a carer.

19. CONCLUSIONS

19.1 The response by agencies to incidents of domestic abuse improved over the period covered by this Review. There was evidence of progress from 2013 onwards, information sharing between agencies strengthened, effective use was made of safeguarding frameworks to coordinate joint working and a response focused on the need for positive action has more recently been adopted by the police,

[60] T Thomas, Criminal Law & Justice Weekly 5th June 2015.

19.2 The services involved with the family were dealing with complex situations, both E and F were accused of violence towards each other and had mental health difficulties. Alcohol misuse was also a feature although this was not fully assessed. There was often resistance by the parents to engage with services, in particular social services, and towards the latter part of the Review period an expressed wish by E to avoid the involvement of the police.

19.3 Referral to a MARAC could have helped services deal more effectively with some of these challenges. In particular, a risk focused coordinated safety plan could have been developed which included the response by all parties to any signs of relapse. The appointment of an IDVA[61] would have provided E with intensive support at an early stage and counselling services for G and H may have been prioritised. Those working with families need to be supported to use their professional judgement when assessing the risk of harm to adults and children when dealing with domestic abuse in order to identify the most appropriate course of action. All agencies need to be equipped, according to their role, to assess the risks from domestic abuse, parental mental health difficulties and substance misuse and refer cases to the MARAC appropriately.

19.4 A range of support was offered at various times to respond to the needs identified. E often initially indicated her cooperation with offers of support but later declined help. Persistent and determined work by the Service Coordinator (Cooperative Working) did enable E to engage with support services and whilst it is not possible to offer that level of practical support in all circumstances it should be considered when significant risks are identified and there are barriers to a victim seeking support such as vulnerability, mental health or fear of authorities' involvement. Not all needs were fully assessed, for example alcohol misuse was certainly a factor in a number of the domestic incidents (although less so more recently) and the needs of E as a carer were not fully understood or responded to. Timely assessments using approved tools are required to ensure that needs are fully identified and opportunities for support taken. A further barrier to providing the right support was the uncertainty around the services available and pathway to access them, this was particularly the case with G and H who had to wait too long before they were provided with one to one help.

19.5 The family of E were not fully aware of the extent of the issues impacting on E and her family or the support services that were being offered. Their understanding was that E was engaging with services and felt if they had been aware that E was not taking up offers of support they may have been able to help encourage her to do so.

19.6 The use of CIN and child protection procedures provided appropriate frameworks for agencies to work together; coordinate activity and share information in order to safeguard the children and respond to their needs. The engagement by agencies in these processes was generally good with committed involvement particularly by; SOTCSC, the CPN, School 1 and the Service Coordinator (Cooperative Working). This work would have been further strengthened through greater communication and engagement with the GP and School 2 (during and after G's transition from School1).

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[61] Refers to the Safelives model of IDVA provision (see footnote 50 for detailed explanation) and not to the IDVA model currently in place in Stoke-on-Trent, where the IDVAs support only victims going through the court process. The IDVA service in Stoke-on-Trent was brought into line with the Safelives model when the new contract for domestic abuse services across Stoke-on-Trent and Staffordshire commenced on 2 October 2017.

19.7 There were several examples of CIN processes being insufficiently robust. Organisations had differing records of whether CIN meetings had taken place or not, meetings were cancelled without notice, minutes were not shared, and actions not followed through. Children's social care normally have responsibility for coordinating the CIN process and professionals involved in CIN meetings should also ensure they are clear about any actions that have been agreed.

19.8 Professionals need to fully consider the impact of stepping down from child protection to CIN process particularly where there has been resistance to engage demonstrated by parents and little evidence of sustained improvement.

19.9 The Children Act 2004 places a duty on partners to safeguard and promote the welfare of children, there is a clear expectation that adult and children's services should work cooperatively to this end and this has been identified as a weakness in serious case reviews[62]. However, in this case there is evidence of children's and adult services working together effectively, particularly the CPN, Service Coordinator (Cooperative Working) and SOTCSC.

19.10 There were some good examples of effective information sharing (e.g. between the CPN and SOTCSC). The recognition of the need to notify other agencies of information related to domestic abuse and systems to support that process improved over the period of the Review this could be further enhanced by including schools and GP surgeries particularly where risks to children have been identified.

19.11 The voice of G and H should have been more evident in contacts that services had with the family. It was not clear that the emotional impact on G and H was fully assessed or responded to. For example, police officers attending reports of domestic abuse did not always recognise the impact on the children or take an active role in engaging with them to provide information and an explanation of what was happening (Stanley, N et al 2010[63]). In the discussions that G and H had with SOTCSC and School staff there was a dissonance between their accounts of life at home and the reality that was known through other sources. The children's views were not always apparent when key decisions affecting them were being made (e.g. step down to CIN and then closure of the case) it was clear that H in particular appreciated the support that had been offered but not what H's thoughts were on the proposed changes to those support arrangements. Professionals need to take account of the reluctance there may be for children to describe adversely what is happening at home and include in their assessments of impact and risk the behaviour of the children concerned as a further means of communication. Information from other sources (e.g. H's increasing BMI, disputes with peers etc.) should be used to cross check those assessments.

