The Safe Durham Partnership

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County Durham
Domestic Homicide Overview Report

REPORT INTO THE DEATH OF ADULT A

DHR Case Reference: DHR/007

Anonymised for publication and dissemination

Final Version

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Contents

1 Background to Domestic Homicide Review

1.1 Introduction

1.1.1 This Domestic Homicide Review (DHR) was carried out following the death of a resident of County Durham, Adult A, in 2013. In 2013 Adult B, with whom she had been in a relationship for approximately one year, was found guilty and sentenced.

1.1.2 We would like to express our profound sympathy to the family and friends of Adult A and assure them that in undertaking this review we are seeking to learn lessons from this tragedy, and to improve the response of agencies in cases of domestic abuse. We also wish to thank them for their invaluable input into the review process.

1.2 Subjects of the review

Adult A	*Deceased*	*Date of Death: 2013 (aged 56)*
Adult B	*Perpetrator*	*Convicted: 2013 (aged 51))*

Both Adult A and Adult B are of White British origin.

1.3 Purpose of a Domestic Homicide Review

1.3.1 This DHR was recommended and commissioned by the Safe Durham Partnership in line with expectations of Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review 2011. The guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

1.3.2 Under such guidance DHRs should be carried out to ensure that lessons are learned following the death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person whom he/she was related or had been in an intimate personal relationship; or
(b) A member of the same household.

1.3.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service responses including changes to 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.

1.4 Process of the Review

1.4.1 This review was conducted in accordance with the Safe Durham Partnership County Durham Domestic Homicide Review Procedure, July 2012 (amended 2013).

1.4.2 At the time this DHR was undertaken there were no other ongoing investigations or reviews taking place in relation to this case.

1.4.3 The Home Office was informed of the intention to conduct a DHR on 26/06/13 and the first review panel was held following completion of the criminal court case.

1.4.4 A Domestic Homicide Review Panel was convened and was made up of the following representatives:

Agency	Job Title
Chair of the Review	Strategic Manager, County Durham Youth Offending Service, Durham County Council
Durham Constabulary	Detective Superintendent
North Durham Clinical Commissioning Group on behalf of the Local Area Team	Safeguarding Adults Senior Manager
Tees, Esk and Wear Valleys NHS Foundation Trust	Associate Director of Nursing Compliance/ Safeguarding Lead
County Durham and Darlington Foundation Trust	Associate Director of Nursing, Patient Experience and Safeguarding

NHS Greater Huddersfield Clinical Commissioning Group	Designated Nurse for Safeguarding Children and Safeguarding Lead, NHS Calderdale, Greater Huddersfield & North Kirklees CCGs
Community Safety Durham County Council	Community Safety Officer

1.4.5 The Independent Chair of the panel, Gill Eshelby, is the Strategic Manager, County Durham Youth Offending Service, Children and Adults Services, Durham County Council. She is independent of all of the organisations that supplied IMRs or extended chronologies for the purpose of the review.

1.4.6 Gill Eshelby has 14 years senior experience in youth justice. She joined CDYOS in May 2000; became Deputy Head of Service December 2001; was Acting Head of Service from December 2006 – November 2008; and in November 2008 was appointed as Head of Service (now Strategic Manager). She is an accredited Youth Justice Peer Reviewer and was previously a member of the YJB's Improvement and Development Programme Board, representing all the YOTs in England. Prior to joining CDYOS, the Chair had 19 years' experience in education as both a head of department and senior teacher.

1.4.7 The Chair has been a member of the Safe Durham Partnership since its inception and is the Board's strategic lead for Integrated Restorative Practice. She is also the Prevent lead for Children's Services. She is a member of various other boards: Children and Families Partnership, Strategic MAPPA Board, LSCB, LCJB.

1.4.8 The Independent Overview Report author is a qualified Probation Officer and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer since 2006, she has undertaken a variety of roles within the domestic abuse and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. The author also currently acts as Chair and/or report author in a number of Domestic Homicide and Serious Case Reviews. Alongside this work she also acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for public and private law cases.

1.4.9 The following agencies were asked to secure their records and asked to complete a chronology relating to their contact with either Adult A or Adult B:

- Durham Constabulary
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- North Durham Clinical Commissioning Group (NDCCG) – on behalf of the Local Area Team
- South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
- County Durham and Darlington Foundation Trust (CDDFT)
- North East Ambulance Service NHS Foundation Trust (NEAS)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Calderdale General Practitioner (NHS England)

1.4.10 Following the review of the chronologies it was then agreed on 30/01/14 that the following agencies would undertake an Individual Management Review (IMR):

- Durham Constabulary
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North Durham Clinical Commissioning Group (on behalf of the Local Area Team)

1.4.11 In addition to the above, SWYPFT provided an extended chronology providing additional analysis of their involvement with Adult B. There was insufficient contact between SWYPFT and Adult B to warrant a full IMR.

1.4.12 It was also identified that it was not appropriate for IMRs to be completed by CDDFT and NEAS, due to their limited contact with either Adult A or Adult B during the period of the review.

1.4.13 The review began in November 2013 and was concluded on 29/07/14 when it was approved by the Safe Durham Partnership. The review went outside of the guidance time of six months due to delays linked to the criminal trial and attempts to gain consent from Adult B for the disclosure of his confidential records.

1.4.14 We would like to thank all those who have given their time and co-operation throughout this review process as Review Panel members, Individual Management Review (IMR) authors, and those staff members of participating agencies who were interviewed as part of the preparation of

IMRs. We would also like to express gratitude to those from the Safe Durham Partnership for their support in the administration of the review process.

1.5 Time Period

1.5.1 The Panel agreed that the time period covered by the review would be from January 2011 to the date of Adult A's death. This was to cover the period during which Adult A was believed to be in a relationship with Adult B, from February 2012, as well as the year leading up to this. Agencies completing IMRs were also asked to include any relevant information prior to this time period that would provide context for the events that subsequently occurred.

1.6 Confidentiality and consent for obtaining information

1.6.1 We are grateful to Adult A's family for providing their consent for the disclosure of information in relation to Adult A.

1.6.2 The Panel Chair contacted Adult B to request his permission for disclosure of confidential records. As permission was not received, appropriate agencies approached their Caldicott guardians to seek agreement for the disclosure of relevant information. All agencies had to consider whether the public interest in maintaining the duty of confidentiality owed to the individuals was outweighed by the public interest in the use and disclosure of confidential information, records and health records for the purpose of this review. It was concluded that there was an overriding public interest in favour of the provision of relevant information, records and health records in order to complete Individual Management Reviews. There was no confidential material relevant to the review that was withheld for legal reasons.

1.7 Terms of Reference

1.7.1 Within the terms of reference it was identified that the purpose of this review was to:

- Seek to establish whether the events that occurred in 2013 could have been predicted or prevented.

- Consider the period of 2 calendar years prior to the death of Adult A, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews or, where appropriate, reports by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of adults and children where domestic abuse is a feature.

1.7.2 In addition the following areas were addressed in the Individual Management Reviews and this final DHR Overview Report:

- Was everything done which might reasonably have been expected to understand and manage effectively any risk of harm? What were the key points/opportunities for assessment and decision making in relation to those identified? Do assessments and decisions appear to have been reached in an informed and professional manner?
- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?
- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Examine whether there were any issues in communication or information sharing. Also were managers appropriately consulted and involved.
- Did any organisational/capacity issues impact on this case?
- What were the considerations in relation to ethnicity, religion, diversity or equality and how did these impact on those involved.
- Were any agencies aware of the use of websites and other social media for engaging in relationships by either the victim or the perpetrator and is there a requirement to raise awareness of the risks that are present by engaging in this activity?

1.8 Individual Management Reviews

1.8.1 Individual Management Reviews were completed by the following three agencies for the purpose of this review. All IMR authors are independent of the case and had no significant involvement with the subjects or in the line management or supervision of staff involved.

Durham Constabulary

1.8.2 The IMR author joined Durham Constabulary in 1998 and was employed as a Response Uniformed Police Constable. In 2004 she was promoted to the rank of Response Uniformed Police Sergeant, and in 2006 successfully completed Ospre 1 and 2 Inspector examinations. In 2011 the author successfully completed the National Investigators Examination and completed a National Investigators Course in 2012. The author has experience of working as a Response Uniformed Police Sergeant, Audit and Inspection Sergeant, Prisoner Handling Team Sergeant and in September 2012 transferred to her current role of Domestic Abuse Sergeant. She also has experience with investigating domestic abuse incidents, attending Multi-Agency Risk Assessment Conferences (MARAC) and Multi Agency Public Protection Arena (MAPPA) meetings which provide a coordinated multi-agency approach to responding to high risk victims and perpetrators of crime.

1.8.3 The author has not had any dealings or any interactions with any staff members associated with this review, with the exception of one historic domestic abuse report from 2002 where the author supervised the officer in charge of the investigation. This historical investigation involved an alleged assault on Adult A, which resulted in her then partner being charged with assault (not Adult B to whom this review relates). The author discussed this potential conflict of interest with Durham Constabulary and the Domestic Homicide Review Panel members and it was determined that the objectiveness of the report was not compromised.

1.8.4 The author wrote the IMR on behalf of Durham Constabulary and in order to complete this review searched Durham Constabulary Databases for any connection with Adult A and Adult B, as well as conducting face to face or telephone interviews with key personnel. In addition the author also liaised with Durham Constabulary Major Crime Team, who were responsible for the investigation into the death of Adult A, in order to gain a clear understanding of the context for the review.

1.8.5 The IMR was supervised by the Detective Superintendent for Special Crime Investigation, Durham Constabulary, and agreed and approved by the Chief Constable.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

1.8.6 Tees, Esk and Wear Valleys NHS Foundation Trust is one of the largest specialist mental health and learning disabilities Trusts in the country,

operating from over one hundred sites in Durham, Teesside and North Yorkshire. The Trust provides a range of services to 1.6 million people in addition to providing specialist services to other parts of Northern England.

1.8.7 The IMR for TEWV was completed by the Senior Nurse for Safeguarding Adults within the Trust's Safeguarding Adults team. Prior to holding this role, the author was employed as a Modern Matron within the Learning Disability Forensic Services for six years. The author was also required to investigate areas of poor practice including Serious Untoward Incidents, Complaints etc. and participate in service review and monitor standards within the Trust's Safeguarding Adults team.

1.8.8 For the purpose of the IMR the author gathered all documentary evidence related to Adult A that was held by the Trust. This included the records in relation to the Affective Disorder Team, Liaison Psychiatry Team, Criminal Justice Liaison, and Crisis Resolution Team services. Information was also taken from the current electronic primary care records system, which is called PARIS. Records of a referral to the Talking Changes service in Durham were not accessible to the author as they are held on a system external to the Trust, however information was supplied by those services for the purpose of the IMR. It was not considered necessary to interview staff as part of the IMR process as the records outlined were felt to be sufficient to review the agency involvement.

1.8.9 The IMR report was approved by the Director of Nursing for TEWV.

North Durham Clinical Commissioning Group (NDCCG) – on behalf of the Local Area Team

1.8.10 The IMR report was written on behalf of NHS England and North Durham Clinical Commissioning Group (NDCCG) Local Area Team. NDCCG commissions care for residents within Durham, Chester le Street, Derwentside and Stanley.

1.8.11 The author of the IMR has been a qualified nurse for 34 years with a background in acute medicine, Community Services and Continuing Healthcare, and continues to work as a Bank Community Nurse. The author began employment as an Adult Safeguarding Practice Officer (nurse) in October 2008 for County Durham Primary Care Trust (CDPCT) and then took up post as an Adult Safeguarding lead with County Durham and Darlington Clinical Commissioning Groups in April 2013.

1.8.12 The documents accessed for the purpose of the IMR included Patient Care Summary and associated documentation such as referral letters. All

information in the practice records pertaining to Adult A was considered. Clarification of information was discussed with the Practice Manager both face to face and via telephone.

