



# Domestic Homicide Overview Report

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DHR SW01

Dee Edwards – Independent Chair and Author  
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## **Preface**

This report of a Domestic Homicide Review (DHR) examines the involvement of agencies in Warwickshire with a woman referred to as A, who died in October 2012.

The Review has been established to meet the requirements of legislation and has been conducted following the Multi-agency Statutory Guidance issued by the Home Office. The purpose of the DHR is defined in the Guidance and this is described in Section 3 of this report.

The Review fulfils a legal requirement but it must be remembered that the need for it has arisen from a personal tragedy for the victim and her close family and friends. The members of the Review Panel wish to express their sincere sympathy for the loss they have suffered and for the distressing consequences they have experienced.

The Panel is also grateful for the co-operation and patience shown by all those who have given their time, experience and commitment to the Review. It is hoped its findings may contribute to the prevention of similar personal tragedies in future. The panel wish to thank the following for their part in the Domestic Homicide Review process:

Warwickshire County Council- specifically Sue Ingram, Domestic Abuse Manager, for her specialist knowledge and skills in advising and guiding the panel through the process, and Holly Collins, Domestic Abuse Administrator, for all her work in producing papers, organising meetings and supporting the Chair;

Warwick District Council for hosting the panel meetings;

Councillor Gillian Roache, for her unswerving support and commitment to the review;

Councillor Michael Coker, for his initial support.

**Dee Edwards**

**Domestic Homicide Review- Independent Chair and Author.**

## **GLOSSARY**

<b>ATR</b>	Alcohol Treatment Requirement – a community sentence imposed by the courts to offenders where alcohol is identified as a significant factor in the person’s offending.
<b>A+E</b>	Accident and Emergency Department
<b>AVA</b>	Against Violence And Abuse, a national violence against women organisation
<b>CCG</b>	Clinical Commissioning Group
<b>CWPT</b>	Coventry and Warwickshire Partnership NHS Trust
<b>DASH</b>	Domestic Abuse Stalking and Harassment and Honour Based Violence Risk Identification, Assessment and Management model
<b>E-CINS</b>	A web based casework management system which shares information securely across multiple agencies
<b>GP</b>	General Practitioner. A number of GPs were involved in supporting the victim and where they are referenced they are numbered, e.g. GP7
<b>IMR</b>	Individual Management Review- reports submitted by each agency participating in the Domestic Homicide Review
<b>IPCC</b>	Independent Police Complaints Commission
<b>LAC</b>	Local Area Team (for the National Health Service)
<b>MARAC</b>	Multi- Agency Risk Assessment Conference
<b>MASH</b>	Multi- Agency Safeguarding Hub- a process which aims to safeguard children and vulnerable adults
<b>SWFT</b>	South Warwickshire NHS Foundation Trust
<b>UHCW</b>	University Hospital Coventry and Warwickshire
<b>WCC</b>	Warwickshire County Council
<b>WDC</b>	Warwick District Council

## **Introduction**

- 1.1** Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004, which came into force on 13<sup>th</sup> April 2011. The legislation requires that a Review should be held “*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or by a member of the same household*”.
- 1.2** There is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs<sup>1</sup> and these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic violence, Crime and Victims Act 2004). However, the powers of this review are limited in that it cannot issue a witness summons which in effect means that there is no legal sanction or power to enforce a request made by the Review panel or Independent Chair that an individual attend for interview or participate in the review. The report will identify when this occurred and what possible gaps in information may have occurred as a consequence.
- 1.3** This Review was initiated on the 7<sup>th</sup> August 2013 and the multi-agency DHR Panel comprised the following members:

Dee Edwards	Independent Chair and Overview Report Author
Detective Chief Inspector Protecting Vulnerable People	Warwickshire Police
Lead Nurse for Safeguarding Children and Vulnerable Adults	Coventry and Warwickshire NHS Partnership Trust
Area Manager	Warwickshire Probation Trust
Senior Operations Manager	Refuge
Safeguarding Adults Lead	South Warwickshire NHS Foundation Trust
Lead Nurse for Safeguarding Adults	Coventry and Rugby CCG
Domestic Abuse Manager	Community Safety and Substance Misuse Team, Warwickshire County Council
Operations Manager	Adult Social Care, Warwickshire County Council
	Community Safety and Substance Misuse

<sup>1</sup> Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – (April 2011).  
[www.homeoffice.gov.uk/publications/crime/DHR-guidance](http://www.homeoffice.gov.uk/publications/crime/DHR-guidance)

Domestic Abuse Administrator	Team, Warwickshire County Council
Area Manager	The Recovery Partnership
Safer Communities Manager	Warwick District Council
Senior Housing Officer	Warwick District Council
District Councillor	South Warwickshire Community Safety Partnership Chair
Community Services Manager	Stratford District Council

The following attended the first panel meeting (with Swanswell presenting an IMR to panel members on 10<sup>th</sup> January 2014), but because of changes to local commissioning arrangements, they were not present at all meetings as standing members of the panel:

Director of Clinical Governance	Swanswell
Service Manager	Families First

- 1.4** The Stella Project Co-ordinator from Against Violence and Abuse (AVA) attended one panel meeting (January 10<sup>th</sup> 2014) to advise on specific aspects of the Review relating to the causal connections between domestic abuse, alcohol/substance misuse and mental ill health and the relationship between domestic abuse and homelessness.
- 1.5** None of the Panel members has line management responsibility for staff involved with the family or the authors of the Individual Management Reviews (IMRs). The Panel members had no knowledge of the victim or her family prior to the notification of her death with the exception of two representatives from the Housing department at Warwick District Council and The Recovery Partnership. The Housing department representative had worked as a Tenancy Enforcement Officer and in this role had met A when she had been a tenant of Warwick District Council between 2000 -2006. The Recovery Partnership representative had previously worked as a nurse within the Community Drugs Team and had met A in August 2009 when she was receiving treatment for her heroin use.
- 1.6** Dee Edwards was appointed as the Independent Chair and Author of the Overview Report and Executive Summary. She attended all of the DHR Panel meetings. Formerly a Domestic Violence Co-ordinator with over 15 years experience in the Domestic Violence sector, she has worked as a Violence

Against Women and Children consultant and trainer in the health sector for the last two years. She has been a panel member in another DHR and in a Children’s Serious Case Review for a different local authority and has successfully completed the Home Office DHR Chair’s training. She has no personal or employment connection with any of the individuals or agencies referred to in this Review.

- 1.7 Relevant Commissioning issues: During the time period covered in the review there have been changes in the provision of drug and alcohol services. Up to November 30<sup>th</sup> 2011, Swanswell provided Tier 2 alcohol services, Coventry and Warwickshire Partnership Trust provided Tier 3 drug and alcohol services (which included Woodleigh Beeches as a detoxification unit). Cranstoun at this time provided Tier 2 drug services; Addaction provided arrest referral drug and alcohol services and Warwickshire Probation Trust provided prison in-reach and resettlement services for drug clients. Services were then transferred to The Recovery Partnership (Addaction and Cranstoun) from December 1<sup>st</sup> 2011.
- 1.8 From September 2013 policing across Warwickshire is being delivered jointly through an alliance with West Mercia Police. Recommendations made in this review will be disseminated across this alliance.

## 2. Methodology

- 2.1 On 3<sup>rd</sup> July 2013 Warwickshire Police wrote to the Chair of the South Warwickshire Community Safety Partnership to advise that A had died in circumstances that may meet the requirements for a Domestic Homicide Review to be conducted. Initial information was requested from a number of local agencies to identify the extent and nature of their involvement with A and her family.
- 2.2 The Chair of the South Warwickshire Community Safety Partnership established a Review Panel on 10<sup>th</sup> July 2013 and each of the key agencies was communicated with by letter advising them of the requirement to provide an Individual Management Review (IMR) in respect of their organisations’ involvement, with a deadline for completion on 25<sup>th</sup> November 2013. IMRs were commissioned from the following agencies:

Agency	Author of the IMR
Warwickshire Police	Detective Chief Inspector ,Major Crime Review Unit Warwickshire/ West Mercia Police
Coventry and Warwickshire Partnership NHS Trust	Named Professional for Domestic Abuse

University Hospital Coventry and Warwickshire	Named Nurse Adult Safeguarding
Local Area Team	Associate Medical Director NHS England
South Warwickshire NHS Foundation Trust	Matron and Safeguarding Adults Lead
Warwickshire Probation Trust	Area Manager
Warwick District Council: Housing	Sustaining Tenancy Manager
Warwickshire County Council Social Care and Support – People Group.	Service Manager/Safeguarding Adults Lead
The Recovery Partnership	Area Manager, Cranstoun
Swanswell	Director of Clinical Governance

**2.4** IMR authors were not in line management relationships with the services they reported on and there were no conflicts of interest for Authors or Panel Members.

**2.5** Chronologies were also requested from the following agencies that had identified a limited contact with the victim:

Families First

Bromford Housing

The Way Ahead Project, The Salvation Army

Leamington Night Shelter- an independent charitable organisation

**2.6** Refuge (specialist domestic violence services) was asked to check if they had any contact with A but they had no knowledge of her.

**2.7** There were no criminal proceedings in this case. (See 4.2).In addition to the Police investigation into A’s death, there have been three independent reviews, making it complex for the family and wider community to understand the processes and differing outcomes. These reviews are:

The Independent Police Complaints Commission Investigation

The Coroner’s Inquest

The Domestic Homicide Review

The timelines and interdependencies of these reports are complex. The original anticipated date of the publication of the IPCC report was January



2014, but this was delayed by a number of factors. The IPCC issued a brief press release regarding their initial findings (August 2014.) However, following an information sharing process between the DHR Chair/ Author and the Lead Investigator for the IPCC, and having considered additional documentation provided by Warwickshire Police for the purpose of this DHR (Warwickshire Police Individual Management Review, completed in January 2013), the IPCC produced an addendum to their report (October 2014) which addresses issues raised as a result of this process. Relevant observations, conclusions and recommendations from the IPCC report and addendum are referred to in section 8.2 (page 81) and section 8.63 (pages 92/93) of this report. It is the IPCC's intention to publish their final report at the same time as this DHR report.

With regard to the Coroner's Inquest, the Inquest proceedings are still in the very preliminary stages. So far there have been two Pre-Inquest Hearings and there is a further Pre-Inquest Hearing scheduled for April 2015. The Assistant Coroner presiding over this matter has been advised that this DHR has been compiled and has directed that this report be disclosed to him once the Home Office have determined that it is adequate for publication. It is understood that the assistant coroner, on having sight of the DHR, will determine its relevance for the scope of the Inquest proceedings and accordingly no date has thus far been set for the formal opening of those proceedings.

Warwickshire Police have also had their own internal review in relation to this (Operation Zagreb 5<sup>th</sup> August 2013). The DHR Independent Chair requested sight of this document because of its potential relevance to the DHR, but this was not forthcoming as Warwickshire Police stated that this was a peer review into the quality of the investigation into the circumstances of A's death. It did not cover events leading up to A's death and so had no bearing on how the Police worked together with other agencies in the months and years preceding her death.

No other reviews or investigations have been conducted in parallel with this DHR.

## **2.8 Timescales**

The DHR was initiated on 7<sup>th</sup> August 2013 with a target date for completion by 24<sup>th</sup> March 2014. It has not been possible to meet this target due to delays caused by the following:

- Extension of the deadline date for Warwickshire Police's submission of their IMR due to the extensive contact with A and her associates;
- Resubmission of some agencies' IMRs to gain additional information;
- Translation of documents to ensure that A's family had an opportunity to contribute to the review;
- The changing circumstances of A's ex-partner which delayed contact with him;
- The delay in the publication of the IPCC report
- The need to explore relevant legal issues prior to publication of this DHR

**2.9** Meetings of the Domestic Homicide Review Panel were held on:

- 27<sup>th</sup> September 2013
- 9<sup>th</sup> December 2013
- 10<sup>th</sup> January 2014
- 24<sup>th</sup> January 2014
- 6<sup>th</sup> February 2014
- 20<sup>th</sup> February 2014
- 18<sup>th</sup> November 2014
- 8<sup>th</sup> December 2014
- 23<sup>rd</sup> March 2015

A separate briefing meeting for the Authors of IMRs was held on 25<sup>th</sup> October 2013, led by the Panel Chair. It was fully attended and feedback from Authors indicated it was helpful and productive.

**2.10** Terms of Reference for the Review were established and supplied to IMR Authors in a comprehensive scoping document. These are stated in section 3 below.

**2.11** The Domestic Violence Crime and Victims Act 2004 creates the expectation that certain public bodies will have regard to the Multi-Agency Statutory Guidance for the Conduct of DHRs. These bodies can be directed to participate in a DHR but the Review has no power or legal sanction to insist that individuals attend for interview. All IMRs have been completed solely for this DHR process and with the full co-operation of staff and no individuals have chosen not to participate. In so doing, agencies wished for lessons to be learned and recommendations made to improve practice.

**2.12** The Overview Report is based on information contained in the 10 IMRs submitted. They were compiled following the Guidance and included a chronology of each agency's contact with the family, an analysis of their involvement to identify learning points, recommendations and an action plan

to address those learning points through future practice. Each agency has identified a Responsible Officer who has signed off their agency's IMR report.

**2.13** IMRs were presented and reviewed in detail by the Panel at their meetings on 9<sup>th</sup> December 2013, and the 10<sup>th</sup> and 24<sup>th</sup> January 2014.

**2.14 Confidentiality**

The DHR Panel has been concerned to safeguard the confidentiality of all involved in this case. Where it has been necessary to refer to individuals in this report an initial has been used in place of their name in order to comply with the DHR Guidance.

The family, friends and associates referred to in this report are:

Initial	Identity	Age at the time of A's death	Additional information
A	The victim	44	Member of a European community
F	An individual present the night before A was found dead	62	A vulnerable adult
E	An individual present the night before A was found dead	50	An associate of A's
G	Former partner of A	38	From the same European community as A but now living in England
D	A's brother	Not known	Living in a European city
I	Friend of A's	Not known	From the same European community as A but now living in England
M	Friend of A's	Not known	From the same European community as A but now living in England
H	Associate of F, E and A	54	Initially identified as an associate but has not participated in the review.
B	Friend of A's	Not known	Unable to trace her current address.

- 2.15** Before becoming publically available the Overview Report and Executive Summary will be redacted to provide the essential information and lessons learned while safeguarding confidentiality so far as possible for A, her family members and staff of agencies involved. This will be limited by the readily identifiable circumstances of the case and its location in Warwickshire.
- 2.16 Family, Friends and Associates' Participation in the review**
- 2.17** The Review Panel has been keen to engage with the victim's family, friends and associates.
- 2.18** The Panel decided that the most appropriate method of approach for A's family was to write directly to them inviting them to contribute to the review. Letters and Terms of Reference and copies of the Home Office information for families were translated and sent securely to A's mother and brother. A's brother D responded positively and relevant questions were then drafted, translated and sent to him in February 2014.
- 2.19** The Chair sent letters to H, E and G to ask them if they wished to participate in the Review. The letter sent to H was 'returned to sender.' E agreed to participate and a meeting was organised which took place on 6th November 2013 at The Way Ahead Project premises.
- 2.20** The letter to G was returned in November 2013 as 'not known at this address.' The Chair received information which confirmed that he was now in Hewell prison having been convicted of fraud. A letter was written to the prison Governor requesting the opportunity to visit G (December 2013). Further information revealed that G had been transferred to HMP Huntercombe. G was interviewed for the review in March 2014.
- 2.21** Another associate of A's (B) was also written to but the letter was returned as 'not now known at this address.' There has been no additional information which has been received by the panel to inform them of B's current location.
- 2.22** The Panel also invited views of two friends of the victim (I and M). They also knew A's ex partner and their respective families and the individuals present the night before A was found dead. It was hoped that their views would help the panel to understand more about A's personal experiences, attitudes and changing circumstances. A meeting with these two friends took place in January 2014.
- 2.23** The Chair held a meeting with Adult Social Care representatives to discuss the most appropriate way of engaging with and supporting F (a vulnerable

adult who had been assessed with memory impairments). Following meetings between F and his social worker, he decided that he did not wish to participate in the review.

- 2.24** All information gathered from the family, friends and associates was done with their full consent.
- 2.25** A copy of the Executive Summary of this report was translated and sent to A's immediate family for comment. Feedback from one member of the family identified that information included in the report had been somewhat distressing for them as they had been unaware of all of the circumstances of A's life, in particular the domestic abuse and the homelessness. In order to give the family members as much support as possible, relevant organisations in their country of origin and residency were identified for them to contact if necessary.

### **3. Terms of Reference**

- 3.1** The DHR Panel identified the following terms of reference for the Review and these were set out for each contributing agency in the scoping document.

The purpose of the DHR was to:

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

### **3.2 Scope of the Review -Time period.**

The DHR focussed on events from 9<sup>th</sup> June 2008 (the first known date of A's engagement with substance misuse services for alcohol dependency) up to the date of her death on 25<sup>th</sup> October 2012, unless it became apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

The main reason why the DHR Panel chose to explore such an extensive time period within the victim's life was to explore all of the factors that may have led her to

become homeless and in a position where she was potentially vulnerable to incidents of domestic violence and to see whether there were lessons to be learned by agencies that dealt with A since her initial engagement with an agency designed to provide support to those with issues concerning alcohol.

### **3.3 Key Lines of Enquiry to be addressed within the IMRs.**

All agencies submitting IMRs were asked to respond to the key lines of enquiry listed below but also to consider the complexity of the case. They were requested to bear in mind that there had been no criminal conviction in relation to the death; there were a number of additional factors which may have camouflaged or hidden the abuse- or led to different interpretations and perceptions about the clarity of the identity of who was the victim and who was the perpetrator (s) of the abuse. These factors may have been connected with the lifestyles and vulnerabilities of the key people involved in A's life during this period and often related to mental ill health and alcohol misuse. Agencies were therefore asked to consider how these complexities may have been factors in their response to the victim and/or alleged perpetrator (s).

### **3.4 History of events and relationships**

- What was the history of the relationship between the victim and the alleged perpetrator of domestic abuse and the other relevant people (F, E, G, and H)?
- What was the sequence of events up to the date of the death?

### **3.5 Information: What knowledge/information did your agency have that indicated that those involved might be victims and/or perpetrators of domestic abuse, and how did your agency respond to this information?**

In considering your response, think about the impact of domestic abuse upon A and specifically respond to the following (where possible):

- To what extent did A consider herself to be a victim?
- To what degree did A's understanding of the risks she faced, impact upon your decision making?
- Does your agency have any information which helps in an understanding of the possible 'triggers' which existed in A's life which may have led to her substance misuse and her changes in circumstance.
- Were practitioners alert to potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
- Has your agency policies and procedures in place for identifying domestic abuse and dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies considered effective? Was it reasonable to expect staff, given their level of training and knowledge to fulfil these expectations? In particular, did staff have knowledge and

awareness of the interrelationship between mental health issues, alcohol misuse and domestic abuse?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way and in keeping with organisational and multi-agency policies and procedures?
- Were joint assessments taking place to assess factors such as substance misuse, mental ill health and domestic violence and abuse?
- How, when and why, your agency shared information with others and its impact?
- Were there missed opportunities for sharing information?
- Was the supervision and management of the case in your agency effective and did it follow agency policies and procedures?
- Should the information known to your agency have led to a different response?
- Was it reasonably possible without the benefit of hindsight to predict, and once predicted work to prevent the harm that came to A?

**3.6 Services: What services did your agency offer and/or provide to meet the victim's needs? Were they accessible, appropriate, empowering and empathetic to her needs?**

- What contact your agency had with the victim and the perpetrator and significant others?
- Had the victim disclosed to anyone, and if so, was the response appropriate?
- Were appropriate services offered or provided or relevant enquiries made in the light of the assessments, given what should have been known at the time?
- Whether practitioners were sensitive to the needs of the victim?
- How accessible were the services for the victim?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim/ alleged perpetrator(s)? Was consideration for vulnerability and disability necessary?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known?
- Was the victim informed of options/choices and supported to make informed decisions?
- Were there identified needs unmet, or conflict identified between her needs and the needs of others?

- Was there any additional action that could have been taken, and would it have made a difference? (Missed opportunities?)

**3.7 Capacity and resources: Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator(s) or any other relevant others? If so, did these issues also impact on the agency's ability to work effectively with other agencies?**

- Were staff reporting any issues and /or concerns in relation to capacity and resources to provide services to the victim? If so, how did your agency respond to these concerns?
- Are there lessons to be learned from the case relating to the way your agency works to safeguard victims and promote their welfare, or the way that it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- Do any of your agency's policies or procedures require amending or do new ones need establishing as a result of this DHR, including those covering risk assessment?
- Identifying good practice where responses may have been over and above the required standards.
- Whether or not the agency feels there are any gaps in their current provision, including skills, knowledge and/or ability to respond effectively.

**3.8** Additional questions were addressed to Warwickshire Police, Adult Social Care and The Recovery Partnership as follows:

**3.9 Warwickshire Police:**

- Did A's previous history relating to domestic abuse impact upon decision making?
- What level of awareness/information did Police have about E's previous history as a perpetrator of domestic abuse? Did this information impact upon decision making?
- What level of awareness was there of F as a potentially vulnerable adult? How did this factor into the risk assessment and decision making process?
- Give an evaluation of the Police intervention on 24<sup>th</sup> and 25<sup>th</sup> October 2012.



### **3.10 Adult Social Care:**

- At the Social Care and Support meeting (26<sup>th</sup> October 2012) what factors contributed to the view that F was at risk from the relationship with A?
- Was A ever subject to the Safeguarding Adult process? If so, what took place?
- What assessments regarding F's mental capacity have been carried out within
- the specified time period?

### **3.11 The Recovery Partnership:**

- What factors prevented The Recovery Partnership from completing a formal assessment after A had left hospital (14<sup>th</sup> February 2012).

### **3.12** The panel agreed to the following values and principles which underpinned the review:

- To ensure that the approach to the review is challenging, analytical, objective, unbiased and independent; that it is underpinned by humility, humanity and curiosity.
- That the review process recognises, in its communication with all concerned, the stress associated with such a review and that it is as a consequence, conducted with compassion.
- The review process will also strive to be thorough and meticulous; will promote honesty and transparency and will most importantly, keep the victim, A, at the heart of the process.

### **3.13** It was agreed by the panel that public and media enquiries directly relating to the DHR will be handled by South Warwickshire Community Safety Partnership.

### **3.14** It was also agreed that the review would also give appropriate consideration to any equality and diversity issues that appear to be pertinent to the victim and alleged perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership; pregnancy and maternity, race, religion and belief, sex and sexual orientation.

### **3.15** The panel agreed that family members and friends, who had expressed an interest in receiving the report, would have the opportunity to comment on the Executive Summary prior to the finalisation of the report.

#### **4. Additional Contextual Information Relevant to this DHR**

**4.1** This DHR is very complex and has raised a number of issues to the author of the report and to the DHR panel which this section seeks to outline.