19.12 The death of E could not have reasonably been predicted by the professionals involved with the family. This was not a case where known domestic abuse incidents were escalating in severity leading up to the fatal incident – the previous domestic incident involving a police response occurred 12 months before the death of E. Agencies had been working together

[62] What about the children? (Ofsted, 2013).

[63] Children and families experiencing domestic violence: Police and children's social services' responses.

over a continuous period from October 2014 to February 2016 under CIN and child protection processes to improve the relationship between E and F and minimise the risk of further domestic abuse and emotional harm to G and H. The Review has identified areas of professional practice where improvements could be made and recommendations have been agreed accordingly.

20. RECOMMENDATIONS

20.1 The Review Panel make the following recommendations:

1. Stoke-on-Trent Local Safeguarding Children Board should seek assurance that appropriate support services are in place for children at risk of significant harm as a result of being exposed to domestic abuse, parental mental health difficulties or parental substance misuse. That the pathways to those services are clear and that professionals are aware of the support available and equipped to advise how to access it.

2. Stoke-on-Trent Responsible Authorities Group should seek assurances that appropriate systems are in place to ensure that organisations (e.g. GP surgeries and schools) receive relevant information about domestic abuse incidents. This should include, but not be restricted to, consideration of Operation Encompass[64].

3. Stoke-on-Trent Local Safeguarding Children Board should seek assurance that Child In Need meetings are properly recorded, communicated and professionals have a shared understanding of agreed actions.

4. Stoke-on-Trent City Council Learning Services (education) department should seek assurance that when children subject to child protection plans move between schools that there are appropriate mechanisms to ensure effective transfer of information and engagement in multi-agency work by the new school. This should include effective two-way communications between schools and children's social care.

5. Stoke-on-Trent Responsible Authorities Group should seek assurance that appropriate cases are being referred to the MARAC and in particular professional judgement in conjunction with risk scores is used to identify the high-risk cases.

20.2 Recommendations for action to improve their services were also made by the agencies that contributed to this Review. These recommendations, along with the associated Action Plans are provided at Appendix B.

20.3 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group. The Stoke-on-Trent Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.

[64] Operation Encompass is a police-led process that involves informing schools before 9am on a school day of police reported domestic abuse incidents, where a child has been in the same household or is affected.

APPENDIX A – TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of undertaking a DHR is to:

- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- **Identify** clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 The victim and alleged perpetrator were intimate partners and lived together in Stoke-on-Trent with their two children. In February 2016 the emergency services were called to their address by the couple's eldest child, who reported that the alleged perpetrator had stabbed the victim. The victim was found to have sustained stab wounds from which she had died. The alleged perpetrator had left the scene but returned a short time later and was arrested. He was subsequently charged with the murder of the victim and remanded in custody awaiting trial.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 22 March 2016 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator is a member of the same household as the victim	**X**

3.2 The recommendation to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group.

4 Scope of the DHR

The Review should consider in detail the period that commences from May 2009, when the perpetrator was provided with service following his referral to Harplands Hospital, until the time of the fatal incident.

The focus of the DHR should be maintained on the following subjects:

Name	E	F	G	H
Relationship	Victim	Perpetrator	Child	Child
Gender	Female	Male	-	-
Age (February 2016)	30yrs	31yrs	11yrs	8yrs
Ethnicity	White British	White British	White British	White British
Address:	Stoke-on-Trent			

4.1 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.2 An Overview Report will be prepared in accordance with the Guidance.

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.

- Domestic abuse and the effectiveness of support services
- Impact of the toxic trio (domestic abuse, drug and alcohol misuse, and mental ill health) on the children and how agencies responded to this
- Mental health of the victim and perpetrator and the effectiveness of support services
- Substance misuse and access to support services
- The employment of the victim as a carer (in a home)
- The victim as carer for the perpetrator

5.2 Stoke-on-Trent Safeguarding Children Board Serious Case Review Sub-Committee was invited to consider any further specific issues it would like to see covered as part of this review.

5.3 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- North Staffordshire Combined Healthcare NHS Trust
- University Hospital of North Midlands
- NHS England North Midlands (in respect of primary care services)
- Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Stoke-on-Trent City Council Children's Social Care
- Stoke-on-Trent City Council Cooperative Working
- Birmingham Community Healthcare NHS Trust
- School 1
- School 2

5.3.1 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subjects of the DHR or their family members. IMRs should confirm the independence of the author, along with their experience and qualifications.

5.4 Where an agency has had involvement with the victim and alleged perpetrator a single Individual Management Report should be produced.

5.5 Background information and a summary of any significant and relevant events outside of the period considered by the review should be included in the IMR.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or alleged perpetrator, during the scope of the Review; this should be notified immediately to Nathan Dawkins, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of

information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Nathan Dawkins, Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (including disciplinary enquiries) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Nathan Dawkins, Stoke-on-Trent City Council.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Summary Reports are required from the following agencies:

- Arch North Staffordshire (including involvement with North Staffordshire Mind)
- Victim Support (to include policy and practice guidance on contact with victims in domestic abuse cases).

