Safer Somerset Partnership

Feel Safe, Be Safe

Domestic Homicide Review Overview Report

Into the death of Marie

Restricted until publication
May 2016

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Independent Panel Chair and Author

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Preface

1.1 Domestic Homicide Reviews (DHRs) came into force in April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be 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) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or
b) A member of the same household as himself/herself, held with a view to identifying the reasons to be learnt from the death

1.2 The key purpose for undertaking DHRs 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 those lessons to service responses including changes to policies and procedures as appropriate; and

- Identify what needs to change to prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

1.3 In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.4 This review was commissioned by the Chair of the Safer Somerset Partnership following the tragic death of Marie (pseudonym).

1.5 The purpose of this Domestic Homicide Review (DHR) is to examine the circumstances surrounding the death of Marie as described in the Terms of Reference.

1.6 The Independent Chair and the DHR Panel members offer their deepest sympathy to the family and friends and everybody who has been affected by the death of Marie.

1.7 The Independent Chair would also like to thank all those who have contributed to this Review, for their time, patience and co-operation.

1.8 The Review process has been carried out in accordance with the expectations of the Multi- Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (revised August 2013). The overview report has been prepared in accordance with Home Office Guidelines (January 2014).

2. Domestic Homicide Review Panel members

Independent Review Panel Chair and Overview report author	Caroline Howard
Somerset County Council Senior Commissioning Officer (Interpersonal Violence)	Suzanne Harris
Bournemouth Churches Housing Association (BCHA) (Outgoing DA service provider) West Coast Project Leader for Young People's services	Debbie Legg
Knightstone Housing (SIDAS) (Incoming DA service provider) Strategic Business Manager	Melanie Thomson
Avon and Somerset Constabulary	D/Inspector Phil Jones
Somerset County Council Children's Social Care Independent Safeguarding Officer Service Manager Quality Assurance and Safeguarding	Melinda Harvey Phil Hutty
Somerset County Council Adult Social Care Team Manager Mental Health	Jane Stroud
Somerset Partnership NHS Foundation Trust Safeguarding Adults lead	Julia Hendrie
Somerset Clinical Commissioning Group (GPs) Designated Nurse Safeguarding Children	Gill Munro
Taunton & Somerset NHS Foundation Trust (Musgrove Park Hospital) Clinical Lead for Safeguarding Adults	Duncan Marrow
Yeovil District Hospital NHS Foundation Trust Senior Sister	Patricia Wilcox
Curo Group (Landlord for tenancy held by family) Head of Tenancy Solutions	Andrew Snee
Mendip District Council Housing Options Team Project and Service Development Officer	Peter McGuire

2.1 Schedule of DHR Panel meetings

Panel meetings were held on

16.09.2015	First panel meeting
14.10.2015	Additional panel meeting for other agencies identified and non-attendees
07.01.2016	Second panel meeting for presentation of IMRs
23.02.2016	Third panel meeting to review draft overview report
17.03.2016	Final panel meeting to review final draft overview report and panel meeting with family members

2.2 The Review panel consisted of senior members of staff from statutory and non-statutory agencies who were able to identify lessons learnt and to commit their organisation to setting and implementing action plans to address those lessons. None of those members of the panel or any of the Individual Management Report (IMR) authors has had any previous contact with the victim or her family.

2.3 The independent Chair and author of this report was previously a Police Inspector with Avon and Somerset Constabulary until her retirement with 30 years' service in April 2015. Working within the field of public protection policy and strategy, she had extensive experience of domestic abuse and of coordinating DHRs within the Police including as a Panel member and an IMR author.

She can confirm that she has had no previous contact or dealings with either the victim or her family and is working totally independently and impartially from any organisation or statutory agency.

2.4 In view of the previous employment of the Chair and author at the time of the murder of Marie, it was recommended by the Home Office that this final report be subjected to a final independent scrutiny prior to publishing. This was completed by independent domestic homicide review Chair, Faye Kamara who has never worked for any of the organisation's featured in this review. Her commentary as "Independent Reviewer" can be found throughout the report.

3. Introduction

3.1 Case summary

On a morning in February 2015 at 8.29am, police were informed by ambulance control that they had received a call stating that a 45-year-old woman (Marie) had been stabbed several times in the garden of a house in a town in the Mendip area of Somerset.

The informant, a neighbour, reported that she had seen the victim's ex-husband leaving the scene in a car and that he had blood on him.

Ambulance staff attended the scene and Marie was declared to have died at 8.58 am.

Police also attended the scene and later found the victim's ex-husband at the location of a single vehicle road traffic collision whereby he had turned his car over in a hedge. He was taken to hospital with minor injuries and was subsequently arrested for murder.

The scene location was the address of the ex-husband and, upstairs in bed asleep at the time of the incident was the couple's 10-year-old child who was at the time residing with Marie's ex-husband.

The couple also had 4 other children, ranging in age from 17 to 23 years, none of whom were present at the time, although the eldest of which arrived shortly afterwards having received a phone call from Marie's ex-husband stating that he had killed her.

It was later established that Marie had previously left the marital home during the summer of 2014 after a long history of domestic abuse and that she had returned that morning to collect the youngest child who was not well enough to attend school.

A post mortem established the cause of death to be from multiple stab wounds and the perpetrator (pseudonym H) subsequently pleaded guilty to murder and was sentenced to life imprisonment with a recommendation that he serve a minimum of 18 years.

3.2 The key purpose for undertaking this DHR is to enable lessons to be learned from Marie's death. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully what happened, how their respective organisations interacted and dealt with any of the family concerned and, most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.3 This Domestic Homicide Review examines agency responses and support given to Marie, a resident of Somerset prior to the date of her death in February 2015.

3.4 Specific terms of reference (TOR) for this review include:

- To review events up to the domestic abuse related homicide of Marie on 26th February 2015. Events should be reviewed for 9 years (from 01.01.2006) preceding

the domestic homicide. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR. This approach was taken given the known significant volume of information, and also because of numerous organisational changes. Asking all agencies to review all their records back beyond 2006 was considered to be impractical.

- Initial information shows that there had been contact with Children's Social Care and Adult Social Care in respect of two or more of Marie's children. This review is required to particularly ensure that any adult and child safeguarding concerns were effectively considered and resolved

- To seek to fully involve the family, friends, and workplace colleagues within the review process

- Consider how (and if knowledge of) the non-physical types of domestic abuse are understood by the local community at large – including family, friends, employer and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

3.5 Agencies contacted

The following agencies were asked by the Somerset Community Safety Partnership (CSP) DHR advisory group to search their files for known contacts with the victim, the perpetrator and their children:

- Avon and Somerset Constabulary
- National Probation Service
- South Western Ambulance Services NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Somerset County Council Adult Social Care
- Somerset County Council Children's Social Care
- Somerset County Council Education Service
- Somerset County Council Youth Offending Team
- Somerset Partnership NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust (Musgrove Park Hospital)
- Bournemouth Church Housing Association (BCHA) domestic abuse service provider until January 2015
- Knightstone Housing (SIDAS- Somerset Integrated Domestic Abuse Service) domestic abuse service provider from Jan 2015
- Yeovil District Hospital NHS Trust
- Mendip District Council
- Taunton Deane Borough Council
- South Somerset District Council
- Victim Support

- Somerset Drug and Alcohol Service
- Curo Group, Landlord for family

4. The review process

4.1 All the agencies contacted were asked to provide information and chronological accounts of their contact with the victim and her family from 1st January 2006 prior to her death, in addition to any events prior to that date which may have been relevant to any violence or domestic abuse.

4.2 With the exception of Victim Support, National Probation Service, South Somerset District Council, Taunton Deane Borough Council, Somerset Drug and Alcohol Service and the Youth Offending Team who held no relevant records of any of those involved, all the above agencies provided information or detailed chronologies in relation to their contacts with the family.

The review has considered all those contacts and they have been integrated into one single chronology which has been summarised throughout section 11 of this report.

In respect of the National Probation Service, it is not clear why they held no records held of H's offending, particularly as he had previously served three terms of imprisonment in 1987, 2003 and 2006, the last two for which he was sentenced in the Somerset area. It is believed that this is due to national changes within the Probation Service in the last two years and previous records are no longer held.

4.3 Somerset County Council Education Department was also involved at the start of the Review process and attended Panel meetings. Although little information was available prior to Marie's death, they were able to provide information and reassure the Panel of the support and interventions that had since been put in place for her youngest child (pseudonym C5) who, at the time of death, was 10 years old.

4.4 A representative from Barnardo's children's charity was also invited to the initial Panel meeting so that every opportunity for means of support for C5 were explored, including their Mandala therapy and play project designed for bereaved children. Whilst this was not taken up by the family the Review Panel members, including those from Children's Social Care were mindful of future support opportunities for all members of the family.

4.5 Also consulted was the homicide family support worker from Victim Support who provided useful information as to the family dynamics and the support they were receiving since Marie's death. Of note, were her concerns in relation to C5's feelings of 'guilt' for the death of Marie, as was present in the house at the time and was the reason that Marie had visited, even though C5 was not aware of the incident taking place.

This family support worker also expressed her concerns regarding the levels of support being offered to the family from Children's Social Care and considered that C1, who was acting as the legal guardian of C5, needed particularly high levels of support as this was a major task for a young adult to undertake and all the family were grieving what was

effectively the loss of both parents at the same time. These concerns were acknowledged by the Children's Social Care representative on the Review Panel.

4.6 Marie's employer was interviewed as part of the Review process and was helpful and cooperative in providing as much information as possible.

Marie's employer is a large social care and housing provider covering many counties of the South and South West of England including the Somerset area. Employing over 1500 staff across those areas, they provided mandatory training on domestic abuse awareness, although this was mainly on the basis of their staff dealing with clients at risk[1].

At the time of Marie's death their main support for any employees encountering difficulties, including as potential victims of abuse, was to direct them towards their Employee Assistance Line, which was a helpline connected to and run by an external provider.

This has since been updated in that they have now included more domestic abuse training and awareness for staff under their Employee Wellbeing Agenda, and their domestic abuse policy was updated in November 2015.

Marie had been employed since 2012 as a care assistant working 30 hours per week with the occasional overtime opportunities. She was very well regarded and had a particular affinity with her clients, many of whom were vulnerable adults with learning disabilities. She was described as being 'amazing' at her job and had won an internal 'superstar award' for her work ethos.

Her line manager confirmed that as her employer they were able to facilitate numerous changes to Marie's working hours during the last six months of 2014 which afforded her the flexibility to accommodate H's demands and regular changes to the childcare for C5.

Marie expressed her frustrations to her colleagues during that time, particularly in respect of her housing issues and, although one of her employer's area of business was as a social landlord (although not her actual landlord), they were able to advise her on courses of action that were available to her. This included the potential for her to apply to her Local Authority Housing Department for Discretionary Housing Payment (DHP) as dual funding whilst she was still committed to paying for the tenancy of the family home whilst living elsewhere.

Although Marie's employer stated that they recognised that she was being subjected to emotional abuse through H's controlling and coercive behaviour, and also financial abuse as she remained liable for a family home that she wasn't occupying, they sought to support her by being flexible with her working hours and advising her wherever possible regarding her housing options.

[1] The Independent Reviewer is unsure why the training Marie's employers offered did not recognise that employees can also experience abuse?

Of note in respect of domestic abuse disclosures was that Marie had told her colleagues on a number of occasions that "he will kill me", and she had also declined to attend their annual Christmas party in December 2014 as she felt that if she drank, H would use it against her in her quest to have C5 living with her.

4.7 During the preparation of this report the DHR Chair also consulted with the victim's eldest child and next of kin (pseudonym C1), brother (B1) and sister-in-law (BW) and her new partner (BF).

Two key aspects of concern from all the immediate family members and Marie's new partner that they requested be covered in this review, were that they wanted to know what more the police, the housing authority and her housing Landlord could have done in order to protect her as she had been fearful for her life and had vocalised that fear on many occasions to friends, family and the key agencies involved.

Although C1 showed some reticence to participate fully, he spoke with the DHR Author on numerous occasions and was updated regularly throughout the process, including the offer for him to attend the final Review Panel meeting to meet the agencies involved which he declined.

Two of Marie's brothers, her sister-in-law and her new partner (pseudonyms B1, BW, B3 and BF) however did participate fully and provided much information and insight into the life of Marie, her character and some of the difficulties she faced over the years whilst married to H.

The family are to be commended for their tenacity, honesty and involvement in this Review.

4.8 In order to provide a holistic approach to this review, the DHR Chair also made several attempts to speak with the perpetrator so as to ascertain what factors may have prevented him from taking the fateful actions that he did. Unfortunately, he was unreceptive to being interviewed stating to his prison offender manager '*I know what I've done, I've held my hands up to it and I just want to move on. I want to forget about it*'.

Although not surprised by this response, the family have expressed their anger and distress over his lack of cooperation and particularly over the fact that H pleaded guilty for Marie's murder and has never provided any answers or shown any remorse for his actions.

They consider that this is another form of control by him, by denying them any explanation or formal closure after her brutal death.

5. Parallel reviews

5.1 A Coroner's inquest was opened but due to criminal proceedings was not continued.

5.2 A criminal investigation took place into the murder of Marie and was concluded upon sentencing of the perpetrator.

5.3 An Independent Police Complaints Commission (IPCC) investigation is currently underway in respect of a number of police contacts that took place with the family prior to the murder. The terms of reference for this investigation include specifically determining whether the incidents brought to the attention of the police were appropriately resourced and progressed; and whether officers involved in progressing reported incidents complied with their training, force policy and relevant national guidance.

5.4 The IPCC investigation is not due to be completed until September 2016 and the DHR Independent Chair and author of this report has been in regular contact with the IPCC lead investigator to ensure consistency of information in respect of incidents under scrutiny.

6. Timescales

6.1 The decision to undertake a DHR was made by the Chair of the Safer Somerset Partnership on 10.04.2015 and the Home Office informed.

6.2 Home Office Statutory Guidance advises that where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. However, the commencement of the Review process was postponed until after the completion of criminal proceedings and a final completion date set for 31st March 2016. Due to a combination of factors, including changes to Review Panel membership, the completion date was revised to be 30th April 2016.

7. Confidentiality

7.1 The findings of this Review are restricted. Information is available only to participating officers/ professionals and their line managers until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased and her family, the following pseudonyms have been used throughout this report:

- Marie — the deceased, as chosen by her next of kin
- H — perpetrator
- C1 — eldest child and next of kin
- C2 — 2nd eldest child
- C3 — 3rd eldest child
- C4 — 4th eldest child
- C5 — youngest child
- B1 — eldest brother of deceased
- BW — sister-in-law of deceased, married to B1
- B2 — 2nd brother of deceased
- B3 — 3rd brother of deceased
- BF — new partner of deceased

8. Dissemination

8.1 This report has been shared with the contributing organisations. In order to secure agreement, pre-publication drafts of this overview report were seen by the Review Panel members, and the Chair of the Safer Somerset Partnership. Also prior to submitting the report to the Home Office, the independent chair visited the family and shared the findings of the review with them.

An executive summary has also been produced in a form suitable for publication. Both the overview report and/or the executive summary may be made public in order to ensure that the lessons of the review are learned through the implementation of the recommendations made.

9. Methodology

9.1 This report is an anthology of information and facts gathered from:

- The chronologies and information provided by all the agencies involved who had contact with the family
- The Individual Management Reviews (IMRs) of participating agencies
- The Police Senior Investigating Officer
- Members of the victim's family, friends and colleagues
- Discussions during Review Panel meetings

10. Profiles

10.1 Marie – Victim profile

Marie was 45-years-old at the time of her death. She had been married to H for approximately 25 years. Together they had five children, who were aged 23, 22, 20, 17 and 10 years at the time of her death.

Their second eldest child was born disabled and it has been noted from information provided that between 1994 and 2012, Marie suffered from bouts of depression partly as a consequence of the stress involved with bringing up five children and also as a result of a difficult, sometimes violent relationship with her husband[2].

[2] The Independent Reviewer would like there to be clarity on the following point; Which agencies factually were aware of this 'sometimes violent relationship'- could this be added to highlight what was known? Was it just the police who were aware?

Marie has been described by her family as a fun loving woman who was fiercely protective of all her children whom she loved very much.

She is described as hard working and wanting to provide the best possible future for them all, despite at times being faced with violent arguments between two of her children (C1 and C3) and their father.

It has also been described by family members and friends that she suffered significant emotional abuse from H over a period of many years. Examples of this form of abuse include being taunted by H that her father was not her natural father as there was no physical similarity, and H telling their youngest child that they were unwanted as Marie had at an early stage planned to terminate her pregnancy.

It has been identified through this review that H was very controlling in many aspects of Marie's life and particularly so after their separation in July 2014. It is apparent that H fully controlled access to C5 and used coercive tactics to ensure Marie complied with his demands.

His control over Marie's housing issues whereby she continued to have to pay rent and bills for the family home when she had moved out, can also be viewed as a form of financial abuse.

During February 2014, Marie met BF whilst on a night out with friends. He stated that he and Marie had a mutual attraction to each other from the outset, but that she had finished the evening with the comment '*I'm in a really dangerous situation, so you probably won't want to see me again'*.

After that evening they had communicated by way of text messages and had started to develop a more serious relationship from around July 2014.

During that time Marie told BF that she was married to a guy who was a *'psycho'*, who had mentally and physically abused her for years, and that he had been *'inside'* a few times. She further stated that their marriage had been over for years and that she was purely there for her youngest child and until C5 reached 16.

On 26 June 2014, Marie initiated contact with the Domestic Abuse FreeFone Service (Daffs) helpline, which at the time was a free phone number for the Avon and Somerset area. This was answered by the local Integrated Domestic Abuse Service (IDAS) in Somerset and Marie was actively seeking advice and support as she wanted to leave H as things had got worse over the previous 6 months, mainly in the form of emotional abuse. A risk assessment was completed and, due to its High Risk, Marie was referred to a Multi-Agency Risk Assessment Conference (MARAC).

As the control and abuse escalated by H, Marie found the strength to leave him and in July 2014 she moved out into temporary caravan accommodation, all the while trying to maintain regular contact with her children and, in particular the youngest child who was still living at the family home with H.

This contact proved to be very difficult to sustain, as H was prone to changing arrangements and refusing to allow access on numerous occasions.

Significant difficulties were also encountered in respect of Marie's accommodation issues in that the tenancy agreement for the family home was in her sole name, H was residing there and Marie was committed to paying all the rent and bills for both that tenancy and also her temporary caravan accommodation.

Family and friends will describe Marie's contacts in relation to her housing issues as being extremely frustrating and overwhelmingly distressing.

This was due to the fact that she considered the only option being presented to her by the Local Authority Housing Options Team was to flee to a refuge, when she felt that she needed to retain some stability for her children by continuing to work in order to pay all her accommodation and other household bills, with her ultimate aim being to return to the family home.

It has been noted throughout this review that Marie made frequent and significant remarks to family, friends and many of the agencies involved expressing her fear and frustrations, including;

'nobody is going to do anything until I'm dead'
'no-one will do anything until I'm 6 feet under'
'he will kill me'
'H is getting away with his behaviour'
'it's just not fair' (in relation to housing issues)
she was *'feeling unsupported by the whole system'*
'the support that was promised' when she left the relationship *'has not happened'*
she has *'had little support or help from agencies designed to help victims of domestic abuse and has had to do it all herself'*

Where appropriate these comments will be examined more specifically throughout this review.

In November 2014, at her own instigation, Marie moved into more permanent privately rented accommodation some 5 miles away and she was able to give up her tenancy to the family home, allowing H to take it over and remain there.

Although there was no formal residency arrangements in place for their youngest child, Marie continued to experience difficulties in respect of access which was controlled by H and he continued to contact her and threaten to harm her.

10.2 H – Perpetrator profile

H was 50 years old when he murdered Marie in the garden of his home in Somerset.

It is believed that he had lured Marie to the house that morning by calling her and telling her that their youngest child was unwell and that she would have to look after C5. It is also believed that H told her that he had already left for work and had hidden his car so that when Marie arrived it appeared that C5 was alone in the house.

H originated from Cumbria, moving to Somerset sometime in the late 1980s when he met Marie. It is not known why he moved south, other than his mother had previously moved to Somerset having separated from his father.

Prior to Marie's murder, he had 11 previous convictions for offences which included Actual Bodily Harm (ABH), Grievous Bodily Harm (GBH) and possession of a firearm and he had previously served three terms of imprisonment, in 1987 for GBH to his first wife[3], in 2003 for an unprovoked attack on a stranger at a holiday park, and in 2006 for handling stolen goods.

In 1987 H was sentenced to 42 months for slashing the face of his previous wife with a knife. His ex-wife was interviewed as part of the criminal investigation into Marie's murder and she described a short relationship of physical and emotional abuse which started when they first met when she was fifteen.

During their short marriage when she was sixteen years old, she stated that H could be bad tempered and he used to take her earnings from her as she was working and he was not. They separated after a year and she returned to live with her mother but H would use coercive and controlling behaviour to get her to return, including cutting his wrists.

She also stated that he had spent some time in a Mental Health Unit and she believed that at one point he had been diagnosed as schizophrenic.

She stated that she had felt that H was going to kill her on a number of occasions and that at one time he had tried to drown her in the bath. On another occasion he locked her into the flat and gave her two options, to take the knife from him and kill him or he would kill her then kill himself. She jumped out of a window onto a nearby roof and waited for him to leave.

On the occasion that H had slashed her face, they were separated and H had met her at lunchtime and told her that, while he accepted she would not return to him, if he couldn't have her then nobody would.

He then dragged her into an alleyway and stabbed her on her left hand side just below her ribs and slashed her face from her inner right eyebrow down the right hand side to her lip and onto her chin and down to her collarbone. He was disturbed by a passer-by who caused him to run off and an ambulance was called.

[3] The Independent Reviewer wishes to highlight; Was H recognised as a serial perpetrator of domestic abuse? And is this a recognised term by A&S?

H gave himself up to the police immediately after the attack and she considered that his refusal to plead guilty was another form of control by him, as she was forced to go through the ordeal of the criminal trial.

H's abuse has had a lifelong impact on her. She stated that she has always looked over her shoulder and it has affected her relationships. Whilst she states that she genuinely feels for Marie and her family, she also states that she is relieved that he is in prison as her fear had never gone away.

Of note in respect of H's controlling and threatening nature, B1 has reported that prior to H's and Marie's separation in the summer of 2014, he had apparently traced his ex-wife on social media and showed Marie her photograph with the threat that that (facial scar) would be what would happen to her should she mess him around.

On 01.06.2003 H assaulted a stranger whilst at a caravan holiday park in Somerset. After a commotion whereby it was believed that H had been attacking Marie, the victim who came out of a caravan to see what was happening, was punched to the left hand side of his face.

The force of that punch caused several fractures to the left side of his skull which required surgery to reset them with five metal plates put in.

H pleaded guilty to this assault and was sentenced to 12 months in prison. He was released on a home detention curfew and a supervision order on 29.03.2004 having served 3 ½ months.