1.9 Family composition

1.9.1 Adult A had three sisters and her parents were deceased. She had been married and divorced on three occasions and was also involved in four other long-term relationships. Adult A had three adult sons to different partners and lived at home with her youngest son. Her eldest and middle sons both live locally with their partners, and each have a son and daughter.

1.9.2 Adult B has two sisters and three brothers. He was in a long-term relationship with his partner (Adult E), who had two sons (not Adult B's), for 32 years and this ended in March 2012 due to his relationship with Adult A. He left his long-term partner's home in April 2012 and lived between his mother's house and Adult A's house, with some limited periods where he also returned to stay with Adult E.

1.10 Involvement of family members

1.10.1 In domestic homicides, members of informal support networks, such as friends, family members and colleagues often have detailed knowledge about the victim's experiences. The Review Panel considered carefully the potential benefits gained by including individuals from both the victim's and perpetrator's networks in the review process. As a result of this consideration the three sons of Adult A were invited to contribute to the review, and her eldest and youngest son (S1 and S3) agreed to meet with the Chair. Adult A's middle son (S2) took the decision not to be involved at this time but was kept updated regarding the process of this review.

1.10.2 At the Chair's meeting with S1 in January 2014, his partner (DL1) was present for some of the meeting. It was also suggested by S1 and DL1 that Adult A's granddaughter (GD1) may also wish to contribute to the review. The Chair subsequently met with GD1 and S3 together in March 2014. At both meetings the Police's Family Liaison Officer was also present.

1.10.3 The Panel would like to express their sincere condolences to the family of Adult A and to thank them for their invaluable involvement in the review process.

1.10.4 Consideration was given by the Panel to Adult A's broader social networks, however no other significant individuals were identified to take part in the review.

1.10.5 In addition to the input from Adult A's family, relevant information from Adult E, the ex-partner of Adult B, which was obtained as part of the Police investigation, has also been supplied by Durham Constabulary to assist in the review process.

2 Domestic Homicide Review Panel Concluding Report

2.1 Introduction

2.1.1 This review report is an anthology of information and facts provided by agencies that had contact with either Adult A or Adult B prior to the death of Adult A in 2013. The report examines agency responses to both Adult A and Adult B, with the purpose of identifying any lessons that can be learned, and improvements that can be made in the response of agencies, to support victims and try to prevent future deaths.

2.2 Summary of the case

2.2.1 Adult A is believed to have started her relationship with Adult B in February 2012, having him met him online through a dating website. The period covered by this review is from January 2011 to the date of her death to allow consideration of the year prior to their meeting and the events that led up to their relationship.

2.2.2 Some historical information has also been provided by agencies in relation to both Adult A and Adult B in order to lend further context to events.

Adult A (Victim)

2.2.3 According to information supplied by Durham Constabulary, Adult A had been married on three occasions and been involved in a number of other relationships. She had been repeatedly involved in domestic incidents reported to the Police prior to her commencing a relationship with Adult B. Within these disputes Adult A was recorded primarily as the victim of the abuse, but also as a perpetrator on a limited number of occasions.

2.2.4 In the course of the Police investigation, it was revealed that prior to her death Adult A had a lifestyle that revolved significantly around Facebook, and a range of other social networks. Her son reported that she had met a number of partners in the last ten to fifteen years via the internet, and her family had warned her of the dangers associated with such meetings. Adult A also had a number of online personas and alias names.

2.2.5 Adult A had a history of contact with health services in relation to mental health difficulties, which included self-harm and suicide attempts. There

were also indicators on records of her suffering from bipolar disorder[1], although the review Panel have been unable to establish where this diagnosis originated. Reference was also often made in agencies' records to her alcohol use and she was reported to be under the influence of alcohol on a number of occasions in relation to her contact with agencies.

Adult B (perpetrator)

2.2.6 Adult B had no previous convictions, although as part of the investigation into the death of Adult A, his previous long term partner of 32 years, Adult E, described her relationship with him as very controlling and emotionally abusive. She reported that he had assaulted her two or three years into their relationship but that this had never happened since. She said however that he would get very angry when drunk and that, as she was aware that he had a temper, she avoided arguing with him and tried to smooth things over. She also reported that Adult B had had an affair after they had been together for approximately seven years.

2.2.7 In the six years prior to the end of their relationship, Adult E described Adult B as very controlling and said that he constantly bullied her, put her down and criticised her to the point where she wished she had died instead of receiving the treatment for her diagnosis of cancer. She described him as being mentally and emotionally abusive and of showing her little affection. She reported that there had been no sexual relations between them for a while following her cancer treatment and that Adult B had stated he did not want sex with her but wanted sex with other people. When they split up she found gay pornography belonging to Adult B and said she had presumed he was sexually confused.

Review Period

2.2.8 The period covered by this review begins in January 2011. From this stage until the point at which it is believed her relationship with Adult B began, in February 2012, it appears from records that Adult A was in contact with both her GP and Tees, Esk and Wear Valleys NHS Foundation Trust due to ongoing mental health difficulties. She attended, or was taken to hospital, on four occasions during this period. The first of these attendances in June 2011 and July 2011 relating to her having collapsed on the first occasion and due to her having lacerations on her leg

[1] Bipolar disorder is someone who will have with severe mood swings. These usually last several weeks or months and are far beyond what most of us experience. They are feelings of intense depression and despair, or feelings of extreme happiness and elation.

on the second. She left hospital on both of these occasions without being seen. Then in August 2011 and October 2011 she was taken to hospital due to suspected overdoses. On the first occasion she did not wait for treatment and the second there was no evidence within blood tests of an overdose. In November 2011 the Crisis Team also called the Police and ambulance service due to concerns that Adult A had taken an overdose. She subsequently denied this to be the case and having been seen by the Crisis Team at an out of hours surgery, it was agreed that she would be contacted the following day.

2.2.9 During this period there was also ongoing conflict in her relationship with her ex-partner, Adult C, and the Police were called out on a number of occasions by both Adult A and Adult C. It would appear that she separated from him in October 2011 as she informed the Police of this in her contact with them, as well as making reference to this separation in her contact with TEWV. She also reported to TEWV that she was concerned about harassment from her ex-partner. Throughout the records of TEWV it is not always explicitly stated if the partner or ex-partner referred to is Adult C, although this would appear consistent with Police records from the time.

2.2.10 From February 2012 there were four more Police call-outs, two from Adult A and two from Adult C, indicating ongoing disputes between them after Adult A's relationship with Adult B began. The last direct reference within Adult A's records to Adult C was in June 2012 when she called the Police to report that he had taken her dog from her garden. Throughout this period Adult A was also in continued, although limited, contact with mental health services, including an incident in June 2012 when following an arrest for breach of the peace she made threats to Police Officers that she intended to kill herself.

2.2.11 The first reference to Adult B within agency records following the start of his relationship with Adult A is in September 2012 when Adult A called Police as he was refusing to leave her home.

2.2.12 During September 2012, Adult B also contacted his long-term partner Adult E, sending her text messages telling her he loved her and that she was his soul mate. At the same time he was making postings on Facebook in reference to his relationship with Adult A. Adult E refused to take him back although she did stay in touch with him and allowed him to stay with her in November 2012 following an incident in when Adult B reported that he had taken an overdose of tablets. She was also present when he was seen at hospital again in December 2012 having once more taken an overdose of tablets and subsequently called the hospital to state that she believed he was mentally ill and had been lying to professionals.

2.2.13 Following this, in December 2012, Adult E phoned West Yorkshire Police to say that she had received a Facebook message from Adult A saying that Adult B was outside of her address. Adult E also reported that Adult B was driving a vehicle and was highly intoxicated, that he had tried to kill himself in the last month, and that she believed he may have mental health issues. As a result Police attended the home of Adult A. *This and the incident in September 2012 are the only two reported domestic incidents in relation to Adult A and Adult B.*

2.2.14 According to information supplied by the Police, approximately two or three weeks prior to Adult A's death she confided in her son that she would cringe if Adult B touched her as she did not like him anymore. As a result she started to sleep downstairs on an "L" shaped sofa. Adult A would sleep on one side and Adult B would sleep on the other side.

2.2.15 There was a family event at Adult A's house in March 2013 where both family members and Adult B were present. Family members reported that no concerning incidents occurred at this event. However, this was the last time they were to see Adult A alive.

2.2.16 Adult A's eldest son (S1) rang the Police as he hadn't heard from his mother for 5 days and was concerned. Her youngest son, with whom she lived, also had no knowledge of her location.

2.2.17 Three days later Adult B was arrested on suspicion of murder and charged the following day. Adult A was not discovered until May 2013, when her body was found over 100 miles from her home.

2.2.18 In 2013 Adult B was found guilty and sentenced.

2.3 The context of agency involvement

2.3.1 The Safe Durham Partnership Domestic Abuse Strategy 2012-15 and the Safe Durham Partnership Joint Commissioning Strategy for Domestic Abuse Services 2011-14 identifies the environment in which practitioners work, the policy frameworks and organisational structures. These documents were referred to by the Review Panel whilst undertaking the review.

2.4 Information from the family

2.4.1 As has previously been outlined, to inform this review the Chair met with Adult A's eldest son (S1) and his partner (DL1), and on a separate

occasion with her youngest son (S3) and her granddaughter (GD1). Information provided within these meetings is summarised below.

Meeting with S1 and DL1

2.4.2 Adult A's eldest son described her as her 'own person', 'someone who knew her own mind', was outgoing, 'the life and soul of the party', and who loved to dance. He spoke of her love for her family, her generosity, and how she would often treat them and 'never see anyone stuck'. He described her as living for her children and grandchildren, especially her granddaughter (GD1), and how she had a 'heart of gold'.

2.4.3 He also identified that his mother was 'not perfect' and 'battled with demons', speaking of her mood swings and how she had some hard times and a lot to deal with in terms of relationships. He described her as having had lots of relationships and of having difficulties settling down. He spoke of how her family had expressed their concerns to her about her use of the Internet as a way of meeting men and described how she often met 'strange men'. He described his mother's fantasy life through the internet, in which she would lie about the jobs of her and her family and try to impress by using a 'posh' voice when she spoke on the phone to someone she'd met online.

2.4.4 In relation to Adult B, S1 said he found him to be someone who always talked about himself and his own achievements, and that he never talked about his family or even his relationship with Adult A. He said he was wary of him and saw him as a 'little weak man' who would never look you in the eye. Despite this however, he had also hoped that his mother would settle down.

2.4.5 As regards Adult A's relationship with Adult B, he described them as having met online and how they had a 'fantasy' relationship in which he had said he was a millionaire and she had said she was a doctor or a nurse. He said that they would both brag about money and it seemed like a competition between them.

2.4.6 S1 described how the first time his mother arranged to meet Adult B, he travelled to her home area from where he lived and then his mother refused to meet him; but that they met when he visited again a second time. During the course of their relationship he said that Adult B had lived with his mother for about 6 months in total but that during this time she would 'kick him out' nearly every week, although he always came back. DL1 described Adults A and B as having a 'love/hate' relationship, in that he loved her and she hated him. S1 also said that his mother kicked out

every man she met as she didn't like them getting close. He described how his mother and Adult B would have 'fall outs' and that Adult B would go and wait in the car if they had argued. He said his mother would tell him about such arguments and ring him and his partner to say she was sick of Adult B and had 'thrown him out'.

2.4.7 He recalled a particular incident on Christmas Day 2012 in which his mother had 'kicked out' Adult B the night before and he had slept in his car. S1 said that he and his brothers had felt sorry for Adult B and S2 invited him to come for Christmas dinner, following which his mother and Adult B got back together.

2.4.8 Despite the conflict described, S1 was adamant that there was no physical violence in the relationship between his mother and Adult B. He described his mother as a 'strong' and 'brave' woman who could look after herself and who 'would have taken (Adult B) on' and defended herself if attacked. He said that his mother would have told him and his brothers if there had been violence, and that he did not believe she was worried about her own safety. He did however say his mother called the Police a few times to get Adult B removed from the house.