Firstly, there were some unresolved issues:

- There was a lack of clarity about the cause of A's death. The cause of A's death is subject to the Coroner's Inquest, yet to take place;
- There has been no prosecution of any individual for assault leading to her death which also creates a situation of uncertainty as to whether A's death was a direct result of domestic violence and abuse;

**4.2** Despite these uncertainties the DHR panel accepted that A's death fulfilled the criteria for a Domestic Homicide Review which is to review *'the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or by a member of the same household'*.

**4.3** The following aims to explain why this case fulfilled the DHR criteria:

At the time of her death in October 2012, A was homeless but spending approximately 3 days a week at the home of F, so could be considered to have been a 'member of the household'. It was also believed that A and F were, or had at some point been, in an intimate relationship.

This house was also frequented by E. There is no information to suggest that A and E had ever been in an intimate relationship.

A's death took place within this household and *may* have occurred as a result of violence from F, who had subsequently disclosed he had repeatedly punched A in the stomach area on the night before she died.

Whilst the police investigation and subsequent consideration of the case by the Crown Prosecution Service identified that there were a number of other plausible explanations for the death of A, the DHR panel made a recommendation to the Chair of the Community Safety Partnership to err on the side of learning and commission a DHR. This recommendation was accepted.

**4.4** One of the main issues that presented itself during the completion of this DHR was the complexity of A's personal life in the years leading up to her death. The Terms of Reference at section 3 above details that the DHR panel chose to examine the five years leading to the death of A. This examination consisted of an exploration of a number of agencies' involvements with A and

the reasons leading to the need for their involvement. A's relationships with others and her personal problems were multi-faceted and this DHR was completed with a view to explore all and every factor that may have contributed to the lifestyle choices that A made, which may have ultimately played a part in the circumstances surrounding her death.

A central principle of a DHR is for the review to place at its heart the life of the victim and to try to understand the circumstances that she was placed in which led to her death. In so doing, the DHR examines agencies' responses to the victim and these circumstances in order to ascertain what lessons might be learned to help change agencies' practices and processes to make life better for others in the future and to help prevent a similar tragic death from occurring in the future. Although the remit of a DHR is to explore 'the circumstances in which the death' of the victim occurred, the DHR panel spent some time examining the information presented to them from A's friends and family, the combined agencies' chronology, and the Individual Management Reviews. This information presented a picture of A's complex life which showed that she had experienced drug and alcohol misuse, domestic abuse, relationship breakdown, mental distress, financial problems and, towards the end of her life, homelessness and criminality which had led to periods of imprisonment.

The DHR Panel believed that it was the accumulation of these factors in A's life which contributed to placing her in circumstances where she became extremely vulnerable and in the circumstances where she died. They believed that these factors could not be ignored by the DHR and that it was important to analyse this information (alongside the critical few months prior to her death and the circumstances of her death) and explore the responses from agencies to A's circumstances during the entirety of this period so that lessons could be learnt.

- 4.5** The Terms of Reference (section 3) required agencies to explore what knowledge they held about the history of A's relationships with the key individuals in her life during this time period (F, E, G and H). Information from the Individual Management Reviews and the agencies' chronologies identified that there had been significant reports of domestic abuse within A's relationship with G (where according to the Police reports, both A and G had been dual perpetrators of the abuse i.e. both had been named as victims and perpetrators). The panel believed that part of the analysis within the DHR should include agencies' knowledge of and responses to domestic violence and abuse within A's relationship with G and that in so doing, valuable lessons would be learned. Some of the recommendations for changes in practice and policy stem from the panel's analysis of agencies' responses to this domestic

abuse. However, the report clearly acknowledges that G was not involved in the immediate circumstances which led to A's death.

## **5. The Facts: History of events and relationships.**

### **5.1 A's previous history**

A was European and had lived in The United Kingdom for over 17 years. There is no agreement on the exact date of A's arrival into the country. CWPT records state that she moved to the UK in 1992 'to escape the drug culture she was involved in there,' whereas Police records suggest that the date of her arrival was 1995. Her brother D said that she first came to England in 1992 (for 6 months to work with a family, supervising their children) and then returned in 1997, initially living and working in London.

Records indicate that A had a long history of substance misuse (the primary substance being heroin) with treatment records in Warwickshire dating back to 1997.

### **5.2 The background to A's death**

On 25<sup>th</sup> October A was found dead at a house in Leamington. The property was occupied by a vulnerable adult (F) who was known to be alcohol dependent and frequented by A and E and others who were also known to be alcohol dependent. At the time of her death, A was homeless but spending some time (approximately 3 nights a week) at F's house in Leamington. She also occasionally frequented a Night Shelter, (14 occasions between March and October 2012) either to receive a hot meal or sleep the night in their accommodation.

According to Police records, on the 24<sup>th</sup> October (the night before she died) the Police received a 'silent 999' call from E's phone at 20.13. The call taker spoke with A, E and F all of whom were reported to be drunk. A said that E 'had beaten her'. E and F sought to reassure the Police that nothing had happened and that everything was ok.

The call was terminated by either A, E or F and the Police call handler had to call back. A was told by the call handler that if she had a problem with E then 'Don't be there'.

The call taker then sought to reassure both E and F that Police would attend within the hour if there was further trouble with A and advised them to call 999, if this was the case.

During the call, the call handler was also aware that another person (a member of the Night Shelter) arrived at the house and A showed him a bruise on her arm which she alleged E had caused.

The Police IMR states that the call from A was recorded on the Police system as a priority response.<sup>2</sup> No Police officers attended the address and at 22.50 Police realised this and tried to make contact, but the mobile phone which had been used to make the initial call was switched off. A message was left on the mobile but no response was ever received. At 07.42 the following day a Police officer attended the house, but couldn't get a reply. The Police log was then closed.

On the 25<sup>th</sup> October at 10.47am the Police received a call from the ambulance service asking for assistance at the scene of what was considered to be A's suspicious death.

Both F and E were arrested on 25<sup>th</sup> October and interviewed by the Police because of their potential involvement in her suspicious death. According to Police records, F at this time recalled an argument between A and E on the evening of the 999 call, but then gave conflicting versions of events thereafter. It is known that F is deemed as being a vulnerable adult who has memory impairments.

Both men were released from custody on 26<sup>th</sup> October on Police bail to allow further enquiries to take place. As these enquiries were conducted their bail was extended with the last bail date of 22<sup>nd</sup> July 2013. However, their bail was cancelled before this date.

The following summarises some of the findings from these enquiries:

- A post mortem examination revealed that A had died from catastrophic bleeding into her abdomen after her spleen had ruptured. She was found to have suffered with a rare condition named Peliosis of the spleen, which may have made the spleen susceptible to rupture. Whether the bleeding was as a consequence of disease or trauma is still unresolved and subject to a Coroner's Inquiry.
- In January 2013 additional information was given to the Police by an associate of F and E's. This was an admission by F to the associate that he (F) had 'beat A the morning she died. His justification for doing this being that 'she deserved it going behind his back selling herself.'
- During a second Police interview with F, conducted in accordance with The Police and Criminal Evidence Act 1984, he claimed that he had repeatedly punched A in the stomach area the night before she died.

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<sup>2</sup> A Police call graded a 'priority' is one where there is a degree of urgency or importance associated with it which requires Police officers to respond as soon as possible, or within one hour

The Crown Prosecution Service determined that because of the medical aspects of the case and the vulnerability and credibility of F, there was insufficient evidence to support a prosecution for any offences.

As mentioned in section 2.7 the Warwickshire Police response to the victim immediately prior to her death has since been subject to an IPCC investigation and the Coroner's inquest has been postponed until this has been completed. The IPCC report was not published at the time of writing this report.

Before looking at and analysing key episodes in A's life there follows a summary of agencies' involvement with F and E (those initially arrested in connection with the death of A) and G (A's ex partner). There is also an analysis of their respective relationships with A. No relevant information relating to H was found from either the agencies' chronologies or IMRs.

### **5.3 F's involvement with agencies**

F was known to the Police, The Recovery Partnership (after A's death), Adult Social Care, UHCW, CWPT, SWFT and Warwick District Council Housing and Property Services.

Police records show that F has 36 previous convictions for 69 offences which include possession of an offensive weapon, assault, robbery, burglary, forgery, deception and theft. His last conviction was in 2009. One offence (2006) related to a domestic abuse incident when he was cautioned following an assault on his then partner.

F was first referred into Adult Social Care via his GP (06 May 2011) for assessment and support. At the time he was homeless and an alcoholic. His eligibility was assessed under the Fair Access to Care Criteria. Following this assessment he has received support with personal care, essential cleaning, and household related support including an Independent Advocate to manage his finances. He has also been allocated a social worker and is perceived as a vulnerable adult because of a number of reported instances when it has been evidenced that he is subject to financial exploitation from others. CWPT, who initiated Safeguarding procedures in relation to F, state in their records (07 June 2011) that F is a 'vulnerable adult, bullied and robbed of money by other drinkers.' He was subsequently referred to Protecting Vulnerable People (PVP- Police department) by Adult Social Care as a result of a knife attack by two others (24 April 2012) and a Safeguarding Alert was received to Adult Social Care from staff at Leamington's Night Shelter (17<sup>th</sup> May 2012) who believed that F was being exploited by others. It was recorded in Adult Social Care records (17<sup>th</sup> May 2012) that one of the Night Shelter workers believed that A may possibly have been one of these people who were 'trying to obtain money from him (F) by preying on his frail state of health.' The Local Housing Authority (Warwick District Council) record that F stated on his housing application form that he had

been homeless for 3-4 years and was having difficulties because 'people are taking money off me and sometimes this is violent'.

CWPT records identify that they treated F in June 2011 for alcohol detoxification. During this treatment he was assessed by Adult Social Care and allocated a social worker. He also admitted to having a criminal record and to having been in prison which he indicated was 'due to violence.'

F was also referred to Swanswell to attend a drop in session (for alcohol treatment) but Swanswell have no records of him ever attending.

He was supported by staff at Leamington Night Shelter who assisted him with his housing application. He became a WDC tenant on 14th Nov 2011, moving in to the property where A died. This property was designated to be occupied by older people.

From July 2012 until October 2012, WDC Housing and Property services received 8 complaints from F's neighbours about the noise and the behaviour of his visitors who included A. WDC Housing and Property Services were in the process of obtaining an injunction to prevent A and others from staying at F's property at the time of A's death.

The only agency records that connect F with A are these Housing records and Police records. The Police records cover 8 reports of anti-social behaviour between August and October 2012 prior to the report of a disturbance on 24<sup>th</sup> October.

F has no diagnosed cognitive impairment but there have been concerns about his memory. His mental capacity was not formally assessed until July 2013 when it was confirmed that he did have mental capacity.

#### **5.4 F and A's relationship**

F and A appear to have known each other for approximately 4 months when A stayed at F's property.

It is difficult to determine whether A and F's relationship was an intimate relationship, although this is strongly suspected. The following section outlines what has been recorded and stated about their relationship from a number of different sources.

Records of an Adult Safeguarding meeting (26<sup>th</sup> October 2012) state that F had talked about A as his 'missus'. When questioned by a Housing Officer, F had said that 'they both sleep in the same bedroom together.' E, A's associate (and one of the individuals who was present the night before A was found dead) also verified this by saying that 'She used to sleep in the same bedroom as him. Whatever went on in that room (I don't know)'.

In the Recovery Partnership case files (14<sup>th</sup> February 2012) A is referred to as F's 'partner'.

As mentioned above (section 5.2), information was received by Warwickshire Police whereby an allegation was made that F had made a confession that he had 'beat' A. F told the Police that his motivation for assaulting her was because 'she deserved it going behind his back selling herself.' However, this admission was considered unreliable because 'F was an alcoholic and had given a number of different accounts with regard to A's death' (Police IMR) .

Interviews with workers from Leamington's Night Shelter stated that F referred to A as 'his girlfriend' and they expressed surprise that A was with him 'because she was a bit of a loner.' However, they felt that she was good for him. They also described a time when, 'on one occasion she went off for a couple of nights so F was a little jealous'.

The WDC Housing Officer who had contact with A during this period had suspicions that A was 'offering sexual favours' to F so she 'could stay the night at the address ....to keep a roof over her head, but they were just good friends.' A's friends (I and M) suggested that she was staying at F's address so that she had an address to register for her social security benefits.

F's use of the word 'missus', his perceived jealousy when A went off for a couple of nights and the WDC Housing officer's suspicions concerning A's offering of sexual favours in return for a roof over her head could be interpreted as indications that there was an intimate relationship between F and A.

However, at a meeting with Probation (23<sup>rd</sup> October 2012) A stated that there was no sexual relationship between her and anyone staying at F's house.

In addition, because of F's status as a vulnerable adult, many professionals believed that A and others (when they frequented his house) were exploiting him and possibly financially abusing him. The Tenancy Enforcement Officer believed that despite the fact that 'A kept the place clean and tidy ...and she put food in the cupboards,' that A was 'top dog' within the relationship with F.

There are no other agency records which evidence that A was involved in an intimate relationship with F.

## **5.6 E's involvement with agencies.**

E is alcohol dependent and a homeless person. He is a rough sleeper who spends some nights at Leamington's Night Shelter and is a regular visitor to the Salvation Army Way Ahead Project.

He is known to Warwickshire Police, having 12 previous convictions for 21 offences between 1978 and 2005. He has also been arrested and investigated for a number of violent acts against his partner/ex-partner. The Police IMR states that 'no further



action was taken regarding these matters [whereby he had been arrested and investigated] either because his partner would not provide an account or complaint to the Police or because he was found not guilty at court.’

He was referred to Swanswell as a Tier 2 (lower level) drinker who required support to improve his motivation prior to engaging in a detoxification process (Oct 2010 – March 2011). From here he was referred to CWPT for a successful detoxification at Woodleigh Beeches in August 2011.

According to Police records E features in one record of anti-social behaviour on 19<sup>th</sup> September 2012 at E’s property at that time. Further recorded contact with the Police is described in the next section.

E was also assessed by The Recovery Partnership sometime after the death of A.

## **5.7 E and A’s relationship**

When interviewed E described his relationship with A as ‘just a friend. A friend to me. We used to walk into town together, have a chat and she’d go her way and I would go mine.’ There is no information from any agency or individual that would suggest otherwise.

In the month before A died, it would appear that E spent some time with her and other street drinkers at F’s property. This could loosely be interpreted as A and E being members of the same household for the purpose of Section 9 of the Domestic Violence, Crime and Victims Act 2004, although this did not form part of the original considerations when deciding to commission the DHR.

A phoned the Police on 11<sup>th</sup> October 2012 to complain that E was following her. However no further Police action followed because by the end of the call A said that E was no longer there.

On 15<sup>th</sup> October 2012 there was another incident when A phoned the Police and E is mentioned as one of the people at F’s house who have been ‘drinking all day and night,’ (according to A).

On 16<sup>th</sup> October 2012, A called the Police shortly after midnight to report E’s aggressive behaviour towards her whilst at F’s house. Police attended the incident which was documented as a ‘verbal altercation caused by excess alcohol.’<sup>3</sup>

The final record of E in relation to A is in her call to Police on the evening of 24<sup>th</sup> October 2012, when she reports that he has beaten her.

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<sup>3</sup> Details of this incident were given to the DHR Author following a meeting with the IPCC on 25<sup>th</sup> July 2014 and have been included to ensure accuracy.

In the interview with M and I (A's friends and neighbours of F) they indicated that A had experienced 'many problems' with E in the days before she died. Their perception of what occurred at that time was that E was 'slapping (her) every day...take money £10 or £5 or £20.'

The Police IMR states that E 'does not appear to have been considered a risk or threat to A, in fact there are information logs to say they had been seen drinking together.....There is no suggestion from Police documentation that he was ever in a relationship with A.'

The information and discussion by multi-agency professionals concerning E also do not identify any intimate relationship between E and A. They also do not appear to consider any risk that E may present to A but instead focus on the threats he was thought to present to F and their attempts to remove him from F's address prior to and post A's death.

Apart from the above Police records, the only other service whose records mention E and A together are WDC Housing and Property Services' records which identify E and A as visitors to F's property and as the cause of anti-social behaviour during the period July-October 2012.

## **5.8 G's involvement with agencies**

Police records show that G and A were convicted of jointly obtaining services by deception in 1998 and were ordered to perform 100 hours community service and pay compensation of £3,742.85.

G was known to CWPT and had contact with CWPT services in his capacity as A's partner.

G had 14 contacts with the Police during the period September 2009-November 2011 which can be divided into the following categories:

- Phone calls to the Police reporting that he was a victim of domestic abuse.
- Requests for welfare checks to be made on A.
- Reports about A 's drinking and driving.
- Requests for Police to assist him in disputes in his relationship with A
- Complaints to the Police about their response to his reporting of incidences.

In September 2009, CWPT records show that G also made a complaint to staff at Woodleigh Beeches following an incident in which A was threatened by another patient.

G has a history of regular engagement with The Recovery Partnership both prior and since the death of A.

## **5.9 A and G's relationship**

It is important to reiterate here that A's relationship with G has been explored not because G had any direct connection with the events leading to A's death but because agencies' records highlight a decline in A's circumstances (both her physical, emotional and financial circumstances) during the period under scrutiny which includes a period of time when A was in a relationship with G. It is believed that it is during this period of A's life that things began to deteriorate for her, which led to a 'spiral' of decline.

When G was interviewed by the Chair of the DHR and a member of the DHR Panel (March 2014) he stated that he had known A since he was 13 or 14 years old. They began their relationship as good friends but this changed into a more intimate relationship over time. He stated that their relationship was 'perfect' at this time.

M (a long term friend of both G and A) confirmed that their relationship existed before they moved to England and said that G had moved to join A, who at the time was living in London. This account was also supported by D (A's brother).

Records show that G and A became WDC tenants in July 1998 with A moving to two further WDC properties before August 2006. It's unclear whether A and G were married or partners and it is difficult to establish the exact date when they may have separated. Records often refer to him as her partner or ex-partner. However, when interviewed, G stated clearly that he was married to A. In 2010 Police records state that A told them that she had been in a relationship with G for 16 years.

A and G were in partnership in a photocopying company (established in 2005) concerned with the supply of second hand Xerox copying machines. In June 2008 it was recorded (chronology June CWPT) that they 'owned a one million pound business' and that A was the Financial Director of the company. In discussion with the DHR Chair, G confirmed that he was the Managing Director of this company.

From June 2008 to Dec 2011 A lived in a house that was valued at over £1,000,000. G lived with her in this property until sometime early in 2010.

During this period both Police and health records evidence that A and G's relationship was difficult and that there was reported domestic abuse.

The Police records describe A both as a victim and a perpetrator of domestic abuse in relation to G which serves to demonstrate that (as with many relationships where domestic violence and abuse is present), this was not a straightforward relationship. In addition, many of the Police records indicate that A was drunk when they arrived

at her house when they attended a reported incident. It would appear that A's intoxication presented the Police with additional difficulties in identifying what had occurred between A and G when the Police were called to specific incidents.

In his written submission to the review, D (A's brother) described being very angry with G (during these years) because of his 'verbal violence' towards A. He stated 'there was never any physical violence when I was present, but he did bad things.' He also mentioned that G 'started putting my sister under psychological pressure.'

When interviewed by the DHR Chair, G denied any physical violence towards A, but said that she behaved violently towards him. He said that he considered that she had 'alcohol and mental health problems.' G did however, describe the installation of an expensive security system with laser beams and close circuit cameras at their joint property, which was located in the countryside. Police records identify that these security systems were used by G to monitor A's behaviour when he had moved out of the property and separated from A. This behaviour could be interpreted as that of a caring partner who wanted to ensure that his partner was safe. However, in their IMR, the Police now also recognise that this behaviour 'could be construed as very controlling.'

According to the Police IMR and Chronology from 13<sup>th</sup> September 2009 and throughout 2010, A and G's relationship appeared to deteriorate. There were numerous calls to the Police during this time ostensibly concerning their dispute over the division of property.

M (a friend) worked for G and A during this time and when interviewed by the DHR Chair, he described their relation as difficult and complex in that, 'he was scared of her and she was scared of him.....She was drinking and he was on drugs.' He said that he had seen 'marks' on A's body and it was M's opinion that she (A) thought of herself as a victim in the relationship and that 'although she loved him, she didn't trust him and believed that he was hiding money from her.'

Both M and D also state that G was seeing another woman during the time they lived at this property which was causing A distress.

D, in his written submission to the review, stated that he believed that A felt increasingly isolated as a result of living in this rural location. He stated that prior to living there she had worked 'at the company' but that 'she started to do things at home more.'

Following their separation, G appears to have had ongoing concerns for A, particularly in relation to her mental health. It is to be noted that during the period February –September 2011 it is recorded that on 6 separate occasions G reported to services that he had concerns for A's mental health.

The last recorded disclosures from A alleging domestic abuse at the hands of G were in February, March and June 2012.

On February 14<sup>th</sup> 2012 A attended UHCW with 'significant facial injuries' which she said were as a consequence of an assault 'by an ex partner (European)' on 5<sup>th</sup> February 2012. However, records show that on the date of the alleged assault A attended hospital on two separate occasions (from 6am-8am and then again at 9am) and discharged herself on the 6<sup>th</sup> February 2012. Neither of these hospital admissions refers to any assault or relevant injuries. We do not know why A gave this date to the staff at the hospital, but there is a record of the significant facial injuries she sustained when she was seen at UHCW on February 14<sup>th</sup>.

On 29<sup>th</sup> February 2012 A visited Warwick Hospital Accident and Emergency department and their records state that she had a leg injury following an alleged assault by her ex-partner 3 days previously. A also alleged that facial injuries were sustained at the same time. The medical staff documented that A's account of the facial injury 'is variable and not consistent with the injury sustained.'

It is not clear why A made these allegations or why the medical staff drew such conclusions in relation to her injuries.

On the 6<sup>th</sup> March 2012 A was admitted to Warwick Hospital Accident and Emergency Department with a head injury. She alleged her "ex" pushed her. A told staff she had split with her partner which is why she had been drinking vodka all day. Records show that a history of events was difficult to take as A gave different versions of accounts and repeatedly locked herself in the toilet.

Because of the circumstances and the lack of clarity in written records, it is difficult to assess and determine exactly what had happened to A to cause such injuries.

Finally, on the 13<sup>th</sup> June 2012 GP records show A was prescribed anti depressants by GP3. Notes reveal that she was 'low and depressed' and that she disclosed that 'her ex partner had physically abused her.' The record also notes 'lost teeth,' but there is no clarity in the notes to evidence that this was the result of domestic violence and abuse. Again, it is important to note that these events are not directly significant to the events of A's death but are here as relevant background information and are part of a number of factors which give a picture of A's increased vulnerability and change in circumstances in the period leading up to her death.

## **6. Integrated Chronology**

All agencies provided a complete chronology to the Panel. What appears in the following sections are all of the relevant contacts.