H's propensity for violence and abuse is noted throughout the chronology and individual incidents, including two key suicide attempts in May 2011 and June 2013, will be analysed where appropriate throughout the review.

H had many contacts with health services and his medical records note a history of drug and alcohol problems, aggressive behavior and recurrent bouts of anxiety, depression and suicide attempts.

From 2006 (the key start date under the TOR), H is reported to have been regularly prescribed anti-depressant medication and attending GP reviews for his emotional and mental health, often termed as 'chronic anxiety reviews'.

H also had difficulties with his eldest child and there were frequent incidents of disagreements and fighting between them with Marie doing her best to try to resolve and calm the situation. She eventually helped their eldest child find a place to move to so that C1 could live more independently which reduced the conflict with H.

11. The Facts/ Narrative chronology

In the period examined Marie, H and their five children had regular contact with a wide range of agencies. This narrative chronology focusses on those contacts that relate to domestic abuse, mental health issues, violence or criminal activity and has been

summarised in year format for ease of reading. The ages of Marie's children (on their birthday for that year), are noted here in order to help provide context.

2006 (ages of children: C1 = 15, C2 = 14, C3 = 12, C4 = 9, C5 = 2)

H attended his GP on four separate occasions in January, twice in July and in November.

In January he attended stating poor sleep due to an upcoming Court case for aggressive behaviour towards police 18 months previously whereby he was arrested for assault (not family related). He stated he was not taking cannabis.

In July he stated that he was sleeping better but now had to apply for his driving licence on an annual basis. His medication for chronic anxiety was reduced.

At his second appointment in July he was seeking 6 weeks' medication as he was going on holiday. Stated mood well and no thoughts of self-harm/overdose. He also stated that his last overdose was 25 years ago.

In November he was referred by way of GP letter to the Alcohol team following his cravings for alcohol. Letter stated that H had a history of alcohol and cannabis problems and a diagnosis of personality disorder.

At the end of December H's GP received a letter from Consultant Psychiatrist linked to the Alcohol Team stating that he enjoyed a stable family life with his wife and five children. Risk screening indicated no apparent risk to children or of suicide and low risk of misusing drugs and alcohol. Medication for alcohol cravings was prescribed for a 4-week period with a review arranged 4 weeks later.

During 2006 Marie attended her GP in July, September and October.

In July she reported that she was depressed having had a bad year with eldest child, weepy, gloomy future, depressed thoughts, poor motivation and energy, insomnia, never laughed, snappy and appetite affected. It is also recorded that her husband was partly supportive and that she had no suicidal thoughts. She was prescribed anti-depressants.

At her visit in September she stated that she was feeling calmer and more able to cope.

In October she stated depression better although she had 'a lot on her plate' and would benefit from counselling. A referral was made.

Between December 2006 and February 2007 Marie attended three sessions of counselling cancelled another three and did not appear for one.

There are three police records held during 2006:

In May, a record of an argument between Marie and C1 which resulted in no further police action.

In March when C1 was cautioned for assaulting H by punching him in the face and stomach and in June when C1 received a police warning for assaulting the younger sibling C3 (aged 11 at the time).

2007 (ages of children: C1 = 16, C2 = 15, C3 = 13, C4 = 10, C5 = 3)

In January H failed to attend his review appointment and was contacted by telephone by the Consultant Psychiatrist. He stated he did not want to be seen again and was discharged.

In July, August and September H attended his chronic anxiety reviews but failed to attend a fourth in October without reason.

In July he stated he had stopped working as he didn't feel well enough. Was finding medication helpful and was hoping to look for work soon.

At the end of July Marie attended GP with depression through death of a close friend and struggling at home. Tired all the time, tearful and mood swings. Medication prescribed.

In August police attended a verbal argument between H and C1. C1 went to stay with friends to avoid further escalation and no further action was taken although CSC and health visitor referrals were made.

2008 (ages of children: C1 = 17, C2 = 16, C3 = 14, C4 = 11, C5 = 4)

In August[4] H reported to his GP that he had an alcohol problem and was drinking 4 litres of cider daily.

Also in August police received two separate calls from Marie and C1 reporting argument between H and C1, whereby C1 was threatening to smash up the house and cars. Police attended and there was no further action as C1 was staying with friends. Police made referrals to CSC and Health visitor.

In November C1 reported to police that H was threatening to "smash C1's face in" as C1 was arguing with C3. Marie was present but refused to speak. Police referred to CSC and Health visitor.

2009 (ages of children: C1 = 18, C2 = 17, C3 = 15, C4 = 12, C5 =5)

In May, September and December H attended three chronic anxiety reviews and stated that he had tried to stop his medication last year but was keen to restart.

[4] The Independent Reviewer would like to highlight whether the Review Panel noticed the trends over summer months in 2007, 2008 for reported incidents?

At the second review he stated that he could 'be evil' in terms of his temper. It was also recorded that he had no thoughts of self-harm or harm to others and that he was polite and smiling with no threatening behaviour. It is also noted that Marie had made him come back to GP as felt after a few months he was slipping back into previous problems. His medication was increased.

At the third review he stated he was now working and 'enjoying it and feeling fulfilled'.

2010 (ages of children: C1 = 19, C2 = 18, C3 = 16, C4 = 13, C5 = 6)

In April and July H failed to attend two GP chronic anxiety reviews but he did attend one in November where he stated that he couldn't understand why the Driver and Vehicle Licensing Agency (DVLA) were saying he had a mental illness and asked the GP to send a letter to DVLA

Also in November H attended his GP and stated he wanted to get his Heavy Goods Vehicle driving licence back. He stated he had been drinking heavily for three years and was on medication but remains free of anxiety and depression.

In December he attended again as he was upset that DVLA had only given him a 12 month licence. It is not known why that was the case but H stated that he now only drank 2 pints per week.

In August Marie attended her GP reporting low mood, 5 kids at home and all getting a little stressful. Future seemed bleak at times although no thoughts of self-harm but negative about the future. Had tried counselling in the past but no help. Medication was prescribed.

2011 (ages of children: C1 = 20, C2 = 19, C3 = 17, C4 = 14, C5 = 7)

In February Marie attended a GP appointment where she reported low mood for some time and worse recently although no plans for self-harm.

On 1st May a call was made to police by a third party who reported that H had 'started' on Marie and one of their children (C4). Police records highlight inconsistencies in that the initial call log states that Marie had split H's lip but the crime record shows that H had split Marie's lip, although this was not photographable.

The police referral to CSC records a physical argument between H and Marie where he had pushed her to her face several times using the butt of his hand and Marie had sustained a cut lip. Marie reports H as being a heavy binge drinker. This assault was witnessed by children present.

Police records show H was arrested for battery but the case was subsequently withdrawn at Magistrate's Court on the 31st May[5].

On the 3rd May CSC were notified by C4's school that C4 had sustained two black eyes whilst intervening in this domestic incident between H and Marie. A record was made by CSC to progress this to an initial assessment from which it was decided that there would be no further action due to H having moved out of the household.

On 21st May H attended the local minor injuries unit of his own volition reporting that he had taken an overdose of around 120 paracetamol tablets triggered by a split with his wife three weeks previously.

He was taken by ambulance to Yeovil District Hospital (YDH) Accident and Emergency department where he was admitted for treatment and discharged himself the following day. It is recorded that the overdose was deliberate although the quantity taken is not believed to have been accurate and a referral was made to his GP.

The Community Mental Health Team (CMHT) contacted the hospital on 23rd May to trace the patient records and was advised that H had been discharged the previous day and had not been referred to mental health services.

After unsuccessful calls from his GP, H called his GP on 26th May and stated he was feeling better in his self now and was working away. He refused any appointment unless it was with that same GP and it is recorded that he sounded rational on the phone and would go in if he felt unwell.

During a routine GP appointment on 7th September, H stated that he had taken the previous overdose as he was unable to sleep, not suicidal.

<u>2012 (ages of children: C1 = 21, C2 = 20, C3 = 18, C4 = 15, C5 = 8)</u>

On 6th May Marie called police reporting H was outside the house and threatening to smash the door in and that children aged 7, 14 and 18 were present. Police attended and H was conveyed to his mother's address.

A CSC referral was made and CSC recorded that the relationship was ending following an altercation after a night out and that H was under the influence of alcohol.

It is also recorded that Marie was determined to end the relationship but was extremely concerned and frightened regarding to H's propensity for violence and abuse, and that she had stated to police that she had read statistics in the newspapers regarding persons suffering significant harm and feared she would become a statistic and that he was capable of carrying it out.

[5] The Independent Reviewer has challenged why? Given there had been numerous reported incidents and his violent behaviour was known?

On 16th May, CSC conducted an Initial Assessment and decided to progress to a Core Assessment however, the following day the 17th May; the decision was updated to no further action due to H no longer being in the household.

At 10.35pm on 20th May police received a call from Marie to state that H had attended the address to collect their child and had threatened to kick her to death unless she left the house within 7 days. She also reported that harassment by text was escalating and that she was afraid of H due to DV in the past.

Police attended and spoke to Marie 2 days later at 7.50pm on the 22nd May and noted that she no longer wished to pursue any police action and she signed an officer's notebook to that effect. She did however ask police to check that calls to her address would be treated as urgent[6].

Police referred the incident to CSC as a verbal argument between Marie and H and an Initial Assessment was completed with a decision for No Further Action as H was no longer in the household.

At 2.30am on 1st July, police were called to an address nearby where H was involved in a fight with a third party (not family member). At his own admission he stated that C4 (14 years) and C5 (7 years) were present, as was his ex-partner Marie.

A police referral was made to CSC. A Core Assessment was completed on the 16th August and was progressed to a Child in Need meeting.

On 9th July, police records show that H had returned to the family home.

At 00.15 am on 7th October, police received a call from C4 reporting a verbal argument between Marie and H which C4 didn't want to escalate. She stated that dad H was the problem, but police attendance would only make matters worse.

Despite her request for police not to attend, a police supervisor decided that it was necessary due to the domestic history and police attended[7].

[6] The Independent Reviewer is of the opinion that the police should have considered other actions given the complaint appeared to be that of stalking/harassment- a PIN notice? A victimless prosecution if there was enough evidence.

[7] The Independent Reviewer highlights this as best practice following The Adoption and Children Act 2002 extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic abuse/violence can have serious implications for children's development.

A referral was made to CSC of a verbal argument between Marie and H whereby Marie smelt of alcohol. This case was closed by CSC four months later on 08.02.2013 after a home visit was conducted.

During 2012, H attended three GP chronic anxiety reviews in May, August and October. On 23rd May, at his review he stated he had restarted his medication and his mood had improved over the previous 2 weeks. He was reported to not be suicidal and had no thoughts to hurt others.

On 1st August he reported feeling fine and was not snappy and his mood was fine and on 3rd October he stated he was well controlled if taking his medication and had no suicidal thoughts.

2013 (ages of children: C1 = 22, C2 = 21, C3 = 19, C4 = 16, C5 = 9)

On 21st January police recorded an incident whereby Marie reported her handbag stolen whilst out in Glastonbury. The handbag was later found and the IMR suggests that her contact with the police over this incident could have been a missed opportunity to ascertain her current situation with H.

On 30th January H failed to attend his GP chronic anxiety review.

On 13th June at 11.52pm police received a dropped 999 call from Marie stating that she had called in error. Police attended and spoke to Marie who stated that H had a vendetta against the police due to a discontinued court case where he was the victim and he had now become increasingly unstable, attempting to set fire to himself and making threats to harm police and his family.

She stated he was no longer welcome at his home address and Marie was concerned for the safety of herself and her 5 children.

Police located H on a public road after he had doused himself with lighter fluid and put rags soaked with white spirit in his shoes and attempted to ignite a lighter. He was arrested for Breach of the Peace and taken into custody.

Referrals were immediately made to both Children's Social Care and the Emergency Duty Team. The Emergency Duty Team then passed the information to Somerset Direct who subsequently passed it to Somerset Partnership Adult Safeguarding team as they were concerned about H's mental state.

Within an hour (at 00.50 on the 14th June) it is recorded that CSC made the decision to progress to initial assessment in respect of C4 and C5. This initial assessment was completed on 28th June with a decision to progress to a Child and Family assessment.

On the 15th June Sompar Adult Safeguarding Team requested that the Community Mental Health Team review the case and consider making contact with H for assessment.

On 18th June CMHT sent an invite letter to H inviting him to contact the team to make an appointment for a mental health assessment.

Also on the 18th June, police referred H to the Court Assessment and Advice Service (CAAS) as they had concerns regarding his mental health. It is also noted that police had advised H that his actions were likely impacting on his family to which he replied "I will have to leave then".

The CAAS completed the forensic history section of the risk information within the RIO records.

Also on the 18th June, H attended a chronic anxiety review with his GP where he disclosed that he had covered himself with white spirit which did not light. He stated he was no longer suicidal and agreed to increase his medication.

On 27th June H met with a CAAS Social Worker at Court and confirmed that he had received a letter inviting him to attend a CMHT assessment but he had chosen not to go. C4 was present during this meeting and, although it is noted that she was supportive, she did not express any concerns during the conversation.

On 16th August the Child and Family assessment was completed recommending that Social workers visit the family on a fortnightly basis, meeting with Marie and H to discuss victim, perpetrator and alcohol support and to work with the family to draw up a family safety plan to address the worries discussed at the assessment. The recommendation was also to ascertain the views and wishes of both C4 and C5 and Child in Need services were to be offered.

This case was subsequently closed by CSC eight months later on 17th April 2014, the reason given that *'both children (C4 and C5) no longer reached the threshold for intervention from CSC. There have been concerns for the children witnessing domestic abuse between their parents however mum has received support'…'and things have been settled since October 2013'.*

In September 2013, H was out with his eldest child C1 (then aged 22 years), when they refused to leave a pub at closing time. Both became verbally aggressive towards a female member of staff when she was collecting glasses, threatening to kill her and slit her throat. H grabbed her wrists while C1 started to smash and kick windows. Marie was present during this incident but claimed that she had seen nothing.

There was insufficient evidence to proceed against H and the incident was dealt with by way of a Community Resolution agreement and a police caution for criminal damage.

<u>2014 (ages of children: C1 = 23, C2 = 22, C3 = 20, C4 = 17, C5 = 10)</u>

On 26th June 2014 Marie contacted the local Domestic Abuse FreeFone Service (DAFFS) Helpline asking for advice on DA and explained that she had suffered physical abuse until 3 years ago, which was now continuing as emotional abuse.

BCHA (Bournemouth Churches Housing Association) who at that time provided the Integrated Domestic Abuse Service (IDAS) in Somerset conducted a DASH risk assessment which resulted in a score of 15, a high risk score which automatically met the threshold for referral to MARAC (the threshold being 14 or above) and the referral was sent to MARAC on 30th June and a referral was also made to the BCHA IDVA Service.

Also on 26th June Marie made her first contact by telephone with Mendip District Council Housing Options Team reporting that she was a victim of domestic abuse and was seeking general advice in relation to her housing as she was at that stage still living at the home address with H.

She outlined that she was being referred to MARAC and that she was soon to be allocated an IDVA. In view of this, the Housing Options Officer identified that she was at high risk of DA and that she was already engaged with domestic abuse services.

Marie wanted to know what assistance she would receive from the Local Authority if she fled her current home and she was advised that she would be offered a refuge placement if she was fleeing abuse as she would therefore be homeless.

She was also advised in respect of her rights to the family home over her husband's and asked to consider legal means such as non-molestation orders and injunctions.

On 7th July Marie contacted IDAS and was advised that as she had been referred to MARAC, she was likely to be allocated an IDVA.

She stated that she was happy with that and that H was currently being nice although she would re-contact the service if this changed.

On the 14th July the referral was received into the IDVA service and Marie was allocated an IDVA. She was also offered a Family Intervention Worker from within the service which she declined.

The IDVA contacted Marie on 16th July and arranged to meet with her eight days later, on the 24th.

At that meeting, Marie disclosed that she had been married to H for 25 years and had suffered some physical abuse, mostly emotional and financial abuse together with controlling behaviour especially in the last 12 months. He had made threats to kill her and any new partner and had pinned her up against the wall on the rare occasion and thrown objects at her (some had hit her on the head).

She had isolated herself over the years as it had been easier than putting up with H's behaviour if she went out with friends.

She believed H had hurt his previous wife by slashing her face and threatened her with a gun. She believed he was banned from using guns.

She also believed he had appointments with the Mental Health Team for depression due to his consumption of alcohol.

Marie stated that she moved out of her home on the 17th July to stay with her brother whilst she looked for alternative accommodation. She was currently living in a caravan and stated that the police had put an information marker on this address and that of her brother's.

Marie was returning to the property to collect her youngest child C5 when she was not working. H was dictating child contact and was not allowing her overnight contact. Her child C4 had returned to live in the family home.

Marie and her IDVA discussed leaving C5 with H and she stated she believed he would not hurt C5, although she was concerned at the emotional damage that could be caused. She stated that C5 had phoned her and told that her that she was loved, but that C5 loved dad also.

They discussed Non-Molestation Orders and Occupation Orders and her housing situation. The social housing property was a Sole Tenancy in Marie's name and she was currently paying the rent for the house together with direct debits for the bills as well as paying rent for the caravan.

H had put some money into her account for the rent last month but he had since told her he was struggling to cope with the house and money.

Marie worked for a social care and housing provider as a Support Worker. She was working approximately 30 hours per week as shift work, mainly through the evenings for approximately 12 hours each shift.

Marie agreed to seek legal advice and to speak to her Local Authority Housing Options Team and she stated that she would like to Divorce H.

On 21st July H rang his GP requesting Anabuse as he stated he had a craving for alcohol but was not presently drinking. He was advised to contact Somerset's alcohol service.

On the 1st August Marie and her IDVA met with an independent Solicitor who told her that she had enough evidence to apply for a Non-Molestation Order and an Occupation Order.

The Solicitor also advised her that she could help with arrangements for the children and a divorce, but she told her that she may have to pay a contribution towards Legal Aid as she was working. She would be able to calculate any figure once Marie had provided all her financial information.

The IDVA stated that she would request a letter of support from the MARAC Chair in respect of Marie being a high risk victim of DA.

At 9.44 am on the 5th August, H called police to say that he had been assaulted by Marie who had hit him and dragged him around the garden.

At 9.59 am on that same day, Marie's brother B1, called police to say that he had taken Marie to the address to collect her youngest child and that H had taken her car keys preventing her from leaving and told her that she had until 5.30pm to move back into the address or else he would kill her.

Police attended but H had already left the scene with Marie's car.

That same day, Marie rang her IDVA and told her of the incident whereby H had threatened to kill her. She stated that she was very afraid of the outcome when he was released. They further discussed the possibility of a refuge placement and Marie asked her to look into availability for the following day.

The phone then cut off and when the IDVA called Marie back she told her that H had just arrived with C4 to collect C5. She stated that she felt very controlled by H even though she had left. She was reminded to update her landlord as advised by the Solicitor.

Later that day, H was arrested by police for threats to kill and was released the following morning without charge, due to lack of evidence.

The following morning upon his release from custody, H handed Marie's car keys to a police officer and the police escorted Marie around the area to find the car which H had hidden on another person's driveway.

On 6th August a Multi-Agency Safeguarding Hub (MASH) discussion took place whereby the details of the incident were shared with Children's Social Care. It was noted that a MARAC was shortly to take place and CSC agreed to call Marie to ensure she had a safety plan in place.

Marie called her IDVA that same day and told her that she had gone away to stay with her nephew in Hampshire for a few days. The IDVA told her that there was currently Refuge accommodation available and Marie said that she would think about it whilst she was away. They arranged to meet on the 14th August.

On 7th August Marie contacted her landlord informing them that she was experiencing domestic abuse, she was being supported by IDVA and she had consulted a solicitor. A new case was opened and referred to a case manager.

The case manager called Marie the following day when she stated that H was refusing to leave the address as although he was not a joint tenant, he had marital rights to the property. The case manager advised Marie that additional security could be put into place at the address on the day that she moved back in.

Also on 7th August a CSC Social Worker contacted the IDVA for an update and was advised that Marie was currently away for a few days. The Social Worker agreed to speak to line manager with regards to appointing a Social Worker to find out the youngest child's wishes.

On 14th August as arranged, Marie met with her IDVA and stated that the communication from H was mainly by way of text which were getting more spiteful and blaming her for living a single life. Marie requested that the IDVA arrange a joint meeting with her landlord as she felt she didn't have enough information when she contacted them recently. Marie also told her IDVA that she would provide her financial information to the Solicitor.

The following day the MARAC Co-coordinator emailed Marie's IDVA asking her to ensure that Marie was engaging in a safety plan as she had not yet been discussed at MARAC[8].

On 17th August Marie called police and stated that H had sent her text messages and attended the caravan where she was living and told her to leave him and their child alone. This was due to the fact that H had taken their second eldest child (C2) out of supported living accommodation for the day to a local annual show, and then taken C2 home to live; H subsequently telephoning Mencap to say that C2 had been unhappy living there.

Concerns were raised in respect of the children living with H and C2's Social Worker was informed.

C2's Social Worker spoke with Marie who disclosed her 25-year history of domestic abuse and that she was concerned that H was using their child (C2) as leverage to get her to return to the family home.

On the 18th August Marie attended the District Council housing office and reported that she had been kicked out of the house and was now living in a caravan. She stated that H had attended the caravan the previous night but had not actually done anything[9].

She stated that she was soon to be discussed at MARAC and her Solicitor was applying for an injunction against H.

She also said that she did not want to return to the house but that she wanted temporary accommodation within a 15-mile radius.

The District Council housing officer made another attempt to persuade Marie to accept a refuge placement so that they could work with her to determine which areas would be safe for her to live in in the longer term.

On that same day, 18th August, Marie's landlord case manager telephoned her and Marie confirmed that she was still paying all the rent and bills on the house and that H had

[8] The Independent Reviewer has highlighted this as good practice.
[9] The Independent Reviewer is unclear if any security measures were offered to Marie whilst living in this caravan. Are there schemes in Somerset to help in these circumstances?

removed their 22-year-old child from the supported living placement despite C2 not having the capacity to make decisions.

She told her case manager that she had approached the Local Authority to make a homelessness application but they were only offering a refuge out of the area and she didn't want to go into a refuge as she didn't want to give up work.

During a telephone call the following day, on the 19th, Marie told C2's Social Worker that she was being offered a refuge 40 miles away and she felt that this would not work for her. She did not want to go to a safe house and leave her job and her family and her view was that she had had to leave her home as she was not safe there but she had not made herself deliberately homeless.

On the 21st August an email was sent to Adult Social Care from CSC in respect of a meeting that had been held between Marie and a CSC Social worker which recorded that Marie felt that agencies were not taking appropriate or immediate action and she had left the meeting early and very upset. CSC were considering whether a Child Protection conference was needed regarding H's emotional abuse in respect of their youngest child.

At 11.45am that same day, Marie called C2's Social Worker and advised her that she had tried to see the children without H being present, but that he had taken C2 and some of the children to Cumbria to visit his family. She said that she was following police and Solicitor advice to have no contact with H, although he had been trying to contact her regarding utility bills.