2.4.9 In relation to agencies that Adult A had had contact with, S1 identified that the Crisis Team had been called out on a few occasions. He said that his mother had a history of self-harm and would cut her arms if things went bad. He said it was not serious and that she would cut the back of her wrists to get attention and would call him and say 'I've been stupid'.

2.4.10 As to whether anything could have been done better by agencies, he said that historically there could perhaps have been better monitoring as the Crisis Team would call an ambulance but then his mother would not go to hospital or would sign herself out immediately if she did. On the whole however he felt the Crisis Team had 'been there for her' and did their job appropriately.

2.4.11 S1 did not think that there was anything that could have been done to prevent his mother's death and said that other than the Crisis Team no other agencies had been involved prior to her death.

2.4.12 What S1 did identify in relation to his mother's death was the extent to which she had used social websites for a number of years. He described her as being on them constantly and how he felt that she had become addicted. He described how he and S2 warned her about them and told her 'one of these days something bad will happen to you because of these websites', but that she told them to 'get lost'. He said he would like to see

something done by the government to warn people about the dangers of websites, such as putting warning notices on them.

2.4.13 S1 also identified that since his mother's death he and S3 have had practical support from Victim Support. He said however that he would like to see support groups set up for families who've lost someone through domestic homicide to speak to people who have been through the same thing.

Meeting with S3 and GD1

2.4.14 Adult A's granddaughter (GD1) spoke of Adult A as her 'grandma and friend'. She described her as being vibrant and lively and liking music and dancing. She said she loved clothes and was always dressed up when she went out, and would act like a younger person. She also spoke of her being very generous to others.

2.4.15 Adult A's youngest son (S3) described his mother as a strong woman who wouldn't take any nonsense. He also spoke of her being a 'hoarder' who liked to buy and sell things from ebay, car boot sales and charity shops. He spoke of her interest in the supernatural and how she had met lots of famous people.

2.4.16 As regards her relationship with Adult B, S3 said that he thought Adult B seemed nice at first, although he was a bit boring and there was nothing very memorable about him. He said he appeared a 'blank' character who only ever talked about himself. He said that he hadn't actually moved in with them but that he would live with them for a few days then go away to his home town. GD1 described Adult B as always talking about himself although he had seemed like a 'normal' person at first. She said she hadn't liked any of her grandmother's boyfriends. Both GD1 and S3 described Adult B as difficult to have a conversation with.

2.4.17 In speaking of Adult A's relationship with Adult B, her youngest son said the start of the relationship was 'okay' but then arguments had started and became regular, resulting in Adult B going back to his own home town every few weeks. He described the arguments between them as 'civil' and not 'massive fights'. He said there was no violence and that his mother was strong and would have retaliated. S3 described his mother as 'hot-tempered'.

2.4.18 S3 said his mother would not talk to professionals about difficulties in the relationship but talked to her sons or their partners. He said his mother had called the Police on occasions when she wanted Adult B to leave and

he was 'dragging it out' by packing his stuff slowly. He said he did not believe his mother was worried about her safety and described her as being in control.

2.4.19 In terms of what might have been helpful in preventing the death of his mother, as with his brother, S3 identified concerns around the use of websites, saying people had no idea who they were contacting and that there should be a warning to this effect on the websites. He said that adults could be vulnerable and that people were risking their lives. Otherwise however he did not feel agencies could have prevented his mother's death, as it came 'out of the blue' and there had been no previous violence.

2.5 Summary and analysis of individual agency involvement

2.5.1 Within this section a summary is provided of each of the four key agencies identified as having had contact with Adult A and Adult B during the time period of this review. Alongside this summary is an analysis of the information provided in relation to agencies responses, decisions made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

2.5.2 The IMR authors and the DHR Overview Report author have attempted to provide a valid analysis and to cross reference information to complete gaps. Where possible, triangulation of sources of evidence has been used to increase confidence in the findings. All of the agencies involved in this review have provided frank accounts of their involvement in order to learn lessons.

2.6 Durham Constabulary

Summary of Involvement

2.6.1 For the purpose of this review, Durham Constabulary provided some additional information outside the timeframe of the review itself, which helps to build a fuller picture of Adult A and the events that led to her death in 2013.

Period Prior to the Review Timeframe: January 2000 – December 2010

2.6.2 During this period Police were called to nineteen incidents at Adult A's home relating to either domestic incidents or concerns for safety. The domestic incident call-outs related to different partners and details of each have not been supplied as this was felt to be outside the remit of this review. Ten of these call-outs related to allegations of domestic abuse and in nine of them Adult A was the alleged victim. During a distinct period between August 2002 and October 2002 there were four call-outs where physical violence was reported. As a result of this physical violence Adult A experienced bruising to her arm, was kicked in the head, and grabbed around the throat.

2.6.3 During this time period the Police also attended Adult A's home on nine occasions due to concerns for safety reported by either the Ambulance Service or Mental Health Crisis Team. These concerns related to incidents of self-harm and threats or attempts at suicide by Adult A.

Review Period: January 2011 – March 2013

2.6.4 As has already been outlined in the summary of this case, during this period there continued to be Police call-outs to the home of Adult A in relation to her ex-partner Adult C. In total there were nine call-outs logged as domestic incidents involving Adult A and Adult C between July 2011 and June 2012.

2.6.5 Following the above incidents with Adult C, Durham Constabulary attended two further domestic incidents at Adult A's home; these incidents both related to Adult B. Details of these are outlined below:

Domestic Incident reported September 2012, 22:04hrs by Adult A

2.6.6 Adult A reported that Adult B was at the house refusing to leave. During the telephone conversation Adult B could be heard 'muttering' in the background. Three Police Officers attended the scene (PC1, 2, 3) and two

of these, PC1 and PC2 were spoken to as part of this review. PC1 stated that he had been to the address previously in relation to domestic incidents and threats to self-harm which had spanned many years. He stated that Adult A wanted Adult B removing from the house as their relationship was over. PC1 stated there was no evidence of a disturbance or violence, which was confirmed by Adult A's son who was in attendance. Adult B was spoken to by Police who stated he had nowhere to go. He was advised to collect his belongings and leave the house. Adult B went upstairs to collect his belongings and was accompanied by PC1 and PC3. Whilst in the bedroom Adult B refused to leave and grabbed hold of the leg of the bed, crying that he did not want to leave. He was informed by the Police that he had to leave. He eventually left the house and followed the Police in his own vehicle to the local Police station, where his belongings were sorted out. He was warned not to re-attend the home address of Adult A and that he may be arrested if he returned. PC1 believed that Adult B returned to his home town out of the area.

2.6.7 PC 2 also reported that she had been to the address several times before in relation to self-harm and alcohol issues. She stated this was the first time that she had seen Adult A 'soberish'. On speaking to PC2 it was evident that some form of dispute had arisen over finance as PC2 stated Adult B was shouting in the background something about money and saying 'tell her how much I have been giving you.' Adult A admitted to PC2 that Adult B had given her money and PC2 believed £10,000 may have been mentioned.[2] She stated that initially Adult B refused to leave the house however did eventually leave after being warned by Police. No domestic violence report was submitted in relation to this incident.

Domestic Incident Reported December 2012, 21:18 hours by West Yorkshire Police

2.6.8 West Yorkshire Police reported that they had taken a phone call from the ex-partner of Adult B, Adult E, to state that she had received a message via Facebook from Adult A stating that Adult B was outside of the house trying to get in. Adult E also reported that Adult B was highly intoxicated and driving a vehicle, and had also previously tried to kill himself and may have mental issues. Police attended the address and spoke to Adult A. PC4 was spoken to and she stated that Adult B was not present and apparently left minutes earlier. PC4 was not aware of Adult A, having had no prior dealings with her. Adult A was reported to have appeared confused, difficult to understand and was very intoxicated. PC4 recalled

[2] It should be noted that in discussion with the Chair of the Review Panel S1 and DL1 refuted that Adult B had given this sum of money to Adult A

speaking to the son of Adult A, who appeared very calm and cooperative. He had been present when the alleged domestic incident had occurred between Adult A and Adult B. He had heard nothing and told Police that Adult A often made up stories when she was under the influence of alcohol. Adult A had no visible injuries and could not give a location where Adult B would be, nor details of his vehicle. Other than being intoxicated Adult A did not appear to the attending officer to be vulnerable and was left in the care of her adult son. PC4 recalled conducting a search of the local area to see if Adult B was in the vicinity, without success. PC4 requested a follow up visit be arranged the following morning for an officer to attend and speak to Adult A so that the facts could be established.

2.6.9 The following day PC5 attended and spoke to Adult A's son as Adult A was in bed, having been heavily intoxicated the previous evening. Adult A's son explained that Adult B came to the house intoxicated the previous night and that he had spoken to Adult B outside of the house. Adult B had been concerned for Adult A as she was drunk. There was reported to have been no argument, no threats and nothing untoward. As far as Adult A's son was aware Adult B did not actually see Adult A and did not come into the house. PC5 did not believe it was necessary for an officer to re-attend the address to speak with Adult A, as she had made no complaints the previous evening and he felt she would probably not recall what had happened. The officer was happy with Adult A's son's account of the incident. No domestic violence report was submitted in relation to this incident.

Concerns for Safety

2.6.10 During the review period the Police also received four concerns for safety reports from the Ambulance Service. One of these related to threats to commit suicide by Adult A's previous partner, Adult C (October 2011). However it was identified when officers attended that an altercation had taken place between Adult A and Adult C so a domestic violence form was submitted as standard risk. The form was not shared with any other agency. Adult A was also conveyed to hospital on this occasion. The other three concern for safety forms related to two reports by Adult A that she had taken an overdose (October 2011 and November 2011) and one that she had locked herself in a bathroom with a knife and made superficial cuts to her wrists (June 2012). On the first two occasions Adult A was taken to hospital by ambulance and on the third occasion she was arrested to prevent a breach of the peace when she became abusive towards her son. There is no evidence of a vulnerable adults form being submitted in October 2011, but forms were submitted at the subsequent two incidents

and shared on both occasions with Adult Services, and with Mental Health Services at the latter.

Analysis of Involvement

2.6.11 Within the IMR completed by Durham Constabulary an extensive analysis is included of each of the relevant incidents identified, including those prior to the period of the review. Within this analysis the author for Durham Constabulary also provided an extensive outline of the policy and the procedures that would have been in place at the time in order to give context to each incident.

2.6.12 As has been seen, many of the domestic incidents within the time period for this review relate to Adult C as opposed to Adult B. However, it is relevant to consider how these incidents were dealt with by the Police as this provides an analysis of current practice; as well as considering the support received by Adult A in relation to domestic violence in the period leading up to, and overlapping, her relationship with Adult B.

2.6.13 In considering the domestic incidents reported it is important to note that in line with Durham Constabulary's Domestic Abuse Policy, officers are instructed to submit a Domestic Abuse report whenever they attend such an incident. During the period under discussion a Domestic Abuse Incident was defined as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality. (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family). Recently the definition has been amended to include young people aged 16 and over.

2.6.14 The Domestic Abuse report also includes a risk assessment, which is conducted with the victim. The risk assessment tool used by Durham during the period of this review was, and remains, the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) model. This model is based upon three grades of risk including Standard (current evidence does not indicate likelihood of causing serious harm); Medium (identifiable indicators of risk of serious harm are present) and High (there are identifiable indicators of risk of serious harm). The potential event could happen at any time and the impact would be serious). Domestic Incidents that are assessed as high risk are referred to the Multi Agency Risk Assessment Conference (MARAC) which was piloted in 2007, rolled out force wide in 2008 and was established practice by 2009. None of the domestic incidents reviewed were deemed serious enough to be referred

to MARAC. In cases where the risk is assessed as standard or medium, permission of the victim is required to share information with other agencies.