6.2 The purpose of the Summary Report is to provide the Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.3 Summary Reports should be quality assured and authorised by the agency commissioning manager.

6.4 In the event an agency identifies another organisation that had involvement with either the victim or alleged perpetrator, during the scope of the Review; this should be notified immediately to Nathan Dawkins, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 The Review Panel will be chaired by Chris Few, an Independent Consultant. The Overview Report will be prepared by Steve Baumber, an Independent Consultant. Mr Few has chaired review panels on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews. Mr Baumber has experience in safeguarding, public protection and the conduct of case reviews. Mr Few and Mr Baumber have no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Staffordshire Police
- North Staffordshire Combined Healthcare NHS Trust
- University Hospital of North Midlands
- NHS England North Midlands (in respect of primary care services)
- Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Stoke-on-Trent City Council Children's Social Care
- Stoke-on-Trent City Council Cooperative Working
- Birmingham Community Healthcare NHS Trust
- School 1
- School 2
- Arch North Staffordshire
- Chair of the Safeguarding Children Board Serious Case Review Sub-Committee (as advisor to the Panel)

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to Nathan Dawkins, Stoke-on-Trent City Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the secure portal established by Stoke-on-Trent City Council for that purpose.

11 Legal and/or Expert Advice

11.1 Nathan Dawkins, Stoke-on-Trent City Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

11.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.3 The Overview Report will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

12 Family Engagement

12.1 The families of the victim and alleged perpetrator will be advised that this review is being conducted via their respective fathers and Staffordshire Police.

12.2 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.3 The Independent Review Panel Chair will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Responsible Authorities Group will give consideration to the support needs of family members in connection with publication of the Overview Report.

13 Media Issues

13.1 Whilst the Review is ongoing the Staffordshire Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department.

14 Timescales

14.1 IMRs and Summary Reports should be submitted by 20 May 2016 with a view to the first Review Panel meeting being convened in the week commencing 6 June 2016.

14.2 The review should be completed and submitted to the Chair of the Responsible Authorities Group by 22 September 2016.

APPENDIX B – AGENCY RECOMMENDATIONS

Staffordshire Police

Staffordshire Police should initiate a review of incidents of domestic abuse with the aim of ascertaining if all the measures introduced are achieving the positive outcomes available.

North Staffs Combined Healthcare NHS Trust

Early Intervention Team to ensure when staff are discussing early signs of relapse with service users this is recorded in detail in the staying well plan, and that carers are involved in staying well and relapse plans.

NHS England North Midlands (in respect of primary care services)

a) The author identified that if Children's Social Care is involved with children and the children have an alert in place on their records, this does not mean that an alert is automatically put on to the parental records. This is not part of the GP contractual obligations however it would be considered good practice for GPs to put an alert on the parental records at the same time an alert is added to the children's records. An example of an alert on parental records may read 'Children known to Children's Social Care'.

Birmingham Community Healthcare NHS Foundation Trust

a) For the School Health Service to receive level 3 domestic abuse training delivered by the Safeguarding Children Team, including the use of the DASH risk assessment tool and referral to MARAC.

b) To ensure that the School Health Service document the journey of the child clearly within the Child Health records.

c) For all children that require paediatric liaison/MASH feedback to have a standardised and clear approach to sharing and managing information.

Staffordshire and Stoke-On-Trent Partnership NHS Trust

a) The in house domestic abuse training includes the emotional impact and is mandatory for qualified school nurses. The organisation needs to ensure that this mandatory training is being received by all school nurses.

b) Unqualified Our Health 5-19 staff who have direct contact with children should receive training on domestic abuse and the impact of this on children. The Partnership Trust currently offers a half day in house training which would appropriately meet this need.

c) Through discrete direct enquiry all children of appropriate age and understanding will be given the opportunity, when seen by a member of the Our Health 5-19 team, to express what life is like for them and to raise anything that gives them concern. The child needs to be seen alone for this to take place. This information should be recorded within the school health record and shared with other agencies as appropriate.

d) As far as is possible a child who is the subject of a child protection plan should have a named member of staff who deals with the health input of the child protection plan. Where this is not possible there must be clear, documented liaison between staff who have had involvement.

Stoke-on-Trent City Council – Children's Social Care

Ensure that risk related to domestic abuse is clearly articulated and addressed by proven, evidence-based practice frameworks in use across all services in Stoke-on-Trent creating a consistent approach by professionals to working with children and their families. The danger statement will be clear about the actual risk and not use shorthand e.g. 'domestic abuse'.

School 1

a) Ensure all members of the nurture team and safeguarding leads have undertaken appropriate training in all three areas of the toxic trio so that they can more readily recognise the indicators and appropriate actions. G may have benefitted from a more structured programme to help him deal with the impact of domestic abuse in the home.

b) Ensure all records are clearly dated with the year so that the chronology of events can be more easily followed, cross referenced and patterns identified to influence actions and support.

c) Ensure there is a clear protocol for the archiving of informal notes and diaries from members of staff working with children being safeguarded and that this is clearly understood by all staff.