At 3.35pm Marie rang again and left a message for C2's Social Worker saying 'Stuff it all just leave C2 where C2 is, she does not care anymore'.

On 23rd August an email from the IDAS Referrals coordinator to MARAC records that Marie had called the DAFFS line a number of times that week and had spoken to different members of staff[10].

She was concerned about her children being in the home with their father and about her child (C2) who had Downs Syndrome being removed from the supported living placement. She was advised to speak to social services or the police about the concerns she had for her children.

She was also upset about her housing situation and said that she is living in a caravan in a friend's garden while he is in their house which is a tenancy in her name. She said that she had been advised by a solicitor that he was entitled to stay there because he was her husband and that her landlord would not do anything to help as she had a tenancy which was occupied. She was advised to speak to Shelter, her solicitor and her housing officer again to check her rights regarding her housing.

[10] The Independent Reviewer is unsure what support was or wasn't being offered to Marie by the IDVA that made her contact DAFFS a number of times that week, is this known?

H knew where she was staying and Marie said that on Monday he had gone to the caravan and was shouting at her on the driveway. She said that he is trying to get her on her own as that is when he will make threats and he will not do this when other people are around, so she is making sure that she is not alone with him.

She was encouraged to call the police if she needed to on 999 and to keep a log of any contact or incidents. She was given the number to call the Shelter Housing Advice Line and she said that she would try that number.

Three days later on the 26th August, CSC completed a CAADA MARAC Research form and Marie expressed her wish to remain in the area and to maintain links with her family and to stay in her current employment.

She also expressed her frustration about being given advice to move out of the area as she felt that the police should be able to protect her to enable her to remain in the area so she could maintain her networks of support.

It appeared that H was restricting contact between Marie and her youngest child C5. This was a situation that had not occurred previously and Marie had been the main carer for C5 throughout C5's life. The research form notes that this could be viewed as an escalation of the domestic abuse.

That same day, Marie spoke with C2's Social Worker and stated that she had had her eldest and youngest children to stay overnight in the caravan. She told her that C2 had come over with H when he had dropped them off and that H had said to C2 'you like living with me, don't you?' to which C2 had put their head down and nodded without giving Marie any eye contact.

The Social Worker requested that Marie ring CSC to update them on her situation and also that she sent in writing in an email her views on what she wanted for C2's future. Marie did this the following day, 27th August, updating the events and contact with H and also expressing concerns about his emotional and psychological abuse of C2.

Also on the 26th, C2's Social Worker also updated the CSC Social Worker on the weekend's events including the contact between Marie and H that C5 had had an overnight stay at the caravan and C2's current situation with C2's father. CSC conducted a home visit with H the following day on the 27th and a letter was also sent to him. The outcome of this visit and letter is not recorded.

On the 28th August 2014, the MARAC meeting was held and the following actions were made:

- For CSC to establish whether H was a suitable person to care for the children.

- For the IDVA to discuss with Marie her housing needs, her future intentions regarding the children and to look at a way to reinstate her back into the family home.

- For the IDVA to establish the details of C2 who was taken out of the care home and to relay the information to Adult Social Care for appropriate action. (This action was completed the same day and the information was sent to ASC).

- For the Somerset Partnership lead who attended the MARAC to inform the GP of the recent circumstances and the MARAC referral and to establish whether there had been a recent referral for H in respect of Mental Health issues.

- For the Somerset Partnership lead to also ensure that H's GP records were flagged with regards to seeking support for MH and alcohol needs.

  A record of this was entered onto the GP progress notes on 12.09.2014, which recorded that this high risk DA incident could impact on H's health, but it should be noted that this referral to the GP was only made in respect of H as Marie was not known to Somerset Partnership services.

On the 1st September 2014, C2's Social Worker expressed in writing to her managers her concerns for her personal safety in respect of contact with H, owing to his observed responses at a previous face-to-face meeting with a CSC Social Worker and a team manager from the Community Team for Adults with Learning Disabilities (CTALD).

The following day on the 2nd, Marie telephoned C2's Social worker and reported that she was not happy as she had had no contact from her IDVA and that she was considering going to her Member of Parliament. She did state however that she was having regular contact with C2 and C5.

On the 5th September, the CSC Social Worker called the IDVA to inform her she was carrying out a Child and Family assessment and also asked her when she would be speaking to Marie as she was feeling unsupported as the IDVA had been on annual leave and she had believed that someone else from the office would be taking over during this time.

Her IDVA sent an email to Marie's Landlord case manager requesting a joint meeting to discuss her housing needs stating that Marie was the sole tenant of the property and that she would like support to move back in.

She also attempted unsuccessfully to telephone Marie, resorting to sending her a text message asking her to call back and telling her that she was trying to set up a joint meeting with the housing provider.

On the 12th September the IDVA met with Marie and a DASH risk assessment was completed giving a score of 12, medium risk.

She stated that C2 was being returned to the supported living placement the following day and that ASC were aware. She still considered that H had taken him out as a tactic to get her to return home which she refused to do.

She said that she had spoken to H and they had agreed child contact arrangements between them and that she had changed her working hours so that she could have C5 overnight.

She also stated that CSC were completing an assessment and asked that the IDVA contact CSC to request that they speak to her first if they decided that C5 was to reside with her, as she was afraid that H would 'kick off' and would injure her.

Marie further said that H had told her last week that he cannot afford to keep the house and that she could move back into the spare room. She told him she would not do this and he said he will hand it back to her. She had not heard any more detail about when this would happen and thought it was another tactic by him to get her to return.

They discussed dates and times for the joint meeting with her landlord which was agreed for the 18th of September.

They also discussed the potential legal proceedings such as Non-Molestation Order (NMO) and Occupation Order (OO) which Marie said that she would have to pay a contribution towards Legal Aid which she could not afford. She was not sure how much she would have to pay but was waiting to hear from the Solicitor.

On the 16th September, a telephone call was made by the RSPCA to the IDVA requesting an update as to whether Marie was still looking for some foster care for her two dogs. It is not known when this was discussed or arranged, but it is believed that this was something that the IDVA had previously suggested to Marie and she had been keen to arrange.

That same day Marie's Landlord case manager emailed the IDVA to cancel the meeting booked for the 18th, as she was now required to give evidence at an emergency Court hearing.

This was followed up with a phone conversation during which she told the IDVA that she had spoken to Marie in respect to the tenancy but appreciated that the matter was very confusing. H had marital rights to the property even though Marie was a sole tenant and they (the landlord) were not able to facilitate a Court Order to remove him to enable her to return.

Marie needed to seek legal advice in respect to an Occupation Order herself and when they had last spoken she was making these arrangements. Once this had been achieved housing would be able to support her with property adjustments in regards to her security.

Marie had already mentioned that she didn't want to live at the address long term once she had returned so had been advised to register her wish with the Local Authority in her sole name. The case manager stated she would be able to write a letter of support in respect to her banding priority.

On the 17th September the IDVA spoke with Marie updating her on contact with her housing provider and the RSPCA request.

Marie stated that she still required foster placements for her dogs and that she needed to complete her Homefinder application in respect of her housing situation. Her IDVA asked her to confirm once she had done this and both she, and her landlord case manager would write letters of support to the Local Authority housing department.

Marie also stated that the CSC Social Worker had contacted her again suggesting that she moved into a Refuge, something she did not want to do as she wanted to be able to work and not uproot her youngest child from friends and family.

She also said that she believed that CSC would not leave C5 with H and this would force her to move anyway. She did say however, that if H's behaviour escalated she would leave.

Marie stated that her child (C4) had asked to stay with her at the caravan as they were having problems with their dad, but she had said no because she was afraid that if C4 left the house that CSC would take C5 into foster care.

On the 24th September, Marie attempted to call her IDVA and left a message to say that CSC would like a joint meeting between the three of them to discuss their concerns. The CSC Social Worker had also told her that if C5 was her priority she would go to a Safehouse.

The IDVA recalled Marie the following day and told her that CSC had concerns about C5 staying with H and that she should go to a refuge.

Marie stated that she was feeling bullied by the Social Worker into uprooting her family and her work. She said she didn't want to leave her support network and the support she was promised when she left the relationship had not happened.

They discussed how safe she was feeling and that she was trying to keep H as happy as possible by not changing his way of life except for the fact she is not living in the family home. She also stated that if she felt that C5 was at risk she would leave. She wanted to remain in the area and the police protect her if H reacted the way she suspected[11].

That same day the IDVA emailed the CSC Social Worker to outline availability for a joint meeting.

On the 29th September, the CSC Social Worker contacted the IDVA arranging to meet the following day at 9.30am. The Social Worker stated that she was pleased that Marie was considering a refuge but the IDVA told her that Marie was considering safety for herself and the family, but was not asking her to look into refuge availability.

[11] The Independent Reviewer believes that a Domestic Violence Protection Notice should have been considered at this point- it is noted that this is highlighted later in the report.

On the 30th, the IDVA called Marie to confirm that she was still able to make the meeting and Marie confirmed that she was although she was not looking forward to it as she felt that she would be pushed into accepting Safehouse accommodation.

At the meeting the CSC Social Worker advised Marie that their file would remain open with support from CSC on a Child in Need basis.

The Social Worker also stated that she was going to see H the following day to tell him the same, in that they were concerned that C5 was likely to continue to suffer or be threatened to suffer ongoing DA as C5 was being used by H to continue to abuse Marie and that C5 was a very unhappy child who didn't feel able to say what was feeling.

The Social Worker stated that she had concerns regarding C5's emotional health and that H could start drinking again and then his care of C5 would deteriorate and that C5 was missing Marie's care as had been the main carer throughout C5's childhood. This had now been exacerbated by C4 having left the family home.

Together they discussed safety regarding Marie remaining in the area and she stated that she didn't want to go to a Safehouse as she needed her family and friends around her and to work.

She asked that if they were happy for her to return to the house and get H to leave with the safety plan in place why couldn't they offer her a property in the area and put those same safety measures in place?

The IDVA explained that a Police Bobby Van referral could be made to look at the safety for her new property (she had already declined a referral at the caravan) and the information marker could be moved.

The Social Worker stated that CSC would not have an issue with C5 living in the caravan whilst Marie looked for another property.

The IDVA stated her concern that if H was likely to behave the way Marie expected him to, that was the reason that the Local Authority offered a refuge as a safety plan because the victim would not be in physical danger from the perpetrator as they would not know where they were.

Marie stated that she felt that H was getting away with his behaviour as she was the one who was being asked to leave and 'why couldn't the police lock him up?' It was explained that the police had taken no further action for the incident and they would not be involved unless there was another one.

This is why they had seen a solicitor regarding a NMO and an OO but Marie had not been able to follow this through as she would have had to pay a contribution to the Legal Aid fees.

The Social Worker suggested that Marie hand back her tenancy to her landlord as she could not afford to pay the rent, but her IDVA advised that she speak to a Housing Officer at the Local Authority first as she may be deemed to have made herself intentionally homeless.

A telephone call was made during the meeting to the Local Authority Housing Options Team who suggested that the duty housing officer be asked to join their meeting. As this was not possible to arrange in such a short time, the Social Worker also agreed to write a letter of support in the hope that the Local Authority would raise Marie's housing banding level up from Bronze.

It was however confirmed by the Housing Officer that Marie had already been told on the 18th of July 2014 that she should not give up her tenancy as she would be putting herself in a vulnerable position as she could be deemed to have made herself intentionally homeless.

Marie advised them both that she had attempted to complete a Homefinder application on-line, but was having difficulties accessing the system.

After the meeting, the IDVA confirmed all the details of their discussion with the CSC Social Worker, the Landlord case manager, and also sent a letter to the Local Authority Housing Options Team confirming that Marie was a high risk victim of DA and supporting a request to raise Marie's banding status to gold.

On the 2nd October, a Local Authority Housing Officer telephoned Marie's IDVA who confirmed that Marie needed to apply for an OO although this would have been very costly.

The IDVA also confirmed that Marie was staying in a caravan in a locked garden so felt safe and that she had declined the opportunity to go to a refuge as she was concerned about the costs. The Local Authority Housing Officer re-emphasised that they considered that she should go to a refuge.

On the 8th October, the Child and Family assessment was completed and recommended a strategy discussion to consider if the threshold had been met to convene an Initial Child Protection Conference (ICPC). This was held two days later on the 10th and an ICPC was agreed to ascertain if C5 could live with Marie and if not, could contact be arranged to take place in a public place.

Also on the 10th October, after a discussion with the Somerset Partnership MARAC lead, H's GP agreed to assess him and review his medication.

On the 17th October the Local Authority Housing Officer telephoned the IDVA and offered to meet with her and Marie. The Housing Officer re-emphasised that a refuge placement was Marie's best option to stay safe.

On the 20th, the Local Authority Housing Department received a letter from the CSC Social Worker, stating that H was not willing to leave the property and that he was fighting for his right to that property under family law.

Four days later on the 24th October, the LA Housing Officer called the CSC Social Worker and stated again that they considered the safest place for Marie was in a refuge whilst she sorted out her interests in the family home.

That same day, the Local Authority Housing Department called the IDVA stating that Marie could not go into gold band as she should take refuge accommodation. When this was conveyed to Marie, she agreed that a meeting with housing would be helpful.

Also on the 24th October, a Child and Family assessment was completed and C4 told Social Workers that they were very sad and upset about the current situation and was upset about not being allowed by dad to see mum after mum had left the family home.

C4 also said that their younger sister (C5) didn't feel safe when it was just dad at home and C4 wasn't there. C4 said that C5 was scared when Dad was drinking, but that he had stopped drinking at that time.

On the 29th October, Marie called the Local Authority Housing Options Team and stated that she would now be prepared to move out of the area (perhaps to another district of Somerset) and would also consider a property in the private rented sector.

That same day the ICPC was held and the decision was made for C5 to be subject to a Child Protection plan under the category of Emotional Abuse. Both Marie and H were present at the conference.

On the 31st October Marie spoke to the Local Authority Housing Officer by telephone and told her that she would have to quit her job as she would not be able to afford the cost of staying in a refuge.

She also said that she would need to pay for legal advice to fight for her tenancy at the family home because her income was too high, however she had no idea about how much this would cost. The Housing Officer asked Marie to find out the costs for this.

Marie said she was happy to now go out of the area but that she did not want to go to a Safehouse or a refuge.

On 6th November, Marie called her IDVA and told her that she was confused with the advice she had been given by the LA regarding giving up her tenancy and her intention to make herself homeless.

She stated that the LA Housing Officer had told her she could go into a Safehouse and still work, but she couldn't see how this was safe as H could follow her to it so was no safer than where she was at that time. She also would not be able to afford the cost of the fuel so this was not an option.

The Housing Officer had asked her to find out how much it would cost to obtain an Occupation Order as they may be able to help her with the cost. She was advised to contact the Solicitor and ask this information before they next met the following week.

Marie stated that the Housing Officer had placed her in Silver banding and it would take a long time to be rehoused as she was approximately about 50th on the list for some properties she was bidding on. She had also spoken to Shelter who told her that she technically could not make herself homeless as she was suffering domestic abuse.

With regard to CSC she stated that everything was staying the same and when she had a new home she could have her youngest child 3 nights a week. She felt that H was being patted on the back whilst she was still in the same position.

Marie's IDVA emailed the Local Authority Housing Department to organise a joint meeting and a date of 21.11.2014 was proposed.

On the 11th November, the BCHA Referrals coordinator sent an email to the IDVA stating that Marie's Member of Parliament had made contact as Marie felt she needed answers to questions about her case.

The IDVA contacted Marie who said that she didn't want help on that day but could they speak at the housing meeting and Marie asked if the IDVA could support her with the 'Help to Let' scheme.

The following day on the 12th, Marie contacted her IDVA stating that she could attend a housing meeting on the 21st and that, as she had received a letter from CSC, she had to secure some housing, so she had bid on two houses in the South Petherton area.

On the 13th, Marie's IDVA was informed by the Housing Department that the Housing Officer was on leave on the 21st so that meeting was no longer possible.

On the 18th, the IDVA spoke directly with the Housing Officer and rearranged the meeting to 25.11.2014 at 11.30am. She also informed the Housing Officer that Marie was no longer in receipt of Child Benefit and had received some legal advice which she would bring with her to the meeting. The Housing Options Team also said that they had spoken to Marie about deposit options in respect of renting property.

Also on the 18th the IDVA spoke with Marie who confirmed that she was looking at other deposit options and was taking a lease on a cottage as she could not stay in the caravan any longer.

She also said that she was very upset that she was still not being helped to move by the Local Authority Housing Department. She was feeling very frustrated that she was still in the same position that she was in when she moved out of the family home.

The IDVA tried to calm her and explained to her that the Local Authority had to follow their guidelines and that they would explain this when they met on the 25th.

Marie stated that she didn't want to move back into the house even for one night and this was what the Local Authority were suggesting. She had not heard from her MP recently and was feeling unsupported by the whole system.

She stated that CSC should be able to help her get a house as she knew of someone whose Social Worker had helped them to be rehoused.

On the 24th Marie advised her IDVA that she had now moved into the cottage and the Police had moved the information marker onto her new address[12].

The IDVA informed Marie that she was closing her file and referring her to the Domestic Abuse Outreach Service for further support and for a Pattern Changing Course which Marie agreed to.

Also on the 24th of November, the CSC first Core Group meeting following the ICPC (which was held on the 29th October) was cancelled due to Social Worker being unwell. It is noted that Core Group meetings should be held within 10 days of each other and the ICPC.

On the morning of the 25th November, the Local Authority Housing Officer telephoned Marie to say that she was unable to make their appointment at 11.30am due to a family emergency. The Officer had first attempted to schedule another colleague to take the meeting but, as this was not possible due to the short notice, she agreed to call again the following day to rearrange it. Unfortunately, when she recalled the following day, the line was so bad that Marie could not be heard so she said that she would make contact on a different day.

On the 29th November Marie called Police to report that she and H had separated in July, and she had moved to the cottage the previous day. Marie had made H aware that she had moved but had refused to tell him her new address, resulting in him calling her 8 times and sending a few text messages.

Due to history of domestic abuse, a Treat As Urgent (TAU) marker was placed on her address and a DASH form was completed. A referral was made to Victim Support, to CSC and also to Education. A Bobby Van referral was also offered to Marie but was not believed to have been taken up[13].

The police referral to CSC indicates that Marie would not disclose her new address to her estranged husband causing him to call her 8 times asking where she was living so that he would know that their child (C5) would be safe when staying at the address.

[12] The Independent Reviewer recognises that this agency identified the risks and Marie's needs and that appropriate actions were taken.

[13] The Independent Reviewer feels this was an appropriate offer by the police and unfortunate that Marie did not take this offer.

On the 4th December Marie is shown on the domestic abuse Outreach Services waiting list and was allocated an Outreach Worker. This originated from Marie being placed on the waiting list from her original call to the DAFFs line in June.

A CSC Core Group meeting was held on 4th December but it is recorded that only a Social Worker and C4 attended.

Confirmation is held within the BCHA records that the referrals to Outreach and Pattern Changing were sent on 5th December.

On the 9th December the Landlord case manager sent a letter to the Local Authority Housing Officer to confirm the status of Marie's tenancy and the conversations between them and requesting that she be given some priority on the housing register[14].

The case manager also called the IDVA who explained that Marie's case had now been closed to the IDVA service. The IDVA explained that although Marie had sought legal advice, she was unsure of the outcome. The Landlord case manager requested Marie's new telephone number which the IDVA said she would have to check before giving it to her.

On the 12th December a BCHA Outreach worker attempted to call Marie but her phone disconnected.

A second Core Group meeting was held on the 16th December but only a Social Worker, H and C1 attended.

On 19th December a threshold decision was made by the Somerset County Council Safeguarding Adults team manager for C2 to be accepted for Safeguarding measures. It was agreed that a formal strategy meeting was required as safeguarding concerns had been investigated and partly substantiated. The outcomes were completed, the police notified and a protection plan was agreed with increased monitoring.

The Outreach worker attempted to call Marie for the second time on the 20th December but the phone could not be connected. The Outreach Worker had read the case notes which stated that it was unsafe to write a letter. As she was unable to contact her by way of phone, it was decided to close the case and wait for Marie to re-contact the service[15].

On the 27th December Marie contacted police to say that since she had moved she had received many calls from H trying to find out her address[16]. She stated that H had been

[14] The Independent Reviewer recognises that this agency identified the risks and Marie's needs and that appropriate actions were taken.
[15] The Independent Reviewer is of the view that it is best practice for 3 attempts of contact to be made before closing the case. Could the service not have used another agency from the MARAC to gain successful contact with Marie?
[16] The Independent Reviewer believes it is unclear whether the police recognised this as stalking or harassment behaviour?

acting very strangely over the past couple of days, travelling up to Cumbria the previous day with the children and was already on his way back. His family in Cumbria had called her voicing their concerns for her safety and informing her that he was very unstable and since they had split up had been very 'low' again.

On the 31st December 2014, the IDVA prepared a referral for pattern changing and Outreach services. There is no evidence that any action was taken by IDVA or the Referrals Coordinator to process these referral forms.

2015 (ages of children: C1 = 24, C2 = 23, C3 = 21, C4 = 18, C5 = 11)

On the 5th January 2015, H was sent a Mental Health review appointment by his GP which he subsequently failed to respond to.

That same day a telephone conversation took place between the Local Authority Housing Officer and the Landlord case manager, stating that Marie's banding would remain the same unless she could provide Solicitor's confirmation that she could not exercise her right to her tenancy and that she was not eligible to Legal Aid. Both agreed that they had struggled to reach Marie in recent attempts and had not heard back from her.

On 12th January CSC held a 3-month review conference which both Marie and H attended. The recommendation was made that their youngest child remain subject to a Child Protection Plan under the category of emotional abuse.

On 23rd January the case manager emailed the IDVA requesting contact details for Marie as they were still struggling to get hold of her.

On the 30th January H contacted the Local Authority Housing Options Team for advice on his housing situation.

He stated that he had split up from his partner with no abusive relationship breakdown and that he was remaining at the house, was paying the rent and was attempting to clear the rent arrears.

He also said that he was worried that he would have to leave the property with his children as his name was not on the tenancy.

The Local Authority Housing Officer recalled H on the 2nd February and he told her he was concerned that his partner was ending the tenancy, but that he wished to stay there with two of his children (aged 10 years and 20 years).

The Housing Officer advised him that he was likely to have rights to the property under the Family Law Act and needed to get urgent legal advice in relation to this. He asked her to put this in writing for him as he was not very good at remembering things over the telephone.

The Housing Officer completed a Personal Housing Plan to send to him and advised him that she could speak to his landlord who was dealing with his case. H stated that he was unable to afford legal advice but would visit the Citizen's Advice Bureau.

On the 4th February CSC held a Core group meeting which was attended by Marie, a Social Worker and her youngest child's school.

On the 5th, H contacted the Local Authority Housing Options Team again and asked for a referral to the Citizen's Advice Bureau. He was told that referrals could only be made for debt issues and that he could attend a drop-in session at the CAB office.