2.6.15 In considering the incidents involving Adult A and Adult C, Domestic Violence forms were submitted appropriately on 3 occasions (July 2011, October 2011 and March 2012) and subsequent action taken within Force Policy. Good positive practice can also be further identified at an incident in July 2011 when a domestic abuse officer who screened the incident used her professional judgement and reassessed the risk posed by the perpetrator in his subsequent action, which resulted in arrest, and re-graded the incident from standard to medium risk. The officer also attempted to contact Adult A to offer support without success, however forwarded a letter to Adult A offering outreach services, support and advice. At a further incident in October 2011 Adult A was also offered outreach services but declined. A domestic violence form was also submitted in October 2011, as an incident that presented initially as a concern for safety later revealed that an altercation had taken place.

2.6.16 In relation to the further six incidents between Adult A and Adult C, no Domestic Violence forms were submitted. In four of these incidents this would appear to be appropriate action in line with Force Policy as the incidents related to property or civil matters, or in one case an allegation of Fraud relating to Adult A. On two of the incidents however, in October 2011, it is stated that Adult A threw Adult C out of the house and that she was fearful of him, as he was a violent man. On both of these occasions a risk assessment should have been completed and a domestic violence form submitted. Furthermore it is of note that these two incidents, and the others relating to property, occurred within a period between October 2011 and November 2011 when there were eight call-outs to Adult A's home. There is limited information to indicate that these incidents were considered together and the pattern considered in terms of potential risk, particularly given that this was following their separation, and also included suicide threats by Adult C (October 2011), both of which are significant risk indicators in relation to domestic violence.

<u>Incidents Involving Adult A and B</u>

2.6.17 The IMR author for Durham Constabulary identified that the domestic incident reported in September 2012 between Adult A and Adult B could have been dealt with in a more positive approach in line with the Force's domestic abuse policy. Information contained on the incident log was very limited and stated that it was not a domestic incident as no argument had taken place whatsoever. It was reported that Adult A's son had confirmed

this, and that Adult B had collected his belongings and left on Police request.

2.6.18 However, the IMR author reported that on speaking to the attending officers it was very clear that a domestic incident had occurred. Adult A had reported to the Police call handler that Adult B was refusing to leave the premises and that he could 'kick off at anytime'. The call handler also reported that Adult B could be heard in the background 'muttering on'. The suggestion that Adult B had the potential to 'kick off' would indicate there was a risk of harm to Adult A. When officers attended and spoke to Adult A, it was established that there was no disclosure of any obvious criminal offences. Officers then decided the appropriate form of action was to remove Adult B from the premises. On speaking to PC1, he stated that Adult B had refused to leave the premises even when advised to do so by Police. In Police presence Adult B goes as far as grabbing hold of the leg of the bed, crying that he did not want to leave and he had nowhere to go.

2.6.19 At this stage it may have been appropriate for officers to take positive action and exercise their powers of arrest under common law and arrest to prevent a further breach of the peace. This would have been justified in order to ensure Adult B did not pose any immediate further risk of harm or damage to property. An arrest may also have been a deterrent to future disputes. If Adult B had been removed from the scene and Adult A spoken to without Adult B being in the premises, this would have given officers an opportunity to speak further to Adult A without disruption and give her an opportunity to disclose any abuse within the relationship, given the fact that she had already stated Adult B could 'kick off' at any time. Instead officers have used their discretion and acted appropriately by ensuring Adult B left the house after some persuasion so as to prevent a further disturbance; however there was always the risk of Adult B returning to the house given the fact that he stated he had nowhere else to go.

2.6.20 Both PC1 and PC 2 were surprised on being informed by the IMR author that no domestic report had been submitted in relation to this incident. PC1 stated that he did not provide any updates for the incident and PC2 stated she was normally the officer in attendance who would submit a domestic violence form. PC2 immediately recognised that a form should have been completed in this instance and a full risk assessment completed, although could not explain why this had not occurred at the time. PC2 did not recall updating the incident. If a full risk assessment had been completed this may have given greater insight into the relationship of Adult A and Adult B and the possibility of disclosing criminal offences. While there is no significant further information to suggest that such a risk assessment would have indicated a high risk, it is impossible at

this stage to know what Adult A may have disclosed. A failure to undertake this course of action therefore resulted in a missed opportunity for greater exploration of the risk and possible actions being taken to manage any further risk identified.

2.6.21 The second domestic incident between Adult A and Adult B, reported in December 2012, would appear to have been dealt with appropriately by the initial attending officer. The attending officer PC4 was spoken to and she stated that she had difficulty in communicating with Adult A, who was under the influence of alcohol. PC4 established that no criminal offences had occurred and that Adult A was uninjured and left her with her adult son. PC4 also made a search of the local area in order to try and locate Adult B who may have been in the local vicinity inside his vehicle. PC4 stated she did not complete a domestic violence report as she had difficulty in establishing what had occurred due to Adult A's intoxicated state. As a result she requested a further visit to be organised the following day to speak to Adult A once sober.

2.6.22 PC5 attended the address the following day. PC5 knew Adult A as he had had previous dealings with her, and had attended the address on previous occasions in relation to domestic issues and self-harm. He described Adult A as an alcoholic with associated problems such as depression. He also stated that he attended on one occasion when Adult A was arrested in the presence of her son. He described how Adult A 'could be difficult when drunk' and said that in his previous conversations with Adult A he had experienced difficulties in communicating with her. He spoke of her not seeming to comprehend what he was saying and that if it didn't fit with what she wanted, she wouldn't accept it.

2.6.23 PC5 reported that Adult A's son had been called upon in the past to try and explain things to Adult A. He stated Adult A's son knew his mother could be difficult and he would try to communicate with her and explain things to her. Due to this, when he attended the address in December 2012 PC5 spoke to Adult A's son as Adult A was in bed. He stated Adult A's son confirmed Adult B had attended the address the previous night and had been spoken to outside of the address and that he did not believe there had been any face to face contact between Adult A and Adult B. PC5 accepted Adult A's son's account of what had occurred and that there had been a misunderstanding via Facebook messaging and Adult A had over-reacted.

2.6.24 At the time PC5 did not believe it was necessary for officers to re-attend the address and speak to Adult A. This was based on the fact that she had made no complaints when spoken to the previous night and her son

said that as his mother had been drunk she would not remember what had happened. PC5 stated that if he believed a domestic incident had occurred, he would have submitted a domestic violence form. However he did not view any of the Facebook messages or speak to Adult A, Adult B or Adult B's ex-partner (Adult E), who originally telephoned the Police. PC5 admitted that in hindsight he should have spoken to Adult A and explored the possible domestic incident further. As discussed previously, this would have allowed a full risk assessment to be completed with Adult A and would have given further opportunity for disclosure and identification of any risk. While this is identified as a missed opportunity for further exploration of any risks directly with Adult A, it is also recognised that PC5 did seek clarification with her son, who had previously assisted the Police in their communication with Adult A. In light of this, it was felt by the Panel that had any further exploration taken place it is unlikely it would have made any significant difference to the actions taken or outcomes from this incident.

Concerns for Safety

2.6.25 Over the period of the review twelve concern for safety incidents were reported in relation to Adult A. However, only four incidents resulted in a Police Vulnerable Adult form being submitted, even though the majority of these incidents included a toxic mix of self-harm / threats of self-harm and alcohol abuse. Of the four forms submitted only one was not shared with partner agencies and this incident was also recorded on a domestic violence form. On six occasions Adult A was transported to hospital via ambulance, which was the correct course of action as the safety of Adult A was paramount. However as has been outlined previously Adult A did not always wait to be seen on arrival at hospital. On none of these occasions did Police Officers submit a Vulnerable Adult form and it was assumed that as Adult A had been taken to a place of safety, there was no need to submit the form. However, due to such forms not having been submitted, an accurate record of the pattern or extent of Adult A's problems did not emerge; which had the potential to create problems in accurately assessing risk to Adult A. As a result information was not shared with the relevant agencies, which may have been able to offer help, support and intervention in relation to Adult A's problems.

2.7 Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Summary of Involvement

2.7.1 Adult A had a long history of involvement with mental health services. The first contact with TEWV NHS Foundation Trust services was with County Durham and Darlington Priority NHS Trust services in 2000. However, there are also references to Adult A having seen other psychiatric services before this time.

2.7.2 Throughout the involvement with TEWV there were various diagnoses made in relation to Adult A. These were 'emotionally unstable personality disorder', 'atypical anorexia nervosa', 'mental and behaviour disorder due to the use of alcohol' and 'severe depressive episodes without psychosis'. There was however no record of a diagnosis of 'bipolar disorder', which has been indicated in other agency records.

2.7.3 Adult A had been known to the Affective Disorder Team within TEWV prior to the period being considered by this review and in February 2011 was discharged from the team as a result of her 'non-engagement'. Following this in March 2011 her partner (believed to be Adult C) contacted the team to request an appointment for Adult A to see the Consultant Psychiatrist, although the records do not refer to the reason for the appointment. Despite Adult A's previous discharge from services, the Consultant agreed to this request and she was offered an appointment and seen by the Consultant in March 2011.

2.7.4 During this consultation Adult A disclosed that she had been getting 'quite irritable' with her partner for the past three months and indicated that she sometimes had impulsive thoughts of wanting to kill him. She acknowledged that he was aware of her thoughts and reported that she had not actually assaulted her partner. A FACE risk assessment was completed at this stage to assess any ongoing risk. Following this, appointments were offered between March 2011 and August 2012 by the Affective Disorder Team, in order to support Adult A and her partner. Adult A however failed to attend any appointment offered for her and in August 2011 her partner rang the Affective Disorder Team for details of carers groups in order that he may receive support. A referral was made for the partner to a carers group as a result.

2.7.5 In August 2011, following an admission to the University Hospital North Durham (UNHD) in relation to an overdose of medication, Adult A was referred to the Psychiatric Liaison service. As she was not willing to stay in order to be assessed, a notification was forwarded to her Care Coordinator

(a Social Worker within the Affective Disorder Team) regarding the incident. A letter was also sent to Adult A requesting her to attend an appointment with a Community Nurse in the Affective Disorder Team in September 2011. Adult A failed to attend this appointment.

2.7.6 In August 2011 a phone call was received by the Affective Disorder Team from Primary Care Services to share that during contact with them her partner had disclosed that Adult A was planning to go on holiday and commit suicide. The Social Worker from the Affective Disorder Team contacted the Local Authority Safeguarding Team and was advised to speak to the Local Authority legal department. This department then advised the Social Worker that if Adult A had capacity to make decisions there was nothing that could be done. A formal capacity assessment was not undertaken as there were no indicators to suggest that Adult A lacked capacity; a person is deemed to have capacity unless indicated otherwise.

2.7.7 A further appointment was arranged with the Affective Disorder Team for October 2011, however Adult A's partner contacted the service and informed them she was unwell due to the medication and therefore unable to attend the appointment at the health centre. He believed a home visit would be more appropriate and it was agreed that this would be organised to assess the therapeutic advantage of remaining with the Affective Disorder Team. This visit took place two weeks later in October 2011.

2.7.8 Four days prior to this visit Adult A presented at the A&E department of the University Hospital of North Durham (UHND) following an impulsive overdose. However, she was discharged before being able to be seen by the Liaison Psychiatry team. Therefore, a letter was sent to Adult A asking her to contact the service within 14 days if she wanted an appointment. The letter also stated that if the team did not hear from her within this time, they would assume she no longer needed the appointment. As Adult A did not respond to the invitation to engage with the Liaison Service, her Care Coordinator within the Affective Disorder service was informed and the case closed to Psychiatric Liaison.

2.7.9 In October 2011 a joint home visit by the Social Worker and Community Nurse from the Affective Disorder Team took place. During this visit Adult A informed them that her partner had now left her home and that following some advice she now had an appointment with a Solicitor to discuss an injunction against him, as he was taking all her possessions. During the home visit Adult A also described symptoms of low mood and reported some suicidal thoughts. As a result a referral was made to the Crisis Team for Support. The Crisis Team subsequently assessed Adult A and found her mood to have improved. She indicated that she no longer felt

suicidal and was looking forward to the future, as her daughter-in-law was due to give birth soon. She also indicated that she was angry with her ex-partner because of the break up. Due to this this presentation within assessment, it was agreed with Adult A that there was no role for the Crisis Team at this time.