The integrated chronology showed that A had extensive contact with services between June 2008 and October 2012, the parameters established within the Terms of Reference. For instance Warwickshire Police cite that 'there is in excess 105 examples recorded of contact between Police officers and staff and A' in this period. Her GP practice had over 40 contacts with her and according to the Local Area Team IMR these primarily were to try and assist with what would appear to have been a "spiral downwards" of alcohol and drug problems.

The following serves to present a picture of how these services were engaged in A's life during this time. The time period (determined by The Terms of Reference - section 3) is approached in chronological order but it has been divided and categorised according to different themes. The title of each theme attempts to describe the dominant factor in A's life during the specified time period, although in reality the themes of domestic abuse, mental distress, and alcohol and drug misuse co-existed at times. They were compounded by a worsening financial situation and homelessness following A's eviction from her property in December 2011. Her behaviour towards the end of her life was perceived as anti-social behaviour fuelled by alcohol misuse.

### **6.1 Theme one: Substance /alcohol abuse: April 2008-October 2009**

CWPT records show that A had four main episodes of contact with CWPT services over the time period specified in this review.

Three of these episodes were with Substance Misuse Services, both in-patient and community services. These were between June 2008 and February 2011 .The fourth episode was with Mental Health Services between February and October 2011. These episodes are integrated into the first two sections of the chronology.

April to May 2008	A attempted two home detoxifications with support from a Community Substance Misuse Nurse.
9 <sup>th</sup> June 2008	A was admitted to Woodleigh Beeches inpatient services (Alcohol Treatment Unit) for detoxification from alcohol. She discharged herself the same day.
October 2008	A engaged with the community substance misuse service sporadically, attending for assessment during October but failing to attend the further three appointments. She was discharged in February 2009 after stating that she no

longer needed the service as she was drug and alcohol free.

- 13<sup>th</sup> September 2009 The first reported incident to the Police of a 'domestic dispute' records an incident when they were called to A's house by G who reported A was 'smashing up his Landrover.' Records state that A was 'drunk and the couple are divorcing.' No offences were disclosed and both were warned about future behaviour. Police recorded this incident as medium risk with G as victim and A as perpetrator.
- 17<sup>th</sup> September 2009 Pre-Admission risk assessment notes (CWPT) for detoxification treatment described A's behaviour as 'verbal abuse towards partner but not to others.' The bruising noted to arms, legs and trunk was recorded as 'bruising from bumping into things.' This bruising was also noted under falls and accidents.
- 19<sup>th</sup> September 2009 A disclosed being a victim of domestic abuse to SWFT staff in Warwick Hospital Accident and Emergency department. Records detailed 'bruising on abdomen and breasts have been caused by her partner.' Records also stated that A said that her partner 'encourages her to drink, so he can control her.' Help in this case was offered but declined by A.
- 24<sup>th</sup> September 2009 A disclosed to Woodleigh Beeches (CWPT) staff stating that her 'partner is abusive towards her, (it is a) physically and verbally volatile relationship....partner is possessive and controlling.'
- 26<sup>th</sup> September 2009 Whilst still undergoing a detoxification process, A reported 'problems at home and marital problems.'
- 2<sup>nd</sup> October 2009 A completed treatment and was discharged. A did not attend any of her follow up appointments and was discharged from the service back to the care of the GP on 8<sup>th</sup> January 2010 as per CWPT discharge policy.

## **6.2 Theme Two: Domestic Abuse: November 2009 – January 2011**

Between 9<sup>th</sup> November 2009 and 5<sup>th</sup> February 2011 the majority of agency contact with A was with Warwickshire Police. For some of this time A was living with G in a

large detached property situated in a rural setting. The Police believe that 'from an unknown date early in 2010 G moved out leaving A to live there on her own' and Police records state that on 1<sup>st</sup> March 2010 he is recorded as living elsewhere. Her brother D lived with her for a short time but according to the Police IMR, that relationship became problematic and he moved away.

There were 23 logged Police calls in this period relating to A.

- 8 of these were categorised as domestic disputes (3 of these were reported as G being the victim and A the perpetrator, 3 with A as the victim and G as the perpetrator and 1 with A as the victim and her brother D as the perpetrator and 1 with D as the victim and A as the perpetrator);
- 2 drink/drive call outs;
- 1 complaint of theft;
- 3 welfare checks in relation to A;
- 1 breach of the peace;
- 1 malicious communication;
- 2 complaints of phone calls;
- 1 mistake call;
- 1 Advice call;
- 1 report of burglary;
- 1 report of disturbance;
- 1 report of theft of a car.

Interspersed in these contacts with the Police are A's visits to health services (GP, Accident and Emergency (A +E) department and the Community Drugs Team). Her contact with her GP and A+ E evidence that A made disclosures that she was a victim of domestic abuse.

### **November 2009**

There were 4 incidents of 'domestic disputes' in November 2009. The incidents on the 9<sup>th</sup> and 10<sup>th</sup> November were assessed as medium risk and those on the 11<sup>th</sup> and 12<sup>th</sup> as standard risk. Two contain reference to A's drinking, one refers to the possibility of a relationship separation and one focuses on G's threats to kill A's dogs.

### **February and March 2010**

26<sup>th</sup> February

G contacted the Police and asked to be arrested. The Police now believe that this suggests that G may have considered that A had already reported an offence committed by him. Bruising was seen on her arm and chest. G reported that A was drunk and preventing him



from going on holiday. This dispute was recorded on the DASH risk assessment as a verbal altercation and medium risk with G as the victim. However, the Police CATs log recorded A as the victim and G as the suspect. There is no indication in Police records as to why this disparity, between the DASH risk assessment recording and the recording on the CATs log, exists.

27<sup>th</sup> February

A was admitted to Warwick Hospital Accident and Emergency department with chest pains. The notes record that she has 'pain when anxious and has been having longstanding argument with partner. Bruising to left arm and left side of chest noted.'

1<sup>st</sup> March

A was seen by GP2 and discussed Relate/Counselling. GP2 identified multiple bruises to arms and shoulders and A revealed she had been arguing with her partner.

1<sup>st</sup> March

A contacted the Police to complain that G had smashed up her room but was no longer living with her. A was identified as the victim and G as the perpetrator and the incident was assessed as medium risk.

19<sup>th</sup> March

G called the Police and reported that A was 'kicking off' and had taken some gold coins. Police attended the scene and advised G that this was a civil matter. This was recorded as a domestic dispute with no criminal offences identified and was assessed as medium risk with G as the victim.

20<sup>th</sup> March

Police received a call from Mayfair Security Services who were responsible for CCTV at A's property. They had been instructed by G to phone the Police if they saw A driving. G also phoned the Police to inform them that A was an alcoholic who shouldn't be driving. When Police arrived, because A was on private property she was not arrested.

25<sup>th</sup> March

G again reported A for being drunk and attempting to drive his car. When Police arrived at the house she had not driven off but was inside the house and no offences were recorded.

**October 2010**

4<sup>th</sup> October Police are contacted by A who stated that 'she had been living separately to her partner G' who was currently abroad but returning to the UK imminently. She told Police she was fearful for her safety and complained that G had made threats to her and had been violent in the past. This is categorised by Police as an 'advice' call.

6<sup>th</sup> October Police conduct a follow up visit to A who stated that 'she believed that G was manipulating the situation', (i.e. their separation), 'so that he could obtain the majority of the property and money.' She was told that this was a civil matter and she should seek legal advice at the earliest opportunity. She denied when asked, that he had made any threats towards her causing her to be concerned about her safety at that time. However, a risk assessment was conducted where she disclosed a history of violence by G towards her in the past which included him punching and kicking her and also burning her skin with a hot poker. She told Police that G was a jealous and insecure person who always thought she was having affairs with other men. Alcohol and drugs are recorded as not being an issue at that stage between the two persons. The Police domestic abuse risk assessment classified the risk to A as standard.

24<sup>th</sup> and 30/31<sup>st</sup> October Police received 3 separate telephone calls. Two of these from A and one from D identifying that D had received threats to kill from a man in Portugal over the phone from 'a male who said his name was Mustafa.' When A phoned the police, she told them that she believed this man to be G, who was abroad at the time. Police records note that at the time A phoned them she was on holiday in Egypt and D was looking after her property while she was away.

27<sup>th</sup> October Before leaving for Egypt, SWFT records show that A attended A+E and had been given analgesia for non specific chest pain and was discharged.

### **November 2010 –January 2011**

1<sup>st</sup> and 2<sup>nd</sup> November Two recorded Police welfare checks, one instigated by A, who was concerned for her brother's wellbeing whilst she was in Egypt and the other instigated by D who was

	worried about A who had missed her flight back to England.
12 <sup>th</sup> November	A reported a burglary at her property. Following a Police investigation it was identified that the 'burglar' was G returning to the property to take his own possessions.
25 <sup>th</sup> November	A called the Police to say that she had received telephone calls from a European man named R who was threatening to kill her family. Police established that the relevant European Police force was dealing with this and there was no further action.
31 <sup>st</sup> December	Police call out (at 23.49) to a dispute between A and her brother D. Domestic Abuse risk assessment identified D as the victim and noted A to be drunk and taking methadone.
12 <sup>th</sup> January	Police call out (at 01.05) to a dispute between A and D. Domestic abuse risk assessment identified A as the victim and the risk as 'standard.'

A's only other contact with services in this period was her ongoing contact with the Community Drugs Team. Despite attending for one appointment on 26<sup>th</sup> November, she failed to attend a further appointment and so was discharged from the service back to the GP (1<sup>st</sup> December). Similarly during December 2010 and January 2011 she missed a further 3 appointments with the Community Drugs Team.

### **6.3 Theme three: Concerns for A's Mental Health and Alcohol/Substance misuse February —December 2011**

This period of A's life appears to be a time when A becomes increasingly dependent on alcohol. It appears to be characterised by the continuing 'fallout' from the breakdown of her relationship with G and the decline of their business; a deteriorating financial situation; the repossession of her property; an increasing number of arrests for theft, assaults and drink related offences, and increasing concerns for her mental health.

During this 11 month period A was repeatedly referred to CWPT Mental Health services through her GP practice.

#### **February 2011**

- 9<sup>th</sup> February A's GP2 talked to her about a referral to a Community Psychiatric Nurse because she was 'upset but not suicidal.'
- 12<sup>th</sup> February Police records state that G contacted them to say he had attended A's property and A had taken his car keys and wouldn't allow him to drive away. When Police officers attended, A locked herself inside the house and refused to answer the door. Police officers were told that her dogs would attack them if they forced entry. A eventually came out of the house and handed the car keys to the Police. She said there had been a misunderstanding. The domestic abuse risk assessment was completed and risk identified as standard with A viewed as the perpetrator of the abuse.
- 17<sup>th</sup> February Warwick Mental Health Crisis Team received an urgent referral from A's GP expressing concerns about her mental health. This call had been triggered by a third party (G) who had rung the surgery 'expressing concerns about A and suicidal thoughts.' The GP's letter, according to CWPT's records states that A has 'recently separated from her partner of many years standing' and that there were concerns including A appearing depressed, having anger issues about the breakup of her relationship and feeling that she had been badly treated.
- 28<sup>th</sup> February A contacted Mental Health services in response to a letter received from them. Records state that 'she was surprised to receive a letter from mental health stating there was nothing wrong with her'. It was also noted by a Social Worker that A 'spoke rapidly and sounded excitable...stated that people think she talks to walls.'
- 28<sup>th</sup> February CWPT records state that A telephoned the Crisis Team and an appointment was made for an assessment on 2<sup>nd</sup> March 2011. A did not attend this appointment or the three subsequent appointments offered by CWPT.
- March 2011**
- 3<sup>rd</sup> March A reported to Police that she was receiving about 20 abusive text messages a day from her ex- partner (G). She said she had kept the messages on her phone.

Officers attended at 14:28 hours that day and found her apparently drunk. Her phone didn't have a SIM card so any messages could not be viewed and owing to her drunken state officers were not able to get a coherent response from her about her complaint. She was found rushing around having discovered the annexe to her house was completely flooded. The officer attending stated she appeared to be either drunk or displaying mental health problems.

Warwickshire Police contacted the Crisis Team who confirmed they were aware of A and had sent a letter out that day to arrange an appointment.

10<sup>th</sup> March

A phoned the Police at 21:39 hours. She was crying and the Police call taker could not fully understand what she was saying. She asked the Police to attend her address to help her and said she believed the Police were not helping her. This was noted as a 'non urgent call.'

11<sup>th</sup> March

Police visited A at 12.27. She said that she was surprised to see the officers and denied calling the previous night and had no recollection of the call. She refused to speak to the attending officer saying she would only speak to CID officers and asked them to leave the premises as they had no business being there.

16<sup>th</sup> March

Police received a call from A who reported that G was listening to and blocking her telephone calls. She said he was contacting persons on her behalf and also making false calls. She demanded that CID officers deal with her complaint and an appointment was made for 16:30 hours. A further call was received from A saying she didn't want to speak to Police. She refused to speak to Police saying they were not dealing with her problems. Police officers attended her home but she would not answer the door. When officers were able to speak to her she told them she couldn't locate the phone to demonstrate the problem and showed them unrelated documents regarding money and her divorce proceedings. A domestic abuse risk assessment was completed which highlighted A's alcohol problems but recorded that there was 'no previous history of violence between the two and that the 'abuse' was happening more often as the couple have long running issues owing to the downfall of their business.' A also

said during the risk assessment that she was scared that G would take all her money and felt isolated from friends and family because they all lived abroad and she did not have the means to return home. The risk to A was assessed as standard.

## **April 2011**

2<sup>nd</sup> April

Police received a call from A at 19:00 hours complaining that her ex-husband / partner had grabbed her and had run off across an adjacent field. A Police search was conducted for her ex partner without success. A was drunk at the time and it transpired that she was frightened that G was going to take her car away from her. A domestic abuse risk assessment assessed her as being a standard risk. Police referred A into WDVSS (Warwickshire's specialist domestic violence service at that time), who attempted to contact her on 5<sup>th</sup> April but were unable to. No further attempts were made to contact A. WDVSS records state that this was because 'there were no children and no offence reported and the couple were stated to have separated – the case was closed.'

4<sup>th</sup> April

A was arrested for Drink / Drive offence which resulted in a refusal to give blood. A was charged with 'failure to provide specimen for analysis.' A was bailed to appear at Court on 13<sup>th</sup> April 2011;

6<sup>th</sup> April

A phone call from A to the Police was categorised as a 'nuisance phone call' and records show that the call taker was concerned that A 'may be suffering from mental health issues';

11<sup>th</sup> April

Phone call from A to the Police in relation to repossession of her cars;

15<sup>th</sup> April

A called Police to report Theft of Vehicles;

18<sup>th</sup> April

The Crisis Team received a referral from the Emergency Duty Team (Social Care) following concerns expressed to them by G regarding A's 'increasingly bizarre behaviour.' The Community Psychiatric Nurse was advised to discuss the matter with A's GP with the suggestion that the Police

should 'request a medical assessment when they arrest her regarding a drink drive incident.'

19<sup>th</sup> April

GP7 attempted to phone A but got no response. GP7 then contacted Police and asked them to call back to discuss the case. There is no record of a call back from the Police to the GP. However, A was seen by a medical professional whilst in custody on 5<sup>th</sup> May 2011 (see entry below).

23<sup>rd</sup> April

G phoned Police requesting their accompaniment to A's property as he wanted to collect his dog. He said he was concerned about A's mental health which he said was deteriorating rapidly and he no longer felt safe when he visited her address alone. Police records state that A was 'suffering with mental health issues.'

## **May 2011**

3<sup>rd</sup> May

Police record a request for assistance from G who complained that following an argument, A had taken his keys and his Rolex watch. He told Police he was concerned that A would stab him. G was at the address to return a dog and Police reported that A had misplaced his car keys. The Police domestic abuse risk assessment stated that there 'was no history of violence between them.' The question in the risk assessment regarding are there any alcohol or drugs issue's was also answered 'no.' It was recorded that G believed that A may have mental health issues. The risk to G was assessed as standard in what Police termed an 'unamicable' separation.

5<sup>th</sup> May

A was arrested at a restaurant for theft of food. She had left without paying and had assaulted 2 members of staff. She appeared to be under the influence of drugs or alcohol. She was seen by a health care professional and found to have a bruised eye. A doctor prescribed methadone for her. She was given the opportunity whilst in custody to see an independent drug/alcohol scheme worker but declined the offer and denied that she was alcohol dependent but admitted that she was dependent on methadone. She was detained until 11:14 hours and

then granted conditional bail to the Police Station at 09:00 hours on 6<sup>th</sup> June 2011. She subsequently failed to answer bail. Prior to release a risk assessment was carried out which recorded that A appeared calm and rational and there were no concerns for her welfare. Whilst in custody she made a complaint that she had been the victim of a robbery.

20<sup>th</sup> May

A phoned Police to report a domestic dispute with G where she had sustained injuries to her arms and elbows. Police officers attended and reported that A told differing stories as to how she had sustained the injuries, claiming initially that G had pulled her to the ground in a dispute over the sale of a quad bike, and then saying she sustained the injury when she fell to the ground whilst trying to stop G leaving in a vehicle. She repeatedly refused an ambulance but agreed to speak to The Crisis team. The domestic abuse risk assessment stated that there was a history of violence between G and A but that this was not escalating and that A did not feel threatened or vulnerable. She stated she felt isolated from family and friends. The Police log for this incident shows A as the victim and G as the suspect. The Police referred A to the Crisis Team who were unable to contact A and a letter was sent to the Police officer dealing with the case informing him of this.

## June 2011

5<sup>th</sup> June

D phoned Police to make a complaint about G who he alleged telephoned to say that he intended shooting A's dogs. Records show that Police officers attended the address but found no sign of a disturbance or evidence that this had occurred. Records also state that contact was made with G and he denied making threats but said he was concerned about A's mental state.

14<sup>th</sup> June

A was arrested (for failing to answer Bail on 6<sup>th</sup> June 2011). During this arrest she assaulted the arresting officer. A custody risk assessment was carried out which recorded that she was intoxicated. Whilst in custody she was examined by a health care professional at 07:59 hours who agreed to her taking methadone she was being



prescribed at that time. She declined the offer of contact with Independent Drug / Alcohol referral scheme worker and was charged and bailed at 10:26 hours with making off without payment and 2 counts of common assault. On her release it was recorded that she was calm and rational and that there were no concerns for her welfare.

23<sup>rd</sup> June

GP8 referred A to Community Drugs Team with a request for methadone.

19<sup>th</sup> June to 15<sup>th</sup> July

Police were involved with A when there were a series of reported incidents where her dogs attacked other dogs whilst out walking and also bit another dog owner. The dogs were seized on 8<sup>th</sup> August 2011 under The Dangerous Dogs Act.

## **July 2011**

9<sup>th</sup> July

A was arrested for theft from a BP Garage. Police records described her as 'drunk and uncooperative'. A was spoken to by a drugs support worker but refused help. She appeared in court for this matter on 11<sup>th</sup> July 2011 and was convicted and fined.

15<sup>th</sup> July

GP5 made a referral to the Community Drugs Team in relation to A's request for methadone. By 18<sup>th</sup> July GP5 was made aware that A had not responded to an appointment made by Community Drugs Team.

29<sup>th</sup> July

GP records show that GP7 had concerns about A's overall mental health and was having discussions with a consultant psychiatrist.

## **August 2011**

6<sup>th</sup> August

D called Police to express his concerns for A's welfare as he had been unable to contact her. Police Officers visited her address twice but could not contact her. Following a second call from D the next day, Police made contact with A and were satisfied she was safe and well.

19<sup>th</sup> August

There was a conversation between GP7 and Police. GP7 was concerned that A was suicidal and planning on killing herself. However, GP7 believed that it was not safe to do a home visit.

- 19<sup>th</sup> August A was arrested for criminal damage to a public house.
- 25<sup>th</sup> and 29<sup>th</sup> Aug Police carried out welfare checks on A (the second being prompted by a call from D). Police did not find A at her home but she had been seen at the Police station on 26<sup>th</sup> August.
- 31<sup>st</sup> August Police received a call from G who was concerned for A. It was recorded that he believed that 'if A saw him, she would stab him.' At 11:24 hours Police officers attended her property where they saw and spoke with her. They had no immediate concerns for her and described her as being 'safe but in need of help' and supplied her with details of a telephone number for counselling services. No further action appears to have been taken or any other agency involved.

## **September 2011**

- 1<sup>st</sup> September The Mental Health Crisis Team received a telephone call from G expressing concerns about A's mental health and stating that she had made numerous calls to the Police. The records note G's concerns as: 'she thinks people are coming in to the house via the loft so has super glued the loft opening shut, trashed the house, constantly phoning the Police and fire brigade, ripped out electricity cables to the home, cut CCTV cables, owns 60 mobile phones, has been seen talking to her hand and an imaginary person next to her, threw bricks at the Police when he went to the house to collect his bike, took dangerous dogs into town resulting in dogs being removed ...' The Mental Health Crisis Team then contacted the Police who confirmed that if they had had any concerns about A's mental health they would have contacted mental health services; therefore it was not considered that an assessment of A's mental health was required at that time.
- 9<sup>th</sup> to 19<sup>th</sup> September CWPT and GP records evidence on-going discussions between the Mental Health Crisis Team and the GP regarding the appropriateness of a mental health assessment under the Mental Health Act. A fax from GP2 to a member of the Crisis team asks for a mental health assessment to be carried out on A and talks of the concern for A saying that 'she has been deteriorating

steadily (since separating from her husband). The house has fallen into disrepair---her business has fallen apart... She has crashed her car and, most recently her guard dogs have been taken away. She has been involved with the Police several times for disruptive behaviour, but there are now concerns about her mental state as G thinks she is suicidal and we have information from a friend of hers that she is going to commit suicide.'

Discussions between health professionals also involved the difficulties of assessing A if she had been drinking, her failure to turn up to appointments and the difficulties they had in contacting her.

16<sup>th</sup> September Police, having visited her property and having not found her there, had concerns for A's welfare with the prospect that she could be a missing person. Some property belonging to A had been found and handed in to Police on 2<sup>nd</sup> September. Her brother D phoned Police and confirmed she had stopped phoning him and her mother. Police circulated information about her as a missing person. A was found on the 17<sup>th</sup> September and returned to her home address.

19<sup>th</sup> September The Mental Health Crisis Team and Police carried out a joint visit to A with the aim of carrying out a mental health assessment. The house was in an extreme state of disarray and A was not around.

20<sup>th</sup> September CWPT records include reference to a discussion between a Social Worker and a Doctor. The Doctor advised the Social Worker to make continued efforts to engage with A, but felt that a mental health assessment would be difficult if she was under the influence of alcohol.

23<sup>rd</sup> September Police records show that A was arrested for allegedly assaulting another female.