The following day on the 6th February, an internal email was sent by the landlord to their accounts department asking for the tenancy of the family home to be reassigned to H once the arrears had been cleared. Information was recorded that Marie could not pursue the tenancy and an injunction through the Court, as she did not qualify for Legal Aid and that due to marital rights this was the only option she could pursue.

On 23rd, H called the Local Authority Housing Options Team again and said that he was paying the rent and the arrears to the landlord and that they would sign the tenancy over to him once the arrears (approximately £200) were paid off.

He stated that he had spoken to his ex-partner who was happy to sign the tenancy over to him and that the landlord had advised him that he had protection from eviction. He was advised where he could look to see if he was entitled to any benefit help with his rent.

On the 25th February the day before Marie's murder, H called CSC to tell them that his youngest child C5 was becoming very unsettled following contact with Marie. He claimed that Marie had a new partner and that C5 was being told by her not to say anything to him.

He described that C5 was now experiencing difficulty sleeping at night, and that C5 had started sleep walking. He stated he had spoken to C5's GP for advice.

He stated C5 was currently out of school. He was advised strongly to contact the school to explain the situation and also to enquire if they had noted any changes in C5's behaviour in school over the past few weeks.

CSC confirmed that they would pass the information on to C5's Social Worker who would also be able to raise this with Marie.

Later that same day H made a second call to CSC asking that it be recorded that 'C5 was doing well in school'.

At 7.41am on the fateful morning during February 2015, H called Marie on her mobile and asked her to look after C5 as C5 was unwell and would not be attending school. It is believed that Marie had then rung into school to say that C5 would be off sick that day.

Less than an hour later at 8.29am, police received a call from Ambulance to attend the address as Marie was collapsed in the garden with multiple stab wounds and a man, believed to be H, had made off from the scene in her car.

He was subsequently located after crashing the car and was arrested and taken to hospital with minor injuries.

A multi-agency strategy discussion was held and CSC records show that Marie had died from fatal knife wounds whilst C5 was asleep in the property at the time.

12. Analysis/ Findings

All the IMRs were carefully examined to ascertain if each of the agencies' contacts were appropriate and whether they acted in accordance with their set procedures and guidelines.

The IMR authors have followed the Review's Terms of Reference carefully and have been thorough, transparent and honest in completing their reviews.

The following is the Review Panel's opinion on the appropriateness of each of the agencies' interventions.

12.1 **Avon and Somerset Constabulary**

Avon and Somerset Constabulary had numerous contacts with the family over a period of many years mainly relating to family disputes and violence between themselves, and also with others outside the family[17].

Whilst the DHR Review Panel have examined in depth each police contact and incident involving Marie and her family, it must be noted that an Independent Police Complaints Commission investigation is currently ongoing and is not due to be concluded until after the finalisation of this Review.

Notwithstanding this parallel investigation, the following incidents of significance to domestic abuse have been analysed in more detail for the purposes of this Review:

01.05.2011

The police arrested H for assault on Marie. They also investigated potential common assaults on C3 and C4 who had been present, seeking to take statements from them. Whilst enquiries continued, the police bailed H conditionally and he was required to reside at his mother's address and have no contact with Marie, C3 or C4.

[17] The Independent Reviewer is unclear whether the police recognised this as domestic abuse.

Both C3 and C4 were interviewed. C4 would not make a complaint of assault against father (H) but would support mother (Marie). C3 made a statement but stated they would not give evidence against dad.

The Police completed a risk assessment (DASH) and rated the risk as Medium and also made a referral to CSC concerning domestic abuse in the household.

When H appeared before Magistrate's Court on 31.05.2011 charged with battery, it is believed that Marie no longer wished to pursue the offence and the case was withdrawn by the CPS.

The question has arisen as to whether the CPS could have progressed this case through judicial proceedings without the support of Marie and police response has been that this was not possible at the time of this incident due to 'victimless' prosecutions not being a consideration and no other supporting evidence being available[18].

It has been established however, that since 2005 the CPS had been engaged in a huge exercise to train prosecutors on Domestic Abuse. This training included early consideration of special measures and the use of witness summonses whereby the case relied solely on the victim's evidence.

In 2005/06 there existed 25 Specialist Domestic Violence Courts (SDVCs) nationally, who provided a specialist approach to dealing with domestic abuse cases. In 2011 these had increased to 143 including two in the Somerset area.

From 2009, due to seriously high attrition rates with 1 in 3 failed DV cases due to the victim failing to attend or retracting her evidence, prosecutors were advised to prepare cases on the assumption that a victim in the end may not support the prosecution.

This relied on the 'golden hour' approach of early evidence gathering so that evidence other than solely that of the victim could be used effectively. Evidence such as how did the victim look, any injuries observed, damage witnessed, the victim's demeanour, any neighbour/ witness accounts and recordings of the first call to police, was to be considered and used.

As the call to police in this incident was made by a friend of Marie's, it may be reasonable to assume that there may have been enough 'golden hour' evidence to have supported this prosecution through to its conclusion.

Additionally, as H was charged with an offence of battery on Marie and there is evidence in the crime report of special measures having been discussed, it is apparent that enough early evidence had been captured to enable the case to have been taken to Court.

[18] The Independent Reviewer recognises that there was consideration of this action by the IMR author.

It is noted however that the information held in police records did not reflect any injuries to C4, who at the time was a 15-year-old child. Neither the initial call log nor the crime report held any information as to C4 sustaining two black eyes whilst intervening in the dispute between mother and father.

Consequently, there are concerns in relation to the level of investigation, particularly as C4 was interviewed two days later on 03.05.2011, the same day Children's Social Care received a referral from C4's school stating that C4 had two black eyes.

06.05.2012

Police records suggest that they may have had the option to consider arresting H. The complaint was that he had threatened to break down the door before the arrival of the police. However, on their arrival they found him calm, but sitting in a car under the influence of alcohol. The officers chose to remove H from the scene by taking him to his mother's address.

As the vehicle was not on a road or public place, the only potential offences were over threats to commit damage or perhaps a Breach of the Peace. The police IMR notes that neither would have been easy to prosecute given how things were when they arrived at the scene.

A verbal threat to 'kick a door in' is insufficient to progress an investigation for threats to commit damage. Consequently, the decision to remove H from the scene was positive in that it also removed any current risk.

The initial DASH assessment was High Risk which should have escalated the incident to MARAC. However, when the officer from the specialist Domestic Abuse Investigation Team (DAIT), which was at that time in existence, spoke to Marie on 13th May 2012 (6 days after the incident), she downgraded the risk assessment, as Marie said there had been no further problems.

There is no recording of the rationale for downgrading the risk and this has been noted as a recording failure, particularly as the officer is no longer employed by the force and could not be consulted[19].

This has resulted in **Police Recommendation 2**

Despite the officer's expertise in the area of domestic abuse, it could be argued that contact made some 6 days after the event may well not provide the best risk information based on the benefit of time diffusing what was a highly emotive and aggressive situation at the time.

A referral was made to Children's Social Care concerning domestic abuse and this good practice has been regularly noted throughout many of the incidents recorded.

[19] The Independent Reviewer feels that this lesson learnt was correctly identified.

20.05.2012

The police IMR states that police attended and checked on the safety and welfare of the children and that Marie did not want any police action and signed an officer's note book to that effect. A DASH risk assessment was undertaken with a Medium Risk recorded and a referral was made to CSC.

The police IMR questions whether the threats to kick Marie to death unless she left the house within 7 days should have been considered a crime, even though she was unwilling to pursue a complaint. Dealing with the matter as an offence of harassment was, in theory, an option but impractical. Marie and N were in constant contact and often in dispute over their children.

The IMR analysis states that differentiating between criminal harassment and ongoing disagreement would have been near impossible and that, notwithstanding Marie's reluctance to take the matter further, the police still took action to try to protect her and her children by providing advice and support and making appropriate referrals.

It has become apparent however from information provided by Avon and Somerset Constabulary to the IPCC for their investigation that the police attended to speak to Marie at 7.50pm on 22.05.2012, two days after the initial call.

The delays in attending this call stemmed from a number of factors, including that the initial call to police was apparently made some 10 hours after the incident so the urgency had diminished, the police were encountering difficulties in resourcing the call due to another ongoing incident, and Marie herself delayed their attendance the following day due to work commitments.

In view of that information however, it can clearly be argued that the police cannot have checked the safety and welfare of the children in a timely manner and also that again, the passing of time and the de-escalation of the incident, had given Marie an opportunity to become unwilling to support any further police action[20].

07.10.2012

The police attended and found H asleep on a sofa[21]. Whilst the police were talking to C4 (then aged 15 years), Marie came back to the address, smelling of alcohol. Officers recorded that Marie was more concerned with what the officers would report to social services than the argument she and H had been involved in earlier.

[20] The Independent Reviewer supports this view.

[21] The Independent Reviewer queries whether there should have been an immediate referral to MARAC on the basis of repeated incidents, known history and offender known for violent behavior

From the wording of the call log and report it appears that the caller C4 was spoken to and was in order. It is not known if C5 had been present, asleep in bed due to the time of night, or if her welfare was checked as per the Constabulary's policy at that time.

As no offences were disclosed and all was calm, the police left. However, a referral was made to CSC concerning domestic abuse.

The police IMR concludes that this was an appropriate response from the police as no offences were disclosed and that the risk to children living in an environment of domestic abuse was recognised and acted upon, due to a supervisor ensuring that officers attended despite the request of the caller (C4) that police should not attend.

21.01.2013

The police IMR records an incident whereby Marie reported her handbag stolen whilst out in Glastonbury. The handbag was later found and the IMR suggests that her contact with the police over this incident could have been a missed opportunity to ascertain her current situation with H.

The IMR does recognise that, as it would be impractical to run database checks on everyone who contacts the police, this would have relied on both local knowledge by police officers or staff, and Marie revealing her history.

As no further information is known in relation to how Marie reported the incident or to whom, it is not possible to analyse this as a potential missed opportunity any further.

The recognition to explore each and every contact as an opportunity to gather intelligence has resulted in **Police Recommendation 1**.

13.06.2013

The police IMR states that police acted quickly and effectively to locate H and stopped him from harming himself (threatening to set light to himself) and that they used detainment for mental health assessment powers.

A DASH assessment of Medium Risk was made and a referral was made to both Children's and Adult Social Care.

However, following the check and test processes of the Review Panel, it has transpired that the arrest was actually made for an offence of Breach of the Peace which meant that once the offence had ceased then no further power to detain H existed, and therefore no Mental Health assessment was made.

Whilst H was detained in custody he was assessed as fit to detain by medical healthcare staff specifically commissioned to work within police detention facilities. He was also seen by a doctor who told the emergency duty team that he did not plan to refer H for a mental health assessment as he had stated that he had no intention to kill himself and that his

protest had been about a collapsed case (not against Marie) where he perceived himself to be the victim.

It is recorded within his custody record that H felt resentful and was a concern to others, particularly the police, and that he may require a psychiatric assessment and not an emergency mental health assessment.

As the police continued to have concerns about his mental health and they believed he required a mental health assessment, the custody Inspector referred him to the Somerset Partnership Court Assessment and Advisory Service (CAAS).

05.08.2014

The initial incident was reported to police at 9.44am and police attended, by which time H had left the scene in Marie's car.

Police arrested him later that day and investigated the offence of threats to kill, but were faced with no supporting evidence from neighbours and a denial from H. Consequently, the evidential tests were not met and, with no prosecution possible, H was released the following morning without charge.

Marie's brother B1 who had taken her to the address would say that H manipulated the situation so that Marie was chasing him around the garden trying to retrieve her keys whilst distraught and shouting, and that the view of witnesses had been skewed as to who was causing the problems. It was both his and Marie's belief that this was why there was no supporting evidence to proceed with any offence, particularly in light of the fact that the threats made to kill Marie were made solely within her earshot and before his arrival from waiting around the corner.

The police IMR questions whether there was an opportunity to have investigated this incident as one in a series of harassment. The IMR concluded that it was an option but impractical as Marie and H were necessarily in constant contact and often in dispute over their children.

Domestic Violence Prevention Notices and Orders were available at the time of this Incident having been introduced in the Constabulary area on 02.06.2014.

DVPNs and DVPOs were introduced to provide immediate protection to victims by enabling the police to immediately issue a DVPN to a perpetrator of domestic abuse requiring the suspected perpetrator not to contact the victim and, in cases where the perpetrator and the victim co-habit, excluding the perpetrator from the premises for 48 hours whilst a DVPO was applied for through the Court.

For a DVPN to be considered there has to be reasonable grounds for believing that the perpetrator has been violent towards or has threatened violence towards an associated person. On this occasion there was a recorded incident of violence threatened towards

Marie however there is no record of a DVPN having been considered which may have been down to the limited knowledge and experience of their use at the time[22].

A strategy discussion took place between the police and CSC and an Initial Child Protection Conference was agreed. The police Guardian intelligence database was also updated to reflect H's increasing controlling and threatening nature.

The IMR notes that police explored all the available options and shared information effectively.

17.08.2014

Police visited H at home following the call from Marie after he had taken their child (C2) out of the supported living placement. They warned him not to attend Marie's address and to seek legal advice if he had issues with her over access to their children.

No criminal offences were disclosed by H's actions in removing C2, but referrals were made to Children's and Adult Social Care.

The IMR reports that police might have considered a formal harassment warning or harassment notice procedures, but that process would have been incredibly difficult to manage given H and Marie's child access arrangements.

The 2009 guidance from the National Policing Improvement Agency is that although a warning notice may be useful in some circumstances, there is no requirement for issuing of Harassment warning notices to inform a suspect that their behaviour may be an offence and that they may be interpreted by the victim and/or suspect as a formal legal action.

The IMR further states that when Marie and H had disagreements relating to child access, it would have been near impossible to differentiate between harassment and simple disagreement. Consequently, the IMR concluded that the less formal approach was appropriate[23].

Although the content of the argument by way of text or in person is not recorded, this incident is the second within a period of 12 days in which H's behaviour was unwanted and has caused distress to Marie to the extent of calling the police. The formality of the warning given to H could therefore be questioned in respect of a course of action for harassment.

Despite the police view that Marie and H were 'necessarily in constant contact' for child access arrangements, it may have been appropriate for police to have considered more fully the legislation and guidance in respect of the Protection from Harassment Act (PHA) 1997

[22] The Independent Reviewer agrees entirely that this could have been an appropriate action by the police and that a recommendation should be made for greater awareness of these tools to help safeguard victims across the police force.
[23] The Independent Reviewer would agree that this was the appropriate approach.

(as amended by Protection of Freedoms Act 2012), as it is widely recognised that there are close associations between harassment and domestic abuse and that many offences of harassment are perpetrated against partners from a previous intimate relationship.

This legislation states it is necessary to prove a course of conduct amounting to harassment (Section 2) or stalking (Section 2a) or fear of violence (Section 4) or stalking which causes serious alarm or distress which has a substantial adverse effect on the victim (Section 4a), to which the perpetrator knows or ought to know amounts to harassment or stalking or fear of violence.

A course of conduct is conduct that occurs on at least two occasions and at the time of this reported incident, together with the incident of 05.08.2014, it could be considered that this requirement had been satisfied.

28.08.2014

Marie was discussed at MARAC. This is a Multi-Agency information sharing and Risk Assessment Conference which, on this occasion, was chaired by the Police MARAC coordinator and as such the information held has been included within the police IMR.

It should be noted that it is not standard practice for the MARAC coordinator to chair the MARAC and would only have occurred if the regular Police Inspector chair or the Deputy Chair were unavailable.

In summary the risks identified were:

Separation
Controlling behaviour
Emotional abuse
CP concerns
History of violence - H
Alcohol – H
Financial issues
Mental Health issues – H
Risk arson
Weapons
Escalation
Isolation
Housing issues – Marie's tenancy

The Actions raised from the meeting were:

1. Establish whether H was a suitable person to care for the children (Action owner CSC with an update that ICPC to be held).

2. Discuss with Marie her housing needs and her future intentions regarding the children and feed back to CSC. (Action owner IDVA)

3. Look at way to re-instate her at the family home. (Action owner IDVA).

4. Establish details of the child (C2) that was taken out of care home and relay to ASC for appropriate action. (Action owner IDVA/ Adult Social Care).

5. Request H's GP records were flagged re seeking support for MH/alcohol needs. (Somerset Partnership).

6. Establish whether there had been a recent referral regarding H for MH. (Somerset Partnership).

The MARAC minutes recorded that Action 4 was completed by the IDVA on the same day 28.08.2014, when the information regarding C2 was passed onto ASC who had arranged a safeguarding meeting for 02.09.2104 to support C2 with making the decision about where they wanted to live.

Actions 2 and 3 by the IDVA were updated on 19.09.2014 when minutes recorded that Marie had spoken to her landlord regarding their support around her tenancy and had had legal advice regarding her housing from her Solicitor who informed her that H had some rights to occupy even though the tenancy was in her name. Marie stated that she would like to move via a mutual exchange as she didn't feel able to return to the property, although she wished to remain in the area. Marie advised that H had told her he would leave the property so that she can return but he had not given her any date as to when he intended to leave. She had also completed a Homefinder Application in her sole name. The IDVA also updated that she had been in contact with CSC regarding Marie.

Actions 5 and 6 were updated on 04.09.2014 and 12.09.2014 where it is recorded that contact had been made with H's GP surgery by telephone and letter informing them that he had been discussed at MARAC following an incident of High Risk and this could impact on his mental health.

There is no update recorded on MARAC minutes in respect of Action 1, although it is known that CSC were already aware and involved with the family.

Although there is a process for updating and recording actions completed, there appears to be no process for MARAC to follow up and review outstanding actions without each case being brought back, something which did not occur with Marie's case[24].

Whilst the MARAC commentary is recorded within the Avon and Somerset Police IMR and actions are the responsibility of each individual organisation it has been agreed by the Review Panel that the actions set were vague and not SMART enough to have been readily and specifically achieved.

[24] The Independent Reviewer would highly recommend that this is considered, as well as the timeliness of action owners reporting back to MARAC on their completion of actions.

Although it is recognised that the capacity of MARACs is overwhelmed due to the number of referrals to be discussed, it may be appropriate for the police MARAC coordinator to devise and implement a checking process in respect of actions set to ensure timely responses to prevent re-victimisation.

29.11.2014

An officer attended and spoke to Marie at her new address. She said she had been separated from H since July 2014 and had just moved to the address and she reported that she had received eight calls from H asking where she was living so he would know where their child C5 was when the child visited. She had also received a number of text messages.

The police call log indicates that the phone calls were of a different nature to the text messages which she felt were sent to cover his tracks. She stated she was afraid that he was going to turn up at the address and hurt her.

The attending officer arranged for a marker to be placed on her new address to treat calls as urgent. The officer also gave safety advice and completed a DASH risk assessment which was Medium Risk. A referral was also made to Children's Social Care.

It is understood that the officer also advised Marie to consider revealing her address to her estranged husband. Considering she had very recently moved to this address and was scared of his actions should he turn up, the officer's decision to advise her to consider disclosing this information was questionable.

It would also appear that no consideration was made in relation to speaking to H regarding his text messages or phone calls, the content of which Marie had written down.

Consideration should also have been given to whether this could have been re-classified to a crime of harassment particularly with the history of calls in the previous few months, and also whether, due to the violent domestic history of the couple with Marie being scared H may turn up and hurt her, a DVPN could have been applied for in order to protect her.

The police IMR notes that the action taken should have been more robust and the described additional safety measures, including a re-referral to MARAC, should have been considered for Marie and her youngest child[25].

The IPCC are considering this incident as part of their investigation as to whether any subject has a case to answer for misconduct or gross misconduct.

[25] The Independent Reviewer believes that the IMR was undertaken thoroughly and lessons were drawn out appropriately.

12.2 **Somerset County Council Children's Social Care**

Children's Social Care records of contact with the family date back to 1991, the year that C1 was born. Initial contact is not believed to be in respect of any CSC concerns but from a request for Occupational Therapy support for C1 following birth.

During the year 2006 records show that both police and family made contact with CSC with regards to managing C1's increasingly challenging behaviour. C1 was aged 15 at that time.

From records it would appear that little support other than signposting was offered to the family and it is noted on the CSC IMR that the younger children would have been witness to arguments and aggression that had taken place. However, it has not been possible to determine from what were then paper records, exactly what the children were seeing and hearing, nor H's role in their parenting.

01.05.2011

CSC received a referral from police regarding the physical assault on Marie by H. Two days later on 03.05.2011, CSC received a referral from school stating that C4 had sustained two black eyes during the dispute.

An Initial Assessment was completed however, the CSC decision was made for no further action as H was no longer in the house and 'ordered' not have contact with the family for two weeks, through his police bail conditions.

06.05.2012

CSC received a report from police where H was described as being under the influence of alcohol, both wanted to end the relationship and Marie was frightened regarding H's propensity for violence and abuse.

An Initial Assessment was completed by CSC, but again the decision was made for no further action as H was no longer in the household[26].

[26] The Independent Reviewer is of the view that domestic abuse was not understood here-in as far as they believed the location of the perpetrator from the victim was what determined the risk- which is not the case in abusive relationships. The Independent Reviewer does not believe that the following was understood by this agency; The Adoption and Children Act 2002 extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic abuse/violence can have serious implications for children's development.

20.05.2012

Police referred the incident where H had threatened to kick Marie to death unless she left the house within 7 days.

CSC completed an Initial Assessment and again the decision was made for no further action as H was no longer in the household.

For each of the three referrals listed above, the IMR author considered that Children's Social Care was too optimistic that H would remain living outside the family home and would not have contact with the family, and that conferences should have been arranged in order to share information and assess risks.

The decisions to take no further action in each case have been seen as missed opportunities to get a better understanding of the family dynamics, to understand what the children were saying and to prevent and protect Marie and the children from other incidents.

This has resulted in **CSC Recommendation 2 and LSCB Recommendations 1 and 2.**

01.07.2012

Police notified CSC that H had returned to the family home and they referred an incident whereby he had been involved in a fight at 2.30am with a person who was not a member of the family. The referral was made due to both his children, then aged 14 and 7, being present.

This did trigger a Core Assessment which was completed on 16.08.2012 and was progressed to a Child in Need meeting which suggested that the family access services including a perpetrator's programme for H provided by BCHA and support for him through Turning Point Alcohol services. It also recommended that Marie be referred for domestic abuse outreach work to help her consider the level of risk within her relationship and to help her stay safe.

The family did not take up the suggested provision and the case remained open with CSC as a 'Child in Need' as defined by Section 17 of the Children Act 1989 where there was no suspected actual or likely significant harm. There are no further records of what actions were taken by CSC in respect of this open 'Child in Need' case.

07.10.2012

CSC received a police referral of a verbal argument between Marie and H which had been reported by C4, who was now aged 15 years.

Although it is believed that CSC conducted a home visit following this incident, there is no further update provided in respect of this referral except for a chronology record stating that the case was closed on 08.02.2013.