2.7.10 On the day after the home visit, at 1.50hrs in the morning, the Crisis Team received a telephone call from Adult A where she became abusive when she was incorrectly referred to as 'Mrs' in the details used to confirm her identity. The records indicated that Adult A was argumentative and insulting, and at one stage referred to herself as a 'doctor' and stated that staff were 'stupid'. The Crisis Team worker recorded that they attempted to clarify the reason for Adult A's call but she again became abusive, and did not at any time express that she had thoughts of harming herself.

2.7.11 At 3.24hrs on the same day, the Crisis Team were contacted by the 'out of hours GP service' to inform them that Adult A had been unhappy with their response when she contacted them for support. The GP also informed the Crisis Team that Adult A had lacerated herself but refused to attend A&E though did agree to a GP visit the following day. This information was shared with her Care Coordinator in the Affective Disorder Team on that day.

2.7.12 Two days later, in response to the information above, the Affective Disorder Team Community Nurse was unable to contact Adult A and therefore planned to call her the following day. The following day contact was made by home visit and on this occasion Adult A explained that she had ignored calls the previous day due to harassment from her ex-partner. She further told staff that she had been at court earlier that week in order to obtain an Injunction to serve on her ex-partner.

2.7.13 A few days later in November 2011 the Affective Disorder Team Community Nurse made further telephone contact. On this occasion Adult A reported feeling brighter, with no suicidal thoughts. She had indicated that she wished to alter her medication regime to fortnightly; this had previously been reduced to weekly to reduce the potential risk of her overdosing. However, following consultation with the GP, her Diazepam prescription was altered to fortnightly as requested.

2.7.14 On that same day in November 2011 at 22.10hrs there were two messages left by Adult A on the Crisis Team messaging service, whilst staff were out on assessments. The messages were difficult to understand. Adult A then made a third call, when staff had returned, and informed them that she had taken an overdose of medication. The

Ambulance Service and Police were contacted. Whilst there, the Emergency Care practitioner contacted the Crisis Team as they were unable to gain any information from Adult A herself other than that she was 'fed up and could not go on'. The Crisis Team attended and Adult A categorically denied any suicidal thoughts and clarified that she had felt down due to an argument with her son, and consequently opened a bottle of champagne and drank one glass. Adult A indicated that she wished to return home and therefore it was agreed that the Care Coordinator would make telephone contact the following morning.

2.7.15 The following day Adult A's Social Worker from the Affective Disorder team carried out a home visit. Adult A was not at home and it was reported by her son that she had gone to the shops. He described her as 'okay' and therefore it was agreed that staff would contact her later that day. There was however no response to this later contact.

2.7.16 A further telephone call on the next day to Adult A's home by the Community Nurse found her sleeping and her son unwilling to wake her up. The Crisis Team telephone numbers were reiterated in order that the family had them should anything occur over the weekend.

2.7.17 A few days later the Community Nurse attempted a home visit and followed up with further contacts, all to no avail. In mid-November 2011 Adult A attended an appointment with the Community Nurse where she described her mood as 'up and down', although expressed no suicidal thoughts. Adult A indicated that she had contacted the Crisis Team in order that she could talk with someone. She confirmed that she felt safer with the injunction in place and with court proceedings progressing. Adult A confirmed that she was in court in January 2012. Further contact was arranged for a week later.

2.7.18 Over a week in November 2011 several unsuccessful attempts were made by the Affective Disorder Team Community Nurse to engage Adult A, either by telephone contact or home visits. Contact was eventually established after a week and Adult A described herself as being more cheerful, although did describe recent stressors due to her separation, and also stated that he ex-partner had been persecuting her. No further exploration was undertaken with Adult A in regard to this as she indicated the situation had been sorted. Despite her previous non-engagement, Adult A also expressed disappointment as she felt that services had not helped her when stressed, and said that she had helped herself. A further appointment was offered for late November 2011.

2.7.19 Adult A's case was discussed with the Affective Disorder Team at the end of November 2011 due to her non-engagement with the service. The clinical team concluded that services would be offered if Adult A was willing to engage in therapeutic treatment, however if she was not willing then she would be discharged until she felt ready to engage.

2.7.20 A further home visit took place in early December 2011, however no contact with Adult A could be established. As a result of this, following discussion within the team, the decision was taken to close Adult A's case. The care records indicate that the case was formally closed on the system in December 2011, and a letter was sent to the GP confirming this.

2.7.21 It is following this last contact with TEWV that Adult A's relationship with Adult B is believed to have begun in February 2012 and she had no further contact with their services until June 2012. On this occasion Adult A was seen by a Community Nurse from the Criminal Justice Liaison Team. This was following a referral from Durham Police as Adult A had been arrested for a breach of the peace the previous night and had been intoxicated and making threats that she was going to kill herself.

2.7.22 During the assessment that followed, Adult A had not known why she had been arrested and indicated that she felt in a low mood due to ongoing relationship problems. There had been no intent to self-harm expressed and Adult A agreed to a referral to the Talking Changes service for support. There was assessed as being no need at this stage for further involvement.

2.7.23 The referral to the Talking Changes service was received in June 2012. Telephone contact was then attempted with Adult A that day, although no reply was received. A letter was then sent the same day requesting that Adult A contact Talking Changes; when she failed to do so a second letter was sent a week later. The case was subsequently closed at the end of June 2012 following another failed telephone contact.

Analysis of Involvement

2.7.24 Throughout Adult A's involvement with the services provided by Tees, Esk and Wear Valleys NHS Foundation Trust, there were consistent contacts made by Adult A who would seek assistance when she had felt she required services; however following such contact there was often little engagement with ongoing support and therapeutic services that were offered. There is evidence that the Affective Disorder Team made significant attempts to engage Adult A following such contact using varied methods of communication such as letters, telephone calls and home

visits. There is also evidence of the involvement of her son, with whom she was living, in trying to establish contact with Adult A.

2.7.25 The IMR author identified that all Trust services followed the agreed Policies and Procedures in place at that time in relation to non-attendance (DNA) and discharge, and that there would appear to have been little more that the Affective Disorder Team could have offered to try and engage Adult A at that time. The GP was informed and an offer made to see Adult A again if she agreed to therapeutic treatment.

2.7.26 The Crisis Team extended their support even after mutual agreement with Adult A to close the case and there was evidence of good communication with other agencies such as the Ambulance Service and Police in emergency situations. Appropriate actions was also taken following the Criminal Justice Liaison assessment with a referral to Talking Changes who attempted to engage Adult A with services.

2.7.27 Within contact on two dates in October 2011 and one in November 2011, Adult A indicated issues of domestic abuse in relation to her partner, which the review process has established is likely to be Adult C given the information provided by Police relating to this time. Within these contacts Adult A stated on the first occasion that she had separated from her partner and that she was seeking an injunction; on the second occasion that she had experienced harassment; and on the third that he was persecuting her. Finally in her contact with the Criminal Justice Liaison Team in June 2012 she also made reference to low mood due to 'ongoing relationship difficulties'. There is no evidence of any further exploration of these concerns by staff or of any subsequent action being taken. Adult A had stated that she was getting advice from another source, although she could not remember who, and it appears that staff felt that the issue was being addressed, and therefore deemed that no further action was necessary.

2.7.28 The IMR author for TEWV identified that, in hindsight, not further exploring the domestic abuse issues disclosed by Adult A was a missed opportunity to ascertain the impact this was having upon her mental health and well being. Furthermore these occasions could have been used to ensure that appropriate support was in place or had been offered. Once again it is impossible to know whether further exploration would have revealed any significant information, however had any risks been identified this could have led to further action being taken in relation to risk management or the sharing of information with other agencies. Depending on the information disclosed this may have resulted in consideration of a referral under the

Durham MARAC or Durham Multi-Agency Safeguarding Adults procedures, which are followed by TEWV.

2.7.29 From the point at which it is believed Adult A's relationship with Adult B began, there is only one period of contact with TEWV in June 2012. Within this no reference is made to Adult B and no indicators presented regarding any ongoing relationship issues.

2.7.30 A further issue identified by the IMR author for TEWV when undertaking the review was that there were multiple records for Adult A on PARIS, the Trust's electronic primary care record. This was identified by staff during the time period in which they were in contact with Adult A, and as a result all records were merged.

2.8 North Durham Clinical Commissioning Group on behalf of the Local Area Team

Summary of Involvement

2.8.1 Adult A was assigned to the GP Practice considered within this review in February 2002 and notes indicate that she had a past history of Borderline Personality Disorder (1970), Alcohol Dependence Syndrome (2003), Anxiety state (2003), and Benzodiazepine dependence (2003). She was also known to have had a medical history of self harm (overdose, 2003). The GP summary of relevant medical history did not include Bipolar Disorder, which is referred to in the chronology on two occasions when Adult A had been in contact with other services. The first was in relation to attendance at the University Hospital of North Durham (UHND) on 20/10/11 following possible alcohol overdose, and the second was following a GP Out Of Hours contact at UHND dated October 2012 following a period of low mood. The review was unable to establish where this diagnosis of bipolar disorder came from.

2.8.2 During the period covered by this review**,** Adult A visited the GP practice on thirteen separate occasions. These included nine visits for physical health related concerns, while four visits related directly to her mental health, all of which were responded to either with a referral to Mental Health services or a medication review and follow up appointment. In addition to this, correspondence was received from other agencies in relation to these mental health needs. This history of mental health needs has been outlined in detail in relation to Adult A's contact with Tees, Esk and Wear Valleys NHS Foundation Trust.

2.8.3 Within GP records at different points there is reference to Adult A having a partner, boyfriend and/ or husband. It is not clear if these refer to one person or different partners as none are identified by name. Practice records indicate that Adult A was married but it did not identify a named individual. There is an entry in the GP records dated September 2011 that she had a husband however a further entry in the GP records dated November 2012 references a letter from TEWV which states she had recently separated from her boyfriend of two years.

2.8.4 In relation to any indicators of domestic violence, there is reference to a consultation in September 2011 where Adult A references unhappiness with her partner and that he 'drinks and smokes cannabis'. The GP identified within records that Adult A needed to make decisions as she was 'clearly being manipulated'. However, during interview for the purpose of this review GP1 clarified that this was not a term used by Adult A and was the GP's opinion following Adult A's disclosures that her partner was drinking and smoking cannabis. There was no further information identified on which this opinion was based.

2.8.5 There is also reference within a consultation in October 2011 to Adult A reporting that her partner had stopped using drugs, and in December 2011 to Adult A stating that 'she cannot face a further court case - ex boyfriend is still wanting some of house belongings'. Reference is also made to there still being an injunction to prevent this ex-boyfriend seeing Adult A. There is no evidence of any further exploration of these issues with Adult A.

2.8.6 Considering this information against that provided by the Police, it would once again appear likely in light of the timescales that the partner referred to is Adult C.

2.8.7 Within GP records there is no reference at all to Adult B, or to any relationship issues with any partner during the time period in which Adult A is known to have been in a relationship within him.

Analysis of contact

2.8.8 There is confusion within Adult A's GP records as to what relationships she was involved in. Her marital status on these records indicated that she was married however there are references to husband, partner and boyfriend. There is however no indication that this had an impact on the care received by the victim from the practice.

2.8.9 The IMR completed by NDCCG on behalf of the Local Area Team concluded that actions relating to Adult A's physical or mental health were completed within a timely manner and give no cause for concern. Adult A had a long history of mental health concerns and it is clear from the GP records that involvement with other services was actioned; however records show that engagement within other services was often difficult to maintain. Letters from TEWV and Accident and Emergency highlighted these difficulties.

2.8.10 The IMR author further reported that consultations with the GP appear to have been managed effectively and it is clearly identified where further input from Mental Health Services such as services offered by Tees, Esk and Wear Valley (TEWV) were requested. An example of this was given as when Adult A visited the GP (February 2011) stating she was having poor sleep and as a result not attending her review sessions with TEWV. The GP offered a short-term solution of medication and re-referral back into TEWV for a mental health review.