24<sup>th</sup> September A was seen by the Police Surgeon whilst in custody who found no evidence of mental illness. Records state that he found her to be 'apsychotic, asuicidal and intact with no evidence of mental illness.' CWPT records show that A was later assessed by a Community Psychiatric Nurse (CPN) whilst in Police custody. According to the records 'A denied having any concerns regarding her mental health, was agitated at the time of the assessment but

explained that this was due to her withdrawing from methadone.' A was advised to contact her GP and engage with the Community Drugs Team in order to obtain methadone; she was also given contact details for the Crisis Team and Independent Access to Psychological Therapies (IAPT).

26<sup>th</sup> September

Police recorded that A was involved in an incident when she fell over and knocked some teeth out. She was taken to Warwick hospital for treatment but did not enter and attend the hospital. On the same day D is reported to have contacted the Police regarding his concerns about A's welfare.

## **October 2011**

A's contacts with services in October are predominantly with the Police and health services and feature the following:

10<sup>th</sup> October

A was arrested for failing to appear at Leamington Magistrates' court (had had no methadone for 11 days and told custody sergeant she needed to get some). Appeared before Warwick Magistrates' court and was fined £50 for failing to appear.

11<sup>th</sup> October

A was arrested for being drunk and disorderly in Church.

18<sup>th</sup> October

GP records state that A had an appointment for a burn on her right arm and chest from a poker.

## **November 2011**

4<sup>th</sup> November

GP records reveal that A had a discussion with GP7 where she disclosed that her partner had 'physically assaulted her on numerous occasions' and claimed that he broke into her home three weeks before. She also requested methadone at this appointment.

6<sup>th</sup> and 9<sup>th</sup> November

GP records report A had been admitted to Warwick Hospital on the 6<sup>th</sup> November having collapsed. The first incident is verified by SWFT medical records who record a three hour stay for observation and a self discharge. The second visit to Warwick Hospital on the 9<sup>th</sup> November

shows A to have been admitted for a detox having been found 'collapsed in the kitchen with cooker on.' She self discharged after approximately 4 ½ hours. There are no indications for domestic abuse noted in the health care records.

14<sup>th</sup> November F moved into the property where A was later found dead. (WDC Housing Tenancy agreement).

17<sup>th</sup> November A was arrested for breach of the peace and was drunk and disorderly. She asked to speak to an independent drug/alcohol scheme worker and records show that when a health care professional examined her they found her to be 'alert and orientated'. She demanded to go to hospital and threatened to self harm if not transferred and was therefore subject to constant supervision. She spoke of wanting to see her doctor so she could go to rehabilitation as she wanted to 'turn her life around'. At that time the custody sergeant recorded that should an addiction worker attend they would come and speak to her.

18<sup>th</sup> November A appeared before Warwickshire Magistrates Court and was convicted of failing to surrender to custody and drunk and disorderly conduct and was conditionally discharged for 6 months. This sentence was later varied as she breached the conditions of her discharge.

22<sup>nd</sup> November A reported an injury to Police. This was assessed as being an old injury, but A was alleging that she had been assaulted by another female. She left the Police station without being seen by anyone.

25<sup>th</sup> November CWPT records show that they had received a letter from F's GP asking for an assessment for F regarding his alcoholism.

## **December 2011**

A's property was repossessed by The Royal Bank of Scotland.

13<sup>th</sup> December Connells Estate Agents reported that the premises that had been repossessed had been broken into. Police officers arrived at the property on 14<sup>th</sup> December and

found that the premises had been broken into but that property had been gathered as if ready for collection. This was recorded as criminal damage only. A was suspected of returning to the premises to collect her property and having forced entry. It appears from Police records that A then stayed with friends until February 2012 when the householder then told Police that she was no longer welcome there.

20<sup>th</sup> December

Police arrested A for theft of alcohol from Tesco in Leamington Spa. She was interviewed and bailed to attend the Police Station at 11:30 hours on 23<sup>rd</sup> January 2012. On that date the bail was varied to 29<sup>th</sup> February 2012. When in custody she stated that her last heroin use was in 2003 but that she was now on 10 ml of methadone.

#### **6.4 Theme 4: Homelessness February – October 2012.**

According to Police records from February until August 2012, A lived at another property that she owned (she had purchased from WDC under the Right to Buy scheme). This property appears to have been rented out to A's tenants. Thereafter she gave her address as F's property. As previously described (section 5.2) at the time of her death, A was homeless but spending some time (approximately 3 nights a week) at F's house in Leamington. She also frequented Leamington's Night Shelter between March and October 2012 either to receive a hot meal or sleep the night in their accommodation.

During this time she also served three terms of imprisonment imposed by the court (13<sup>th</sup> April- 2nd May, 9<sup>th</sup> May- 12<sup>th</sup> June and 2<sup>nd</sup> July- 16th July).

This period of A's life is characterised by bouts of heavy drinking, aggressive and anti-social behaviour, visits to Accident and Emergency departments and multiple arrests by Police for thefts and failure to comply with bail conditions. For instance, Police records reveal that A was arrested for theft on 7 occasions between February and June 2012.

The following are some specific instances that represent an increasingly chaotic lifestyle.

#### **February 2012**

5<sup>th</sup> February

A was admitted to Warwick Hospital Accident and Emergency department at 06.08 am following a fall at the

hospital entrance when she was heavily intoxicated. A sustained bruising in the fall and had 2 alcohol related seizures in the department. She was admitted for detoxification and investigations. A discharged herself on 6<sup>th</sup> February against medical advice.

14<sup>th</sup> February

UHCW records show that A is transferred from Warwick Accident and Emergency Department to UHCW. A alleged that she had been assaulted by an ex partner on 05/02/2012. Records state that she also referenced his nationality. There is no Police record of this assault being reported to them.

Hospital notes state she had significant facial injuries and required specialist services only available at UHCW. She was reviewed by an alcohol liaison practitioner who noted that A's drinking for the last year was 'due to the DVA with her ex-partner.' In preparation for the surgical procedure, A was prescribed an alcohol detox regime to reduce the risk of complications during and following surgery.

The Recovery Partnership records show that a Recovery Worker was not able to assess A on that day when they visited her in Coventry Hospital 'due to levels of intoxication and were unable to communicate effectively due to a broken jaw.' Their records also note the injuries were 'from domestic violence by her ex-partner' and that this information 'was taken from written hospital information.'

15<sup>th</sup> February

A decided that she would not proceed with the required surgery. She was discharged and transported to Spire House Union Street to discuss emergency accommodation because she had stated that it was unsafe to return to her current address as this was where her partner lived.

27<sup>th</sup> February

A visited The Way Ahead Project (Salvation Army) at 10.30 am but is drunk and verbally aggressive. Records stated that 'having refused to leave she was walked off the premises and lashed out at a member of staff'.

29<sup>th</sup> February

A visited Warwick Hospital Accident and Emergency department with a leg injury following an alleged assault

by her ex-partner 3 days previously. Allegations are made that facial injuries were sustained at the same time. The medical staff document that A's account of the injury is variable and not consistent with the injury sustained. It is noted that A lived alone but had recently got back with ex-partner, however no names are documented. A has a fracture confirmed and was treated with a non-weight bearing plaster cast and pain relief. A does not follow instructions given by nursing staff and 'walks on the plaster.'

2<sup>nd</sup> March

A failed to attend a fracture clinic outpatient's appointment. However, later she attended Warwick Hospital Accident and Emergency department with a foot injury but refused to go into the department to be seen by a doctor. She was advised to contact the fracture clinic the following Monday morning to reschedule her check-up.

3<sup>rd</sup> March

A was admitted to Warwick Hospital Accident and Emergency Department after being found by paramedics at the railway station. The medical staff stated that A was found on rail tracks intoxicated, however paramedics found her behind a car in the car park having been witnessed to fall. Her plaster cast was disintegrated; she was described as 'cold and hungry.' A's injury was treated and she was given food and discharged. Whilst in the waiting room A was found drinking vodka so was escorted from the premises.

That evening, Police arrested A following a disturbance at a public house in Warwick. She was wanted in relation to a theft from a shop earlier that day. She was detained at Warwick Police Station where she was described as very drunk, abusive and uncooperative. The Custody Sergeant was unable to carry out a full assessment on her owing to her drunkenness. She was recorded as having a bandage on her right ankle where a plaster cast had been removed two days before and that she appeared to be able to walk. When she was seen by a health care professional they recorded that she was so drunk that they were unable to understand what A was saying. The health care professional recorded no apparent injuries on the custody record.



- 6<sup>th</sup> March A was admitted to Warwick Hospital Accident and Emergency Department with a head injury. She alleged her “ex” pushed her. A told staff she had split with her partner which is why she had been drinking vodka all day. Records show that a history of events was difficult to take as A gave different versions of accounts and repeatedly locked herself in the toilet. She was then admitted for overnight observation and then discharged.
- 7<sup>th</sup> and 14<sup>th</sup> March A had outpatients’ appointments at Warwick Hospital that she failed to attend.
- 8<sup>th</sup> March A appeared before Leamington Magistrates Court for the offence of Theft-Shoplifting. She was sentenced to a 12 month Community Order with Supervision. She failed to attend her induction appointment on 9<sup>th</sup> March and whilst under Probation Supervision during this order she only attended 2 office appointments and failed to attend 4 other offered appointments.
- 12<sup>th</sup> March The Recovery Partnership was contacted by A’s GP5 to refer A into their service. The Recovery Partnership sent a letter to A informing her of their drop-in service. This letter was sent to the property that she had been evicted from (which was the address given to The Recovery Partnership by the GP).
- 28<sup>th</sup> March The Probation Service asked The Recovery Partnership to assess A’s suitability for an ATR (Alcohol Treatment Requirement), a community treatment order which can be imposed by the courts. An appointment was arranged for A on 5<sup>th</sup> April which she failed to attend. Another appointment was made for 10<sup>th</sup> April.
- 4<sup>th</sup> and 8<sup>th</sup> April Leamington Night Shelter records show that A stayed overnight.
- 13<sup>th</sup> April A sentenced to 2 months imprisonment. This action was taken as a result of her failure to comply with her community order (from 8<sup>th</sup> March).
- Probation’s IMR comments that ‘at this stage A had not been assessed for an Alcohol Treatment Requirement and it appears that her lack of engagement did not allow her Offender Manager to develop any meaningful supervision plan; in order to engage A to help her address

some of the issues that she was facing at the time. Her failure to engage and comply with the Order resulted in this 2 month custodial sentence.'

Police records identify A's actual sentence was a total six weeks imprisonment.

E is recorded as a regular attendee at The Way Ahead project during April (9 times).

24<sup>th</sup> April

WCC Adult Social Care records noted that a decision was made to refer F into the Police PVP as a consequence of an attack on him by two men when he was injured with a knife. When Police visited F on 26<sup>th</sup> April he refused to discuss the matter. However on 14<sup>th</sup> May as a consequence of this situation, F was marked as a vulnerable person on the Police system.

9<sup>th</sup> and 11<sup>th</sup> May

A appeared before Warwickshire Magistrates Court and was convicted of theft and assaulting a Constable. She was sentenced to a total of six weeks imprisonment and released on 13<sup>th</sup> June 2012.

17<sup>th</sup> and 30<sup>th</sup> May

WCC Adult Social Care records detail safeguarding concerns for F following a safeguarding alert made by a worker from the Night Shelter who 'had rung the Police on 10<sup>th</sup> May at 14.57 to say he had visited F's address and was threatened by a female who was accompanied by a male. He believed they were trying to obtain money from F by 'preying' on his frail state of health.'

8<sup>th</sup> June

Whilst A was in prison she was released to appear before Warwickshire Magistrates Court. She was convicted at court of Battery (Guilty Plea) which resulted in a Community Order with a supervision requirement and an order that alcohol treatment was required.

13<sup>th</sup> June

GP records show A was prescribed anti depressants by GP3. Notes reveal that she was 'low and depressed' and that she disclosed that 'her ex partner had physically abused her, The notes also stated 'lost teeth.' She also said that she was drinking a bottle of wine a day.

14<sup>th</sup> June

Police records state that A was arrested for failing to appear at Court. She was drunk and violent. She was examined by a health care professional who prescribed

	diazepam for her alcohol withdrawal. She also saw a representative from the Recovery Partnership and engaged with them according to the custody record.
15th June	A attended Court and was remanded on bail.
19 <sup>th</sup> June	A arrested for theft. She denied the offence and was bailed (on the 20 <sup>th</sup> June) to appear at the Police station on 10 <sup>th</sup> July.
29 <sup>th</sup> June	A arrested for theft and assault. She remained in Police custody until 2 <sup>nd</sup> July when she was put before the court and remanded in custody in HMP Peterborough.
9 <sup>th</sup> July	A Recovery Partnership Engagement and Recovery worker carried out a video link assessment at probation with A from custody. The assessment worker found A suitable for an Alcohol Treatment Requirement (ATR) and gave her an appointment to attend The Recovery Partnership in Leamington for 24 <sup>th</sup> July.
16 <sup>th</sup> July	A was sentenced to a 12 month Community Order for Common Assault. This was imposed with supervision and a requirement to attend Alcohol treatment. During this period of Supervision A attended 5 Probation office appointments (19 <sup>th</sup> , 30 <sup>th</sup> July 1 <sup>st</sup> , 2 <sup>nd</sup> , 7 <sup>th</sup> August), and failed to attend a further 5 Probation appointments.
2 <sup>nd</sup> August	At a meeting with Probation, records note that A disclosed that she had problems with depression, anxiety and panic attacks and she expressed interest in seeing the Cognitive Behavioural Therapist. She also completed a housing referral and an application form for the Mayday Trust.

During A's Community Order, records also show that she failed to attend 3 Alcohol treatment appointments with The Recovery Partnership (31<sup>st</sup> July, 1<sup>st</sup> and 8<sup>th</sup> August)

## **6.5 Theme five: Anti- social behaviour August-October 2012**

### **August 2012**

6 <sup>th</sup> August	WDC Housing made their first visit to F's house following a complaint from a concerned neighbour who was worried about visitors to F's house. The report notes that the neighbour has concerns for F 'as he has onset Alzheimer's and those people are eating his food and drink and he cannot stop them as they shout at him all the time.'
10 <sup>th</sup> , 11 <sup>th</sup> and 12 <sup>th</sup> Aug	WDC Housing records identify further complaints of anti-social behaviour from F's house. All involve F and A shouting and swearing.
23 <sup>rd</sup> , 24 <sup>th</sup> and 29 <sup>th</sup> Aug	A attended court. On the first occasion she was convicted of failing to comply with the requirements of her community order. On the 24 <sup>th</sup> she was charged with assaulting a Police constable, failure to appear in court and battery. On the 29 <sup>th</sup> she was given 16 weeks imprisonment, suspended for 12 months. The existing Community Order was revoked but she was given additional requirements to attend for Alcohol treatment and to attend the Women's programme (run by the Probation Service), with the aim of helping A to establish a stable lifestyle away from crime, to resettlement successfully in the community and to avoid further offending.
29 <sup>th</sup> Aug to 25 <sup>th</sup> Oct	Probation records state that during this period A attended 9 office appointments (3 <sup>rd</sup> , 11 <sup>th</sup> , 19 <sup>th</sup> , 25 <sup>th</sup> September, 2 <sup>nd</sup> , 9 <sup>th</sup> , 12 <sup>th</sup> , 23 <sup>rd</sup> 24 <sup>th</sup> October) and 1 Alcohol treatment appointment (24 <sup>th</sup> October).
30 <sup>th</sup> August	Police recorded another anti-social behaviour incident where A and a male (both drunk), had been involved in a fight at F's house.
6 <sup>th</sup> September	Agency records state that G 'had no contact with A...they could not be together due to her alcohol issues.'
8 <sup>th</sup> September	Both WDC Housing and Police records detail that on 8 <sup>th</sup> September A was drinking heavily, was extremely drunk and was at F's property.
9 <sup>th</sup> September	Probation Trust's case records reveal that A attended her appointment and was sober and engaging positively.  A visited the Night Shelter to have food and shelter but left at 10.45pm.

- 12<sup>th</sup> September WDC Housing records show that a support worker from Bromford Floating Support contacted them to express her concerns that 'F is being taken advantage of by A who appears to be staying with him'.
- 18<sup>th</sup> September WCC Adult Social Care received an email from a worker at the Night Shelter saying that F's 'wound was as a result of being attacked in town.' There is no Police record to confirm that they were involved in a call out in relation to this incident.
- 18<sup>th</sup> and 26<sup>th</sup> Sept There were two further reports received by the Police from F's neighbour regarding Anti-social behaviour. Both of these featured F. On the first occasion the complaint related to F coming to the neighbour's house and knocking on her door/window each time A left his house and shouting, 'I know she's in there , let her out'. On both occasions he had also 'dumped a load of A's clothes' in the neighbour's front garden. On the 26<sup>th</sup> he was drunk, had forgotten his keys and gone to the wrong house.
- 19<sup>th</sup> September Police records show another anti-social behaviour incident involving E and another male who were drunk at E's house.
- The Night Shelter records detail A as having spent this night with them.
- 20<sup>th</sup> September A report of the anti-social behaviour incident (on 30<sup>th</sup> August, see above) was received by WDC Housing who followed it up with a visit to F's home. The Housing Officer recorded that F admitted that 'A helped him drink his cider and eat his food' but that when A 'gets her money she buys food and drink.' F is reported as saying that he 'could not let her go hungry or have nowhere to live and that she was welcome in his home until she got her own place.' It was pointed out to F that his tenancy was being put at risk due to the problems that A was contributing with anti-social behaviour at the address. The records also state that F said they (F and A) were both sleeping in the same bedroom together.
- 20<sup>th</sup> September The Recovery Partnership records evidence concern from a project worker who had recently been informed that A has had her Alcohol Treatment Order (ATR) revoked and had been given another ATR on her return to court (29<sup>th</sup>

August). The concerns specifically relate to the fact that no assessment has been carried out on A in relation to this ATR and that A's circumstances may have significantly changed since her original video-link assessment in HMP Peterborough. The records state that the worker intended to speak to the Offender Manager in relation to this. Records for the 1<sup>st</sup> October show that the Project Officer had expressed these concerns to the Offender manager.

20<sup>th</sup> September

A Safeguarding Adult meeting was convened at 13.00 under Safeguarding Adults' procedures to review F's care. The records of this meeting state that WDC Housing were aware that A and another person were causing the complaints about noise at F's home and that 'A seemed to be the main culprit.' Those at the meeting agree that 'A could pose a threat to others as she is on Probation for assaulting a Police officer.' The care package proposed reflects this concern for safety with 2 carers being allocated to F, 'due to potential safety issues.' A further meeting was planned for 22<sup>nd</sup>.

21<sup>st</sup> September

Police records show that A was arrested after being found drunk and sitting in a car with the engine running (at 13.50pm). She was charged with failing to provide a specimen, criminal damage and vehicle interference. Records also show that she was 'loud and abusive to officers' and that she informed the custody sergeant that she had 'loads of mental health issues'. She was bailed to Leamington Spa Magistrates Court on 10<sup>th</sup> October 2012.

25<sup>th</sup> September

A visited Probation and was described in their records as 'sober and coherent'. She discussed difficulties with mood and anxiety, and was given a district council referral to fill out (for housing). She also discussed a letter she had received about money that she owed in relation to tax and said that 'this was her husband defrauding her'.

26<sup>th</sup> September

Night Shelter records show that A visited at 21.12 but did not stay overnight, leaving at 23.30pm.

28<sup>th</sup> September

At 23.59pm Police received a report of a disturbance in a street and that A had been assaulted. She was described as very drunk and not making very much sense. An

appointment was made by the Police to see her the following day owing to her drunkenness but she failed to keep the appointment.

30<sup>th</sup> September

Night Shelter records show that A arrived at 20.55 but left at 23.00pm.

2<sup>nd</sup> October

Probation Trust records describe A reporting that she had been beaten up by 5 girls whilst trying to defend a vulnerable friend. She showed staff bruises to her body. Staff advised her with regards to safeguarding in situations when disputes of this nature occur on the streets.

SWFT records evidence F attending Warwick Hospital Accident and Emergency department with hip and abdominal pain. It was noted he 'smells strongly of alcohol.' He had a follow up outpatient's appointment on 10<sup>th</sup> October at 11.00am.

## October

6<sup>th</sup>, 8<sup>th</sup> 10<sup>th</sup>,

12<sup>th</sup>, 17<sup>th</sup> Oct

Salvation Army records show E attended their Project.

9<sup>th</sup> October

A reported to Probation that her bag had been stolen from the house she was staying at. Records note she was drunk but denied this. Her Probation officer agreed to try and complete A's housing application on line.

10<sup>th</sup> October

A's Probation officer saw her after her court appearance for a criminal damage offence. She had pleaded not guilty.

A WDC Housing file note described an interview with F's next door neighbour who complained of an incident at 16.00pm when she heard A and F shouting and swearing. The file noted that the neighbour 'knows that A takes F's food and drink and that F may be deprived'.

At 16.47 Police records also detailed a complaint from F's neighbours about a disturbance at his house. The neighbour reported the sound of a man shouting, apparently trying to get a female to leave and lots of door banging. Police attended and found broken glass which F said was caused by him trying to break into his own property. A was not present at the time of the arrival of Police.

Night Shelter records show that A stayed overnight arriving at 21.06 and leaving at 8am the following day.

11<sup>th</sup> October

WDC Housing records indicated that another visit to F's home was carried out. The Housing Officer discussed the recent reports of anti-social behaviour with F. A was at the house but was asked to leave the room while this was discussed with F. Records described A 'bursting into the room to say that she stayed with F 3 times a week'. F was advised that WDC would take enforcement action through the courts because his behaviour and that of his visitors was causing 'harm, alarm and distress,' to his neighbours.

Police records describe that A telephoned the Police at 21.20 'rambling' about a male named E following her. She called from a public phone box and was quite difficult to understand. By the end of the call to Police she said the male was not there anymore. No further Police action was taken.

12<sup>th</sup> October

Probation Trust records state that A attended her appointment, handed in her housing application forms and that the Probation officer managed to get her an appointment later that same day with the benefits agency.

14<sup>th</sup> October

Police records show that a worker from the Night Shelter reported F as missing. She was concerned because F was a vulnerable adult and an alcoholic with memory problems who also had no access to money. F was later seen on CCTV in Leamington Spa with A and was safe and well.

15<sup>th</sup> October

WCC Adult Social Care records detail a telephone call (at 9.29am) on 15<sup>th</sup> October from a Tenancy Enforcement officer to discuss F's neighbour's complaints about A.



Police records describe two calls from A (at 16.23 and 21.56) to complain that someone called 'S' was banging on her door and breaking things. A was at F's home. According to Police records, during the first call she handed the telephone to F, but E, who was also present, apparently grabbed it and cut the phone off. Police contacted A who said she was fine and indicated that they had been drinking all day and night.

Following the second call Police officers went to F's home at 22:33 hours and found A drunk and saying she didn't want or need the Police. No further action was taken. Police have been unable to trace the identity of the person referred to as S.