No records have been provided as to any contact or actions with the family, particularly in respect of the 'Child in Need', during the intervening four-month period from the last referred incident on 07.10.2012 to its case closure.

It is reasonable to conclude that following a series of referrals from police regarding domestic abuse within the household during that five-month period, that more information should have been recorded and subsequently provided to the DHR process. This is particularly so, in respect of what actions may or may not have been taken, and any rationale behind those decisions[27].

This has resulted in **CSC Recommendation 1.**

13.06.2013

Police referred a serious incident to CSC involving H dousing himself in lighter fluid and attempting to ignite a lighter.

This triggered the completion of an Initial Assessment in respect of C4 and C5 and on 16.08.2013 a Child and Family Assessment was completed, which identified a safety plan based on support rather than protection.

The fortnightly visits decreed by this safety plan were to be undertaken by a Senior Social Work Assistant (SSWA) and the IMR author indicates that, given the serious nature of the incident, a Social Worker should have undertaken the visits. It is also noted that the plan needed to be SMARTer and address the areas of risk including the escalating worries, and that a multi-agency and a strategy discussion was needed.

It transpired that after this safety plan had been set, there had been a number of telephone calls to establish if the family had engaged with various support services, but no physical visits had been made by CSC between June and September 2013[28].

This conflicts with information on the IMR which states that, after *'a further two visits'* the case was closed on 17.04.2014 and the families' involvement with CSC was ended with the view that *'things had settled down since October 2013.'* It was however noted that after this case closure, C4 and C5 could be supported through universal services.

This information was not well recorded and it appears that the evidence to close the case was not based on a comprehensive assessment, merely on the basis of no further calls having been received.

This has resulted in **Recommendations 1 and 3.**

[27] The Independent Reviewer agrees entirely with this statement.
[28] The Independent Reviewer was unsure whether as part of the IMR- the level of support offered to the family was discussed to establish whether what was offered sufficed?

05.08.2014

CSC received another referral from the police when H told Marie that she had until 1730 to move back in or else 'I'LL KILL YOU.'

An Initial Assessment was completed and a Multi-Agency Safeguarding Hub (MASH) discussion took place the following day, where CSC agreed to call Marie to ensure she had a safety plan in place. However, as Marie was away at that time, a CSC Social Worker spoke with her IDVA and agreed to arrange to appoint another Social Worker to find out C5's wishes.

Two months later, on 08.10.2014 and triggered by this incident, a Child and Family assessment was completed recommending a strategy discussion to consider if the threshold had been met to hold an Initial Child Protection Conference (ICPC).

The strategy discussion was held two days later on 10.10.2014 and the decision was made to hold an ICPC to determine if C5 should live with their mother and if not, could child contact occur in a public place.

This ICPC was held on 29.10.2014 and the conference heard that C5 was frightened of father and was worried when he was drinking alcohol. The outcome was that C5 was to be subject to a Child Protection Plan under the category of Emotional Abuse.

Both Marie and H were at the conference and a safety plan was made focusing mainly on telling the parents not to behave in certain ways i.e. 'H will not physically or emotionally threaten Marie, nor will she threaten him. If this occurs, they will feed back to the allocated Social Worker immediately. They will not argue and H will not threaten to take his own life.'

The plan did, however, recommend that the Social Worker was to complete an assessment about risks to C5 and contact and residence arrangements.

It is not known why this 'trigger' did not occur until two months after the incident particularly as the following took place during the intervening time:

17.08.2014

CSC received another notification from the police of an incident involving a further argument via text between Marie and H, after he had removed their 22-year-old child from supported living accommodation.

26.08.2014

The CSC Social Worker completed a CAADA MARAC Research Form with Marie and correctly identified that H's behaviour had changed and that he was now using the contact arrangements for C5 as another way to control Marie.

The Social Worker also questioned the emotional harm this may cause C5. Furthermore, she identified 'this could be viewed as an escalation of the domestic abuse.' Marie was frustrated about being given advice about moving away, as she wanted to maintain her support links and to keep her job.

24.11.2014

A first Core Group meeting was cancelled due to a Social Worker being unwell.

Further Core Group meetings were held on 04.12.2014 whereby only a Social Worker and C4 attended, and on 16.12.2014 where only a Social Worker, H and C1 attended.

HM Government Safeguarding Children guidelines outline that Core Group meetings should be multi-agency based and include family members and professionals who have direct contact with the family. The first Core group meeting should be held within 10 working days of the ICPC and its purpose is to 'flesh' out the Child Protection Plan and decide on what steps need to be taken.

Even though the first Core group meeting had to be cancelled due to illness, this had been arranged nearly one month after the ICPC and therefore did not meet Government guidelines. There has been no explanation as to why this did not take place within the correct timeframe[29].

Children's Social Care needs to review the timeliness and effectiveness of Core groups to ensure that they meet Government guidelines for the prompt identification and actions to address risks to children on Child Protection Plans[30].

This has resulted in CSC **Recommendation 4.**

29.11.2014

CSC received a police referral in relation to H calling and texting Marie asking for her new address and using C5 as an excuse to gain this information.

There is no recorded information as to whether CSC took any action with regards to this referral.

[29] The Independent Reviewer is in agreement with the IMR author whom was right to highlight this point.
[30] The Independent Reviewer is also of the view that this could have provided more opportunities to engage with Marie.

12.01.2015

A 3-month Review Conference was held and Marie and H both attended. The decision was made that C5 remain subject to the Child Protection Plan under the category of Emotional Abuse.

Records show that the second safety plan from this Review Conference was a duplication of the safety plan made at the first on 29.10.2014. It was also recorded on the Conference outcome notes that 'no Core Group meetings had been held since the last CP Conference' although this clearly was not correct as two Core Group meetings had been recorded on the Children's Social Care LCS recording system and one other meeting had been cancelled.

Overall, the issues in relation to accurate recording of information and actions by CSC staff has been apparent from the conflicting and sometimes lack of information provided to the DHR process. This has made it quite difficult to ascertain a clear flow of action and decisions undertaken in respect of specific incidents and concerns relating to a child living in a household experiencing domestic abuse.

Concise recording of information by Children's Social Care was a notable issue of concern throughout this particular DHR and this has resulted in **Recommendation 1.**

25.02.2015

The day before Marie's murder, H called CSC and reported that C5 was becoming very unsettled after contact with mother.

CSC confirmed that they would pass the information onto C5's Social Worker.

26.02.2015

On the day of Marie's murder, CSC were informed by C5's school that C5 was off sick and that Marie had rung in to report this.

Due to the proximity of the two above calls to Marie's murder, no further action had been instigated by CSC in respect of the information received.

12.3 **Somerset County Council Adult Social Care**

Marie and H's child, C2, was a young adult of 22 at the time of Marie's death. C2 had learning disabilities and Down's Syndrome. C2 had previously been living successfully at a residential college placement arranged by Children's Services. At the age of 18 C2's case was transferred to the Adult Learning Disability Team and the Social Worker arranged for C2 to move when C2's college placement ended.

C2's Social Worker assisted C2 to move into supported living accommodation close to where parents lived. C2 had 24 hour support provided by Mencap and also attended local day and social activities five days a week. The Social Worker liaised closely with Marie over C2's welfare and day-to-day arrangements. This liaison had never involved H as the Social Worker understood that he was busy with work commitments.

The Social Worker recorded in detail her involvement and work with C2 on SCC's client database system, Adult Information System (AIS). There are detailed records for C2 from 2011 to-date. There is no reference to any knowledge of the domestic and emotional abuse experienced by Marie up until the entries of August 2014.

The most significant contacts during the period of the Terms of Reference for this review are as follows:

17.08.2014

H collected C2 from their supported living placement to go out for the day, then telephoned to say that he would not be returning C2 as C2 was not happy living there.

Concern was immediately raised as the home manager understood C2 to be very happy in the accommodation and an incident report was provided to C2's ASC Social Worker.

18.08.2014

C2's Social Worker spoke with Marie on the telephone who disclosed a 25-year history of domestic abuse from H and that she had left him in July. Marie stated that she believed it was an attempt for H to use C2 as leverage to get her to return to the family home.

C2's Social Worker phoned Children's Social Care who advised that on 08.08.2014 there had been an incident reported to the police where H had threatened to kill Marie. It is noted that this incident of the 8th was not reported to the Learning Disability Team at the time.

Had the Learning Disability Team been made aware of the events of the 8th August and been included in the multi-agency discussion that is known to have then taken place, there may have been some discussion and evaluation of the prospect of H taking his child (a vulnerable adult) out for the planned day trip out ten days later. In the event, H's plan was to pick C2

up and seemingly use them, by refusing to return C2 to C2's own home, in an attempt to get Marie to return to their family home. This was certainly Marie's expressed belief[31].

The concerns of C2's home manager to Adult Social Care, Children's Social Care and the Community Team for Adults with Learning Disabilities (CTALD) was appropriately and expediently raised.

Marie's disclosure of domestic abuse was not recorded within her AIS file[32] and, as AIS functionality allows for case notes to be linked to other AIS case records, this information was therefore not linked to C2's file, something which may have been crucial in determining any levels of risk posed to them from living with H. At this stage it was not possible to have predicted that C2 was at risk of being used, as the risks posed by H were not known.

This has resulted in **ASC Recommendation 1.**

19.08.2014

The Community Team for Adults with Learning Disabilities (CTALD) confirmed that they could not remove C2 from father's house under any safeguarding process and that this could only be achieved through the Court of Protection. A letter was sent to H inviting him for a meeting to discuss C2's accommodation.

On the same day C2's Social Worker telephoned Marie who stated that she did not want to go to a safe house 40 miles away and she did not want to leave her job and her family. She said that she was taking advice from Housing and a Solicitor and her IDVA.

This information was not linked to Marie's AIS file.

Although efforts were made by the CTALD to safeguard C2's freedoms once he was living with his father, they do not appear to have been effective and did not recognise that C2 was also a victim of coercion and control.

The view was that C2 was unable to comprehend the real dynamics of the situation and that they were being used, and it was against their previously expressed wishes of living independently of the family.

It also does not appear that any legal advice was sought from the Somerset County Council legal team as a result of a vulnerable adult being removed from their home.

This has resulted in **ASC Recommendations 2 and 3**.

21.08.2014

[31] The Independent Reviewer believes this is a valid point and the lack of information being shared could have assisted the multi-agency response to this family.
[32] Same point as above.

Adult Social Care received a police referral relating to the incident on 17.08.2014 where H had removed C2 and had visited Marie at the caravan. This was reported as a High Risk domestic incident.

Again, this report was not linked to Marie's AIS file.

Marie telephoned C2's Social Worker expressing frustration with the situation, including that the police had advised her that she should not have contact with H. This is noted as being difficult due to the on-going contact with their youngest child who was at the time living with H.

26.08.2014

Marie emailed C2's ASC Social Worker giving an update of events and contact with H and also expressed her concerns about C2 being emotionally and psychologically abused by him.

Comments on the integrated chronology relating to the incident whereby H had said to C2 in Marie's presence 'You like living with me don't you?', indicates that C2's Social Worker had concerns about the degree of coercion and control that C2 was being subjected to by H.

Although these concerns have been identified as a result of the Review process, there is no information to show that ASC had made any personal contact or visits to assess C2's welfare whilst C2 was staying with H. C2's Social Worker did however visit C2 whilst C2 was at day care activities, but this did not appear to alter any strategy in respect of the concerns identified.

28.08.2014

As a result of the letter sent on 19.08.2014, a meeting took place between H, C2's Social Worker and a CTALD team manager where H stated he planned to keep C2 at the family home but agreed that he could return to his day care provision. It is recorded that H kept his fists clenched throughout the meeting.

29.08.2014

Marie telephoned C2's Social Worker and discussed H's continuing unpredictability, including that he was "being nice at the moment" to encourage her to return.

Adult Social Care received a more detailed police referral relating to C2's removal from the home following the MARAC which took place the previous day. This noted that the extent of H's previous convictions and potential for violent behaviour had become clearer and a strategy meeting was requested for 02.09.2014.

This multi-agency strategy meeting was to include police, IDVA, an advocate and representatives from the two service providers for C2's care, however it is not known if this took place and there appears to be no outcome recorded.

This has resulted in **ASC Recommendations 4 and 6.**

01.09.2014

Following the information received from the MARAC, C2's ASC Social Worker emailed her line manager expressing concerns for her personal welfare when meeting H due to his observed responses at the previous face-to-face meeting held on 28.08.2014.

As a result, at a CTALD team meeting held on 03.09.2014, staff were instructed that H was only to be seen by two members of staff and in a public place.

This has resulted in **ASC Recommendation 5.**

05.09.2014

The CTALD team received a phone call from H stating that he would return C2 to their supported living home on either the 5th or 6th September.

19.12.2014

The original Safeguarding Adults Referral Record (K form) was started on 21.08.2014 detailing concerns that H had taken C2 out and was refusing to return C2 home. However, the Safeguarding Adults threshold decision to accept C2 as a safeguarding case was made on 19.12.2014, four months after the safeguarding referral was done.
It is clear in the August 2014 records that it had been agreed that a formal strategy meeting should be held, however, a record on AIS shows that the production of the minutes from this meeting was delayed. In the event, there is no record on AIS of the strategy meeting minutes in respect of C2 being taken by father (H).

Equally, there is no record of a protection plan, despite concerns recorded about whether C2 was able to freely consent to leaving own home, and the level of coercion and control C2 was subject to as a vulnerable adult from father.

In addition, there is no record of any legal advice having been sought over how to protect C2's rights, given the actions of father (H) and what legal remedies would have been available e.g. urgent referral to the Court of Protection.

02.01.2015

The Adult Social Care Learning Disabilities Social Worker was advised by C2's supported living provider that C2 had returned from father's after a stay for the Christmas period. C2 returned covered in eczema and there were concerns that C2's prescribed skin creams had not been used. Concerns were also raised due to C2's disclosure that they had been drinking with dad.

It is noted that C2's Social Worker would discuss this with Marie, but no further outcome is recorded.

This has resulted in **ASC Recommendations 1, 6 and 7[33].**

12.4 **Somerset Partnership NHS Foundation Trust (Sompar)**

Prior to the date specified in the terms of reference for this DHR, H had self-referred to mental health services in Somerset in April 2004 after his release from prison when he requested a mental health outpatient appointment. At that point he was known to mental health services as a patient with personality difficulties, history of suspected mixed anxiety/depressive disorder and alcohol dependency problems. He had a history of traumatic past with subsequent criminal behaviour.

An appointment was offered in April 2004 which H failed to attend. As a result, he was discharged from mental health services until November 2006.

30.11.2006

H was referred to Somerset Partnership Alcohol Team by his GP. The referral stated that H had a history of alcohol and cannabis problems.

H was offered an assessment by a Consultant Psychiatrist who documented that he reported a stable family life. Risk assessments were completed electronically and the screening indicated no apparent risk to children or of suicide and a low risk of misusing drugs and alcohol.

H was prescribed medication and offered a further review four weeks later to which he failed to attend. When contacted by the Consultant by telephone H stated he did not wish to be seen again as a result he was discharged from secondary mental health services in May 2007.

23.05.2011

Sompar records reflect contact from the Yeovil District Hospital NHS Foundation Trust (YDH) informing the local Community and Mental Health Team (CMHT) that H had taken an overdose on 21.05. 2011 following a split from his wife three weeks previously.

CMHT contacted the hospital to seek further information and were informed that H had taken a significant number of paracetamol believed to be in excess of 96 and had been admitted to the wards. During the admission he had stated it was not a suicide attempt but that he had taken the paracetamol as he wanted to sleep and he self-discharged the following day. A referral from the hospital was not received by mental health services during

[33] The Independent Reviewer believes that the Review has highlighted a number of lessons learnt and adequate recommendations.

this admission, therefore secondary mental health services were not provided to H at this time.

14.06.2013

Police shared information with the Local Authority Somerset Direct, the provider for both Children and Adult Social Care services, that H had been arrested after dousing himself with lighter fluid and attempting to ignite a lighter. Somerset Direct contacted Sompar Safeguarding Adults Team who requested that the local CMHT review the case and consider making contact with H for assessment. On 18.06.2013 CMHT sent a letter to H inviting him for assessment.

At the same time the Police also referred H to the Sompar's Court Assessment and Advisory Service (CAAS) as they had concerns regarding his mental health in custody and the doctor who saw H whilst he was detained did not make a mental health referral, something the police believed he needed.

CAAS agreed to offer an assessment on the 27.06.2013 when H was due to appear in Court and it was agreed that CMHT would send a letter to H to offer an appointment prior to his Court date.

H received the letter but did not attend the offered CMHT appointment, telling the CAAS Social Worker on his Court date that he did not have mental health problems and did not need an assessment. At this time, he was accompanied by C4 who, notes state, was supportive and appeared not to have any particular concerns about her father.

Electronic records indicate that CAAS completed the forensic assessments but did not electronically record comprehensive risk alerts, screening and information. This could be as a result of domestic abuse assessment not being part of electronic risk screening and consequently staff not being prompted historically to consider whether it is a contributing factor to risk assessment.

CAAS are well placed to complete risk screening and assessment of patients charged with offences whom they offer mental health assessment to. Completion of the risk alert, risk screen and information forms would have promoted effective internal information sharing, risk management and have informed professionals to consider the need for safeguarding referral[34].

This has resulted in Sompar **Recommendations 1, 2 and 3**.

06.08.2014

Sompar Safeguarding Children's Team were made aware of H's threats to kill his wife and the case was to be discussed at the Multi Agency Risk Assessment Conference (MARAC).

[34] The Independent Reviewer strongly agrees with this statement.

Sompar's MARAC Lead attended the MARAC on 28.08.2014 where a recommendation was given to the Trust to inform H's GP of recent circumstances and the MARAC referral. This action was completed on 12.09.2014 by way of written correspondence and telephone discussion with H's GP.

No further contact was had by the Trust prior to Marie's death on 26.02.2015.

Although the Sompar Safeguarding Children Team were aware of high risk domestic violence and abuse within the family prior to the MARAC, there is no record to evidence information sharing with the Sompar Adult Safeguarding Team or consideration of a Safeguarding Adult's referral.

This has resulted in Sompar **Recommendations 4**, **5 and 6.**

12.5 **Clinical Commissioning Group**

In general, there exists a vast amount of information relating to contacts by H, Marie and their family with their GP surgery and the narrative chronology provides the history of the health care provided by primary care services.

The following have been analysed in more detail owing to their significance to domestic abuse or the mental health of H or Marie:

H contacts

19.01.2006

Records show that H was awaiting a court attendance re aggressive behaviour towards police, following arrest with the victim suffering a bloody nose. He was currently not working and taking anti-depressants, and he stated at that time that he was not using cannabis. There was no further reference to this in the records with the focus in the following six months on his need to apply for a driving licence every twelve months.

30.11.2006

H's GP refers him by way of letter to Alcohol services due to his cravings for alcohol. The letter states that H has a history of alcohol and cannabis problems and a diagnosis of personality disorder. No further information is available with regards to this diagnosis.

29.12.2006

Letter received by GP from Consultant Psychiatrist stating that H enjoyed a stable family life with his wife and five children. Risk screening indicated no apparent risk to children or of suicide and low risk of misusing drugs and alcohol. Medication was prescribed and a review was arranged for 4 weeks' time.

2007

During 2007 H attended three chronic anxiety reviews with his GP and failed to appear for a fourth. During one review on 26.07.2007 he stated that he had given up work as he didn't feel well enough but that he was finding medication helpful.

04.08.2008

H reported to his GP that he had an alcohol problem and was drinking 4 litres of cider daily. No further information has been provided with regards to any action taken by the GP.

2009

During 2009 H attended three chronic anxiety reviews and of note he reported on 16.09.2009 that 'he can be evil' in terms of his temper and his medication was increased.

This disclosure was rightly explored to ascertain if there were any risks of self-harm or harm to others. There is however, no comment of any impact on his family or social history.

2010

H failed to attend two chronic anxiety reviews but when he attended a third on 03.11.2010 he asked the GP to send a letter to DVLA as he could not understand why they were saying that he had a mental illness. No further information has been provided with regards to any action taken by the GP or where the DVLA information regarding mental illness originated.

21.05.2011

A referral was received at the GP surgery relating to H's apparent overdose of 120 paracetemol tablets and his admission to A&E.

Although the GP made attempts to make telephone contact, H recalled the surgery and spoke to the GP on 26.05.2011 and stated that he was working in Wales every day, but 'felt better in self'. He was encouraged to attend the surgery if feeling low, to which he made it clear that he wished to only have appointments with this same GP.

For the most part this continuity was maintained and when he was seen in September 2011 he stated that he had taken the overdose as he could not sleep, not because he was suicidal. Attendance continued as part of his regular chronic anxiety reviews and his medication was amended accordingly.

2012

H attended three chronic anxiety reviews each stating that he was feeling fine, his mood had improved, he was well controlled if taking his medication and he had no suicidal thoughts or thoughts to hurt others.

18.06.2013

H attended a chronic anxiety review with his GP where he disclosed that he had attempted to set himself alight on 13.06.2013. He stated that he was no longer suicidal and agreed to increase his medication.

It would appear that this disclosure was made directly to the GP and that the surgery had not received any formal referral from any other agency despite the fact that the police, Sompar Adult Safeguarding team and Community Mental Health services and Children's Social Care had all been involved.

2014

It would appear that H had no chronic anxiety reviews during 2014 and only one contact with his GP on 21.07.2014 stating that he had a craving for alcohol and was requesting Anabuse. He was advised to contact Somerset's alcohol services.

The advice given to self-refer is questionable taken in context with H's history of depression and self-harm and it may have been more appropriate for an appointment to have been made for further discussion resulting in a formal referral being made to alcohol services[35].

12.09.2014

H's GP surgery received a letter from Sompar Adult Safeguarding team advising that H had been involved in a High Risk domestic incident against Marie and that they had been discussed at MARAC and that this could impact on H's health.

The surgery called the Adult Safeguarding team for further information and it was confirmed that Marie had called the police.

A domestic abuse alert was put on the records and it is noted that the GP was going to call H in for a medicine review. No further information has been provided with regards to any action taken by the GP or any outcome.

05.01.2015

H was sent an invite for a mental health monitoring review on 04.02.2015 which he subsequently failed to attend.

[35] The Independent Reviewer strongly agrees with this statement.

Marie contacts

19.07.2006

Marie presented to the GP with feelings of low mood, depressed thoughts and insomnia. She stated that this had been for the last six months and it is of note that it coincided with her partner's arrest and pending court attendance.

In seeing a different GP to H there was not perhaps an opportunity to consider the impact on the family and perhaps a missed opportunity to explore her comment that her partner was 'partly supportive'.

Over the next few months Marie attended her reviews and although with medication appeared to be feeling better, she was given the opportunity to access counselling as she 'had a lot on her plate'.

There is no evidence of exploration of issues in her family life and as she attended only two of the six counselling sessions, through non-attendance and cancelling rearranged sessions, there was little opportunity to provide adequate support. She is later seen to comment that she had not found the sessions helpful.