2.8.11 It was evident towards the end of the review period that Adult A missed a few appointments for medication review and blood tests between January and February 2013.

2.8.12 The attempts to make contact with Adult A within these dates were considered as accepted practice.

2.8.13 The IMR completed by North Durham CCG identified that there was no evidence from the information available of direct disclosures from Adult A that she was a victim of domestic abuse, and therefore no key incidents where it appears information relating to potential harm was missed or not acted upon. However, the incident in September 2011 where the GP identified that they felt that Adult A was 'being manipulated' suggests that the GP had some concerns in relation to things Adult A had said. There is also a later reference to Adult A's anxiety and her feeling that she cannot face a further court case relating to her ex-boyfriend, as well as reference to an injunction still being in place. This indicates therefore that Adult A did discuss her situation with her GP, and her expressed anxieties and disclosure regarding an injunction can be seen as indicators of abuse. However there is no evidence of any further exploration or assessment of this and, as raised previously, while the outcome of any such assessment cannot be known in hindsight, any information revealed within this could have resulted in the undertaking of appropriate risk management actions.

2.8.14 It was also identified that the GP practice did not have a Domestic Abuse Policy in place during the time period covered by this review. Since

October 2013 there has been a 'Domestic Abuse Aide Memoire for Primary Care in County Durham', which guides GPs as to the steps to take both in cases where there are direct disclosures made, or they suspect domestic abuse. The Practice Manager has also been made aware of the Safeguarding Adults Policy for GP practices.

2.9 South West Yorkshire Partnership NHS Foundation Trust

2.9.1 SWYPFT were not requested to complete an IMR due to their limited contact with Adult B (perpetrator), however they did produce an extended chronology outlining their contact with him during the period of this review. A combined summary and analysis of this contact is provided below.

2.9.2 In November 2012, Adult B was assessed in A&E due to an overdose of tablets. He attributed this, in part, to the break-up of a long-term relationship of 32 years. He also disclosed that he was in a short-term relationship and stated that he had been defrauded during this. He said that he regretted this relationship and was seeking reconciliation with his ex-partner, Adult E. During the assessment he stated that he felt suicidal and also reported to be living in his car. He was brought into A&E by his ex-partner who stated that she did not want reconciliation but would support him in the short term. While no direct reference was made to the names of the long term and short term partner it would appear consistent with other information within this review to presume this relates to Adult E and Adult A respectively.

2.9.3 A number of structured tools were completed during the above assessment, including a Comprehensive Health and Social Care Needs Assessment, Level 1 Risk Assessment and Management Plan, and Mental Health Clustering Tool. As a result of these Adult B was not identified as posing any ongoing risk of self-harm or having a diagnosed mental illness. He was discharged to stay with Adult E, and advice was given around seeking accommodation. It was also agreed that he would visit his GP to discuss medication and obtain a sick note. A referral was also made for cognitive behavioural therapy to the Improved Access to Psychological Therapy Service (IAPT).

2.9.4 SWYPFT identified that these interventions were in line with the Trust's policy and practice guidance. The assessment was also found to be of good quality with information elicited from a number of sources; record keeping was also felt to be of a consistently good standard portraying Adult B's story well.

2.9.5 In November 2012, SWYPFT received a telephone call from Adult E expressing distress at Adult B's behaviour and voicing frustration that he continued to reside at her home. Advice was given regarding housing options and setting boundaries with regards to behaviour. It was reported that SWPYFT offered support and advice to Adult E, which was considered appropriate and proportionate given the nature of the relationship. SWYPFT also identified that Adult E offered no examples to support her view in regards to Adult B's behaviour; there was also no evidence that he had suffered a significant mental health problem or been assessed as having a mental illness.

2.9.6 In November 2012, a further telephone call was received from Adult E stating that following the previous phone advice Adult B was no longer residing at her home and she had no current address for him.

2.9.7 In December 2012, Adult B was assessed in A&E following a further overdose of tablets. His ex-partner Adult E stated that Adult B continues to see the 'other woman' in Durham and continues to treat her badly. Adult B was reported as having no permanent address although he was living between his mother's and girlfriend's addresses, as well as living in his car. He also stated in the assessment that he 'would not do this again'.

2.9.8 Although Adult B was assessed on this date, no new Comprehensive Health And Social Care Needs Assessment, Level 1 Risk Assessment/Management Plan, or Mental Health Clustering tool were completed. There is clear documentation of this fact within the clinical record, with the rationale given as 'all assessments still valid and up to date, no changes'. Whilst the structured assessments were not completed, the details and information required were reflected in the clinical records and this included the formulations for decision making. Within the complied chronology by SWYPFT, it is stated that the absence of the assessments was compensated by the high quality of clinical record keeping and demonstrated decision making. As a result of these Adult A was not identified as posing any significant risk to himself or others.

2.9.9 A GP letter was sent following this assessment in A&E and the previous referral made to the Improved Access to Psychological Therapy (IAPT) service was ongoing. Discharge was therefore agreed with Adult B, with agreement that he would see his GP the following day regarding medication. No mental health follow-up was deemed necessary by the assessment team.

2.9.10 In December 2012, a telephone call was received from Adult E who stated that Adult B was 'very seriously mentally ill, he had been lying to

professionals taking drugs and alcohol and lived in a fantasy world'. The staff member who spoke with Adult E explained that due to confidentiality and data protection act that they were unable to discuss Adult B's details due to not having the appropriate consent. However staff did explain to Adult E that if she was concerned he was drinking alcohol whilst driving his car, then she should contact the Police.

2.9.11 Within the Chronology it is noted that while Adult E voiced concern that Adult B was 'lying' to staff', staff could only base their assessments of Adult B on the information provided to them at the time of the assessment. Furthermore as Adult B was not receiving an ongoing service from SWYPFT at this time, and had not been assessed as suffering from a mental disorder, it was also felt to be appropriate and in line with Trust policy that Adult E was given advice to contact the Police if she had further concerns.

2.9.12 It was also later confirmed by SWYPFT that following the earlier assessment Adult B had attended his GP as recommended and no concerns had been received from the GP. It was felt that GPs would be skilled at identifying and referring individuals where they feel specialist mental health intervention is required, and this was not the case for Adult B.

2.9.13 In January 2013, the IAPT service discharged Adult B as they had been unable to make contact. IAPT, which is an independently commissioned service, confirmed that repeated attempts were made to contact Adult B by telephone and letter. However, as no contact was established Adult B was discharged unseen, in line with practice at the time of this referral. Within the Chronology it is commented that this was a 'good example of follow up, particularly tenacious given the often transient nature of crisis assessment work'.

3 Conclusions and Lessons Learned

3.1 It has been identified throughout this report that there is limited information from agencies around Adult A's relationship with Adult B. No records linking Adult A and Adult B have been identified by agencies, other than the two Police call-outs to domestic incidents in September 2012 and December 2012.

3.2 What has emerged however is a picture of Adult A as a woman with vulnerabilities, who over the years has had intermittent but ongoing contact with services in relation to her mental health; within much of this contact reference is also made to her alcohol use. While Adult A often accessed services in relation to these difficulties, the pattern of her contact suggests this would often be at crisis point, and that once this subsided she would not engage with the longer term therapeutic services offered. It is also clear that she had been a victim of domestic abuse within previous relationships, but that she was not offered specific support to address this. These factors combined highlight the extent of her vulnerabilities.

3.3 This vulnerability has particular resonance in light of the way in which Adult A met Adult B through the internet. Family have spoken of her heavy use of the internet and the fantasy life she lived through it. They spoke of having warned her of such meetings and their fear that she was placing herself at risk, however they felt she was unresponsive to such warnings.

3.4 As regards Adult B, a picture emerges of a man with a history of controlling and emotionally abusive behaviour towards his ex-partner, Adult E. Adult E also appears to have had ongoing concerns regarding his mental health and the relationship he had developed with Adult A.

3.5 In order to identify the lessons that can be learned from this review a number of specific areas were outlined within the terms of reference, and addressed within the completed IMRS. Information is summarised in relation to these below and key lessons learned have been highlighted.

3.6 Were the family aware of any domestic abuse that may be taking place?

3.6.1 Input from the family for the purpose of this review has demonstrated that they were aware of 'difficulties' in the relationship between Adult A and Adult B, but that this was not considered significantly different from Adult A's previous relationships. However, none of the family members interviewed identified the relationship as abusive, and they were adamant

that their mother had experienced no previous physical violence from Adult B.

3.6.2 The family also described their mother as a strong and brave woman who they believe would have 'fought back'. However it has been identified that Adult A had previously experienced domestic abuse on a number of occasions and that this included Police call-outs relating to Adult B, one of which her youngest son was present at.

3.7 Were there any barriers experienced by the victim or family in reporting abuse? Was abuse present in any previous relationships, of either the victim or perpetrator, and did this affect the victim's decision on whether to access support?

3.7.1 There have been no specific barriers identified throughout the course of this review in relation to either Adult A, or her family, reporting abuse; indeed evidence can be seen of Adult A calling the Police on a number of occasions throughout the review period. As previously identified two of the call-outs related to Adult B, although on one of these occasions the Police were called by his ex-partner.

3.7.2 However, as has been discussed, Adult A had experienced domestic abuse, including physical violence, in previous relationships, and this may have impacted in relation to how she viewed Adult B's behaviour. Research has shown that experiencing repeated abuse can result in some victims 'normalising' such behaviour. In addition, fear of the perpetrator can also prevent those experiencing abuse from reporting. As such, it should be considered that there may potentially have been further incidents with Adult B, in which Adult A did not call the Police. However it is impossible to know if this was the case.

3.7.3 Similarly in relation Adult A's family, information provided by them directly, as well as information supplied by agencies, indicates that they had supported their mother throughout a number of difficult and abusive relationships, as well as supporting her in relation to problems she experienced around her own mental health and alcohol use. It is therefore against this context that the behaviour of Adult B and his relationship with Adult A would have been viewed.

3.7.4 It is also now known that Adult B demonstrated emotionally abusive and controlling behaviour throughout the period of his long-term relationship with Adult E. There is evidence within the review that Adult E had concerns about his behaviour and his mental health and alerted people to this in her calls to both SWYPFT and the Police. While the response to

these calls can be see to be appropriate and proportionate in relation to the information supplied at the time, it has also been identified that no further exploration appeared to take place with her in relation to the concerns expressed. Had this occurred, information might have come to light earlier regarding the nature of Adult B's behaviour within his relationship with Adult E; this could then have been used to prompt or inform any assessments in relation to any risk posed to others.

Lesson Learned: There were missed opportunities to gather further information from Adult E in regard to her concerns around Adult B's behaviour, which could have been used to inform the assessment of risk.

3.8 Was everything done, which might reasonably have been expected, to understand and manage effectively any risk of harm? What were the key points/opportunities for assessment and decision making in relation to those identified? Do assessments and decisions appear to have been reached in an informed and professional manner? Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

3.8.1 As was outlined in the analysis of Durham Constabulary's response to incidents, in relation to Adult A's previous relationship with Adult C there were a number of incidents in which reports of domestic abuse were dealt with appropriately and proactively, with Domestic Violence forms being submitted (July 2011, October 2011, and March 2012). In these cases the assessment of risk, and the response to it, would appear appropriate to information presenting within the incident at the time.

3.8.2 However, there were two further incidents in October 2011 in which while there were domestic abuse indicators, no Domestic Violence forms were submitted, and therefore no risk assessments completed. As a result, decisions taken at this time were based on an incomplete picture of the risk. In addition a number of other incidents relating to property issues occurred within this distinct period, resulting in the Police having been called to the house on eight occasions within less than six weeks. There was little evidence within the review to suggest that these incidents were considered together in the assessment of risk, each having been dealt with in isolation with a failure to consider the wider picture demonstrated by such successive call-outs. Had this been identified it may have prompted a more in depth assessment of risk that considered the increased frequency of incidents, the recent separation, the threats of suicide/incidents of self-harm by both Adult A and Adult C, and the presence of alcohol as a disinhibiting factor.