16<sup>th</sup> October

Police records document a telephone call from A shortly after midnight where she was complaining about E's aggressive behaviour towards her whilst she is at F's house. Police responded to the call by attending the scene. The incident report stated that this was a 'verbal altercation caused by excess alcohol.'<sup>4</sup>

17<sup>th</sup> October

WDC Housing records state that they were informed by a worker from Bromford Floating Support that 'she coordinates a Support Package for F via Social Services' which included assisting the worker from The Night Shelter 'with arrangements for daily supplies of alcohol, cigarettes, food and money to F'.

21<sup>st</sup> October

The Night Shelter records show that A stayed there overnight.

23<sup>rd</sup> October

Probation records detail that following the Probation Officer's observation that A had a bruised left eye; A disclosed that she had been assaulted by a male she stayed with. Staff advised her to report the incident to the Police and also questioned her about the living arrangements and if there was any abuse of a sexual nature taking place. A said there was no sexual contact and the records also state that she said that 'he was frail and she cannot hit him back.'

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<sup>4</sup> Details of this incident were given to the DHR Author following a meeting with the IPCC on 25<sup>th</sup> July 2014 and have been included to ensure accuracy.

24<sup>th</sup> October

A attended her ATR appointment with The Recovery Partnership. Records stated that 'A gave no indication, nor showed any signs, of being at risk of harm from others.' She completed a care plan and identified housing as her main priority.

At 20.13 Warwickshire Police received a silent 999 call from E's mobile phone. When the call was transferred to the Police by the operator it was made clear that this was a direct request for the Police from a female. The Call Taker spoke to A, E and F all of whom appeared drunk. There is no detail on record as to how E and F became involved in the telephone call. A complained that E had assaulted her, that he had 'beaten her today,' and that he had 'just beat her up now'. The Call taker recorded that she also heard A say 'so you're going to beat me now,' and 'don't touch me again'. E and F both sought to assure the Police that nothing had happened and everything was OK. According to the Police IMR, the call was terminated suddenly and inexplicably by E and the call taker had to call back.

During this return call, (made by the Police to E's mobile phone) A was told by the call taker that if she had a problem with E then 'don't be there.' The call taker also appeared to have then spoke to F and E and sought to reassure them that Police would attend within the hour but that if A 'kicks off' before we arrive, call back on 999'. No action was taken in respect of A's complaint of assault.

The call ended at 20.31 hours and was recorded as a priority response.<sup>5</sup> According to the Police IMR, the documenting of the call as a priority response (and not as an emergency response) was as a result of the Call Taker viewing previous records in relation to A at this address, although no specific further detail is given. No Police officers attended the address and at 22.50 staff realised this and attempted to call the complainant's telephone but it was switched off. A message was left on the phone but no response was received by the Police.

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<sup>5</sup> A Police call graded a 'priority' is one where there is a degree of urgency or importance associated with it which requires Police officers to respond as soon as possible, or within one hour

25<sup>th</sup> October

At 07.42am as a follow up action to the previous night's telephone call, a Police officer went to F's house but got no reply.

The Ambulance Service was notified at 10.17am that they were needed to attend F's house. At 10.47 the ambulance staff requested the attendance of the Police at what they described as a 'suspicious death.'

## 7. Summary and Findings

*'What services often see, when a woman has responded to her traumatic experiences by turning to substance misuse, is a woman who is angry, who drinks, who appears manic, who keeps turning up at Accident and Emergency departments, who keeps calling out the Police when she and her partner are arguing/fighting – but she never wants to do anything about it, she is anti-social, doesn't pay her mortgage and is threatened with eviction.'*<sup>6</sup>

The Panel felt that the above description encapsulated how many services may have perceived A during the period focused on by the review. This was a time when A experienced drug and alcohol misuse, domestic abuse, relationship breakdown, mental distress and financial problems, all of which led to a significant deterioration in her circumstances. A moved from living a relatively affluent lifestyle to becoming homeless and destitute.

The last 18 months of her life was characterised by an increasingly chaotic lifestyle which included alcohol misuse, criminality, periods of imprisonment and homelessness.

Arriving at an understanding of the factors which placed A in a chaotic lifestyle where she became vulnerable has been a central part in the review process. The DHR panel believed that there needed to be two strands of analysis to the report; one to explore, understand and analyse the journey that A took which led to her vulnerable situation and in so doing analyse agencies' responses to her.

The second strand of the review has focused on the time leading up to A's death where she may have been subject to assault and /or domestic abuse from both F and E which may have led to her death with a view to identifying where agencies that dealt with A during this period may have had room for improvement so as to pinpoint future actions for agencies to improve their practice.

This section will explore these findings.

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<sup>6</sup> 'Complicated Matters: Domestic and Sexual Violence, substance use and mental ill –health.' Jennifer Holly, Stella Co-ordinator, Against Violence and Abuse (Presentation to Warwickshire DHR Panel 10/02/2014)

7.1 An exploration of the known factors which may have led to A's deterioration in circumstances.

The following section begins by describing what are believed to be A's reasons for her ongoing drug and alcohol misuse and the possible reasons for her mental distress.

The review has considered the following research which has provided useful information and a theoretical framework to assist in an understanding of A's deteriorating circumstances:

- Research which identifies the causal connections between experiencing domestic abuse and drug/alcohol abuse and mental ill health.<sup>7</sup>
- Research which identifies that experience of domestic and sexual violence is significantly more common among women offenders than the general female population.<sup>8</sup>
- Research which clearly evidences that substance misuse is 'both a cause and consequence of homelessness amongst women and is often used as a coping mechanism to deal with mental health problems or experiences of violence, abuse or trauma'<sup>9</sup>.

In addition, the panel received a presentation entitled: 'Complicated matters: Domestic and sexual violence, substance use and mental-ill health,'<sup>10</sup> which drew on similar research and reinforced the complexities and interrelationship of domestic abuse, mental ill health, drug and alcohol use and homelessness.

This research will be referred to in the remainder of this report.

## 7.12 Known reasons for A's alcohol /substance misuse.

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<sup>7</sup> Humphreys, C. & Regan, L., 2005. *Domestic Violence and Substance Use: Overlapping Issues in Separate Services, Final Report*, available to download at [www.gldvp.org.uk](http://www.gldvp.org.uk) and Domestic Violence and Mental Health edited by L.M Howard, G.Feder,R Agnew Davies. The Royal College of Psychiatrists 2013.

<sup>8</sup> Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners*; (London: ODPM) <http://www.thelearningjourney.co.uk/file.2007-10-01.1714894439/download> and Women in Prison (2009) *Response to Together We Can End Violence Against Women* (London: Women in Prison);

<sup>9</sup> *Rebuilding Shattered Lives: The Final Report Getting the right help at the right time to women who are homeless or at risk.* Sarah Hutchinson, Anna Page and Esther Sample. St Mungos March 2013

<sup>10</sup> 'Complicated Matters: Domestic and Sexual Violence, substance use and mental ill –health.' Jennifer Holly, Stella Co-ordinator, Against Violence and Abuse (Presentation to Warwickshire DHR Panel 10/02/2014)

'Traumatised people who cannot spontaneously disassociate may attempt to produce similar effects of numbing by using alcohol or narcotics'<sup>11</sup>.

The review has been provided with information that when A arrived in England she was misusing heroin. Although CWPT records state that 'she came to England to escape the drug culture she was involved in' no other information has been found to indicate why this addiction had occurred. There are also many references (both from Police and Health records) which substantiate that A was taking methadone throughout the period of time that the review focuses on. However, both her brother D, and her ex partner G, did not comment on this addiction, both stating that A had no problems with drugs. It is therefore difficult to firmly conclude when her substance misuse started.

A said on a number of occasions that she was drinking as a consequence of problems arising from her relationship with G. For example, in September 2009 she told CWPT that she was drinking because of 'relationship problems' and she is also recorded as saying in the same month that her partner 'encourages her to drink so he can control her'(SWFT case notes). In February 2012 it was noted by UHCW staff that she told them that she 'had been drinking for the last year' because of domestic violence and abuse with her ex-partner.

In addition to this, CWPT records revealed that A disclosed several times during assessments that she began to drink heavily after being told that it was unlikely that she would be able to have a baby. WCC Fostering and Adoption Development team records show that on 23<sup>rd</sup> February 2009 A made enquiries about the possibility of becoming a foster carer; there had been several previous enquiries with regard to fostering and adoption dating from 19<sup>th</sup> August 1998. The fact that A made these enquiries may lend some support to the notion that she was exploring alternatives having been informed that she was unable to conceive. In addition, A had also stated in April and May 2008 that her aim to be drug and alcohol free was driven by her desire to have a baby through IVF treatment.

When interviewed for the review, G said that A experienced 'desperation over not having a child,' and that they had investigated adopting a child from India, without success. He identified this as the cause of her alcohol dependency and mental health problems.

Evidence from a number of agency records indicated that A was misusing alcohol because she was finding it difficult to cope with the following: inability to have children, failure of her long term relationship with G, financial pressures, domestic violence and abuse within the relationship. It would appear that all of these factors played a considerable part in A's deteriorating circumstances.

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<sup>11</sup> Complex PTSD: a syndrome in survivors of prolonged and repeated trauma.' J.Herman. Journal of Traumatic Stress. 1992

In the presentation to the DHR Panel from AVA the following points were made which would appear to be relevant to A's situation:

- Women are more likely to start using drugs/drinking heavily because of their partner's substance use/ or as a response to trauma of some kind.
- Research identifies that many women resort to using substances as a response to, and a means of, personally dealing with the abuse they are experiencing. Survivors of Domestic Violence and Abuse may turn to substance use as a form of self-medication and relief from the pain, fear, isolation and guilt that are associated with violence. Substance/alcohol misuse is therefore used as a coping strategy.
- Two thirds of women who have experienced domestic violence and problematic substance use began using problematically following the experience of domestic violence<sup>12</sup>
- Research also evidences that women experiencing domestic abuse are up to fifteen times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.<sup>13</sup>
- Some women are introduced to substances by their abusive partners as further means of increasing their control over them.
- It is generally accepted that there is a strong association between domestic abuse and use of substances (by both perpetrator and victim)<sup>14</sup>

### 7.13 A's mental health

Although there were growing concerns for A's mental health, the only formal mental health assessment that was undertaken (24th September 2011) determined that she was not suffering from a diagnosed mental health illness. 'She was apsychotic, asuicidal and intact with no evidence of mental illness.' (Section 6 page 45) Much of A's behaviour was interpreted as a result of her alcohol misuse.

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<sup>12</sup> Humphreys, C. & Regan, L., 2005. *Domestic Violence and Substance Use: Overlapping Issues in Separate Services, Final Report*, available to download at [www.gldvp.org.uk](http://www.gldvp.org.uk)

<sup>13</sup> Stark, E. and Flitcraft, A. (1996) *Women at risk: Domestic Violence and Women's Health* (London: Sage); Yale Trauma Study, Maryland Department of Health, Journal of American Medical Association (2001), quoted in Lewis, Gwynneth, Drife, James, et al. (2001) *Why mothers die 1997-1999: Report from the Confidential Enquiries into Maternal Deaths in the United Kingdom* (London: RCOG Press).

<sup>14</sup> Galvani, Sarah (2010) *Grasping the nettle: Alcohol and domestic violence* (Alcohol Concern; available at <http://www.ccrm.org.uk/images/docs/10.1agrappingthenettlefactsheet.pdf>); Stella Project (2nd ed., 2007) *Domestic violence, drugs and alcohol: good practice guidelines* (London: AVA; available at: [http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/stella-project-toolkit-\(2007\).aspx](http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/stella-project-toolkit-(2007).aspx))

In relation to A's mental distress consideration needs to be given to the following factors:

- Some of A's mental distress was potentially a direct consequence of what seems to be her experiences of domestic abuse within her relationship with G; a relationship that she described as 'volatile' and one where records show that G had both physically abused her and was controlling and possessive. A's brother D described G putting his sister 'under psychological pressure' and being 'verbally abusive to her.'
- It is understood that when A moved into the house in a rural setting she began to feel increasingly isolated, and this, according to her brother, 'made her ill'.
- The possibility that concerns for the state of her mental health were focussed on by agencies because of G's reporting of his concerns about her behaviour. It is to be noted that during the period Feb –September 2011 it is recorded that on 6 separate occasions G reported to services that he had concerns for A's mental health.

Despite some joint working (e.g. around A's formal mental health assessment in September 2011), there was limited evidence of agencies sharing information in a consistent way or carrying out joint assessments which could take into account the factors in her life. For instance, in the Safeguarding Adults meeting held on 20<sup>th</sup> September 2012 (convened to review F's care), there is discussion about A primarily because she (and another person) were causing the complaints about the noise at F's house and also because she is perceived as posing a threat to others because of her past history ('on probation for assaulting a police officer.' Section 6 page 56). However, there is no discussion about her possible vulnerabilities or a formulation of any co-ordinated action to support her. This was primarily because the focus of the meeting was the safeguarding of F and also A did not meet statutory thresholds which would have triggered a Safeguarding Adults plan and no other processes currently exist to support extremely vulnerable individuals with complex needs who do not meet these thresholds. A also clearly demonstrated mental capacity and was either unwilling or unable to engage with agencies at certain times within the review timescale. It is also important to note that she did not have a formal mental health diagnosis other than her substance misuse

The following section of the report summarises what information services held about A's experiences of domestic abuse.

## **7.2 A's experiences of domestic abuse.**

**7.21** The DHR Panel accepted that the circumstances surrounding A's death satisfied the criteria for a DHR to be conducted as it appeared her death may have

resulted from violence, abuse or neglect by a member of the same household as herself for the purposes of Section 9 (1) (b) of the Domestic Violence, Crime and Victims Act 2004. However, regard has been paid in this review to The Home Office definition of Domestic Violence and Abuse. This definition is prescriptive in that it details a set of actions and behaviours which will be considered as Domestic Violence and Abuse if they occur between those that are or who have been in intimate personal relationships or if they occur between family members. We cannot say with any certainty that A had been in an intimate personal relationship with F and there is no evidence to suggest she was in an intimate personal relationship with E. Despite this, Section 9 (1) (b) of the Domestic Violence, Crime and Victims Act 2004 does not require there to have been an 'intimate personal relationship' before the need for a DHR is 'triggered'. Nevertheless, it is worth paying regard to The Home Office definition of Domestic Violence (despite the need in this definition for there to have been an intimate personal relationship or family relationship between the perpetrator and the victim) as it details the types of behaviours that can be considered abuse and these can be considered in association with the wording of Section 9 (1) of the Domestic Violence Crime and Victims Act 2004 which requires a review when a death appears to have been a result of 'violence, abuse or neglect'.

The definition of DVA within the Home Office definition is as follows:

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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



This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.<sup>15</sup>

It is understood that agencies adopt The Home Office definition of DVA when considering whether they are dealing with an individual who may be in a domestically violent or abusive relationship. Accordingly, if agencies do have a set protocol for responding to allegations of domestic abuse, it may be that these protocols are only engaged if the information available to them about the individual's circumstances satisfies the definition of DVA in accordance with The Home Office definition.<sup>16</sup>

## **7.22 Information that services had that there was domestic abuse between A and G.**

The review has identified a significant period of time between September 09 and October 2010 when domestic abuse featured in A's relationship with G. This was not always recognised as domestic abuse by the agencies that had contact with A. Although it is difficult to determine with any certainty, it could be argued that greater recognition of domestic abuse by agencies together with intervention and support at this stage in A's life, may have changed the course of later events for A.

Agencies recognised that there was domestic abuse within G and A's relationship and there are records that indicate that this may have been still happening after they had separated. (See section 6 pages 48, 49, 50)

Between November 2009- January 2011 13 disclosures of domestic abuse, when A was in a relationship with G, were made to the Police.

The risk assessments carried out by the Police identified both G and A as victims and perpetrators of abuse.

Many of these incidents were categorised not as domestic abuse but seen within a context of a marital dispute because the couple were separating, with additional problems connected to A's alcoholism which possibly made it difficult for Police to assess the situation fully because of A's presenting behaviour which was often aggressive, contradictory and chaotic.

On 2 occasions as a result of the domestic abuse disclosures to the Police A was referred to domestic violence support services. She did not engage with these services, and because she was not assessed as High risk (and did not have

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<sup>15</sup> <http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence>

<sup>16</sup> The definition (above) was revised by The Home Office in March 2013 to include reference to 'coercive control' and also to lower the age requirement from 18 to 16 years of age. Before March 2013 agencies would have been working within protocols, procedures and policies which referenced an earlier Home Office definition of Domestic Violence.

children), there was no referral into MARAC or impetus from these services to pursue the situation further. A closer and more detailed assessment of the accumulated call outs to A and G may have given rise to an elevation of the risks in the relationship and a referral into MARAC.

From a health service perspective there was evidence that A was a victim of domestic abuse whilst in her relationship with G.

When A was in the care of CWPT in relation to her drug and alcohol misuse, she made several disclosures regarding domestic abuse, and injuries observed by staff also could have indicated that she was a victim (between June 2008 and November 2010). A also put some of her injuries down to falling or could not remember how they had occurred. However she did not make any disclosures of domestic abuse during her last period of involvement with CWPT services in September 2011 when she was assessed by the Crisis Team.

On the one occasion (February 2012) A spent time in UHCW she did disclose that her 'significant facial injuries' had been caused by her ex partner and they made efforts to ensure that she was safe on her release from treatment. The Police had no record of this assault and information was not passed to them from UHCW. However, there is some doubt concerning the veracity of the date of this alleged incident (05 February 2012) as A was at that time recorded as being in hospital.

This evidence of domestic abuse was also identified by The Recovery Partnership's Engagement and Recovery officer's involvement with A at UHCW in February 2012. Their records indicate that they knew A was there as a result of violent attack from her ex-partner where she had sustained a broken jaw. However they were unable to speak to her at this point because of her injury and intoxication and did not pursue the case once A had left the hospital. (See Missed Opportunities section 8.2)

When the Recovery Partnership next encountered A (24<sup>th</sup> October 2012), records state having carried out an assessment that she 'gave no indication, nor showed any signs, of being at risk of harm from others'.

GP records show that A did disclose domestic abuse on many occasions. However it was noted that she considered herself to be safe. This information was not shared with other agencies at the time.

SWFT had 13 contacts with A between 2009 and 2012. On 4 of these occasions A either disclosed or made an allegation that she had been assaulted by her partner or ex-partner.

### **7.23 Information that services had that there was domestic abuse between A and F in the period leading up to her death.**

Section 5.4 explores whether A and F's relationship was intimate and concludes that this is a matter of interpretation; F may have perceived that he had an intimate relationship with A, but A denied that their relationship was intimate.

A disclosed she was the victim of an assault by F at a meeting with her Probation officer on 23rd October 2012, the day before her death. Records indicate that she had 'a bruised left eye.' The Probation Officer followed both good practice and procedure by offering support and advising A to report the matter to the Police. A did not act upon this advice but stated that F was 'frail and that she cannot hit him back.'

According to the Police IMR, F later admitted this assault to the Police.

Examining records from the time, excluding A's direct disclosure to the Probation service, there appears to be very little evidence that agencies believed that A might be a victim of domestic abuse with F as the alleged perpetrator or that F was a potential perpetrator.

From a Police perspective, when A was living in the same property as F, the incidents that were recorded involving both of them were not classified as domestic abuse. Officers did not think of them as partners. Incidents between A and F were interpreted as either a result of drunkenness or as anti-social behaviour. Police did have knowledge of F's violent history. He had 36 previous convictions for 69 offences which included possession of offensive weapons; assault, robbery and burglary. He had also been cautioned in 2006 following an altercation with his then partner which resulted in her having a head injury. The Police IMR states that 'he received a caution in this instance because his partner refused to make a complaint'.

Despite his violent history, Police did not consider him to be a threat to A. On the contrary, at the time, the Police IMR states that 'concerns expressed that he was at risk from his relationship with A.'

However, the Police IMR also states that F 'had displayed controlling behaviour towards A as evidenced by her neighbours on a number of occasions.' This comment refers directly to the neighbours' reports to the Police on 18<sup>th</sup> and 26<sup>th</sup> September (see pages 55, 56) which were logged and interpreted by the Police as anti-social behaviour incidents.

Following A's death, the Police IMR records that 'F admitted that he had repeatedly punched A in the stomach the night before she died'. He is reported to have told the Police that he did this because A had been 'selling herself'.

This admission was considered to be unreliable because of F's memory impairment problems and because he had given a number of different accounts in relation to A's death.

Two other agencies, Adults Social Care and WDC Housing, who were involved with A at this time, had no knowledge of A as a victim of domestic abuse or in fact as a

victim of abuse from those whom she was part of the same household as. They also did not consider F to be a potential perpetrator of domestic abuse. He was however categorised as a Vulnerable Adult, following his assessment as such by Adult Social Care.

Adult Social Care became familiar with A in September and October 2012 in the context of a Safeguarding meeting concerning F. In this meeting A was perceived as a possible threat to F because her anti-social behaviour was a threat to his tenancy. From records of this meeting and the Housing IMR there appears to have been a dominant perception from many staff that A was 'taking advantage of F'.

From July to October 2012 WDC Housing had received 8 complaints from neighbours of F relating to instances of anti social behaviour and visited the property he was residing at on 3 occasions. A was regarded as one of the main causes of this anti-social behaviour. Evidence for this was gathered from neighbour's complaints and Housing officers' visits to the property. One instance of this anti-social behaviour took place on 10<sup>th</sup> October 2012 when a WDC Housing officer interviewed F's next door neighbour who complained of an incident at 16.00pm when she heard A and F shouting and swearing. Police records on the same date also detailed a similar complaint from F's neighbours about a disturbance at his house. The neighbour reported the sound of a man shouting apparently trying to get a female to leave and lots of door banging. Police attended and found broken glass which F said was caused by him trying to break into his own property. A was not present at the time of the arrival of Police. This was not classified as a domestic abuse incident but as anti-social behaviour.

In August 2012 when A made an application for housing (deferred as she was in prison), her application form made no statement regarding domestic violence or abuse<sup>17</sup>, and she stated that she was living at F's address. The Probation service made a referral for housing on 2<sup>nd</sup> August following her release from prison but this was refused because of her history of anti-social behaviour. This application form also made no reference to her being the victim of domestic abuse. Both of these examples would appear to support WDC Housing's lack of knowledge of A's experience of domestic abuse. The refusal of A's housing application because of her history of anti-social behaviour indicates that this behaviour was the prominent presenting issue for WDC Housing and that this focus on A's anti-social behaviour, particularly the antisocial behaviour between A and F, may have prevented them from seeing the wider picture that A was potentially suffering DVA at the hands of F.

## **7.24 Information that services had that there was domestic abuse between A and E in the period leading up to her death.**

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<sup>17</sup> Warwick District HomeChoice application form does offer an opportunity for applicants to disclose domestic violence /abuse if this is their reason for applying for housing.

Section 5.7 examines the relationship between A and E and can find no evidence of an intimate relationship. Neither were they related. That being the case, any incidents between them would not meet the Home Office definition of Domestic Violence & Abuse as outlined at paragraph 7.21 and would therefore not be subject to a DASH risk assessment.

However, as pointed out in section 5.7, during the month before A's death, E did spend time at F's house and could therefore loosely be classified as 'a member of the same household' thus bringing his actions and his relationship with A within the scope of the DHR due to the extended criteria presented within the DHR legislation. There is also some evidence which supports the impression that A was intimidated by E's behaviour and possibly subject to assaults from him.

According to the Police IMR, A's two reports to Police in relation to E (on 11<sup>th</sup> and 24<sup>th</sup> October) appear to have been perceived by Police as two separate unconnected events.

The additional information forwarded by the IPCC to the DHR author (after the submission of the Police IMR), records another complaint to the Police from A (on the 16<sup>th</sup> October 2012) about E's aggressive behaviour towards her whilst she is at F's house. Following the Police visit to the house there is a record of this as a 'verbal altercation caused by excess alcohol'. Due to the nature of E and A's relationship it is understood that these incidents would not be treated as incidents of domestic violence. However, this incident was again treated in isolation and was not interpreted as representing part of a pattern of possible escalating risk from E towards the victim.

The DHR Panel gave consideration to the incidents (on the 11<sup>th</sup>, 15<sup>th</sup> and 16<sup>th</sup> October 2012) as possible stalking behaviour (as defined by The Protection from Harassment Act 1997)<sup>18</sup> and concluded the following:

- There is no evidence from the Police IMR that E had previous convictions/offences that could be classified as stalking or harassment
- Although following someone could be categorized as stalking behaviour, to qualify as stalking this has to be part of a course of conduct by the perpetrator which involves at least two incidents. When E followed A on 11<sup>th</sup> October it would appear that this was a 'one off' situation which is likely to have caused her alarm and distress and she may also have feared violence from him. However, there are no further records of him following A.
- In both of the incidents on 15<sup>th</sup> and 16<sup>th</sup> October 2012, E's behaviour could be described as aggressive and intimidating and could have caused

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<sup>18</sup> <https://www.gov.uk/government/publications/a-change-to-the-protection-from-harassment-act-1997-introduction-of-two-new-specific-offences-of-stalking>

fear of harm and distress to A but his behaviour does not fit the description of stalking behaviour as described in the legislation.<sup>19</sup>

The Police IMR states that E had 12 previous convictions for 21 offences between 1978 and 2005. He had been arrested and investigated for a number of violent acts against his partner/ex partner. No further action was taken further to the arrests and investigations for the alleged violent acts against his partner because the partner did not provide evidence or because when the matters did result in prosecution proceedings, he was not found guilty.

The Police IMR also clearly indicates that all of E's history as an alleged perpetrator of domestic abuse against his partner/ex-partner is available via Police information systems and could have been accessed by any call takers receiving complaints about him. The Police IMR outlines how 'call takers are required to access a "person data table" ' to search for the person concerned and if found, link that person to the incident.' This information would be additional relevant background in respect of E's potential risk to A, regardless that the situation between them was not one of domestic violence and abuse.

It would appear that in the above instances where A complained to the Police about E's behaviour, there was no action taken to link E's previous history with his alleged current behaviour.

Instead, the Police records would indicate that at this time in A's life her 'reputation' with the Police may have coloured their response to her.

The Police IMR acknowledges that A 'was almost certainly subject to assaults of varying degrees by her male partners and associates and there is clear evidence which shows she assaulted others without provocation on occasion'.

The Police IMR notes that 'the tone of comments recorded on the relevant log' on the night of 24<sup>th</sup> October 2012 'support the conclusion that a more sympathetic view was displayed towards F and E than to A,' despite the records noting that A was overheard to say, 'so you're going to beat me now' and 'don't touch me again'. The incident was also summarised in Police records as a verbal argument between A and E 'with F in the middle'.

The Police IMR concludes in relation to this call, 'as in other cases, it was A who the call taker assumed was the cause of trouble, and even if there may be some truth in that assertion, her complaint of assault against E was ignored. No action was taken in respect of the assault'.

However, as noted in a previous section (4.4) in the interview with M and I (A's friends and neighbours of F) they indicated that A had experienced 'many problems'

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<sup>19</sup> Appendix 5 of this DHR details Warwickshire Police Stalking and Harassment Procedures and training

with E in the days before she died. Their perception of what occurred at that time was that E was 'slapping (her) every day...take money £10 or £5 or £20'.

This information was not known by agencies at the time.

Regarding both F and E, only Police records reveal that both had violent histories and there was no imperative, at the time, to share this information with other agencies.

## **8. Analysis, Lessons Learned and Recommendations**

Government Guidance<sup>20</sup> requires that:

'The Overview Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and report or information commissioned from any other relevant source'.

This review is complex and has called for 10 Individual Management Reviews from various agencies that had dealings with A before her death. This section presents a thematic analysis of agencies' responses to A as required in the Terms of Reference. It also highlights lessons learned and key recommendations.

The DHR Panel has also considered all information available to the Review in the context of the nine protected characteristics identified by The Equality Act 2010, i.e.

- age
- being or becoming a transsexual person
- being married or in a civil partnership
- being pregnant or having a child
- disability
- race including colour, nationality, ethnic or national origin
- religion, belief or lack of religion/belief
- sex
- sexual orientation

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<sup>20</sup> Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Home Office 2011 Page 18 [www.homeoffice.gov.uk/publications/crime/DHR-guidance](http://www.homeoffice.gov.uk/publications/crime/DHR-guidance)

The victim in this case demonstrates a number of these protected characteristics. The DHR has paid attention to issues of gender, marital roles and expectations. The Review has also made particular efforts to understand the significance of the victim's national origins. These considerations have informed the Review's analysis and recommendations.

## **8.1 Analysis by theme**

A number of themes emerged as the information was examined during the review process. Many of these themes have been noted and addressed in Domestic Homicide Reviews nationally.

Themes to be covered:

- Missed Opportunities
- Good practice
- Access to Services
- Recognising domestic abuse
- Domestic violence and abuse: policies, procedures, training and supervision
- Assessment processes
- Responding to individuals with complex needs (e.g. domestic abuse, substance/alcohol misuse, mental health problems, homelessness)

## **8.2 Missed opportunities**

The following points of contacts with A have identified missed opportunities for increased intervention and support which may have led to a different long term outcome for A. It is not possible to predict if these interventions would have changed the course of events for A.

- In February 2012 when A was transferred from Warwick Hospital to UHCW for specialist surgery because of her broken jaw (allegedly caused by domestic abuse from G) there was no referral to the Police Protecting Vulnerable People Unit from either UHCW or SWFT. This would be an expectation as the reported assault constituted a criminal offence, and therefore, meets the threshold for reporting (UHCW Safeguarding Vulnerable Adult Policy and Referral Pathway OPER-Pol-004-10). Had this line of enquiry been followed it may have offered A greater levels of long term protection. The referral to the Police Protecting Vulnerable People Unit would have triggered a criminal investigation into the



allegation of domestic abuse from G; if the risk to A was determined as 'high' risk ( against the criteria set out in the ACPO DASH risk indicator)<sup>21</sup> A would have been referred into a Multi-Agency Risk Assessment Conference where A would have received the offer of support from an Independent Domestic Violence Advocate (IDVA) and a multi-agency safety and support plan would have been initiated; the referral into the PPVPU would have initiated a multi-agency response to A's situation which could have meant that further incidents where A was involved may have been subject to multi-agency information sharing and a co-ordinated plan of action in response to her situation. In so doing, A would have been offered immediate protection and also, (depending on her response to the support offered), more long term protection.

- The lack of intervention and support from The Recovery Partnership Alcohol and Substance Misuse Service, who visited A in hospital on this occasion, can also be viewed as a missed opportunity. In relation to The Recovery Partnership's response to A on this occasion there were specific service delivery factors which would have impacted on their opportunities to engage A. These were primarily to do with the early stages of the development of their new contract to deliver drug and alcohol treatment services. This meant that there was only one Engagement and Recovery Worker assigned to attend UHCW for three half days per week. Subsequently the service has developed and expanded and 'hospital liaison' has become an established strand of the services delivered by The Recovery Partnership. There are now two Engagement and Recovery Workers permanently assigned to UHCW. They attend daily with the aim of engaging with any individual who is admitted or attends with drug or alcohol related issues. They are well known and in regular contact with staff throughout UHCW. If the service had been able to offer this level of service at the time of A's last visit to UHCW, A may have engaged effectively with the service. This may have led to A pursuing and completing in-patient detoxification and further long term treatment for her alcohol dependency
- Further missed opportunities were WDC Housing and Police responses to incidents at F's house between 6<sup>th</sup> August and 15<sup>th</sup> October 2012 which reveal that both agencies responded to these as incidents of anti-social behaviour and did not consider that there may have been incidents of domestic abuse occurring with A as the victim. Police records detail seven incidents in this time span where A is named. Four of these are

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<sup>21</sup> ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment model determines the level of risk to the victim. Those identified as 'high risk' are at risk of serious harm or potential homicide cases and are referred into a Multi-Agency Risk Assessment Conference.

classified as anti- social behaviour incidents and three are classified as 'Reports of a Disturbance'. Where A is described in these incidents she is described as 'drunk'. Police Professional Practice Guidance on the Investigation of Domestic Abuse<sup>22</sup> emphasises that incidents of anti social behaviour might be linked to domestic abuse, 'even when they may not appear to be linked at the time of reporting.' The focus of both WDC Housing and Police actions appear to be in response to A as a 'problem' rather than as a potential victim of either F or E. Analysis of why agencies may not have recognised A as being at risk of potential DVA from F, or at risk of potential non-domestic violence & abuse from E, can be found at section 8.5 and is pertinent to both WDC Housing and Police responses above.

Two of the anti-social behaviour incidents reported to the Police by A's neighbours (on the 18<sup>th</sup> and 26<sup>th</sup> September 2012) are described in the Police IMR as incidents where F 'displayed controlling behaviour towards A.' This controlling behaviour was not noted at the time in Police records but was an interpretation of behaviour by the IMR author. This would imply that officers dealing with these specific reported incidents were viewing them through the 'lens' of anti-social behaviour and did not perceive the possibility of DVA existing between F and A. This serves to further reinforce the point made above.

In the Police response in the period leading up to A's death there are a number of significant missed opportunities:

- Firstly, the Police responded to A's reports against E (on 11<sup>th</sup>, 16<sup>th</sup> and 24<sup>th</sup> October) as isolated incidents. Although correctly not categorised as Domestic Abuse, these incidents never the less represented a pattern of possible escalating risk from E towards the victim which, had they been viewed as such, may have elicited a different Police response.
- Secondly, the Police response on the night of the 24<sup>th</sup> October 2012 and on the morning of 25<sup>th</sup> October 2012 can be interpreted as significant missed opportunities to intervene in a situation which may have led to A's death.

Key to an analysis of these two episodes is an examination of the call taker's response to the 999 call, the documented recording of this call and the Police response as a consequence of these factors.

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<sup>22</sup> Guidance on Investigating Domestic Abuse. Association of Chief Police Officers and The National Police Improving Agency: page 18. <http://www.acpo.police.uk/documents/crime/2008/2008-cba-inv-dom-abuse.pdf>

The reported conversation between the call taker and A provides evidence to support the view in the Police IMR that A had gained a particular reputation because of the numerous reported incidents involving her, and that this reputation 'coloured' the response to the situation. This understanding that this perspective was held is further reinforced by the advice from the call taker to F and E which identifies A as the source of the problem, even though the reported assault was against her and that the initial call was terminated by E whilst A was complaining that he had assaulted her.

The Police analysis of the call taker's response to A (in their IMR) concludes that there was 'no recorded explanation as to why A's complaints were not responded to appropriately or why E and F were considered to be at risk to the extent that they were advised to phone 999.' But that this may be 'an example of A's antecedent history impacting upon decision making.'

In addition to the call taker's response to A, the Police IMR states that there is also no evidence of the call taker accessing information systems which may have linked A's allegations of E's assault with his previous history as an alleged perpetrator of domestic abuse. If these information checks had occurred then A's allegation may have been responded to in a more appropriate way.

Further analysis of the call taker's response by the Police within their IMR also states that 'policy and procedure in respect of dealing with complaints from members of the public was not adhered to.' This comment highlights the fact that despite the call being received by Warwickshire Police at 20.13pm on 24<sup>th</sup> October 2012 and assessed and recorded as requiring a priority response,<sup>23</sup> Police did not visit the address until 07.42am on the 25<sup>th</sup> October and then, on getting no reply left the address. Police records state that 'it (the call) doesn't warrant an emergency response.' The call was also recorded as a 'nuisance call' and as a 'priority response.'

The Police IMR notes that this situation evidences a critical missed opportunity for Police involvement, assessment and intervention.

The lack of further investigation that night or the next morning appears to reinforce that A was not seen as being vulnerable or a potential victim of domestic abuse or assault.

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<sup>23</sup> A Police call graded a 'priority' is one where there is a degree of urgency or importance associated with it which requires Police officers to respond as soon as possible, or within one hour

The relevant findings of the IPCC's investigation into Warwickshire Police's response to A on the 24<sup>th</sup> and 25<sup>th</sup> October 2012 broadly reflect the above analysis of this episode as a missed opportunity.<sup>24</sup>

In relation to the call handler's management of the telephone call from A ( on the 24<sup>th</sup> October 2012,) the IPCC report concludes that although all 'three parties were challenging to deal with over the phone' (possibly because of the influence of alcohol,) A clearly disclosed in this conversation that she had been assaulted. The report also concludes that because of A's previous involvement in incidents of nuisance or rowdy behaviour this 'may have prejudiced the response and attitude of those handling the incident to the extent that it was treated as just another call.' The report also states that A's vulnerabilities (because of her lifestyle and alcohol dependency) were not recognised by the call takers.

The addendum to the IPCC report (October 2014), which explores whether the background information pertaining to A's contact with the Police over a broader time frame<sup>25</sup> should have been considered when the Police responded to her on the 24<sup>th</sup> October 2012, makes the following conclusions which are also relevant to this section of the DHR report:

- A's history of making calls alleging domestic violence does not seem to have been considered in relation to her telephone call on 24<sup>th</sup> October 2012.
- At the time of the telephone call (24<sup>th</sup> October 2012) no intelligence checks were made on either F or E.
- There was no enquiry by the call taker (on the night of 24<sup>th</sup> October 2012) to ascertain if A was in a relationship with either F or E.
- The call taker didn't consider A's potential vulnerability as a result of her previous alleged reports of domestic abuse ( against a previous partner).

Police Professional Practice Guidance on the Investigation of Domestic Abuse<sup>26</sup> refers specifically to the requirement that 'call takers should be trained to respond to reports of domestic abuse'.

The guidance also clearly points out the importance of call takers being able to recognise incidents that are not overtly domestic abuse such as reports of anti-social behaviour and reports of assaults. The guidance states that call takers should, on receiving such a call, 'prioritise the safety of the victim.'<sup>27</sup>

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<sup>24</sup> Information taken from the IPCC report prior to publication, but with permission of the IPCC as part of the information sharing process.

<sup>25</sup> Information contained within Warwickshire Police IMR covering the period 2008-2012.

<sup>26</sup> Guidance on Investigating Domestic Abuse. Association of Chief Police Officers and The National Police Improving Agency; page 13. <http://www.acpo.police.uk/documents/crime/2008/2008-cba-inv-dom-abuse.pdf>

<sup>27</sup> Ibid Page 21

The evidence above demonstrates deviation from such guidance and also indicates that the Police call taker did not view the situation as one of domestic abuse or assault.

Warwickshire Police's Standard Operating Procedures in relation to initial reports of Domestic Abuse (September 2007) acknowledges that 'a majority of reports of domestic abuse are made via the Communications Centre by phone' and that 'in order to ensure a professional response...the call handler must ask for as much information from the victim as possible,' and 'prioritise the safety of the victim'. The procedures also indicate that if telephone calls are cut off 'this requires an urgent reassessment of the call grading'.

In addition, the procedure also sets out a checklist for gathering information which includes asking if medical assistance is required. These procedures were clearly not followed in this instance.

The Independent Police Complaints Commission (IPCC) in their investigations of 33 national cases where there were concerns that the Police may have failed to adequately protect a victim of domestic violence, have also identified that call handling was a common weakness in the Police response. They noted a failure by call handlers to take and record full and accurate details.<sup>28</sup> The IPCC reviews (from different Police forces, between April 2010 and March 2013) identify this as a common problem at a national level.

The Coroner's Inquest will determine the cause of A's death based on the evidence from A's post mortems. It is therefore difficult, at this stage, to assess to what extent Police intervention could have prevented A's death.

### **8.3 Identified Good Practice**

During the years that the review covers services did demonstrate considerable efforts to offer support to A.

For example, her GP practice maintained A as a patient despite their knowledge that she was not still living at the address she had used to register with them.

Both Probation and The Recovery Partnership records show that A was developing some trust and positive engagement with them in the weeks before she died.

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<sup>28</sup> Women's Access to Justice: From reporting to sentencing. All Parliamentary Group on Domestic and Sexual Violence. S Hawkins and C Laxton. Women's Aid 2014

CWPT records also show that staff made every effort to engage with A on numerous occasions and services were tolerant and understanding of her sometimes chaotic approach.

A, like many other individuals with complex needs and an increasingly chaotic lifestyle, failed to attend appointments or was not contactable at the known addresses or given mobile phone numbers. However, all agencies continued to repeatedly attempt to engage with her despite her tendency to fail to respond.

Some positive multi-agency working, good information sharing and good communication is clearly evidenced from the Police, GP practice and Mental Health Crisis team when they shared concerns about A's mental health and formulated a plan to ensure that a mental health assessment was carried out – September 2011.

There was also evidence of positive multi-agency working between staff at UHCW, the Alcohol Liaison nurse and WDC Housing when they assessed A and provided a plan to protect her following her discharge from hospital in February 2012.

Positive multi-agency working in relation to Safeguarding Adults was demonstrated by Adult Social Care, WDC Housing, The Night Shelter and the Police with regard to the co-ordination of actions to safeguard F as a vulnerable adult.

#### **8.4 Access to Services**

A's nationality does not appear to have been a barrier to her accessing services. Her friends identified that her English language skills were quite sophisticated in that she would help them to understand any official letters that they received and advocate on their behalf. She also was a successful business woman whilst in her relationship with G.

However the author's meeting with A's friends from the same European community identified the following:

- The typical pathway to information about services, for individuals from this community who live in this area of Warwickshire, is via self –identified 'key' people from the same European community. These may either work in the Voluntary Sector or may simply earn this status as a result of time spent in the UK, their level of language skills and their knowledge of local services and their understanding of how the 'system' works. A had asked for assistance from one such person in relation to her alcohol misuse.
- Members of this European community appear to have very little knowledge of local domestic abuse services and the referral pathways into these, and this in itself presents a barrier.
- It is also unlikely that the 'key' people in the community have knowledge of domestic abuse or the local services available to victims.

Although A did disclose domestic abuse to statutory services, there needs to be recognition that other migrants from a similar European background now living in Warwickshire may not have the language skills or knowledge of services to enable them to access appropriate support and help. It is therefore important to recognise the need to equip the identified 'key' individuals with relevant and up to date information about local domestic abuse services.

A local service targeting Warwickshire's migrant workers which aimed to identify the needs of the communities, assist with legal advice, give translation services and provide a first point of access to signpost new communities to services and support, was in existence between 2005-2011, funded through Government Office West Midlands Migration Impact Fund (MIF). Partner organisations involved in the project included Warwickshire County Council, Warwickshire Race Equality Partnership, Warwickshire's Volunteer Centres, Warwick University Volunteers, Legal Advice Warwickshire (LAW) and Warwickshire Community and Voluntary Action (WCAVA).

The initiative also appointed a new Police Community Support Officer (PCSO) recruited from the migrant community, to provide support for the network of PCSOs across Warwickshire in their relationships with migrant communities.

The project came to an end when the new Communities Minister decided to end the MIF as part of his remit under the coalition government in 2011.

Anecdotal information strongly suggests that the continuing issue for all migrant communities in this area are language barriers which cause difficulty in accessing services e.g. the NHS, housing, education and in seeking employment. This was confirmed by the experience relayed in the interview between I (A's neighbour) and the Chair and Panel member.

Research has also identified the need to engage with minority communities to ensure that they have access to domestic abuse services.<sup>29</sup>

### **Learning point**

Further work needs to be done to engage minority communities in Warwick District to provide information about domestic abuse services

### **Recommendation:**

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<sup>29</sup> 'Tackling Domestic Violence: Effective Interventions and Approaches' M.Hester and N. Westmarland. Home Office Research, Development and Statistics Directorate 2005 and <http://nicemwomenbreakout.wordpress.com/2013/11/08/cedaw-nicem-and-domestic-violence-the-many-challenges-facing-bme-female-victims/>

To improve awareness about local domestic abuse services with 'key individuals' of minority communities within Warwick District through the organisation of events to provide information about local domestic abuse services.

## **8.5 Recognising domestic violence and abuse**

### **8.51 Examination and analysis of service interventions and responses to A identify a number of factors which influenced a lack of recognition of A as a victim:**

Throughout the time period covered in this DHR, agencies often focussed on what they considered to be specific presenting issues which related to their profession. It would appear that there was a certain amount of 'tunnel vision'. For example:

- Housing officers saw A in relation to her anti-social behaviour and her potential exploitation of F as a vulnerable adult;
- Health professionals often responded to A because of her alcohol/drug misuse;
- Police officers viewed A as both a perpetrator and victim of domestic abuse but also as someone who had considerable contact with them because of the crimes committed in the context of her alcohol dependency;
- Probation workers saw A as an Emerging Prolific Offender

Examples to support this analysis are taken from agencies' records and cover the entire time period of the Terms of Reference.

a) The Police call out on 13<sup>th</sup> September 2009 to A and G is recorded as a domestic dispute with G as victim and A as the perpetrator and is assessed as medium risk. Records indicate that there were two telephone calls regarding the incident. In the first call from G it is noted that he is 'very distressed' and that he states that A is an alcoholic. A then phoned the Police to say that she 'would show the Police her bruises tomorrow'. It is recorded that G then told the Police that A had her bruises from falling over but that she 'would tell them that he had hit her'. A also discloses on this occasion that she had recent problems with alcohol.

For this incident, there is no evidence of a further examination or reference to any bruising when Police attended which suggested officers' acceptance of G's explanation for the bruises (i.e. that she had fallen over because she had been drinking) and an interpretation of A as the perpetrator in this situation. This acceptance of G's point of view is supported when the risk assessment was completed with G named as the victim with reference to the risks A posed to him.



This was the first time that the Police had been called out to a 'domestic dispute' between the couple and the Police response indicates a lack of professional curiosity about whether domestic violence and abuse was actually occurring.

The Chronology of events then reveals that A attended Warwick Hospital Accident and Emergency department on the 19<sup>th</sup> September 2009 and disclosed that she was a victim of domestic abuse. The records note the bruises to her abdomen and chest. She was offered help in relation to domestic abuse but declined.

A's refusal to respond to the help offered to her on this and numerous other occasions appears to reinforce the view that she did not consider herself to be a 'victim.' A's 'resistance' to the support offered to her and the panel's belief that she did not consider herself to be a 'victim', may also have played a part in her decline in circumstances and the view that started to emerge amongst agency workers that incidents involving A were that of anti-social behaviour rather than incidents involving DVA.

- b) The Police and the Police call handler's response to events on the night of 24<sup>th</sup> October when it would appear that A was not perceived as a victim of assault or of domestic abuse further to her telephone call, and that their response was coloured by 'A's antecedent history impacting upon decision making.'(Police IMR) See section 8.2 Missed Opportunities.
- c) SWFT in their IMR point out that they had 13 contacts with A between 2009 and 2012. On 4 occasions A either disclosed or made an allegation that she had been assaulted by her partner or ex-partner. The response to the initial disclosure was appropriate despite help not being wanted by A, on the 3 other occasions A's intoxication was seen to be the primary issue, therefore further enquiries were not made at that time.
- d) In CWPT's IMR there is no evidence to suggest that staff recognised or responded directly to A's disclosures around domestic abuse. The evidence suggests that staff often considered risk within the context of substance misuse and that injuries observed during assessment were much more likely to be considered in relation to falls than to domestic abuse.
- e) Likewise A's GPs provided excellent support for A but as the Area Team IMR comments their main focus was on her 'direct clinical care' and 'DV was not at the forefront' of their concerns.
- f) Probation's recognition and response to A having experienced domestic abuse (with F as the alleged perpetrator) has been noted as good practice. However the recognition occurred because A had visible signs of physical abuse which prompted an excellent response from the probation officer concerned. Prior to this, Probation's engagement with A was as an offender. As such she was subject to domestic abuse checks through Probation's Domestic Abuse Case Administrator

which, at the start of every new Probation Commencement, checks all cases against Police systems. All allocated Offender Managers automatically receive an email summary of any domestic incidents or a NIL return for their Offender. This check is to identify if the offender is a perpetrator of domestic abuse. In A's case the Offender Manager received a NIL return at commencement. The check did not offer the opportunity to consider the possibility of A as a victim of domestic abuse which would suggest a flaw in Probation's systems, the assumption being that all offenders are potential perpetrators not potential victims of domestic abuse.

**8.52** Professionals' perceptions of A's character, behaviour and her own fluctuating recognition of risk may have prevented them from considering her to be a victim.

This point is supported by evidence from IMRs when staff were interviewed and described A as being 'feisty', 'lively', 'volatile, 'a survivor' with a strong 'defence mechanism,' a character who 'did not see herself as a victim'. She was also perceived by some staff to be a 'flamboyant' character who 'gave as well as she got'.

This view of A was potentially reinforced by her own conflicting views of herself in relation to G; during some assessments she is recorded as not feeling threatened by her partner yet on other occasions reporting being very fearful of her partner. A herself reported that her relationship was volatile and that she was verbally abusive to her partner. She 'did not appear to perceive the risks presented to her by the abusive behaviour she describes from her partner' (CWPT IMR).

A's comment to her Probation Officer in relation to her allegation that F had assaulted her (when she attended a meeting on 23<sup>rd</sup> October 2012) also possibly gives an insight into her perception of herself as not being a victim. She did not indicate whether she would report the matter to the Police but instead argued that 'he (F) was frail' and that she could not hit him back.

The above examples demonstrate the complexity of the label 'victim.' The 'assumption of the "perfect victim"' has recently been identified in the All Parliamentary Group on Domestic and Sexual Violence report<sup>30</sup> as a factor which is seen to impact on the Police response if a woman does not appear to match that ideal type of 'victim.' However, in relation to this case, evidence would suggest that many agencies had a similar 'photo fit' of the 'perfect victim.' Evidence also suggests that A did not always perceive herself as a victim.

**8.53** These points of view were compounded by A's increasingly aggressive and chaotic behaviour, fuelled by alcohol consumption (and methadone) which often made it incredibly difficult for professionals to assess her situation (either in relation to her mental health needs or the possibility of domestic abuse).

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<sup>30</sup> Women's Access to Justice: From reporting to sentencing. All Parliamentary Group on Domestic and Sexual Violence. S Hawkins and C Laxton. Women's Aid 2014

The SWFT IMR evidences this when it states that ‘as A’s attendances intoxicated increased, we believe staff became less sensitive to A’s needs, especially when A’s behaviour was perceived as difficult.’

**8.54** A often presented to services as an aggressive, drunk, chaotic and complex individual who did not willingly respond to the help that was offered. These presenting features helped to camouflage A’s vulnerabilities and often prevented services from regarding her as a victim of domestic abuse. In some instances this view of A demonstrated a failure by staff in a number of agencies to recognise indicators of domestic abuse and to respond to disclosures. It would appear that professionals did not see beyond the social norms and assumptions about addiction and use professional curiosity to ascertain what had triggered A’s behaviour and addiction. In particular, it identifies the need for professionals to have a good understanding of the complexities of domestic abuse and the causal connections between domestic abuse, substance and alcohol misuse and mental health.

### **Conclusion and learning point**

The review has identified the need for all agencies to look beyond an individual’s presenting issues; to challenge commonly held stereotypes of what constitutes a domestic abuse victim; to recognise the causal connections between domestic abuse, alcohol/substance abuse and mental ill health; to recognise that some DVA victims may be afraid to engage with help offered due to the complicated psychological impact DVA can have on its victims and to use professional curiosity to help them reach a deeper and broader understanding of the individual.

### **Recommendations:**

The panel have supported the following multi-agency recommendation: To improve agencies’ understanding of domestic abuse –so that they understand and recognise the complexities and dynamic of domestic abuse and its impact on victims.

A programme of domestic abuse multi-agency training will be provided for both voluntary and statutory sector organisations. Training will be audited and for those attending, a sample survey will be used to capture the possible impact of the training on the individual’s perception and understanding of domestic abuse and of how this will impact on their work role.

In addition individual agencies have identified the need to revise or review the provision of their own training in the light of the above review findings.

## **8.6 Domestic violence and abuse: policies, procedures, training and supervision.**

Section 8.5 which has analysed professionals' ability to recognise domestic abuse links directly with the analysis in this section which focuses on services' domestic abuse policies. The existence of robust domestic abuse policies, procedures and training should reflect positively in frontline professional's ability to recognise and respond appropriately to domestic abuse.

The review found that the presence of policies, procedures and training was variable across the agencies and that there had been revisions to all of these during the timescales specified by the review.

Specifics worth noting are:

### **8.61 The health economy**

a) CWPT's domestic abuse policy had been developed and reviewed between 2006-2012. The 2006 policy stated that staff should ask about domestic abuse during assessments within prescribed safety parameters; consider safety strategies and signpost victims to support agencies, and arrange a multi-agency meeting if appropriate. However evidence from the IMR states that those substance misuse staff interviewed for the purpose of the review had received no specialist domestic abuse training between 2008-2010. They had Safeguarding training at level 1 and 2<sup>31</sup> and would therefore have had a level of awareness in relation to domestic abuse but no specialist knowledge. In addition, at the time, risk assessments did not ask specifically about domestic abuse and therefore staff were unlikely to get a direct disclosure. Staff would also have been unaware of specialist domestic abuse risk assessment tools such as the CAADA DASH Risk Indicator Checklist. It was therefore not reasonable to expect that staff would have the skills and knowledge to recognise and assess risk in relation to domestic abuse at this time.

During interview the Mental Health Crisis Team Community Psychiatric Nurse, who conducted the mental health assessment on A on 24<sup>th</sup> September 2011, confirmed that he was aware of the CAADA DASH Risk Indicator Checklist but as A did not disclose domestic abuse during the assessment the use of the tool was not indicated at that time.

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<sup>31</sup> All health professionals are trained to recognise child maltreatment and to take effective action as appropriate to their role. The key Safeguarding Children competencies required for all health professionals were outlined in 'Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document 2010 (Royal College of Paediatricians and Child Health.) All training for health professionals is compliant with the competencies outlined in this document. Levels 1-3 relate to all staff. Levels 4, 5, and 6 to specific roles. A third edition of the Intercollegiate Document was published in March 2014.

The 2013 revision of the Domestic Abuse policy now includes referral pathways and a risk assessment tool for clinicians.

Since January 2012 CWPT have provided 'Scars of a Quiet Denial' training -one day domestic abuse awareness raising training. In addition to this from January 2013 CWPT Level 2 Safeguarding Training has been extended to include training for all clinical staff in the use of the CAADA DASH Risk Indicator Checklist.

- b) GPs had no domestic abuse policies or procedures at the time when they were engaging with A and there was limited training.

Prior to 2012 there was some Child Protection training for GPs which may have referenced domestic abuse but it is difficult to confirm the degree of content with any certainty. During 2012 GPs in Warwickshire received Safeguarding Children Level 2 training which had an element of Domestic abuse training within it. With such limited training it was therefore not reasonable to expect that GPs would have the skills and knowledge to recognise and assess risk in relation to domestic abuse at this time.

South Warwickshire CCG has recently drafted a Domestic Abuse Policy for GPs.

The current NHS reorganisation gives NHS England the responsibility for GP training (from April 2014) and the delivery of domestic abuse training is recognised within the Public Health/CCG/NHS England recommendations. The Local Area Team (for NHS England) is recruiting a dedicated GP to provide Safeguarding training (including Domestic Abuse training). This named GP will also be responsible for producing Individual Management Reviews for Domestic Homicide Reviews and Serious Case Reviews.

- c) Prior to 2011 the SWFT IMR states that they 'are unable to establish if staff received specific safeguarding training on domestic abuse and what to do if they had concerns'.

SWFT staff have received Safeguarding Adults training since 2008 which is an awareness session provided for all levels of clinical staff. Maternity services provide specific domestic abuse training for midwives. However it has been identified that domestic abuse training was lacking for the Accident and Emergency department. This is now a key action in their Action plan.

SWFT Domestic Abuse policy was ratified in 2011. Although there is no formal assessment tool for risk assessing domestic abuse, staff receive training to document disclosures thoroughly. Safeguarding Adults training does not currently (or did not at the timescale specified in the review) include the inter-relationship between mental health issues, alcohol misuse and domestic abuse; therefore joint assessments were not taking place. GPs receive a copy of the Accident and Emergency department attendance, so are aware when a patient has attended

and of the reasons for their attendance and could therefore use this information to help support the specific issues that the patient has.

d) UHCW did have a Domestic Violence and Abuse Policy which provided staff with guidance on recognising the potential indicators of DVA and how to respond appropriately. However, the efficacy of the guidance was difficult to judge in relation to A's limited period of time spent in hospital (1 day in February 2012). Although staff training did raise awareness about the interrelationship between mental health issues, alcohol misuse and DVA, there is no evidence that UHCW staff specifically considered this as an associated problem when they were dealing with A. Staff did however recognise the risk associated with her returning home by referring her to appropriate agencies to facilitate safe housing and the alcohol services to provide advice with regard to her alcohol dependency. As part of the lessons learned from this DHR, UHCW are sustaining their existing training schedule to ensure that all key staff (including Emergency Department staff) are aware of their responsibilities for reporting and referring appropriately in relation to Domestic Violence and Abuse.

e) The Recovery Partnership

All staff are tasked to complete annual Safeguarding e-learning which includes Domestic Violence identification, validation, support and referral on. All staff have a minimum standard in Drug and Alcohol National Occupational Standards (DANOS) in risk assessment skills and are competent to undertake risk assessment and draw up risk management plans. Staff's individual training needs are reviewed regularly in line management supervision and through the appraisal process.

Each Recovery Partnership base has an identified MARAC lead so should further referral be considered necessary service users are identified to these leads for further action. The MARAC leads also scrutinise all case records and service user databases prior to MARAC meetings to identify if perpetrators or victims are known to Drug and Alcohol Treatment services since Dec 2011 (beginning of local treatment records held with Addaction).

f) Swanswell have recently developed their Domestic Abuse Policy (ratified in March 2014).

## **8.62 Local Authority**

During the period of the review WDC Housing had no Domestic Abuse Policy but used an Anti- Social Behaviour Policy in cases of domestic abuse. They were involved in referring individuals identified into the MARAC. WDC Housing Advice does have a domestic advice procedure which enables professionals to make

decisions bound by legislation. There is a code of guidance identifying which steps must be taken when someone presents to housing as a victim of domestic abuse.

The Housing Officers involved in A's case had all attended domestic abuse training and understood the referral process for victims.

WCC Adult Social Care responds to domestic abuse victims within the framework of Warwickshire Inter-agency Safeguarding Vulnerable Adults Procedure 2011 and also refers when appropriate into the MARAC. However, there is currently no systematic domestic abuse training for Adult Social Care staff.

To assist clarity in relation to the domestic abuse referral process the Panel has identified the need for the development of a county wide multi-agency referral protocol.

In addition, a domestic abuse policy needs to be developed for Warwick District Council Housing and Property Services.

As part of the requirements of the Care Act 2014, Warwickshire County Council Adult Social Care intends to revise the Safeguarding Vulnerable Adults' Policy to be integrated into the development of The Care Act responsibilities around Provision of Information and Advice, and into support planning pathways for adults with care and support needs who are at risk of domestic abuse. Staff guidance on domestic abuse will also be developed to accompany this.

Additional Domestic Abuse training also needs to be provided for specific staff within WDC Housing and Property Services and WCC Adults Social Care.

### **8.63 Warwickshire Police**

Warwickshire Police IMR states that they 'have published a domestic abuse policy and procedure which emphasises the priorities of:

- protecting the public,
- investigating all reports of domestic abuse;
- early intervention to prevent escalation;
- encouraging officers to be robust in their response to offenders and being proactive in providing services for victims;
- and finding innovative solutions to difficult issues.'

Standard Operating procedures for initial reports of domestic abuse and a Standard Operating policy for attending officers were implemented in 2007.

Specific procedures followed by Warwickshire Police in relation to risk assessment underwent changes during 2008-2012. By 2012 the Association of Chief Police

Officers DASH (Domestic Abuse Stalking and 'Honour' Based Violence) risk assessment tool was adopted.

Patrolling officers are routinely trained in identification of signs of domestic abuse and responding appropriately and are supported in practice by specialist officers and staff as well as specialist internal and external websites. However, despite this training, there appeared to be some confusion from officers attending the scene, regarding the identification of domestic abuse within the relationship between A and G and also some confusion from officers' responses in relation to A's reporting of E's alleged behaviour towards her in October 2012. This is evident from the Police records (see Chronology)

The response of Police call takers to A's situation would suggest that further training for Police call takers in the identification of the signs of domestic abuse and the need for appropriate and timely responses is required.

The IPCC report into Warwickshire Police's response to A's situation makes the following recommendations which are relevant to recommendations made by this DHR:

- a) Warwickshire Police create a tag on their intelligence system for domestic abuse victims and domestic abuse perpetrators so that information is known in relation to the victim/suspect which would assist if a victim or suspect moves address or starts a new relationship, and would assist a call handler to assess the situation and vulnerability of the caller instead of trawling through incidents logs. They may want to consider tags for other vulnerable situations such as homelessness and alcohol dependency.
- b) Call handlers should conduct searches on all parties that may be relevant to the incident as well as victims so that they can assess the situation and inform officers attending of intelligence.
- c) Call handlers and other appropriate control room staff should have a training input on recognising and considering factors around the vulnerability of those they come in contact with.
- d) Warwickshire Police should consider whether the frequency of calls to an address and the vulnerability of those living at the address should result in more positive action. The force should identify addresses subject to multiple calls and repeat victims which could be subject to a more strategic approach.
- e) Call handlers should be reminded of the need to ascertain what the relationship is between both parties and ascertain any intelligence or information contained within police systems, allowing calls to be graded appropriately.

## **8.64 Warwickshire Probation Trust**



The Probation Trust follows Best Practice Guidance for Probation Trusts which has been published to support the National Offender Management Service's Domestic Abuse Strategy.

Within this guidance the focus is on managing and working with an offender who has been convicted of domestic abuse related offences. To this end there is comprehensive guidance and two specific assessment tools which help to assess the offender's mechanisms of abuse and the frequency of this abuse towards their partner within the last year.<sup>32</sup>

However, this guidance would not have been relevant to A's situation as a female offender who had been a victim of domestic abuse. Her offending was not considered to be connected with any experiences she had of domestic abuse.

Warwickshire Probation Trust in their recommendations for this review is ensuring that staff consider and recognise that offenders may be victims of domestic abuse. The Women's Aid Guidance, 'Supporting women offenders who have experienced domestic and sexual violence,'<sup>33</sup> has been identified as useful in supporting this work.

Probation staff are required to undertake a range of both mandatory domestic abuse training and awareness training of domestic abuse services in order to ensure that they have the skills and knowledge to undertake interventions with both victims and perpetrators of domestic abuse. These have included the following

- Domestic Abuse Checklist for Offender Managers 2012.
- Re-Modelling of Domestic Abuse Services in Warwickshire 2012.
- Domestic Violence Workbook 2010.

More recent training has been:

- Working with Domestic Abuse 2013.
- Domestic Violence and Relationship Abuse Project 2013.

It is evident from the probation officer's intervention with A in October 2012 that there was recognition of the possible signs of domestic abuse and an understanding of expected procedural responses.

## **Conclusion and learning point**

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<sup>32</sup> Best Practice Guidance for Probation Trusts to compliment the NOMS Domestic Abuse Strategy. Appendix 1: One –to One Tools Tolman- men and Appendix 2: one-to One Tools Marshall- men

<sup>33</sup> Women's Aid Federation of England (Women's Aid) for the Women's Team, National Offender Management Service. N Norman and Dr J Barron September 2011

Although some agencies had domestic abuse policies in place during the timescale of the review, there was evidence that these did not exist in some agencies. Even when domestic abuse policies were in place, the DASH Risk Indicator Checklist was not generally used by agencies between 2008-2010.

During 2008-2010 CWPT staff did not receive specialist domestic abuse training and therefore did not appear to understand the possible complexities of domestic abuse and substance misuse or demonstrate professional curiosity pertaining to domestic abuse. Like other agencies, they were also not trained to use the DASH Risk Indicator Checklist. As a result of learning lessons from this DHR, from January 2013 CWPT have included DASH Risk Indicator Checklist training within their level 2 safeguarding training for all professionals.

Some Police officers who responded to domestic disputes between A and G, despite receiving some domestic abuse training, did not appear to understand the possible complexities of domestic abuse and also demonstrated a lack of professional curiosity. This point also applies to the Police response to the telephone call made by A prior to her death.

From many agencies' perspectives, knowledge of domestic abuse care pathways and specialist local domestic abuse services was also variable.

The specific learning from the review is the need to ensure that domestic violence and abuse policies are developed and updated; that a multi-agency, countywide domestic abuse referral protocol is developed and that these are integrated into agencies' domestic abuse training programmes.

**Additional learning which is relevant to the Health Sector/ economy:**

- a) The impact of domestic abuse on an individual's health is to be noted in A's case. There were some significant missed opportunities by health professionals for identification of domestic abuse and referral into services. There is an increasing recognition of the important role that health professionals play. This recognition is supported through the recommendations in the recently published NICE Domestic Violence and Abuse Guidance.<sup>34</sup>

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<sup>34</sup> 'Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively.' Public Health Guidance. NICE PH50 February 2014. <http://guidance.nice.org.uk/PH50>

Within the Warwickshire local health economy, there are only two professional groups (Health Visitors and Mental Health Professionals) that have a mandatory and prescribed way of asking the question about domestic abuse<sup>35</sup> Whilst there is national guidance for health professionals,<sup>36</sup> this has not been fully adopted across the Warwickshire Health Services. Therefore the panel recommends that there is a constant and consistent implementation to ensure that all the Warwickshire Health Services ask the question about abuse and signpost and employ strategies to help and support victims and perpetrators in domestic abuse situations.

The review panel would also want to recommend the adoption of this approach at a national level also.

- b) The panel also recognised the centrality of the GP's role and the need for local GPs to be able to identify and respond to domestic abuse and to refer in to support services and the MARAC where appropriate. A specific recommendation (below) has been included to ensure that this takes place.

### **Recommendation**

To develop a process whereby local GPs are informed about MARAC process and are involved in 'two way' information sharing and referrals into MARAC

## **8.7 Assessments**

In the time period of this review A was subject to a number of assessments including assessments to identify the level of risk from domestic abuse, health assessments undertaken whilst A was in Police custody, a formal mental health assessment and an assessment for an Alcohol Treatment Order by The Recovery Partnership. This section will firstly analyse domestic abuse assessments and then focus on analysis of some of the other forms of assessment.

### **8.7.1 Domestic abuse risk assessments**

It would appear from the evidence presented to the review that the majority of agencies were not systematically using recognised domestic abuse risk assessment tools when A disclosed domestic abuse in her relationship with G .The exceptions to this were Warwickshire Police, Warwickshire Probation Trust and The Recovery Partnership.

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<sup>35</sup> 'Routine Enquiry and Risk assessment for Domestic Violence and Abuse- Guidance for Health Visitors ' 2009 and 'Asking the Question about Abuse' Routine Enquiry for Mental Health Services.' Department of Health 2008

<sup>36</sup> 'Improving Harm: Children, Young People and Domestic Violence : A Practical Toolkit for Front-line Practitioners ' Department Of Health 2009

In the one instance where A disclosed that F had assaulted her (to Probation on 23rd October 2012) it appears that there was no formal risk assessment undertaken. However, probation staff did offer support and advice to A regarding the disclosure, but A did not choose to take this advice.

## **8.72 Warwickshire Police Domestic Abuse Risk assessments**

As previously mentioned, Police did not perceive that A was a victim of domestic abuse within her relationships with either F or E.

When Police received three calls from A (on 11<sup>th</sup>, 16<sup>th</sup> and 24<sup>th</sup> October) when she complained about E's behaviour towards her, no risk assessment was undertaken.

As stated throughout this report, the DHR Panel believed that it was important to explore and analyse agencies' responses to A throughout the period determined by The Terms of Reference for the review, to establish improvements in practice and process. The following summarises the key points identified by an analysis of the domestic abuse risk assessments carried out by Warwickshire Police in their responses to A in her relationship with G during the period 2009-2011. This was a complex situation where Police assessed A and G as dual perpetrators; there was also evidence of both drug and alcohol misuse within the relationship

There has been a detailed analysis of these but because this is not the prime focus of this DHR, the panel are of the view that only a brief summary is necessary within this report.

- Risk assessments were undertaken with a lack of reference to previous risk assessments which led to an inconsistency in the levels of risk. This led to incidents being treated in isolation rather than as a series of linked incidents. This may have reduced the potential for intervention and support. The intervention and support may have helped A and may have reduced the likelihood of her situation worsening. However, it seems unlikely from her responses to other services offered, that she would have engaged with services at this stage.
- There were noted inconsistencies between what was written in Police logs and what was written in risk assessments. Some of the omissions and /or inconsistencies relate to the alcohol and drug issues that were factors in G and A's relationship. These inconsistencies may have prevented the elevation of risk levels.
- A had never been assessed as a 'high risk'<sup>37</sup> victim of domestic abuse. Police had referred her (with her consent) to Warwickshire Domestic

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<sup>37</sup> ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment model determines the level of risk to the victim. Those identified as 'high risk' are at risk of serious harm or potential homicide cases and are referred into a Multi-Agency Risk Assessment Conference.

Violence Support Services (WDVSS) and to Stonham's Domestic Abuse Support Service, but she had not pursued these offers of support.

The Police IMR closely analyses the numerous domestic dispute call outs they made to A and it makes the following points:

- There have been significant changes to Police perceptions and understanding of domestic abuse since this case. Some of these are as a result of increased training and awareness raising and others as a result of risk assessment improvements. For example:
- Many of the 'domestic disputes' between A and G (in 2009) which were viewed as arguments over divisions of property when the couple were in the process of separating, would now be viewed by the Police in a different light and would have provided greater opportunities for intervention.
- There have also been amendments to the DASH risk assessment which now includes a question about the suspect mistreating an animal or family pet. If this had been in the DASH risk assessment tool in 2009 it would have elicited a significantly different Police response to A's claim that G was threatening to 'kill her dogs.' (11<sup>th</sup> Nov 2009)
- The perception of A that G was threatening to kill members of her family would now be seen as potential harassment and intimidation of A.

West Mercia and Warwickshire Police Forces' Draft Domestic Abuse Strategy (October 2013- March 2016) outlines the aspiration for 'consistency in approach to domestic violence across areas.' It also states that the forces will 'ensure compliance with the DASH risk assessment tool, but seek to rationalise it to a right first time approach.'

In addition, the recent HMIC (Her Majesty's Inspectorate of Constabulary) report *'Everyone's business: Improving the Police response to domestic abuse,'* (2014) Warwickshire Police were one of eight Police forces in the UK who were identified as having demonstrated good practice in its response to victims of domestic abuse. The report stated that, 'The public in Warwickshire can have confidence that the force is working well with partners to tackle domestic abuse and keep victims safe. Tackling domestic abuse is a priority for the force and staff demonstrate a high level of commitment and understanding throughout the organisation.'

In the report, two of the six recommendations to further strengthen Warwickshire Police response to victims of domestic abuse, have relevance for the findings of this DHR and are as follows:

- The force should implement a robust quality assurance process that provides systematic audits of domestic abuse calls.

- The force should conduct a training needs analysis to establish what domestic abuse training is required across the force, and develop a timed implementation plan.

## **Recommendation**

In light of the findings of this review Warwickshire Police have advised that they will review working practices in relation to the identification of repeat Domestic Abuse incidents risk assessed as Standard/Medium, which when taken together could be collectively considered to be High Risk. They will then introduce a process for the escalation of such cases into MARAC.

This will be considered as part of the alliance's approach (between Warwickshire and West Mercia Police Force).

### **8.73 The Recovery Partnership**

The Recovery Partnership risk assessed A according to their service standards as set out in their domestic abuse policy and risk assessment processes. However their assessment and risk assessment procedures are carried out based on what the individual tells them. Because A had not been previously assessed as 'high' risk in relation to domestic abuse, there was no information shared between agencies. The review has identified that it would be beneficial for The Recovery Partnership to examine and update, as required, training and current practice at assessment, and care plan review, to ensure a consistent approach to gathering risk information on past (or recent) domestic abuse to better inform current or future inter-agency working and/or safeguarding processes. There is also a commitment to review risk assessment and domestic violence assessment tools and to ensure that all clients are asked about domestic abuse.

### **8.74 Warwickshire Probation Trust**

Analysis of Warwickshire Probation Trust's risk assessment of A has been previously dealt with in section 7.64

#### **Conclusion and learning point**

During the timescale determined by the Terms of reference for this DHR, some services (e.g. Housing, Adult Social Care, Health organisations) were unfamiliar with domestic abuse risk assessment tools.

The inclusion of a common risk assessment process across all agencies within their current practices is now evident and many of the updated domestic abuse policies

now refer to the CAADA DASH Risk Indicator Checklist. However there is a need for ongoing training of frontline staff to ensure their familiarity with the tool and a recognition that this should be done in conjunction with recognised good quality domestic abuse training.

Agencies involved in the local health economy and in Warwick District Council and Warwickshire County Council services who participated in the review have recommended that their domestic abuse training, and any multi -agency training, will in future include an awareness of the Domestic Abuse Stalking and Harassment and Honour Based Violence (DASH) Risk Indicator Checklist.

In addition, to combat the evidence from the review that services /agencies had 'tunnel vision', considering only the problem that A presented with and thereby failing to recognise the signs that there were difficulties in other areas of her life, it is recommended that agencies consider all aspects of a client's life when undertaking assessments.

### **8.75 Alcohol Treatment Requirement Assessment Process**

An Alcohol Treatment Requirement (ATR) is one of a range of community sentences available to the courts. It is applied to offenders who present serious problems with alcohol and where alcohol is identified as a significant factor in the person's offending. Once an ATR order is imposed by the courts, the individual must agree to a treatment plan with Probation and the treatment provider (in A's case, this was The Recovery Partnership). The treatment plan is tailored to the individual with a view to reducing or eliminating alcohol dependency

According to The Recovery Partnership's IMR, a Recovery Partnership Engagement and Recovery worker carried out a video link assessment with A (who was in custody at HMP Peterborough) on the 09/07/12. A was found to be suitable for an ATR. During sentencing on the 16/07/12 A was also found suitable for ATR. There were a number of documented appointments offered in an attempt to engage A during August and September 2012. But it was not until 24/10/12 that she attended The Recovery Partnership for the first time as a requirement of her ATR community order. However, her ATR had been revoked at one point, but on her return to court she was given another, without being assessed. The Recovery Partnership's IMR points out that this failure to re-assess would possibly have meant that A's change in circumstances were not taken into consideration and that as a consequence an ATR might not have been appropriate for A at this time. Part of judging an individual's suitability for an ATR is assessing their willingness and ability to engage and abide by the order's requirements. A had moved from a position of enforced sobriety in a prison (where her initial ATR assessment was carried out), to a homeless woman who was associating with street drinkers. The Recovery Partnership worker expressed her concern, both verbally and in writing at this set of circumstances.

It may well have transpired that a custodial sentence would have been more suitable for A and may well have made a difference to her circumstances on 24/10/12.

This issue has identified a recommendation to ensure that community treatment orders are not issued without the individual being assessed. A meeting between The Recovery Partnership, Probation and Court representatives occurred in February 2014 to action this recommendation.

### **8.76 Custody suite – health assessments**

During 2011 and 2012 A was in Police custody on 20 occasions when she was risk assessed by the Custody Officer and also assessed by a health care professional. The current healthcare provider undertaking such assessments for Warwickshire Police is Primecare.

In the majority of cases an examination by the health care professional was required so that A could be prescribed different medication to reduce the effect of her alcohol withdrawal or to substitute for methadone.

On two occasions (3<sup>rd</sup> and 15<sup>th</sup> March 2012) there was inconsistency between the injuries that were recorded by the custody officer and those recorded by the healthcare professional.

On the 3<sup>rd</sup> March 2012 A was recorded as suffering from a broken ankle and a fractured left eye socket, neither of which were recorded by the Health care professional. Both of these injuries are again referred to on the 15<sup>th</sup> March in the custody assessment but are not referred to by the health care professional.

On the 1<sup>st</sup> March 2012 although the custody assessment records state that A had pre arrest injuries of a broken ankle, the health professional's report states that she 'had no apparent injuries' and this is later endorsed by the custody record which states that she has 'no apparent injuries.'

The need to accurately record injuries to those who are in custody and to ensure there is a consistency in the recording of these injuries (by custody officers and health professionals), has been identified as a key learning point and the following recommendation has been made:



To review Police working practices to ensure that Custody Staff accurately record injuries sustained by detainees.

The issue has already been raised with Primecare and the learning is to be disseminated as part of Custody training.

### **8.8 Responding to individuals with complex needs (e.g. domestic abuse, substance/alcohol misuse, mental health problems, homelessness) which when taken together exposes them to high risk**

A's situation in October 2012 represented the plight of many homeless women in the UK today who have 'severe, interrelated and exceptionally complex problems which contribute to their homelessness and make their recovery challenging.'

It is recognised by recent research that substance misuse is 'both a cause and consequence of homelessness and is often used as a coping mechanism to deal with mental health problems or experiences of violence, abuse or trauma.'<sup>38</sup>

This research, involving homeless women, concludes that women who are homeless are amongst the most marginalised people in society. It also evidences that:

- 32% of women said that domestic abuse contributed to their homelessness.
- 44% of women had been abused by their partners.
- 70% of the women had mental health needs.
- 48% of the women had a substance use problem.
- Many homeless women experience 2 or more mental ill health, physical ill health and substance misuse problems.
- One third of women who have slept rough have been involved in prostitution.
- Almost one half have an offending history and one third have been to prison.
- 75% of domestic abuse incidences result in physical or mental health consequences for women.

In addition to the above statistics, and pertinent to A's situation, research also tells us that over one half of women in prison have experienced domestic abuse, compared to a quarter of all women.<sup>39</sup>

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<sup>38</sup> Rebuilding Shattered Lives: The Final Report Getting the right help at the right time to women who are homeless or at risk. Sarah Hutchinson, Anna Page and Esther Sample. St Mungos. March 2013

<sup>39</sup> Social Exclusion Unit (2002) Reducing reoffending by ex prisoners, London: Social Exclusion Unit

During the 5 years that this review covers, A's personal situation deteriorated and became more complex; professionals often did not share information regarding her situation because she failed to reach the levels at which it is deemed that she required safeguarding support as a vulnerable adult or as a domestic abuse victim.

Although extremely vulnerable as a consequence of her alcohol and drug misuse, her experiences of domestic abuse and her homelessness, she had no diagnosed mental health issues and no one had identified her as a 'vulnerable adult.' She clearly demonstrated that she had 'mental capacity' to make and take her own decisions. Possibly because of her resilient independence, she did not have any professionals who advocated on her behalf. This situation can be compared with F who was judged to be vulnerable and therefore had professionals and volunteers supporting him and advocating for him, which had led to his assessment as a vulnerable adult and the implementation of a care plan which supported him.

As previously mentioned in the report, agencies were often viewing A in relation to a single presenting factor and there had been no comprehensive assessment of her needs.

Her lifestyle as a homeless woman who was a street drinker, associating with other alcoholics, put her in positions of risk. The Police IMR states that there was a strong possibility that A was exchanging sex for a roof over her head and that she was also prostituting herself in order to have enough money to buy alcohol. Both of these acts can be interpreted as acts of exploitation and highlight A's increasing levels of risk and vulnerability. The Police IMR also states that there was evidence that she had been subject to assault from her fellow associates and that she had assaulted others.

In the weeks leading up to her death, A was viewed by some agencies (in particular Housing and Police) as having a reputation associated with her alcoholism and her anti-social behaviour. At this time WDC Housing were investigating an injunction against A which would have prevented her from staying at F's address. This was a protective response by WDC Housing to deal with the increasing numbers of anti-social behaviour complaints from F's neighbours and to thereby safeguard F by enabling him to remain in the property. However, although A had been told by a Tenancy Enforcement officer in July to present herself as homeless and she had not done this, there was no consideration given to A's situation and the impact that this may have had upon her life. There was no co-ordinated safety planning or safety net for A.

The Police IMR considers that if A had lived and had been subject to an injunction preventing her from staying at F's address this would have invariably made her completely homeless thus exposing her to greater danger.

## Conclusion and learning point

A's situation has highlighted a gap in both processes and services in relation to vulnerable individuals with complex problems who fail to reach the thresholds for support, and therefore, fall through any safety net that is currently in place. The panel concluded that this was not a unique gap relevant only to Warwickshire, but one which is a national issue.

A similar learning point has been recognised in the Warwickshire serious case review of Gemma Hayter (an adult with learning disabilities who was murdered in 2010.<sup>40</sup>) This review concluded that the Adult Safeguarding process and the threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where the evidence is through a larger number of low level triggers.

Recommendations from the Gemma Hayter serious case review included:

- The development of procedures and/or guidance by Warwickshire Safeguarding Adults Board to ensure that multiple low level concerns/referrals are escalated and multi-agency meetings are held to discuss the safeguarding of the individual.
- That Warwickshire Safeguarding Adults Board explores the feasibility of setting up a Multi-Agency Safeguarding Hub (MASH).

Early stage discussions are currently taking place about the development of a Warwickshire Multi-agency Safeguarding Hub.

Nationally, there are currently many different emerging MASH models. A MASH would provide triage and multi-agency assessment of safeguarding concerns in respect of vulnerable children and adults. It aims to bring together professionals from a range of agencies into an integrated multi-agency team. The MASH team makes assessments and decisions depending on statutory need, child protection or early help. Quicker response times, a co-ordinated approach and better informed decision making ensures that vulnerable children and adults are protected.

Warwickshire is also developing partnership working around an Empowering Communities Inclusion and Neighbourhood management System (E-CINS), 'a web based casework management system which shares information securely across multiple agencies. It aims to enable support to quickly and effectively be wrapped

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<sup>40</sup> <https://www.warwickshire.gov.uk/seriouscasereview>

around victims, offenders and vulnerable persons. It provides the ability to identify persons and cases of greatest risk and vulnerability.’<sup>41</sup>

E-CINS will initially be implemented in Warwickshire for multi-agency case management around two key themes: Priority Families and Anti- Social Behaviour. It is anticipated that domestic abuse cases may, to begin with, be identified within the Priority Families’ work, but may become a key strand of work at a later stage in the E-CINS development. The following partners will initially be working with this initiative: Warwickshire County Council, Warwickshire Police, Warwickshire Fire and Rescue Service, Stratford and Warwick District Councils and Rugby Borough Council, with others to come on board at a later date.

The following recommendation aims to build on those cited above from the Gemma Hayter serious case review. The panel believe that because of the ongoing context of budget constraints for all public sector organisations, the recommendation should be considered in the light of, and in tandem with, other developing initiatives in Warwickshire. E.g. E-CINS and Multi- Agency Safeguarding Hub (MASH) models.

### **Recommendation:**

For Warwickshire Agencies to carry out a scoping exercise to explore the feasibility of a co-ordinated multi- agency approach to sharing information, risk assessing and supporting individuals with complex needs (e.g. victims of domestic abuse, homeless, alcohol/substance misuse/mental health issues) who may be vulnerable, but who do not meet current statutory thresholds.

Within this process to consider:

- A single point of contact to co-ordinate responses and professional involvement- and a lead practitioner to co-ordinate service responses
- A multi- agency care management system (similar to a MARAC) to assess and manage cases.
- A review of existing agency assessment tools to ensure that relevant questions are included which cover the following: domestic abuse, mental ill health, substance misuse, accommodation needs.
- The development of an advocacy system for this client group- to broker relationships with agencies.
- Information sharing protocols.
- Guidance for voluntary organisations (who support this client group) who work in partnership with the statutory sector.

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<sup>41</sup> As stated on the website- [www.empowering-communities.org/tag/ecins](http://www.empowering-communities.org/tag/ecins), E -CINs

## **8.9 Analysis of the review process:**

The review process has been described in section 2 of this report and has followed the national guidance for Domestic Homicide Reviews. By and large the process has been implemented as required.

**8.91** There was one requirement which proved difficult to meet and this was the timescale. There were five factors which meant that the original deadline for the report had to be altered.

- There were delays in the production of IMRs and in particular the Police's IMR. For the Police, the IMR process had revealed extensive information about A which needed a thorough exploration which could not be achieved within the given timeframe. They were therefore given an extension.
- Some of the other agencies found it difficult to produce quality IMRs because of the lack of experience amongst their staff in writing IMRs. This DHR has been the first DHR within Warwick District, and although staff attended the DHR IMR briefing session they still experienced difficulties. Because of IMR quality issues identified by the Independent Chair at the meeting on 9<sup>th</sup> December, the Panel agreed to request resubmission of all IMRs with a new deadline of 6th January 2014. This new deadline was also granted to Warwickshire Police for their first IMR submission. To ensure the accuracy and quality of the IMRs, the Chair identified areas for expansion and clarification for each of the submitted IMRs. Following resubmission they were found to be completed fully and to a satisfactory standard. Second versions of the IMRs were received by the Panel on 10<sup>th</sup> and 24<sup>th</sup> January 2014.
- Translation of essential information e.g. Terms of Reference, letters and interview questions for family members took longer than anticipated.
- The Panel also decided to delay the report to allow for the publication of the IPCC report. However, the IPCC decided to alter the publication of their report so that it would coincide with the publication of this DHR.
- The report was subject to scrutiny from Warwickshire County Council Legal Services which caused additional delays.

As a consequence of the learning from this process, the review panel have created two specific recommendations for Home Office consideration.

### **Recommendation:**

**8.92** That The Home Office DHR Quality Assurance Panel produces clear and detailed guidance for DHR IMR authors.

**8.93** That The Home Office produces guidance to Community Safety Partnerships on the recommendation to seek legal assistance and guidance at the onset of DHR processes where there have been no criminal convictions or where the scope of the DHR encompasses events and /or individuals which are not directly connected with the circumstances of the death, but are deemed to be relevant to the overall review or in any other circumstances that may warrant the need for legal guidance.

### **8.93 Analysis of the involvement of family and friends in the review process.**

The review made every effort to involve family and friends/associates in the review process. This involved the following methods:

- Translating letters, leaflets and interview questions for family members and finding secure mechanisms to send and receive information
- Tracing associates and friends with the assistance of partner agencies e.g. Police, Housing, Probation, The Salvation Army.
- Discussion with Adult Social Care to assess the best possible ways of approaching and supporting a vulnerable adult who was invited to participate in the review.

The only difficulty encountered in this process was the failure to engage with some of A's associates who because of their current lifestyle may have changed addresses frequently or become homeless and therefore were non contactable.

### **8.10 Summary of Lessons Learned**

The review has identified a number of areas where improvements could be made by implementing changes to promote good practice and a more effective response to victims of domestic abuse.

The key issues to be addressed were identified as follows:

- Addressing the updating of domestic violence policies, procedures and training of front line professionals in the agencies identified in the review so that they can intervene with confidence and with a clear understanding of the dynamics of domestic abuse and an understanding of appropriate care pathways.
- Improving domestic abuse risk assessment processes across all agencies.

- Improving awareness amongst professionals of the causal connections between Domestic abuse, alcohol and substance misuse, and mental health issues.
- Ensuring that professionals look at clients with a wider lens than the single issue that they may be presenting with to their service.
- Developing systems for supporting vulnerable adults with complex needs which when taken together exposes them to high risk
- Improving involvement from GPs in the MARAC process.
- Engaging with key members of minority communities to help develop an understanding of domestic abuse and local referral and support processes.

## **9. Conclusion**

The content of this report has been based on material found in the records of all of the agencies invited to participate in the DHR, the Individual Management Reviews from these agencies and interviews with family members, friends and associates of A. In addition to these sources of information, there has been a robust process of information sharing and discussion at the DHR Panel meetings. The findings and conclusions, that are in the interest of the public to be aware of, are formed from the DHR Chair and Author's professional opinion further to the consideration all of this available information.

With the information gathered from the review process, the panel believe that there were many complex factors that contributed to the situation that A found herself in just before her death. The primary factors included: A's experiences of domestic abuse; her inability to have a child; her ongoing substance and alcohol misuse; her mental distress; the breakdown of her long term relationship with G; the physical isolation she felt living in a large house in a very rural setting. She also felt isolated from her family and friends in her country of origin. The financial pressure from a failing business was an additional stressor.

All of these interconnected factors most likely contributed to her eventual homelessness and her chaotic lifestyle. As a homeless woman dependent on alcohol, her life choices were limited; she had mental capacity to make decisions but the decisions that were open to her were restricted by her situation and more often than not, these decisions placed her in risky situations with associates who were similarly struggling with their own problems and survival.

The panel concluded that given the situation that A found herself in during the last months of her life, it was very likely that something life threatening would have occurred. However, having analysed the evidence from agency records and friends

and family contributions, it was difficult for agencies to predict the possibility that A might die as a result of domestic abuse or as a result of violence, abuse or neglect from somebody who was a part of the same household as she was. Although some agencies recognised that A had experienced domestic abuse within her relationship with G, this was unconnected with events that surrounded the circumstances of her death. In the immediate period before her death, the majority of agencies who came into contact with A had no information which suggested that she was a victim of domestic abuse within her relationship with F. The only agency that recorded that A had been assaulted by F was Probation (on the 23<sup>rd</sup> of October). A was advised to report the matter to the Police, but chose not to do this.

Although Police records have information documenting the victim's concerns and allegations relating to E's behaviour towards her on three occasions during October 2012, the Police did not interpret these incidents as domestic violence and abuse, as A and E were not in nor had been in an intimate personal relationship. However, they did treat these disclosures from A as three separate and unconnected incidents of anti-social behaviour rather than them being seen as potentially a pattern of escalating risk from E towards A. Similarly, other agencies who were involved with A's life during the period immediately prior to her death perceived her as someone who was involved in anti-social behaviour and not as a person at risk of harm from violence (domestic violence and abuse, or otherwise.)

An additional significant factor that is central to A's situation and one that has to be considered is A's undiagnosed and rare health condition, Peliosis of the spleen, which could have (and indeed may have) terminated her life at any moment.

The review has highlighted the ways in which agencies could have improved their responses to identifying domestic abuse and to A's disclosures of domestic abuse. Recommendations are in place that aim to increase the support to individuals who have complex needs similar to those A experienced.

In conclusion, A's seemingly fiercely independent personality, her increasingly chaotic lifestyle and her reluctance to accept offers of support, make it difficult to determine whether additional and /or different offers of support, if they had been in place, would have been accepted by her.

## **10. Implementation of Learning**



The lessons to be learned from this Review (8.10 above) must be followed up to ensure that practice improves, and where practice has already been addressed as a result, mechanisms must be put in place to embed and maintain the improvements.

The IMRs have provided evidence in their reports and on this basis Action plans with recommendations for each agency have been formed. (See Appendix 2) These have within them identified actions which are to be achieved within a specified timescale. These will be monitored regularly by The South Warwickshire Community Safety Partnership.

Each agency is expected to provide feedback to their agency and the IMR authors, as well as to the professionals who were involved with the IMR process.

The recommendations, noted within this report, which cover all agencies working together to make improvements have also been given specific timescales. These, together with recommendations for national changes, will be monitored by The South Warwickshire Community Safety Partnership. (See Appendix 4 for Multi-agency action plan)

The dissemination of key learning will be targeted to the professionals in the member agencies of The South Warwickshire Community Safety Partnership. There will also be a shared learning event which disseminates learning from this and another Warwickshire DHR which will be available for professionals from a wide range of agencies.

***Dee Edwards BA MA***

***Independent Chair, Domestic Homicide Review Panel and Overview Report Author***

***June 2015.***