31.07.2007

Marie attended the GP surgery reporting depression through the death of close friend through cancer a month previously and that she was struggling at home, tired all the time, tearful mood swings, and her friend's daughter needed her support as well.

She was prescribed medication to be reviewed a month later.

Although H had had a number of GP contacts by this time, there does not appear to be any record of Marie being asked about her relationship with her partner or of any support available.

17.08.2010

Marie attended the surgery reporting low and finding life stressful managing five children, and although no thoughts of self-harm, she viewed the future as bleak. Counseling had not been previously helpful and she was prescribed anti-depressants. There is however no record of her relationship with her partner or of support or that she was asked about this. available.

16.02.2011

Six months after her previous appointment, Marie attended again and was seen by a different GP and noted to have low mood with no thoughts of self-harm.

Again there is no documentation of social history being recorded and managing the demands of a large family.

From October 2012 – 2014 it is recorded that Marie was giving considerable support to one of her children who was suffering from depression. It is recorded that she was supporting their attendance at the GP, encouraging them to rest, to eat meals and often ringing the surgery on their behalf when she was concerned.

During this time Marie also attended the surgery for minor ailments and routine appointments.

There is no record of any social history having been discussed during these attendances which could be considered as missed opportunities that may have provided some insight into the family dynamics or any partner problems.

Analysis

In general, H showed a lack of concern in either his non-attendance or using emergency appointments for repeat prescription or minor concerns, however despite a number of failures to appear for booked appointments, he was attending on a regular basis for review of his emotional and mental health during the time period relevant to this review.

The family had all been registered with the practice for more than nine years preceding the time of the incident. Although well known to the surgery staff, it is of note that no less than sixteen GPs provided consultations for the family members.

Both Marie and H received consultations from eight GPs, with only two seeing both partners giving little opportunity to see the relationship in its entirety. Since his paracetamol overdose in 2011, H made a concerted effort to see the same GP, but his problems were reviewed in isolation and not in the context of family life.

Consultations with different GPs is not unusual for a busy practice but does give heavy reliance for the need for high-quality record keeping and that all records of attendance are fully comprehensive with clear outcomes of the presenting problem and forward planning for future appointments, where relevant. On most occasions there is little record of social or family history having been asked or recorded for Marie or H.

This has resulted in CCG **Recommendations 1 and 2**.

There is no evidence that practitioners had an awareness of domestic abuse during the consultations, nor was there any disclosure. Depressive illness has a significant impact on partners, but particularly children and there was no documentation supporting seeing the child behind the adult[36].

It is of note that practitioners find it difficult to ask questions about domestic abuse and lack the knowledge to identify early signs. It is therefore essential that GP safeguarding leads receive the tools and confidence to cascade the learning from domestic abuse training to

[36] The Independent Reviewer thoroughly supports this statement.

their practices[37].

This has resulted in CCG **Recommendations 3, 4 and 5**.

12.6 **Integrated Domestic Abuse Service (IDAS)/ Somerset Changes**

Somerset Integrated Domestic Abuse Service (IDAS) and Somerset Changes were two separate specialist domestic abuse services which together provided:

- Community outreach support (medium/ standard risk) across Districts of Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset (IDAS)
- IDVA service for High Risk individuals of domestic abuse (Somerset Changes)
- Refuge/ Safe-house accommodation (IDAS)
- Pattern Changing Course (Somerset Changes)
- Voluntary Perpetrator Programme (Somerset Changes)
- Domestic Abuse Freephone (DAFFS) Helpline and central referral point into the medium/ standard risk and refuge/ Safe-house services (IDAS)

Bournemouth Churches Housing Association (BCHA) had responsibility for the IDAS (including Domestic Abuse Freephone Helpline) from January 2014 to January 2015, and for Somerset Changes (IDVA, Pattern Changing and Voluntary Perpetrator Programme) from April 2011 to January 2015.

In the years 2006 to 2014, the Refuge/Safe-house and outreach (medium/standard risk) services were delivered by several different providers and in differing formats. The Domestic Abuse Freephone Helpline was available throughout this same period, although the call handling was delivered by several different providers.

The Integrated Domestic Abuse Service (from January 2014) offered both 1 to 1 support, in addition to providing peer support through weekly drop-ins which were held in each district.

Customers could access the IDAS in person, by telephone or through other forms of communication such as email and text.

The service was staffed between the hours of 9 am and 5 pm although maintained a level of flexibility in order to meet the needs of the community, e.g. where a client worked full-time a visit could be made after working hours in the community.

Outreach services also provided support to clients in safe-house accommodation, supporting on a weekly basis.

[37]same as above.

26.06.2014

Marie made contact with IDAS helpline asking for support about her domestic abuse relationship. She stated she was physically abused up to 3 years ago however she was now facing emotional abuse. A DASH risk assessment was completed and Marie scored 15.

Due to her High Risk score, a MARAC referral was completed by the BCHA IDAS referral coordinator and sent on the 30.06.14 to the MARAC Coordinator and the BCHA IDVA service.

In summary, Marie's referral to the IDVA service took 3 weeks to be acknowledged and allocated to an IDVA and a further 10 days until the IDVA first met with her on 24.07.2014.

This was a significant delay for Marie's case to be picked up by the IDVA service. BCHA procedure stated that a case should have been allocated within 24 hours of receipt of the referral and contact by the IDVA made within 24 hours after the case allocation.

This has resulted in IDAS **Recommendation 1**.

Despite the delays in allocation and initial contact, once the IDVA had engaged with Marie, she actively supported her in many ways with many different agencies.

01.08.2014

The IDVA attended a meeting with Marie and a local Solicitor to access legal advice to apply for a Non-Molestation Order and an Occupation Order. Marie was asked to provide a letter of support from the MARAC chair and a personal financial statement. The IDVA subsequently arranged for the MARAC Chair to provide a letter to the Solicitor outlining that Marie was a High Risk victim of domestic abuse.

28.08.2014

Although Marie's IDVA was not available to attend the MARAC due to annual leave, Marie's case was presented to MARAC and it is noted that some of the actions set were updated or completed by her IDVA upon her return. However, it appeared to the Review Panel that some of the MARAC actions were not SMART and any incomplete were not reviewed by the MARAC.

This has resulted in Safer Somerset Partnership **Recommendation 1**.

A note within the integrated chronology dated 05.09.2014 however, states that Marie expressed to the Children's Social Care Social Worker that she was feeling unsupported as her IDVA had been away on annual leave and that she believed that someone else would have taken over.

The BCHA IMR clarifies that clients were always able to contact the IDVA office and access support if they needed it.[38]

Over the following few weeks, the IDVA made contact with Marie, her Landlord, her Local Authority Housing Options team and the CSC Social Worker in what resulted in unsuccessful attempts to set up meetings between them to discuss Marie's housing issues.

Throughout these contacts Marie was adamant that she did not want to go into a refuge as she needed to continue to work to be able to pay for her accommodation and bills on both properties.

12.09.2014

Marie met with her IDVA and advised her that due to her working status, Legal Aid would not cover all the costs and she would need to make a contribution. Marie was unable to find the required funds as she was committed to paying rent on the property where H and the children were living as well as the caravan she was accommodated in.

25.09.2014

Marie expressed her frustration and distress to her IDVA that she was being bullied into uprooting her family and her work to go into a refuge and that she did not want to leave her support network.

30.09.2014

Marie met with her IDVA and the CSC Social Worker who outlined CSC's concern regarding C5's emotional health whilst still living with H. Marie's safety was again discussed with the suggestion that she go into a refuge, something that she stated repeatedly was not a suitable option for her, as she considered she needed her friends and family around her and she needed to continue to work.

Marie stated that if they were happy for her to return to the house and get H to leave with a safety plan in place, why couldn't they offer her a property in the area and put those same safety measures in place? She felt that H was getting away with his behaviour and that she was the one being asked to leave.

Marie stated during the meeting that she was going to hand back her tenancy as she could not afford to pay the rent, but she was advised that she may be deemed to have made herself intentionally homeless. At that time, the IDVA attempted to invite a Local Authority Housing Officer to join the meeting but due to the short notice, this was not possible to achieve. The IDVA then assisted Marie with making a Homefinder application.

[38] The Independent Reviewer queries whether this made clear to Marie? What is their protocol when a worker takes leave/is absent from work?

Over the next few months, the IDVA continued to engage and support Marie and continued to make contact with and attempt to set up meetings with, her Landlord and Housing Department.

Due to numerous failed attempts to set up meetings over what was a considerable period when Marie was at High Risk, this should have been escalated by the IDVA to a more senior manager within IDAS/Somerset Changes so that communication could have been made between senior managers in each agency to ensure a more successful outcome[39].

This has resulted in IDAS **Recommendation 7**.

Following this on 06.11.14, Marie met with the Local Authority Housing Department who advised her that they maybe able to assist with funding for Solicitor and requested that she provide costings.

Marie failed to provide this information and shortly afterwards she sourced her own private rented accommodation. Had the offer of assistance been offered sooner Marie may have been successful in gaining an Occupation Order enabling her to return to her home with her children.

18.11.2014

Marie expressed to her IDVA that she was very upset that she was still not being helped to move. She stated that she was feeling very frustrated that she was still in the same position that she was in when she moved out of the family home and she was feeling unsupported by the whole system.

24.11.2014

Upon contact by the IDVA, Marie informed her that she had now moved into privately rented accommodation. The IDVA informed her that she would now be closing her file and would refer her to a Pattern Changing course and also to Outreach for further support, which Marie agreed to.

04.12.2014

Evidence in Marie's electronic file shows that the referrals for Pattern Changing and Outreach were completed and notes within Marie's Individual Support and Safety Plan by the IDVA, shows that these referrals were sent on 05.12.2014.

However, there is no evidence of these referrals being received by the IDAS Outreach service or the Pattern Changing team. The IDAS Outreach team failed to pick up the referral

[39] The Independent Reviewer agrees with this statement.

sent by the IDVA on 05.12.14 and instead used a previous referral made on the 07.07.2014 when Marie first made contact with the service.

This earlier referral information lacked detail including information gained through the IDVA service and also the correct telephone number for Marie, therefore not highlighting the risks related to Marie's case in more detail[40].

12.12.2014

The Outreach worker subsequently phoned Marie on her old number but the phone could not be connected. It was judged by the Outreach service to be too high risk to send a letter as this may have been intercepted by H and a decision was made to wait for Marie to make contact.

This decision was based on the outdated information from 07.07.2014 that Marie was still living with H, whereas she was living in her own accommodation and therefore it would have been safe for a letter to have been sent.

Considering the length of time that had passed since the initial referral information had been recorded on 07.07.2014, this should have triggered some question as to how accurate the information was and it would have been appropriate under the circumstances for the Outreach worker to have at least made contact with the IDVA for more up-to-date information.

The above two entries have resulted in IDAS **Recommendation 4**.

Analysis

Case files were examined to establish if BCHA procedures had been followed in relation to regular reviews of the Risk Indicator Checklist (RIC) and the Individualised Safety and Support Plan (ISSP). There is no evidence to confirm procedures were followed accurately.

Marie's individual safety plan was reviewed 3 times with her between 24.07.2014 and 12.09.2014, however this was regularly updated when actions were highlighted or completed. The risk assessment was reviewed twice with her between those same dates, highlighting a slight decrease in score. However, neither the risk assessment nor the safety plan were formally reviewed prior to case closure as per BCHA Procedure and this was a failing on the part of the IDVA.

This has resulted in IDAS **Recommendation 5**.

[40] The Independent Reviewer believes that attempts to make contacts and receive referrals within this organisation/service should be reviewed.

Between 06.08.14 and 24.11.14 Marie attempted to resolve her housing situation by speaking to the following professionals on multiple occasions, BCHA IDVA, Children's Social Care Social Worker, Local Authority Housing Options team, her Landlord and her Solicitor.

On many occasions Marie faced conflicting information which she found confusing. The only advice from the LA Housing team was for her to go to a safe house i.e. refuge provision.

Marie deemed this not to be suitable for the following reasons:

- It was not financially viable due to work commitments, the cost of paying rent on the family home, the cost of petrol and costs of living in refuge. In addition, she feared that if she failed to pay the costs at a refuge and therefore lost her accommodation she would be found to be intentionally homeless by the LA Housing team
- H would be able to follow her to the refuge therefore not making this a safe option
- Should she have chosen to remove her youngest child C5 from H's care to go to a refuge (this was the advice from CSC), she knew this would heighten the risk as H had used C5 as the main form of control over her
- She would need to return to the area where H lived due to her remaining 4 children living there. She believed this heightened the risk to her due to H's control over the other children.

BCHA considered that Marie's knowledge of what would trigger increased risk from H was based on her experience of H's behaviours during their 20+ year relationship, therefore making her the expert on the risks she faced[41].

BCHA records that on 3 separate occasions Marie stated she felt bullied by professionals to go to a safe house. In addition, the IDVA attempted to set up a multi-agency meeting however this was cancelled or attempted to be rearranged on 3 separate occasions. Ultimately, this multi-agency meeting failed to take place[42].

The BCHA IMR author believes that if all housing options had been considered from the moment Marie approached professionals for housing advice, including funding costs for Legal Aid to assist with an Occupation Order, then a housing resolution could have been found sooner, enabling Marie to remain at home with her children, and potentially removing one of the controlling factors H had over her.

This has resulted in IDAS **Recommendation 6.**

When handing service over from BCHA to the new Somerset Integrated Domestic Abuse Service provider (Knightstone) in January 2015, Marie was identified on a document titled 'Clients waiting list' sent by BCHA to Knightstone, however Marie's Outreach case file was not sent over by BCHA.

[41] The Independent Reviewer fully supports this statement.
[42] Same as above

This was potentially due to the fact that the referral for Outreach was made on 05.12.2014 and that the Outreach worker, working from old information of 07.07.2014, considered it too dangerous to contact Marie and decided to wait for her to re-contact the service, hence her Outreach file was pending, lost or closed.

Files were also not requested by the new provider Knightstone, however it is recognised that this would have required the new service provider to identify that this client's file was missing and this is likely to be an unrealistic expectation based on the amount of information transferred by BCHA during the handover process. If this had been identified this may have provided additional information or alerted the Knightstone service to the loss of contact with Marie.

This has resulted in IDAS **Recommendations 2 and 3**.

Knightstone's Observation.

Knightstone's view on the transfer process is that during the service transition period due to a change in the commissioned provider, there was a systematic approach to ensure that all clients within the service were accounted for.

In November and December 2014, Somerset County Council as the service commissioners, sought a monthly Client Profiling Assessment Sheet from BCHA, the final one of which was provided on 16.12.2014.

Client Files from the High Risk IDVA service operated by BCHA were then transferred to Knightstone as 'Zip files' through the CJSM secure email accounts of each IDVA to the CJSM secure account of the Strategic Manager at Knightstone. These files were then securely stored in readiness for the IDVAs (who were transferring across to the new service under TUPE regulations) to access on 13.01.2015, the first day of the new contract.

At Knightstone's request, the Medium Risk (Outreach) files were also sent by secure email to their Strategic Manager to be stored and managed in readiness for the TUPE transfer of the BCHA IDAS manager to the Knightstone service on 13.01.2015.

This was arranged so that the same manager could access the files after her transfer from BCHA to Knightstone and re-allocate them to the Medium Risk Outreach workers within the new service.

Any missing files after the new contract start date of 13.01.15 were listed by the IDAS manager who was now working for Knightstone and BCHA continued to send across files until the end of January 2015.

Marie's Outreach file was not transferred and was not listed as missing.

This has resulted in IDAS **Recommendations 2 and 3**.

12.7 **Mendip District Council Housing Department**

26.06.2014

Initial contact was made by Marie when she phoned the Housing Options Team and her call was immediately transferred through to a Housing Options Officer so that she could receive some initial advice regarding her situation.

The Officer recognised the seriousness of the domestic abuse as Marie advised that she was soon to be discussed at MARAC. This information gave the officer an indication that she was already engaged with Domestic abuse support services and gave the Officer an indication as to the level of risk that was posed to her.

The notes record that she was still living at the property and wanted to know what assistance she would receive from the Local Authority if she fled her current home. In the first instance, the Housing Officer advised Marie that she would be found a refuge if she was fleeing domestic abuse and therefore homeless. She was also advised to phone 999 if she was in immediate danger. Marie was told that she could make a Homefinder Somerset application.

Analysis

The Housing Officer's primary concern was for the safety of the applicant and a refuge placement was consistent with Government guidance ('Supplementary Guidance on Domestic Abuse and Homelessness') especially in a high risk case. The Officer gave Marie advice regarding her current tenancy, injunctions, mutual exchanges and homelessness.

Although there was no domestic abuse policy in place at the time, standard internal procedures stated that Marie's case should have been opened as a 'prevention case' so that an Officer was assigned to the case straight away.

A prevention case is a case where somebody believes that they may be homeless in the near future and the IMR author's view is that this case met the threshold. A prevention case is recorded as such so that it can be monitored on a periodic basis by a case Officer (a Housing Options Officer)[43].

The Officer could have been more specific with Marie in relation to how they were going to remain in contact with her and what would have been a safe method of communication, and notes recorded on the 26.06.2014, should have reflected this agreed method of communication, as the period during which a victim is planning or making their exit, is often the most dangerous time for them and their children.

This has resulted in MDC **Recommendation 1**.

[43] The Independent Reviewer strongly supports this statement.

18.08.2014

Marie presented to the Housing Options Team drop-in session at the Council offices in Shepton Mallet, a drop-in service to give face-to-face housing and homelessness advice. She informed the duty Housing Options Officer that she had been "kicked out" of the family home and was now living in a caravan and sofa-surfing at a friend's house and had been since the 15.07.2014.

She said that H had attended the caravan the previous night, however had not done anything but she had reported it to the police. The notes reflect that Marie had communicated to the duty Housing Options Officer that her Solicitor was assisting her to apply for an Occupation Order to remove her husband from the property.

The duty Housing Options Officer talked to Marie about her potential status on the Homefinder Somerset register if she managed to get an Occupation Order and return to live at the family home with her youngest child C5, as she would be under-occupying her 4-bedroom house by 2 bedrooms and this situation would entitle her to Gold banding on the Homefinder register, in line with Homefinder Somerset policy.

Marie declined to make a Homefinder application at that stage. Another offer of refuge was made to her on the basis that she did not appear to be safe as the perpetrator H now knew where she was staying. The Housing Options Officer explained that Marie could apply for different types of injunctions which would prevent the perpetrator from contacting her or coming near her. Marie declined the offer of refuge stating she wanted to be closer to her children.

Analysis

The Local Authority have temporary accommodation units in Shepton Mallet consisting of 6 self-contained flats in a block. However, it was not deemed safe for Marie to stay there as it could potentially have put her and other residents at risk as there were no special security measures, with no on-site staff or other security.

The Housing Officer decided that placing her within this temporary accommodation within a few miles of her home would not have been a safe option for her with no security measures and specialised support in place to help protect her.

The Housing Officer deemed Marie to be at risk by the fact that the perpetrator knew her current location at the caravan, even though she had fled there. Refuge placements remain secret and in the main, placements in refuges are made outside of the client's original 'home' location.

Placing Marie into a refuge, which is a specialised unit equipped to deal with the risks posed by perpetrators finding victims, was of primary importance to the Housing Options Team. While the Team recognised that every case was different, in this instance Marie displayed the signs that she was still at risk from her perpetrator who had located her in her temporary caravan accommodation and so her safety was the primary concern.

The notes show that Marie became frustrated with the meeting and left before it had

concluded and it is believed likely that the officer may have covered additional advice topics had she stayed until the end. The officer did not raise a prevention case on the system.

This has resulted in MDC **Recommendations 1 and 4.**

24.09.2014

The Housing Options Team received a paper application form from Marie asking to join the Homefinder Somerset housing register.

Analysis

This application was received nearly 3 months after Marie first presented as fleeing domestic abuse when, at the initial meeting on the 26.06.2014, she was set up by Housing Options staff on the Homefinder system and given her unique reference number and instructions on how to make an on-line application. It is not possible to determine why it took Marie 3 months to make the application.

A Homefinder Somerset application is vital if the applicant wants to be considered for re-housing within the social sector. Agencies and organisations supporting victims of domestic abuse need to encourage applicants to apply as early as possible as the applicant will have no re-housing options within the social sector without an active application. In addition, their banding is prioritised once an application is assessed, according to the date they applied for re-housing.

In Marie's case she lost 3 months' worth of date due to delaying making the application. This is important, as clients who are being considered by a housing association for a particular vacancy will be assessed based on what band the client is in and also how long their application has been effective from. So for example, if two clients were being considered for a property in the same banding, the property would be offered to the client who had applied on the Homefinder register first.

Once Marie's Homefinder application was made, it was activated within one week and placed into bronze banding. This activation was within the 15 working day target for banding of all Homefinder Somerset applications.

30.09.2014

Following submission of her application on 24.09.2014 Marie was asked to provide supporting information for her application to be considered further. As a result, on 30.09.2014 Marie and her IDVA called into the Housing Options duty session to supply the mandatory supporting information to support her Homefinder application. Her application was then processed.

02.10.2014

A Housing Options Team Officer rang Marie's IDVA who confirmed that Marie knew that she could apply for an Occupation Order, however this would have been very costly. The Housing Officer was informed that Marie was staying in a caravan in a locked garden and

felt safe and that she had declined to go to a refuge as she was also concerned about the costs. There is reference in the notes that a Children's Social Care Social Worker had advised Marie to give up her tenancy. The notes also state that CSC would not allow C5 to live in the caravan with Marie.

The Housing Officer re-emphasised that in their opinion Marie should go to a refuge for her safety.

Analysis

The IMR states that the Housing Options Team believed that it was the primary responsibility of the IDVA to be aware of the process in getting an emergency injunction and to know of the local and national organisations that provided this service.

The LA Housing Options Team have recently been made aware that the National Centre for Domestic Violence (NCDV) provides a free, fast emergency injunction service to survivors of domestic abuse regardless of their financial circumstances. The NCDV have informed the team recently that they will do an immediate assessment for legal aid over the phone with a client suffering from Domestic Abuse. They have stated that depending on the income of the client, the cost could be anything up to £100 for clients on higher incomes and this would be to cover the costs of the Court application fee and process serving costs.

The NCDV can also arrange stage payments and other payment options so that nobody is excluded from receiving help. They also stated that the calculation for Legal aid help involves looking at the applicant's income, the number of dependent children, the outgoing rent or mortgage and other outgoings.

As it appeared that Marie's income was approximately £1200 per month and she was still liable to pay rent and had dependent children, it is likely she might not have incurred any costs for an injunction. Marie could have used this service on the 26.06.2014 and given what the Housing Options Team understands, it is possible she could have had an injunction in place the following day.

Although it is accepted that the Housing Options Team were not aware of this NCDV service at the time, their IMR states that they would have assumed the IDVA, as a specialist domestic abuse worker to have been aware of all the options available to the client to seek injunctions irrespective of their income. Had this service been used then Marie would also have been able to consider other legal remedies such as a Prohibited Steps Order which she may have been able to obtain to prevent H from taking her children away from her[44].

This has resulted in MDC **Recommendation 3**.

When Marie presented concerns about affordability of a refuge placement, she should have

[44] The Independent Reviewer is of the view that Domestic Abuse is a societal issue and all agencies have a part in place in reducing harm caused by this terrible issue. It would appear that this agency is reliant on the domestic abuse specialists which suggests a training and awareness gap.

been advised by the Housing Options Team and her IDVA that:

- Even though the rent was high in a refuge, she would have been entitled to a much higher rate of Housing Benefit and this would have been tapered depending on the income that she earned

- She would also have been able to claim Housing Benefit for up to 52 weeks on her existing property (the family home), in addition to claiming housing benefit on the refuge. Certain rules apply to this, e.g. her income would be taken into account and she would have to be intending to return to the family home. This is called Dual Housing benefit.

There is no evidence on file that either of these options were discussed by the Housing Options Officer.

This has resulted in MDC **Recommendations 2 and 4**.

17.10.2014

The Housing Options Officer agreed with Marie's IDVA to wait until the outcome of her Legal Aid application and the options around injunctions and other legal remedies to help Marie to return home were fully considered. There were implications to giving up a social housing tenancy which Marie needed to be fully aware of as it was unlikely she would secure this type of tenure again due to recent legislative changes through the Localism Act 2011.

It is recorded that the IDVA reported to the Housing Options Officer that Marie was "now coming round to the idea of a refuge".

Analysis

It is really important that existing social housing tenants realise how valuable an assured housing association tenancy is and how difficult it is to get such a tenancy again following the legislative changes through the Localism Act 2011. Most social landlords now offer fixed term tenancies which are reviewed every 2 to 5 years. In addition, if an applicant proceeds down the homelessness route and a homelessness duty is accepted, most councils offer applicants a private rented property to discharge any homeless duties owed, rather than a housing association tenancy which was historically routinely offered.

Notwithstanding this, Housing Options Officers have to strike a balance between informing the client of likely outcomes if they give up their existing tenancy and awareness around the fact that injunctions may not be appropriate in all domestic abuse cases as it may not be enough to deter further violence or abuse from perpetrators. Consequently, it is accepted that applicants should not be expected to return home on the strength of an injunction alone and therefore there is absolutely no obligation on an applicant to apply for one, although this is one option available to them.

It is considered that there were 3 main injunctions that Marie could have applied for, a Non Molestation Order, an Occupation Order or a Prohibited Steps Order, however the IMR

states that as a District Council they could not offer specific legal advice around this but could encourage applicants in Marie's situation to work with their IDVA worker, the NCDV or other independent advisor to explore their options around the specific injunctions available.

Neither Marie nor her IDVA disclosed what kind of injunctions (if any) she was looking into or seeking Legal Aid funding for. From LA Housing records, it was unclear who was taking the lead on this and the Housing Options Officers' expectation was that this would have been the IDVA's responsibility[45].

The notes reflect that the Housing Options Officer and the IDVA both felt that Marie may accept a refuge placement as she was "coming round to the idea" and they may have both seen this as progress. This could provide a reason as to why injunction options were not fully discussed until Marie was in the safety of a refuge.

20.10.2014

The LA Housing Options Team received a letter from the CSC Social worker outlining that H was not willing to leave the family home and that he was fighting for his right to that property under family law.

24.10.2014

Records show that the Housing Options Officer telephoned the CSC Social Worker and told her that the safest place for Marie was in a refuge and that the Council would consider a homelessness application from her if it was deemed not safe to return to her home.

On the same day the Housing Options Officer called the IDVA and advised her that Marie could not be placed in gold banding as she should take refuge accommodation.

Analysis

The Homelessness code of guidance is clear on the requirements for the 'safety of the applicant and ensuring confidentially must be of paramount concern' for victims of domestic abuse who have fled their home. In the IMR author's view, the only place that could have given Marie genuine safety was a refuge and the Housing Officer was right to continue to encourage and offer this.

A refuge has a confidential address and location and is staffed with trained professionals to help victims of abuse stay safe. The refuge is the only type of accommodation which has security measures and appropriately trained staff to protect the occupants. The LA has to make sure that any accommodation offered at any time (even in an emergency) is suitable for the applicant and the LA IMR author's view is that a refuge would have been the only appropriate accommodation offer in a high risk domestic abuse case.

[45] The Independent Reviewer supports this and strongly suggests the MARAC meeting/Chair applies a model that ensures all partners are aware of their responsibility.

Notwithstanding the guidance and views of the Local Authority in this situation, it may be prudent to advise a more lateral approach when clearly faced with someone who is adamant and determined that refuge accommodation is not appropriate for them. Being presented with only one possible option, going to a refuge, would appear to have been one of Marie's biggest causes of frustration and distress through all her interactions with the Housing Options Team[46].

29.10.2014

When Marie's Homefinder application was initially received on 24.09.2014, it was placed in bronze band. On 29.10.2014, it was moved to silver band. Marie was informed of her silver band status the same day together with her right to request a review of this banding.

Analysis

In the IMR author's view, the Housing Officer was slow to move the banding to silver in this case, as silver banding 'for other homeless' would have been the appropriate banding according to the Homefinder Somerset Policy, given that Marie was no longer living at her social housing tenancy and was homeless.

The author also notes that applicants can be awarded gold banding for a category called 'Harassment', however the current wording of this category does not support it being used for Domestic abuse cases, rather for violence or harassment from somebody outside of the home (i.e. non-Domestic Abuse). The IMR author has requested that the Homefinder Somerset Group look at the wording of this category and consider changing it to include domestic abuse. It is however noted that victims of domestic abuse who are homeless can get reasonable preference (gold band) on the register if they are accepted as homeless following a formal homelessness application.

Sometime within the following month, Marie found a private sector tenancy in the same town as she worked and less than 6 miles away from the home that she had fled. The Housing Options Team would not have deemed it appropriate to have assisted Marie to live in a location so close to her perpetrator as the property would not have been deemed suitable on safety grounds.

In addition, as it was believed that Marie had not received the intensive advice and support from a refuge, it was considered that she may not have had the knowledge and skills to stay safe from her perpetrator in the medium term.

During the period of time that Marie moved to her new property, the Housing Options Officer tried to maintain contact with her on a number of occasions, however she was either unavailable or did not answer the calls.

This has resulted in MDC **Recommendation 1.**

[46] The Independent Reviewer recognises this point and does support the statement.

12.8 **Curo Group (Landlord)**

During the period 06.08.2014- 06.02.2015 Marie had five contacts with her Landlord case manager. In the main, these contacts were phone calls around the status of her tenancy and the legal implications surrounding the joint tenancy and matrimonial home rights.

A review of these contacts shows that domestic abuse was talked about and the correct advice was given at all times by Curo Group (CG) in its capacity as the Landlord. Marie's case manager was aware that she was being supported by an IDVA and a number of conversations took place directly between the case manager and the IDVA, mirroring those that had been had directly with Marie, so the IDVA was aware of the advice that had been given.

CG was not routinely invited to MARAC in Somerset, so they were unaware of when the MARAC was taking place.

The Landlord believes it should have been clear to agencies that Marie lived in a CG property as contact had already been made with Marie and her IDVA. It also well known by other agencies including the Police, which specific properties in the area were managed by them and it is considered that it may have been beneficial for them to have been invited to the MARAC[47].

This has resulted in Curo Group **Recommendation 1**.

06.08.2014

Marie informed her Landlord on her initial report that she was safe and miles away. She stated that she had an IDVA and she was seeking advice from a Solicitor about her situation.

During the next contact on 08.08.2014 Marie informed her Landlord that she was moving to a caravan and that she had seen a Solicitor about divorce proceedings, a Non-Molestation Order, an Occupation Order and the fact that her husband had matrimonial rights and she stated that her IDVA was supporting her with this.

Her case manager checked that she had everything in hand and confirmed that the relevant information markers were in place on the caravan. Marie also mentioned security when she moved back into the family home and her case manager informed her that they could carry out all of these works the day she moved back.

18.08.2014

During this contact Marie confirmed that she had made a homelessness application to the Local Authority and if she was placed in temporary accommodation she would end the

[47] The Independent Reviewer agrees entirely with this statement.

tenancy to force the issue. She stated that she had told the LA that she would not accept a refuge due to not wanting to leave the area.

The Landlord confirmed to Marie that the Local Authority had the duty for homelessness and temporary accommodation and that they, as Landlords, did not have any temporary properties available. Marie also confirmed that she was progressing her Solicitor's advice. She stated that she was being fully supported by her IDVA and needed nothing more from her Landlord at that time.

Marie's case manager agreed to stay in contact and she followed up with a welfare call to Marie the following day to see how things were.

Between September and December 2014, there were a number of telephone conversations between Marie's IDVA and her Landlord case manager to discuss housing issues. Additionally, one meeting was setup and although this had to be cancelled, it was considered that the telephone contacts explored all possible options and clarified Marie's rights to tenure.

09.12.2014

The Landlord case manager called Marie's IDVA who told her that the case had now been closed to the IDVA service. The case manager requested Marie's new contact number but the IDVA stated she would have to check with Marie first before passing it on.

It is not known what other information was shared between the IDVA and the case manager as, although Marie had already moved into her privately rented accommodation on 28.11.2014, the case manager sent a letter to the LA Housing Options Officer on 19.12.2014 giving an overview of Marie's tenancy and asking that she be given some priority on the housing register.

05.01.2015

The case manager received a telephone call from the LA Housing Options Officer who stated that they had written to Marie but had not heard anything back. They also stated that they would want the tenant (Marie) to fight for the tenancy through the Court and they had asked her for the result of the legal advice. This again, is some 6 weeks after Marie had already moved into her private rental property.

23.01.2015

The case manager emailed the IDVA requesting updated details for Marie as they were still unable to contact her.

It would therefore appear that neither the Landlord nor the Local Authority had been made aware of Marie's move to a more permanent privately rented address.

06.02.2015

Marie called her Landlord and informed them of her new address. She stated that she had been unable to pursue the tenancy and an injunction through the Court as she did not qualify for Legal Aid and she stated that she was unable to contribute to the rent on the family home as she was now paying for a different property. It was agreed that the tenancy be re-assigned to H once the arrears had been cleared.

During the period relevant to the Terms of Reference of this Review, H had only one contact with the Landlord, also on 06.02.2015. On review of this contact the Landlord's IMR states that all policies were followed and the correct advice was given around the rent arrears and the potential re-assignment of the tenancy. H was aware of his responsibilities around the tenancy and the payment of rent. He was informed that he may have to seek legal advice based on his matrimonial rights and apply for a property Transfer Order.

Marie's Landlord was fully aware that they were one of a number of agencies who were supporting her at the time. The IMR states that the case manager followed procedure at all times and did everything in her capacity as the Landlord and that all the advice given was in line with policy and exactly what CG as a landlord should have been doing.

CG have a Domestic Abuse policy and work within the guidelines of this policy at all times. There were difficulties surrounding the tenancy, but her Landlord considers that Marie was given clear information on the legislation and law that applied, and all points of law surrounding H's matrimonial rights over the tenancy were checked with a Solicitor prior to being communicated to him.

Although it does appear that the Landlord case manager made regular efforts to remain in contact with Marie and check on her welfare, the lack of a joint meeting between Marie, her IDVA and both her Local Authority and Landlord to discuss issues regarding the tenancy in her name, is significant with regards to Marie's distress and frustrations.

Whilst it may not always be possible to predict an enforced cancellation of an arranged meeting due to some other emergency arising, the re-arrangement of a face-to-face meeting should have been prioritised, particularly when the High Risk factors of domestic abuse were known by the agencies involved. It seemed apparent throughout this review that there was no clear lead professional co-ordinating support for Marie despite being identified as high risk and discussed at MARAC[48].

This has resulted in Curo Group **Recommendation 2**.

[48] The Indpendent Reviewer is of the view that this is an extremely valid learning point for the Review and the multi agency partners in the area.

12.9 **Yeovil District Hospital NHS Trust**

23.01.2012 – 02.05.2014

Marie attended three routine medical appointments not related to domestic abuse. No information indicating any problem was given or requested during the clinic appointment and subsequent follow-ups. There was no evidence recorded of being accompanied to the appointments and no discussions recorded about home circumstances.

Marie's attendances were for routine assessments and were unrelated to any history of violence/abuse or injury. She would have been examined on each occasion and no evidence of injury was noted.

21.05.11

H attended A&E with a reported overdose of around 20 Paracetamol the previous evening and then a further 96 tablets at around 3pm. He had ridden on a bicycle to Shepton Mallet Minor Injuries Unit and was subsequently transferred to YDH. He stated to the ambulance crew that he had split from his wife 3 weeks previously and was staying with his mother. However, he did not share this information with staff on admission to YDH. H stated it was a not suicide attempt but he wanted to sleep as he had been having disturbed nights.

H self-discharged on 22.05.2011 despite doctor's attempts to ensure he stayed in to see the psychiatric team. H insisted he would contact the psychiatric team at Shepton Mallet on his discharge and a GP summary letter reflects this information. Although the plan was for H to follow up with a psychiatric review, the assessment score for self-harm/depression indicated a low risk.

No further information was available to indicate if a referral or appointment had been made or if H had been seen. No evidence was recorded of a discharge address but the next of kin noted on his admission was given as his mother.

It is considered that more information could have been provided in the GP's referral in respect of the necessity and clear direction for follow-up appointments, particularly when these relate to psychiatric concerns.

This has resulted in YDH **Recommendation 1**.

H had also undergone routine investigations at YDH, but it was only on this admission that any concern was raised relating to self-harm in form of an overdose. Although this appeared to be sparked by his split from his wife, there was nothing in his presentation or discussions to indicate any domestic abuse had occurred or was likely. H had moved out of the family home and was reported to be living with his mother at the time.

There was also no evidence in any of the children's attendances at the hospital to indicate that any concerns relating to domestic abuse had been identified. In the majority of instances, it is not possible to determine who accompanied the child to hospital.

12.10 **Musgrove Park Hospital NHS Trust**

There is no evidence that Marie had any contact with services provided by Taunton and Somerset NHS Foundation Trust.

H had thirteen contacts with the Hospital from 2009 until Marie's death. These attendances included outpatient appointments, day case surgery and inpatient admissions.

A review of these attendances indicates that there was no evidence of any information related to domestic abuse. H was taken to the hospital following the death of his wife on 26.02.2015, but this has not been included as it falls outside the scope of the review.

As no domestic abuse issues were raised during this review, there has been very limited scope for analysis.

A general review of Trust processes confirms that the Trust has a domestic abuse policy, with guidance for staff on how to identify abuse and what actions to take. There are no actions required by the policy that have been identified as relevant to this case. This includes domestic abuse assessments and referrals to other agencies where domestic abuse may have been apparent or suspected.

Taunton and Somerset NHS Foundation Trust does not attend the MARAC covering Marie's area, but does offer a limited review of the cases discussed and shares any recent relevant information. All victims discussed at the MARAC, who are on the hospital system, are now flagged to alert staff about their domestic abuse risk. This is a process that started during 2015, therefore there was no flag on the system for Marie prior to or at the time of her death.

As part of the analysis, it was identified that C2 and C3 had both previously attended the hospital although there was no indication that these were related to domestic abuse.

13. Effective practice/ lessons learnt

13.1 **Police**

The family was well known to the police with domestic disputes between H and Marie as well as other members of the family. In addition, the police dealt with incidents involving H and other people.

From records held it is clear that the police recognised the risk H posed to Marie and their children. This is supported by evidence of the police making multiple referrals to social care which triggered the MARAC process. In addition, they often provided advice, support and guidance and took action to diffuse situations e.g. arresting H or removing him from the scene of conflict or warning him regarding future conduct.

It is common for professionals, including the police, to lose focus on children who live with domestic abuse involving their parents. The question, 'what is it like to be that child?' is sometimes missed, but in this case the police IMR author believes that they maintained an effective child focus by making multiple referrals to Children's Social Care.

It is recognised that it is often easy to identify potential missed opportunities with the benefit of hindsight. Consequently, it is very important to recognise that a review faces none of the pressures and distractions faced by all agencies and particularly so, by police officers on the spot.

With the benefit of hindsight, the police might have had an opportunity to talk to Marie about the domestic abuse she suffered when dealing with her report of a stolen handbag. Such a conversation and up-to-date assessment might have provided useful information about current or escalating risk.

Again, with the benefit of hindsight, it would be easy to suggest the police might have made referrals back to the MARAC or to Mental Health Services when they received information on 27.12.2014 about H's emotional state. However, it is fair to say the police had shared information and made referrals many times before and the family's situation was well known to other agencies and the author of the police IMR did not believe the absence of such a referral had any impact on the eventual outcome.

It is however recognised that the police had opportunities to have dealt with incidents in a different manner and could have considered the use of more formal sanctions, such as the use of harassment warnings and Domestic Violence Protection Notices and Orders. The IPCC investigation is considering and reporting on whether there is any organisational learning that can be used to prevent a recurrence of the event, in addition to determining if there is any good practice that can be shared.

Although it cannot be certain that any of these measures could have ultimately prevented Marie's murder, they may have provided more opportunities to use more robust powers to

have arrested and dealt with H, so as to limit his contact and thus reduce the risks to Marie[49].

13.2 **Somerset County Council Children's Social Care**

It is acknowledged that there needed to be a better understanding of the patterns of domestic abuse, risk indicators, more timely intervention and 'SMART'er plans in Marie's case.

Each event needed to be seen in context with the history and a better analysis of the impact of domestic abuse on each child's safety including that of Marie.

The children's voices needed to be heard and their views acted upon. C5 did not feel safe and was worried about Marie' safety. Despite, C5 and sister, C4, voicing their views, C5 remained living with H.

The ultimate question that needed to be resolved was 'Should C5 have remained in the family home with H?'. Despite numerous referrals, assessments, intra and inter-agency discussions and meetings, there appeared to be no specific answer or outcome to this question and C5 remained in H's care throughout the last 6 months of 2014. This was a time that should have been seen as a High Risk indicator given the chronology of significant events and Marie being in a new relationship and being separated from H[50].

As it was also recognised that H's control over Marie's contact for C5 was a form of coercive control and abuse, Children's Social Care should have equally prioritised resolving those contact issues. This aspect also appeared to have 'drifted' on without any resolution over the same period of time.

During the years 2011 and 2012, with many referrals received by CSC, the opening and closing of referrals where there was a pattern of domestic abuse appeared to be haphazard and it is noted by the CSC IMR author that professionals were too optimistic that the risk had reduced simply because the perpetrator had left the home.

It has been recognised throughout this Review, that domestic abuse should have been seen as a child protection issue and not as a Child in Need of support, and the timeliness in respect of arranging meetings to meet Government guidelines is questionable in a number of incidents.

[49] The Independent Reviewer supports this statement.

[50] same as above plus there is no recognition of the following legislation in this finding; The Adoption and Children Act 2002 extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic abuse/violence can have serious implications for children's development.

13.3 **Somerset County Council Adult Social Care**

Although it is noted that ASC records did not begin until 28.01.2010, it is known that Marie had her own AIS case file record but there was no information relating to domestic abuse recorded on her file.

Had this information been recorded within Marie's file, then the AIS system would have allowed for her case notes to be linked to C2's file and may have flagged the concerns over C2 being taken from supported living accommodation to live with H in an environment of disclosed domestic abuse.

Adult Social Care have expressed concerns on the integrated chronology that Children's Social Care may not have considered the welfare of C2 as a vulnerable adult when they visited H after he had taken C2 home to live with him.

However, it would also appear that ASC made no visits or calls to H in respect of any concerns or to check C2's welfare between the time C2 was removed on 17.08.2014 and a meeting that was held on 28.08.2014.

That meeting took place as a result of a letter sent to H inviting him to discuss C2's accommodation and to which H, C2's ASC Social Worker and a CTALD team manager attended.

Again, ASC expressed concerns over H's demeanour during the meeting, so much so, that an instruction was made that H should only be seen by two members of staff H and only in a public place. This concern too, did not instigate any urgency for any proceedings for the protection of C2 and it was a further three months, on 19.12.2014, before a threshold decision was made for C2 to be accepted as a Safeguarding case when a formal strategy meeting was arranged and a protection plan agreed.

In total this was approximately four months after the history of domestic abuse had been disclosed to Adult Social Care and where concerns had been raised in respect of the emotional abuse of C2 by H.

Following the Safeguarding strategy meeting, it would appear that no minutes from the meeting were recorded. In relation to the investigation and Protection Plan, in hindsight it is clear that it was not established whether C2 indeed had mental capacity to express their judgement in respect of the concerns raised.

Despite C2 having been accepted as a Safeguarding case the week previously and the concerns surrounding H's care of C2, C2 spent Christmas with H and was returned to the supported living home on 02.01.2015 covered in eczema and stating that they had been drinking with dad.

13.4 **Somerset Partnership NHS Foundation Trust**

Sompar's IMR indicates that whilst Sompar staff did consider and complete risk screening and assessments throughout H's involvement with them, there was limited opportunity to clearly, independently explore any types of domestic abuse within his marital relationship.

It acknowledges that this may have been as a result of domestic abuse assessments not being part of an electronic risk screening process and consequently staff were not being prompted historically to consider whether it may have been a contributing factor to the offence.

This had been previously reviewed and has been implemented as a result of Somerset DHR 005 conducted in 2014.

The analysis also reflects a historic omission of considering the impact and risk management of H's behaviour on the wider family, as well as himself, through adult and child safeguarding processes. These processes are now firmly embedded in Trust policy and procedure.

Services and teams throughout the Trust have clear pathways to follow and prompts to seek advice and consider safeguarding referral and processes. 'Think Family' is reinforced across the Trust through the integrated Safeguarding Service that now covers safeguarding children, adults, MARAC, MAPPA and PREVENT. However, a recommendation to improve and develop this concept further will be made[51].

Specialist services such as Psychiatric Liaison Teams in Musgrove Park Hospital are now available to patients. Although the lack of this provision for H may not have directly impacted on the outcomes leading to the DHR process, more joined up and clearer care pathways are now available between NHS provider agencies.

H was invited to engage with services when concerns were raised by professional with whom he was in contact and over the years he was offered specialist secondary mental health services from various resources within the Trust. The Trust are confident that they worked well in responding to communication, information and referral from external agencies, with no issues in relation to timeliness.

Although events were not prevented, the processes within Sompar's MARAC Lead role did facilitate communication and information sharing with primary care and this resulted in timely offer of review and assessment of H. It is noted that the MARAC procedures are not subject to an up-to-date Trust policy and are dependent on individual professionals' approach. This will be rectified as a recommendation from this DHR process.

[51] The Independent Reviewer believes that this is needed and any learning to come from this should be shared wider than this area alone.

13.5 **Somerset Clinical Commissioning Group**

The family had all been registered with the practice for more than nine years preceding the time of the incident. Although well known to the surgery staff, it is of note that no less than sixteen GPs provided consultations for the family members.

Both Marie and H received consultations from eight GPs, with only two seeing both partners giving little opportunity to see the relationship in its entirety. Since his paracetamol overdose in 2011, H made a concerted effort to see the same GP, but his problems were reviewed in isolation and not in the context of family life. On most occasions there is little record of social or family history having been asked or recorded for Marie or H.

Consultations with different GPs is not unusual for a busy practice but it is therefore essential that all records of attendance are fully comprehensive with clear outcomes of the presenting problem and forward planning for future appointments, where relevant.

Although the options of both medication and counselling were offered appropriately to Marie, it may have been more helpful to have explored in more depth her non-compliance with sessions rather than accepting frequent cancelled appointments or non-attendance as her right to choose.

Regular anxiety reviews with patients are excellent practice, particularly where there is a prompt response to contact patients after a suicide attempt, however a history of missed appointments should also have triggered an opportunity to explore social history further.

It has been recognised that patients' records need to include questions with regard to social history, particularly when they are or may be attending with emotional and depressive episodes. The impact of a busy family life cannot be overestimated and the 'visibility' of partners must be evident in consultations, particularly when there are children within the family.

Taking social history should include asking questions as to 'how are things at home?' as domestic abuse can happen in any household and the emotional impact particularly on children is lifelong lasting. Consultations should take a 'think family' approach and see the child and children behind the adult and 'professional curiosity' should be routinely practiced with the mantra 'believe the unbelievable'.

Marie and H's GP practice's approach to engaging in this Review and accepting offers of training with respect to the GP "domestic abuse champion" initiative, has been recognised as a positive step forward to expand knowledge in this area[52].

[52] The Independent Reviewer believes that this is essential and a step forward to ensuring all agencies are playing their part in raising the awareness.

13.6 **Integrated Domestic Abuse Service (IDAS)/Somerset Changes provided by BCHA**

During the transfer of contract to another commissioned service provider, it is essential to provide a seamless service. Up-to-date records of support require complete handovers and incoming service managers should be fully briefed on clients, including the most up-to-date risk and action plans. It is vital that care is taken to ensure the continued positive motivation and confidence of all staff, throughout any transfer process.

Staff need to be confident in their role as advocates for clients to escalate concerns or delays, both internally and externally through the line management structures within relevant organisations. This case details a five month delay for a housing request to be responded to. This is a significant timescale for a person at risk. Additionally, the subsequent offer was seen as inappropriate by the client. Case management should have focused on barriers to a resolution to Marie's housing circumstances exploring all possible alternatives.

Advice given to Marie around housing was clearly contradictory at times. This was a difficult period in her life and the inconsistency and uncertainty would have failed to reassure her. Agencies needed to work more closely together to ensure they were delivering a consistent message. In the role of advocate, the IDVA attempted three times to arrange a multi-agency meeting however was unsuccessful due to cancellations and unavailability of external professionals.

As such, the IDVA would have benefited from an escalation process within the IDVA service to obtain her line manager's guidance and support to communicate to external senior managers within relevant services, in order to arrange a multi-agency meeting for a comprehensive discussion to find a suitable resolution for Marie's housing needs.

This case also identified the importance of actions needing to be reviewed at MARAC after they had been set. Whilst the responsibility of actions remained with individual agencies, there appeared to be no checking mechanism to ensure that they were completed to a final or satisfactory level. Had this been available, this may have assisted Marie to resolve her housing situation sooner and with a more appropriate outcome[53].

Each case presented to MARAC should have a clear action plan with completion dates to ensure focused work to increase safety in a timely manner. In Marie's case this is particularly relevant in relation to the MARAC action for her to be placed in gold banding and the significant delay to find a housing resolution for her.

There should be a clear referral procedure between the IDVA and Outreach services regardless of which organisation is delivering the service. Communication meetings should take place and be recorded between the services, with the aim of reviewing referrals to ensure a smooth transition and flow of information. Minutes and records should be audited by service managers to ensure that meetings are effective and consistent.

[53] The Independent Reviewer is fully supportive of this statement.

It is recognised that this communication did not take place between Outreach services and the IDVA in December 2014 and resulted in the Outreach Worker using outdated information in an attempt to contact Marie, which ultimately culminated in her being 'lost' in the system and not receiving ongoing support.

It is vital that all procedures related to risk management or support are followed and completed prior to any case closure. Any outstanding actions must be transferred and highlighted to any new service provider or the case must not be closed.

In Marie's case, the DASH Risk Assessment was not reviewed regularly during client engagement or prior to her case closure. This was contrary to the BCHA procedure for managing risk for IDVA clients.

Marie was also requested by the Housing Options Team to provide costs for the solicitor to undertake court proceedings for an Occupation Order and a Non-Molestation Order. This was not completed by Marie and was not reviewed by her IDVA prior to case closure. This should have been highlighted on the ISSP (Individual Safety and Support Plan) and was therefore not picked up as part of case management prior to her case being closed. This action should also have been recognised and reviewed by MARAC as being uncompleted.

Despite these failings, it is acknowledged that the reports completed by Marie's IDVA were comprehensive and helpful[54] and she showed commitment throughout the case in attempts to communicate with all agencies involved, with limited evidenced support of any line management, advice or intervention.

13.7 **Mendip District Council Housing Department**

A prevention case was not raised at the outset by the officer who spoke to Marie on the 26.06.2014 or the 18.08.2014. This meant that Marie was not assigned a case worker and the Housing Options Team were relying on her to re-contact the service in order to give her advice on her situation on a reactive basis.

Prior to October 2014, it was the responsibility of the Housing Officer dealing with the case to raise it as a prevention case on a crisis driven basis. Since October 2014 the Housing Options Team have introduced a Triage system and all cases that are at risk of homelessness are raised as "prevention cases" by the Triage officer. This new process ensures that all cases raised are immediately assigned a Housing Options Officer who is responsible for monitoring cases. As Marie presented herself prior to October 2014, the triage system had not been implemented and the responsibility for it to be raised was held by the Housing Officer.

A method of future safe communication with Marie was not discussed at the initial call on the 26.06.2014. This should be included in the Housing Options Team domestic abuse procedure to remind staff to do this.

[54] The Independent Reviewer also highlights this as best practice.

Mendip District Council Housing Options Team are committed to giving all people who are at risk of homelessness advice in writing. This advice will inform victims of domestic abuse of their right to make a homeless application irrespective of their decision to accept or reject a refuge placement and this will be clearly evidenced on each file. It is not known why this did not happen in Marie's case.

Once a homelessness application is made the Local Authority will consider its interim accommodation duties which could include emergency accommodation or a refuge, or the right for the applicant to decline these and make their own arrangements, e.g. stay with friends or family until a decision is made on their application.

Advice regarding affordability of existing accommodation commitments, injunctions and refuge placements should be discussed with the victim and confirmed in writing.

The Local Authority IMR considers that the Housing Options Team were justified in making repetitive offers of a refuge placement to Marie as in their opinion she would have benefited from the safe, short term and intensive support offered by a refuge.

However, it is recognised that it is the client's choice whether they take up the offer of refuge support or not and other options such as homelessness applications, access to private sector options, staying with friends, injunctions etc. should all have been discussed with Marie in parallel with any refuge offer[55].

In respect of a meeting which had been arranged between the Housing Officer, Marie and her IDVA for 25.11.2014, which had to be cancelled at very short notice by the Housing Officer on the morning of the meeting, it is acknowledged that more could have been done to re-arrange it, particularly as this was a major source of frustration and distress for Marie.

13.8 **Curo Group - Landlord**

During the last six months of 2014, it is recorded that some difficult conversations surrounding the tenancy of the family home took place between Marie and her Landlord and, although advice and information was communicated to Marie and her IDVA support at all times, the Landlord's IMR states that they could have done no more in respect of the tenancy.

Curo Group, as a Landlord, state that they were aware of the NCDV information in relation to assistance for no-cost or low-cost injunctions. They also state however, that they believe that whilst the advice is free, the action in respect of obtaining injunctions and orders is not. Curo Group further state that this is something they cannot get involved in and this role should be performed by the IDVA.

[55] The Independent Reviewer strongly supports this statement and is of the view that multiple options should always be explored with victims, in order for them to feel empowered to make a decision.

Despite their awareness, it would appear that no NCDV information was shared with Marie in order to help her retain her tenancy and take the course of action that she wanted but felt unable to pursue, due to Legal Aid funding issues.

It is apparent that Marie's case manager did take personal responsibility for maintaining and trying to maintain regular contact with her, and although no meeting took place, the telephone contacts ensured all relevant information was discussed with the IDVA[56].

CG have identified that they should be represented on MARAC for any cases that involve them as a Landlord. Understandably, this will require them being made aware of incidents being referred to MARAC for any of their tenants identified as being at High Risk of DA.

This awareness may result from a disclosure by a tenant or any referral from another agency including a specific request from the MARAC coordinator, but does not preclude case managers from also undertaking 'professional curiosity' when presented with tenants apparently experiencing difficulties.

13.9 **Yeovil District Hospital NHS Foundation Trust**

There is no evidence of failure to appreciate any domestic difficulties from any presentations of Marie or H at the hospital and, due to the nature of their attendances, it is evident that they were not seen together as a couple within the Trust.

Although H had been admitted to the hospital on 21.06.2011 for a suspected suicide attempt following his reported overdose of a large quantity of Paracetamol, his disclosure that this had been triggered by a split from his wife three weeks previously was not probed any further.

Had this been considered as an opportunity to obtain social history, this may have provided more information as to the state of their marriage and may have revealed concerns in relation to mental health issues or domestic abuse.

The self-discharge of H the following day could not have been prevented, as he was deemed to have mental capacity and could not be detained. However, it appears there was a failure to ensure that he attended an appointment for a psychiatric review following a significant overdose. H's GP surgery was advised, but with no clear request to ensure that a follow-up occurred.

Neither Marie nor H had been flagged to the trust at any time in respect of potential domestic violence or abuse.

[56] The Independent Reviewer recognises this as good practice.

13.10 **Taunton and Somerset NHS Foundation Trust (Musgrove Park Hospital)**

Although there were numerous attendances at MPH over a period of years by all members of the family, each case was examined and there were no clear domestic abuse issues identified.

Once again, whilst recognising that each visit in this case may not have presented a clear opportunity, exploring family history further should always be considered, particularly whenever the merest suspicion of DA is raised.

14. Equality and diversity

There were no equality and diversity considerations in this case.

15. Conclusions

In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Marie, N and their family in line with the Terms of Reference?
- Have the agencies openly identified lessons to be learned and addressed?
- Will the actions they take improve the safety of domestic abuse victims in Somerset?
- Was Marie's death predictable?
- Was Marie's death preventable?

The IMRs have been open, honest and thorough. The agencies have used their participation in the Review to consider their policies and practices and, where appropriate, have identified lessons learnt from their contacts with Marie in line with the Terms of Reference.

The Review Panel is satisfied that the agreed recommendations address the needs identified from the lessons learnt. Provided those recommendations are fully and promptly implemented, they should improve the experience of victims seeking help and advice and will improve the safety of victims of domestic abuse in the Somerset area.

The panel has acknowledged that there were very many contacts significant to the risks posed to Marie.

In considering all of the information provided relating to those contacts, the Review Panel believes that, whilst there existed a high risk of significant harm or injury, there was nothing to suggest that Marie's case had any factors unique to other high risk cases.

It is therefore viewed by the Review panel that, although Marie herself had predicted her own death on a number of occasions, her death was not predictable by the agencies involved.

It has been agreed however by the Panel, that there were many missed opportunities, particularly between June and December 2014, to have lowered those risks.

It was clear that Marie was adamant that she wanted to be in her own home. The tenancy was in her sole name and she received conflicting advice from different agencies in respect of what she could, should, and shouldn't do.

Marie considered that the only option being offered to her was to flee to a refuge with her youngest child, something she communicated very strongly on numerous occasions to many agencies that she was not willing to do.

It is considered by the Review Panel, that if Marie had been enabled to move back into the family home by whatever means available, then she would have taken back a level of control, which in turn would have reduced H's control of her circumstances.

Taking into consideration all the factors and contacts with H, particularly by police and health services, more positive action in respect of opportunities for his detention and prosecution for offences and any subsequent mental health assessments may also have had a bearing on the outcome.

It is also believed by the Review Panel that Marie considered that, in her own way, she was self-managing her risks by allowing or accommodating H's demands and control over her child access arrangements in order to keep him as calm as possible and not overly inflame the situation.

It must not be underestimated however, that Marie herself was the best judge of the risks imposed by H on her safety and her persistent remarks over the 6 to 8-month period of their separation prior to her death, that he would kill her, should have been taken more seriously, notwithstanding that many friends, family and colleagues did not believe that it would actually happen.

The fact that the IDVA, the Local Authority Housing Options Team, the Landlord and Marie herself were all in contact with one another at different times, sometimes with conflicting information, has been recognised as a major problem in this case. The identification of a single agency to take responsibility would have provided consistency and may have helped to allay Marie's concerns and frustrations.

It has been agreed that it was vital for a lead agency to have been clearly identified and appointed as the risk to Marie appeared to be escalating. This action should have been undertaken through the MARAC process to have ensured that the flow of information and management of actions was more consistent.

It has therefore been concluded by the Review Panel, that had all the above factors been taken into consideration and implemented, Marie's death may have been preventable[57].

[57] The Independent Reviewer believes that this is summarised very well, with clear evidence and agrees with the statements related to predictability and preventability.

16. Recommendations

The agencies have put forward their recommendations as follows:

16.1 Avon and Somerset Police

1 The police should seek to take opportunities to engage with domestic abuse victims when contact occurs and opportunities arise outside the usual response to domestic incidents themselves. A culture of approach, rather than waiting to be approached, might bring about improved contact between police and domestic abuse victims.

2 Where DASH assessments are changed by police staff or police officers after the event, the rationale for that change should always be recorded. The recording of decision making rationale would allow for more effective ongoing case review.

3 The police should use elements of this DHR as a case study in training to raise awareness of the importance and effectiveness of the paramountcy principle. The police often faced high tension situations with difficult adults, but they did not allow their focus on the safety and welfare of the children to be compromised. This may be achieved in a number of ways in training settings.

4 To ensure officers are aware of all tactical options for progressing positive outcomes for Domestic Abuse. Training and awareness in relation to DVPN/DVPO and Stalking and Harassment (including coercion and control) to be included within training and refresher packages.

5 To support the availability and information to victims and perpetrators there is a need to ensure that pathways to identified support networks are available.

16.2 Children's Social Care (Somerset County Council)

1 Ensure that all comprehensive case audits address the following:
   a. Clarity of recording
   b. Rationale for decision making
   c. Management oversight of progress on actions
   d. The voice and experience of the child

2 Ensure that Domestic Abuse training is compulsory for all CSC staff proportionate to their role[58].

[58] The Independent Reviewer believes that the following should be highlighted specifically; The Adoption and Children Act 2002 extended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another'. This recognises the fact that witnessing domestic abuse/violence can have serious implications for children's development.

3 For Child In Need cases - expectations of visiting frequency, and regularity of review are set out in the practice framework and highlighted to all teams as the agreed standard.

4 Ensure that Core Groups are held in a timely manner in accordance with Government guidelines for the prompt identification and actions to address risks to children on Child Protection Plans.

16.3 Somerset Safeguarding Children Board (LSCB)

1 Review and refine the multi-agency domestic abuse policy and procedures under the LSCB to incorporate a multi-agency risk identification tool (i.e. the Domestic Violence Risk Indicator Checklist).

2 The domestic abuse policy and procedure 'Children Affected by Domestic Abuse – last updated in October 2014' needs to develop guidance on safety planning, emergency planning including procedures for closing a case file, and good practice guidance.

16.4 Adult Social Care (Somerset County Council)

1 With ASC case recording the AIS functionality to copy case notes from one family member to another should be used to facilitate full record keeping where relevant.

2 Where a vulnerable adult is the victim of control and coercion, information on their wishes needs to be collated in a timely and speedy way. SCC ASC Safeguarding Adults processes should be reviewed and amended to ensure this.

3 Where a vulnerable adult is the victim of control and coercion, SCC ASC should ensure that Social Workers have access to prompt legal advice on the processes to ensure the protection of individual rights under the Human Rights and Mental Capacity Acts, and also now, the Care Act. This should include information on referrals to the Court of Protection in urgent cases. SCC ASC Safeguarding Adults processes should be reviewed and amended to ensure this.

4 Where MASH and MARAC meetings are held in respect of domestic abuse within families, if there is a family member who is also a vulnerable adult, contact should be made with the allocated worker, where relevant, or to the SCC Adult Safeguarding Team, in all cases to ensure the effective sharing of information and invitation to subsequent meetings. This is to ensure that the risk of domestic abuse to the vulnerable adult is also considered within the MARAC. It is particularly important where a person may lack capacity and needs others to act in their best interests, under the Mental Capacity Act.

5 In cases involving domestic abuse and personal safety ASC should review their

	Safeguarding Adults processes to ensure that referrals to the Police Public Protection Unit are pursued, so that teams are provided with advice on available actions and police support in all cases.
6	In Safeguarding Adults and Domestic Abuse cases, SCC ASC needs to improve the clear recording of all: • Safeguarding Adults meeting minutes • Adult Protection Plans • Managers' decisions • Risk Assessments.
7	The lessons from this Domestic Homicide Review should be reviewed and disseminated within the training commissioned for SCC ASC staff.

16.5 Somerset Partnership NHS Foundation Trust

1	Somerset Partnership CAAS to record electronic risk alerts, screening and information following assessment of all patients.
2	Somerset Partnership Safeguarding Service to produce an internal Domestic Abuse and MARAC protocol/procedure.
3	Somerset Partnership Safeguarding Service to review and update Trust Domestic Abuse Policy and flowchart.
4	Somerset Partnership Safeguarding Service to review protocols to share information and risk management of safeguarding cases which involve both adults and children.
5	The Trust will utilise the Multi-Agency Safeguarding Hub (MASH) to work with partner agencies ensuring timely response and co-working when appropriate.
6	The Trust will utilise more fully the existing safeguarding information pathways (e.g. staff newsletter, safeguarding intranet pages and staff training) to raise awareness of domestic abuse and the protocols for managing these cases.

16.6 Clinical Commissioning Group

1	Feedback and debrief to be offered to the General Practice prior to final publication.
2	For the practice to consider a review of consultations to include social questions.
3	Specific training in domestic abuse and knowledge of the GP champion approach.
4	Adoption once ratified the CCG domestic abuse policy for primary care for all practices,

	in consultation with NHS England and LMC.
5	Circulate lessons learnt from DHRs regarding the need to clearly document social history during consultations.[59]

[59] The Independent Reviewer is of the opinion that there should be another recommendation linked to asking the question about how things are at home when a patient attends with anxiety/depression etc…?

16.7 Bournemouth Churches Housing Association (to include SIDAS (Knightstone HA))

1 Case intake policy and process to meet 'Safe Lives Leading Lights' required standard by ensuring that clients are contacted within 24-48 hours from referral date, and engagement to take place within 5 days of the initial contact if it is safe to do so. (Contact and engagement should be "meaningful" as described in the SCC Domestic Abuse Service Intake Process)

2 Where an IDVA service is being transferred from one provider to another a standard procedure is recommended that all active cases 6 weeks prior to the transfer date remain active throughout the transition to a new provider. The new provider should not close cases until a full review has been undertaken by the allocated worker to ensure all actions have been completed and risks managed and reduced. This recognises the challenges a service transfer can bring to a team of staff.

3 The outgoing provider should provide the incoming provider with client case files as soon as practicable and no less than 3 weeks prior to transfer date, enabling the outgoing provider to organise consent forms from clients and organise files ready for transfer. This will be subject to obtaining client consent.

4 Clearer communication between IDVA and Outreach services with particular focus on transfer of referrals and hand over process for the client. Ideally this would be a team meeting with written records which can be audited.

5 All cases should be closed as per the required standards of 'Safe Lives Leading Lights' whereby a recorded case management meeting is held and exit actions are completed with a client to include a final assessment of risk as part of that procedure.

6 All agencies need to take into consideration the client's wishes and risk concerns around recommended safety plans offered by professionals, with particular understanding that the client will understand the perpetrators patterns of behaviour the most. Where possible, these wishes should be accommodated in options provided.

7 Promotion of escalation processes within all agencies for all professionals working with high risk victims of domestic abuse. Promoting the benefit of escalation to find a resolution and removing any negativity from the escalation process.

16.8 Mendip District Council Housing Department

1 Housing staff should have a clear procedure for dealing with domestic abuse cases which should include that such cases are raised as prevention cases at the earliest opportunity.

2 Procedures should reflect that options such as homelessness applications, access to private sector options, staying with friends, injunctions etc. should always be discussed in parallel with any refuge offer, with these options confirmed in writing.

3	Housing staff who are working with Domestic abuse victims need to be aware of the national and local organisations that offer emergency injunction services and the costs of such services (especially where the client is working).
4	Housing staff who are working with Domestic abuse victims need to be able to advise on affordability issues relating to existing accommodation commitments and refuge placements.

16.9 Curo Group

1	To gain representation on Somerset MARACs by signing up to the Somerset MARAC Operating Protocol.
2	In circumstances where a tenant is identified as a victim of domestic abuse, and is already known to be in receipt of DA specialist support, a discussion will be had with that specialist DA agency to determine who is the lead professional co-ordinating support to the individual/family.

16.10 Safer Somerset Partnership

1	MARAC to review actions agreed for cases with specific focus on actions which are not complete due to a barrier. MARAC attendees to seek resolution as multi-agency group and agree alternative actions to reduce the risk.[60]

16.11 Yeovil District Hospital NHS Foundation Trust

1	Ward staff need to be reminded to ensure clear direction for GP in respect of follow-up appointments especially when these relate to psychiatry.

[60] The Independent Reviewer is also of the view that there should be a recommendation to strengthen MARAC actions being SMARTer and clear decisions being made about who holds responsibility for what given the learning between housing and IDVA?

Appendix A

Glossary of Terms

ASC	Adult Social Care
CAADA	Co-ordinated Action Against Domestic Abuse *(now known as Safe Lives)*
CAAS	Court Assessment and Advisory Service
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSC	Children's Social Care
CTALD	Community Team for Adults with Learning Difficulties
DAFFS	Domestic Abuse Freephone Service
DASH	Domestic Abuse Stalking and Honour Based Violence *(Risk Indicator Checklist)*
DHR	Domestic Homicide Review
DVPO/ DVPN	Domestic Violence Protection Orders/ Notices
GP	General Practitioner
Guardian	Police Crime and Intelligence management system
ICPC	Initial Child Protection Conference
IDAS	Integrated Domestic Abuse Service
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LA	Local Authority
LMC	Local Medical Committee
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NCDV	National Centre for Domestic Violence
NMO	Non-Molestation Order
OO	Occupation Order
SOMPAR	Somerset Partnership NHS Foundation Trust
SSP	Safer Somerset Partnership
STORM	Police command and control system

Appendices B and C – See separate documents