3.8.3 The CAADA (Coordinated Action Against Domestic Abuse) guidance around the use of the CAADA-DASH Risk Indicator Checklist in identifying potential high risk victims of domestic abuse, highlights potential escalation as a significant risk factor. This can be assessed by looking at the number of Police call-outs within a twelve month period; a starting point of three call-outs within twelve months is suggested to be indicative of such escalation, although this can be adapted locally. Within Durham Constabulary and the Durham MARAC procedures however there are no specified number of incidents that would lead to an automatic referral. Therefore even if all incidents had resulted in the appropriate identification of domestic abuse indicators and the submission of Domestic Violence forms, this would not have led to automatic referral into MARAC unless during the completion of the risk assessment significant indicators were identified to indicate serious harm. 'Serious harm' is defined as 'a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be difficult or impossible'.

3.8.4 In the case of the Police's response to Concern for Safety incidents where, while appropriate actions were taken to manage the immediate risk, the assumptions made that Vulnerable Adult forms did not need to be submitted, often as the victim had been taken to a place of safety, resulted in each incident being viewed in isolation. This then led to missed opportunities to inform and involve Adult Services that may have led, once more, to a more coordinated multi-agency approach.

3.8.5 As regards the two incidents attended by the Police in relation to Adult A and Adult B, it has been identified that a more positive approach may also have led to increased opportunity for assessment. In September 2012 it has been identified that no risk assessment was undertaken or domestic violence form submitted, although officers could not in retrospect identify why they had failed to take such action. At the incident in December 2012, while the initial incident would appear to have been dealt with appropriately by the attending officer, at the visit that was arranged for the following day Adult A was reported to be in bed and her son was spoken to in her absence. The officer who undertook this visit did not deem it was necessary to return the following day to speak to Adult A directly. This decision appears to have been based on his previous knowledge of Adult A and his perception of her known alcohol use and mental health problems. Consequently, he has taken the view that it was more appropriate to speak to her son. In doing so he missed an opportunity to get the direct views of the alleged victim in this case. Similarly no follow up contact was made with Adult B, or Adult E who originally reported concerns and who in retrospect it has been revealed had significant information relating to Adult B. As a result, a missed opportunity occurred

to gain a greater insight into the situation, ascertain the views of Adult A herself and thus complete a comprehensive risk assessment.

Lesson Learned: There were historic incidents in which Durham Constabulary's officers did not recognise and correctly classify all domestic abuse and vulnerability incidents; as well as two incidents relating to Adult B in which the opportunities for further exploration of the situation with Adult A, or other sources, were not taken.

3.8.6 As regards to contact by other agencies, within the timeframe of the review specific opportunities for assessment in relation to Adult A's experience of abuse in her previous relationship with Adult C can also be seen. While Adult A made no direct disclosures of domestic abuse, there is evidence that she did report difficulties within consultations with her GP in September 2011 and December 2011, when she spoke of unhappiness with her partner and of having an injunction against him. Despite these indicators no further exploration or follow up action appears to have taken place by the GP. Similar references were made to staff by Adult A in her contact with TEWV in October 2011 and November 2011, when she spoke of the injunction and concerns around harassment and persecution. It has been identified that these were missed opportunities for further exploration with Adult A regarding the impact this was having on her mental health and well being, and whether she had access to appropriate support.

3.8.7 During the period in which Adult A was in a relationship with Adult B, the review has not identified any significant contacts by her with health services that indicate any missed opportunities in relation to assessment. However during this time Adult B was in contact with SWYPFT and two significant points of assessment have been identified in November 2012 and December 2012, when he was assessed following overdoses of tablets. Both of these incidents were felt to have been dealt with appropriately; with full risk assessments being completed on the first occasion, and reference to these made on the second occasion, as well as a record of the clinical decision making that occurred. In addition, Adult E also made contact with SWYPFT around this time in relation to concerns she had about Adult B's mental health, his relationship with Adult A, and his presentation to services. However despite this there does not appear to have been any attempts to explore this further with her, as discussed previously.

3.8.8 It was also identified within the IMR completed by NDCCG that there was a general pattern within Adult A's contact with her GP for specific action to be taken around her presenting concerns, many of which were often in relation to mental health, but a lack of exploration around any broader

issues underpinning this and her general circumstances. As such a limited picture of Adult A was known. Had general enquiries been made in relation to her broader home/social circumstances, and how these may have been impacting on her mental health, this would have also provided opportunities for possible disclosure around any ongoing relationship difficulties or domestic abuse. This can also be seen to be a factor within Adult A's contact with TEWV.

3.8.9 Finally, Panel discussion highlighted that in her contact with agencies, Adult A had been reluctant to engage with agencies other than at crisis point, and that this alongside her having capacity to make such decisions, presented a significant challenge in terms of creating opportunities for disclosure and further exploration of issues.

Lesson Learned: There was a lack of consideration and further enquiry by agencies in relation to Adult A's home/social circumstances. This included historical missed opportunities to follow up on indicators of domestic abuse in order to assess any risk further and ensure appropriate risk management and support was in place.

3.9 Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

3.9.1 Durham Constabulary have identified a number of incidents, as detailed previously, in which Domestic Violence forms or Vulnerable Adult forms were not submitted as appropriate by the Police Officers attending the scene. While it was outlined that procedures and policies are in place to support the submission of such forms the IMR author for Durham Constabulary highlighted that this is still reliant upon officers attending correctly identifying the situation and acting in accordance with this. The issues around this have been demonstrated in the two call-outs relating to Adult A and Adult B. On the first incident in September 2012 officers recognised in retrospect that a form should have been submitted but failed to do so at the time. Whereas in December 2012 the officer who attended the next day did not consider there to have been a domestic abuse incident, despite the fact that he did not speak to Adult A herself in relation to this.

3.9.2 In order to guard against such situations, since approximately 2011, communications supervisors within Durham Constabulary have been responsible for closing domestic abuse incidents. This is to ensure incidents are dealt with in line with National Standard or Incident Recording (NSIR), National Crime Recording Standard (NCRS), and to ensure the

incident has been dealt with appropriately. If the sequel to an incident does not match the initial call, for example a caller reports they have been assaulted yet the sequel does not confirm an assault or negate an assault, the attending officer will be challenged. The communications supervisors also check quality control to ensure a domestic abuse qualifier has been added to the incident and that the officer has stated a vulnerability form will be submitted where appropriate.

3.9.3 Furthermore, since February 2014 all incidents tagged domestic abuse, or closed as domestic abuse, by communications staff will be reviewed by the domestic abuse specialist sergeants for compliance. Each day Safeguarding Detective Sergeants read all domestic related incidents reported to the Police during the prior 24 hour period. The incidents are defined by the NSIR closing code and domestic abuse qualifier. The Safeguarding Detective Sergeants ensure all domestic incidents have been dealt with appropriately, such as positive action taken in relation to domestic incidents, crime correctly recorded and investigated and Domestic Violence forms and risk assessments submitted. If these actions have not been completed the matter is brought to the attention of the Senior Management Team at the Daily Management Meeting and the incident reallocated to the attending officer or uniform response for completion of actions.

3.9.4 In addition to the above in order to increase awareness among frontline staff Durham Constabulary have also identified a number of recommendations from this review that will be implemented to increase officers awareness of the submission of Vulnerable Adult forms and to ensure that all relevant Safeguarding training is mandatory for frontline staff.

3.9.5 In relation to GPs and TEWV staff, no significant training and awareness issues were identified within the IMRs in relation to practice that had occurred. However the IMR completed by NDCCG did include a general recommendation to ensure that training strategies and programmes of safeguarding Adults and Children include the appropriate levels of Domestic Violence training for Staff in Primary Care. Similarly the IMR by TEWV included a general recommendation to increase awareness, knowledge and understanding within the Trust workforce in relation to the domestic abuse agenda.

3.9.6 A further area that also emerges within this review is that agencies were aware of issues relating to Adult A's mental health and her use of alcohol. There is evidence within the incident reported to the Police in December 2012 that the response of the Police Officer the following day was in part

influenced by his perception of Adult A due to his previous contact with her, through which he was aware of her mental health and substance misuse difficulties. This was demonstrated within his account of why he chose not to return to speak to her directly but instead base his actions upon the report of her son. It is also of note that in a number of previous incidents where Domestic Violence forms were not submitted appropriately, Adult A was also recorded to have been under the influence of alcohol or mentally unwell, which raises the question of whether this impacted on officers' views of the situation; although it is recognised that it cannot be assumed. Similarly, this may have been a factor in relation to Adult A's contact with other agencies in terms of the focus on her mental health presentation, which may have contributed to the lack of recognition or further exploration of the domestic abuse indicators disclosed.

3.9.7 In relation to this, the Home Office's 2013 publication 'Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned' recognised that such difficulties in addressing complex needs are a recurring theme in domestic homicide reviews. It identified that: *'In a number of cases the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, sexual abuse, alcohol, substance misuse and mental health illness. In some cases the domestic violence and abuse was not always identified because agencies were focusing on addressing, for example, the mental health or substance misuse.'*

Lesson Learned: There is evidence of the presence of the complex mix of mental health issues, substance use and domestic abuse in the case of Adult A. This may have been a contributing factor in those circumstances where domestic abuse indicators were not explored further, or domestic situations not correctly identified, due to a focus on Adult A's presenting mental health and alcohol issues.

3.10 Examine whether there were any issues in communication or information sharing. Also were managers appropriately consulted and involved.

3.10.1 Within Adult A's contact with TEWV and her GP, there is evidence of appropriate communication between these and other services in relation to Adult A's presentations and ongoing treatment. There is no evidence to suggest however that the information she gave in relation to her relationship with Adult C was shared any further. However given the limited nature of such information, and the fact that this was not further explored, there was no compelling reason to share this in terms of Safeguarding or public interest based on what was know at the time.

Greater exploration however may have prompted increased justification for sharing of information.

3.10.2 Similarly there is no evidence of SWYPFT having shared the concerns expressed by Adult E with any other services, although once again the information, as it stood, would not have warranted sharing in terms of Safeguarding or the public interest.

3.10.3 In relation to Durham Constabulary, occasions have been identified in which Police Officers did not appropriately consider, submit or share domestic violence or Vulnerable Adult forms with other agencies. As such there was a lack of information sharing throughout this case that meant that agencies were working in silos without an awareness of the wider picture, although it is recognised that this was primarily in relation to Adult A's relationship with Adult C.

3.10.4 In considering this Durham Constabulary outlined that the CRU (Central Referral Unit) was established in June 2011 as a model to establish best practice around information sharing and collaboration between partner agencies within the safeguarding arena. The CRU was designed to act as a central point where all referrals from across every area of Police business within County Durham relating to vulnerable children, vulnerable adults, and domestic abuse, would be routed. Each referral is reviewed, risk assessed and researched, ("the screening process") and the CRU makes decisions on the appropriate means of dealing with each on its merits, and in turn share information with partner agencies where appropriate. This ensures a consistency in decision making and response. The staff who undertake the screening process within the CRU are experienced safeguarding detectives (Detective Constables and a Detective Sergeant) who will make a decision about each referral individually (with the exception of standard risk domestic abuse incidents which are screened by the Police support staff within the CRU and if concerns are raised the domestic abuse incident is forwarded to the DC or DS for screening).

3.10.5 The CRU does not have an investigative capacity – any matters requiring further Police investigation are referred to the appropriate Local Area Team. Partner agencies including social services (both child and adult services) and mental health services contribute a physical presence within the CRU and are available for immediate consultation and information sharing. There are plans for Health and Outreach Services to also contribute a presence in the CRU. Partner agencies can also access Police systems to input / access information of relevance to a particular

case. Processes and practices within the CRU have developed and evolved over time.

3.10.6 In order to eliminate duplication for Police Officers who respond to incidents, in time it became agreed best practice that only ONE referral would be made for an incident. The officer would deem what the most appropriate method of referral was in each case, e.g. domestic abuse, vulnerable adult, vulnerable child. This is generally dictated by the predominant nature of the incident. However, by the very nature of safeguarding there are circumstances where an incident might encompass all three. An example of this might be a violent domestic abuse incident whereby a male partner physically assaulted his female partner, the couple have children who were present and witnessed the incident, and one or both of the adults involved have substance dependence problems or mental health issues. This could be recorded as any of the three types of referral. The screening process within the CRU would identify the other issues and each matter would be addressed accordingly – there would be no need to submit referrals under more than one category.

3.10.7 In relation to this, if Vulnerable Adult and Domestic Violence forms had been submitted as appropriate throughout Adult A's contact with the Police this, along with partner agency information, may have resulted in a clearer understanding of problems and risk in terms of providing a clearer picture of the wider situation and made for a more compelling case for intervention both earlier during her contact with Adult C, or later following the incidents with Adult B.

3.10.8 It was identified within Panel discussions that within County Durham a Multi-Agency Safeguarding Hub (MASH) is currently under development, which would further assist in addressing some of the issues highlighted by this review. MASHs are co-located teams that aim to improve safeguarding approaches for children and vulnerable adults, through improved information sharing and timely responses. In the case of Adult A the existence of such a MASH would have facilitated the sharing of information between the Police, TEWV and Adult Safeguarding, and potentially led to consideration of the 'wider picture' in terms of Adult A's vulnerabilities.

Lesson Learned: Opportunities in which potential domestic abuse indicators or safeguarding concerns were not identified or explored further, resulted in reduced opportunities for the sharing of information with other agencies.

3.11 Did any organisational/capacity issues impact on this case?

3.11.1 None of the agencies involved in this review identified any issues relating to organisational capacity or resources.

3.12 What were the considerations in relation to ethnicity, religion, diversity or equality, and how did these impact on those involved.

3.12.1 The individuals identified in this review were all white British. No significant issues in relation to their race, religion, belief or language have emerged as part of this review.

3.12.2 Adult A's gender can be seen to be a factor in relation to her having been a victim of domestic violence, given that research has shown women are more likely than men to experience interpersonal violence, and severe or repeated incidents of violence and abuse. Women under the age of thirty are also at considerably greater risk than those over the age of forty[3]. It was noted by the Panel that Adult A, at the age of 55, was therefore not within this increased risk category. This led to discussion of whether this may have impacted on the missed opportunities identified, in that staff may be less likely to recognise abuse indicators when the victim is an older woman. However there was no evidence of this having been the case in agencies interactions with Adult A; although the Panel did recognise that this was an important factor for all agencies to be aware of within their practice.

3.12.3 Adult A has also been identified as a woman with vulnerabilities linked to her alcohol use, mental health issues and her experience of previous domestic abuse. The impact of these vulnerabilities in terms of agencies responses has been discussed throughout this report.

3.12.4 No further areas in relation to equality or diversity were identified as having impacted in relation to the case of Adult A.

3.13 Were any agencies aware of the use of websites and other social media for engaging in relationships by either the victim or the perpetrator and is there a requirement to raise awareness of the risks that are present by engaging in this activity?

3.13.1 Information that has come to light since the death of Adult A, both through the course of the investigation and through speaking to her family, has identified that the role of social media and dating websites was significant

[3] Walby and Allen, 2004

in terms of the events that led up to her death. Her family expressed concerns about the level and nature of her use and the extent to which she would meet men through such forums. Furthermore they reported that she lived a 'fantasy life' through it and this was reflected in the nature of her relationship with Adult B, in that they both appeared to have created alternative personas.

3.13.2 What has also emerged from this review is that agencies were unaware of these concerns, as no reference had been made to them in their contact with Adult A. The only indication of website use was that relating to the incident reported in December 2012 when Adult A had been sending Facebook messages; although this in itself did not indicate any concerns or give clues as to the extent or nature of her use. Such lack of awareness among agencies around this side of Adult A's life would not appear unreasonable as there was nothing directly to suggest that it should have been known to professionals with whom she was working. However it does perhaps link into another issue that has been identified from this review, which is the lack of broader exploration with Adult A around her relationships and her social circumstances.

3.13.3 Following the conviction of Adult B there was a press release in which Durham Constabulary's Superintendent stated that Adult A lead a lifestyle which revolved around Facebook, online games and social networks. A warning was issued as follows:

'I cannot stress enough that some people, who may be vulnerable, are putting themselves at serious risk by using certain websites. We are not talking about the well-known and reputable dating sites, but those which put the emphasis purely on the sexual, physical side. There are a lot of men, and (Adult B) was one of them, who pretend to be something they are not. They actively seek out and prey on those who are vulnerable and then attempt to control and coerce them.'

3.13.4 Indeed within this a key issue has been identified and that is the vulnerability of Adult A, as has been evidenced throughout this review. The role of Adult A's online life in the events leading up to her relationship with Adult B therefore cannot be ignored.

3.13.5 While Adult A's family said they had warned her of the risks and that she ignored them, they nevertheless felt very strongly when interviewed for this review that there was a need to highlight such risks to others. Although it is recognised that as Adult A did not heed warnings of her family, to whom she was very close, it is unlikely that she would do so if this warning were to come from other sources.

3.13.6 The Panel in this case concluded that it was important to learn from the death of Adult A through highlighting the need for the public to be made aware of the risks associated with the use of certain websites, and the extent to which these can be used to target and prey upon vulnerable people.

Lesson Learned: This review has highlighted the dangers associated with the use of certain websites and how they may increase risks relating to adults who already have vulnerabilities.

4 To what degree could the homicide have been accurately predicted or prevented?

4.1 None of the agencies involved in this review identified within their IMRs that they believed the tragic death of Adult A to be predictable or preventable. With just two previous Police call-outs to incidents in relation to Adult A and Adult B, Adult B's lack of previous convictions, and no known history of physical violence, there were no significant indicators to suggest Adult B's capacity for such fatal violence.

4.2 However it has been identified that there were other risk factors present including Adult B's history of controlling and abusive behaviour towards his ex-partner Adult E, including a previous physical assault, his two reported overdoses, and the extent of Adult A's vulnerability and her previous experiences of domestic abuse.

4.3 There were also some missed opportunities to gather further information, undertake full risk assessments and to share information with other agencies. Had this occurred a fuller picture may have emerged. It is recognised however that these opportunities were limited and it is not possible to know in hindsight whether further exploration and assessment would have succeeded in identifying any higher level of risk. In light of this the Panel felt it unlikely that this would have impacted on any actions taken.

4.4 In conclusion, it was highlighted within Panel discussions that much of the information relating to Adult A's experience of domestic abuse linked to her previous partner and that there was very limited information that was known, or could reasonably have been expected to be known, by agencies in relation to Adult B or his relationship with Adult A. Furthermore, given the timing of Adult A's death, three months after the last reported domestic call-out, it is difficult to say that the missed opportunities prior to this, would

have definitively changed the course of events that occurred later or thus prevented the tragic death of Adult A.

5 Recommendations

5.1 *General Recommendations arising from the review*

As a result of the lessons learned identified the following general recommendations have arisen from this review.

Recommendation 1 (National):

A coordinated national response is needed to increase public awareness around the dangers related to the use of certain internet sites and how these may be used to target and prey on individuals with vulnerabilities.

Target date: 31st March 2016

Recommendation 2 (Local):

Police and Crime Commissioner, Sexual Violence Implementation Group, and Safe Durham Partnership to implement a local action plan to increase public awareness around the dangers related to the use of certain internet sites (as outlined in the previous recommendation).

Target date: 31st March 2015

Recommendation 3 (Local):

All agencies to ensure that the key lessons learned from this review are disseminated to staff and included in existing and future training. These key areas include:

- Ability to recognise domestic abuse indicators.
- Importance of further exploration regarding an individual's home/social circumstances.
- Need to undertake enquiry when information is shared indicating abuse from the victim or third parties, even if no direct disclosure is made.
- Importance of ensuring action is being taken to address concerns and not assume it is being dealt with elsewhere.
- Understanding of the dangerous interplay between substance use, mental health and domestic abuse and the need to ensure that focus on other

difficulties does not prevent domestic abuse from being recognised or victims engaged with.
- Awareness and understanding of domestic abuse referral pathways.

Target date: 31st March 2015

Outcome Measurement: All agencies to provide feedback to the Safe Durham Partnership as to how lessons learned will be disseminated to staff, and how key areas are to be addressed within training.

Recommendation 4 (Local):

Development of the Multi-Agency Safeguarding Hub (MASH) to be progressed as a matter of urgency, and to include procedures in place to ensure adequate feedback mechanisms to agencies regarding their referrals.

Target date: 31st March 2015

Outcome Measurement: MASH established with clear procedures regarding feedback mechanisms in place.

5.2 *Individual agency recommendations arising from IMRs*

Those agencies that undertook IMRs have identified individual agency recommendations in order to both respond to specific issues identified within the IMR process and to generally improve practice in relation to domestic abuse.

Durham Constabulary

- The Constabulary must reinforce to front line staff.
    - Mandatory minimum standards for submission of a Vulnerable Adult Form where there is a concern (if not related to a domestic abuse incident as vulnerable adult issues will be addressed on the domestic violence form).
    - Mandatory minimum standards for submission of a Vulnerable Adult Form where the incident involves incidents involving self harm and attempted suicide (or threats of).

- With immediate effect all incidents tagged domestic abuse, or closed as domestic abuse, by communications staff will be reviewed by the domestic abuse specialist sergeants for compliance. Safeguarding Detective Sergeants will read all domestic related incidents reported to the Police during the prior

24 hour period. The incidents are defined by the National Standard or Incident Recording (NSIR) closing code and domestic abuse qualifier. The Safeguarding Detective Sergeants will ensure all domestic incidents have been dealt with appropriately, such as positive action taken in relation to domestic incidents, crime correctly recorded within time scales and investigated, Domestic Violence forms and risk assessments submitted. If these actions have not been completed the matter will be brought to the attention of the Senior Management Team at the Daily Management Meeting and the incident reallocated to the attending officer or uniform response for completion of actions. These checks will continue until such times as the force is satisfied that the Front Line understands and complies with force policy with regard to submission of Domestic Violence forms and carrying out proactive arrests of perpetrators.

- To circulate written guidance to operational officers regarding the minimum standards as to when a Vulnerable Adult form should be submitted and educate staff around issues of mental health, self harm and alcohol.

- Relevant safeguarding National Centre for Applied Learning Technologies[4] (NCALT) packages to be reviewed by the Safeguarding SMT to ensure all relevant training packages are mandatory for all officers, not only safeguarding officers.

North Durham Clinical Commissioning Group on behalf of the Local Area Team

- Best Practice would be to ensure that Adult Safeguarding and Children's Safeguarding training strategies and training programmes include appropriate levels of Domestic Violence training for staff in Primary Care.

- Ensure that when reviewing policies and procedures that they are sensitive to the special risks to and needs of older women who are victims of domestic abuse. This is an on-going action from previous DHRs.

Tees, Esk and Wear Valleys NHS Foundation Trust

- To increase awareness, knowledge and understanding within the Trust workforce in relation to the domestic abuse agenda.

[4] NCALT is a collaboration between the College of Policing and the Metropolitan Police Service. NCALT assists the 43 Police Forces in England and Wales and the wider policing community in adopting new learning technologies. NCALT produces local and national e-learning.

Glossary of Terms

CDDFT	County Durham and Darlington Foundation Trust
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CRU	Central Referral Unit
DHR	Domestic Homicide Review
IAPT	Improved Access to Psychological Therapy Service
IMR	Individual Management Review
MASH	Multi-Agency Safeguarding Hub
NCALT	National Centre for Applied Learning Technologies
NDCCG	North Durham Clinical Commissioning Group
NEAS	North East Ambulance Service (NHS) Foundation Trust
NSIR	National Standard or Incident Recording
NCRS	National Crime Recording Standard
SWYPFT	South West Yorkshire Partnership (NHS) Trust
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust