Final report

Domestic Homicide Review
Overview Report

REPORT INTO THE DEATH OF ADULT 'X' ON 18th DECEMBER 2011

Report produced by Professor Pat Cantrill

Date: July 24th 2012

Revised 18th January 2013

CONTENTS

SECTION ONE: INTRODUCTION AND BACKGROUND

1.1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of X in Doncaster. South Yorkshire Police were called to a domestic incident at the home of X and Y, a married couple, on 18th December 2011. Following assessment by paramedics X was transferred to hospital where he was later pronounced dead. Y was charged with the murder of X. At her trial in July 2012 she was found not guilty of both murder and manslaughter. There was recognition at the trial that Y was also a long term victim of domestic violence and the homicide was accepted by the jury as an act of self-defence.

1.2. Reasons for Conducting the Review

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'

The purpose of a DHR is to:

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

The guiding principles which underpin this review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible
- **Impartiality** – those conducting the review should not have been directly involved with the victim or the family
- **Thoroughness** – all important factors should be considered
- **Openness** – there should be no suspicion of concealment

- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest
- **Co-operation** – the agreed procedure and statutory guidance contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 should be followed.
- **Resolution** – action should be taken to implement any recommendations that arise.

1.3. Process of the review

A DHR was recommended and commissioned by Doncaster Community Safety Partnership and the DHR Executive Group on 11th January 2012 in line with expectations of Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

It has been decided that the Doncaster Children Safeguarding Board will not be commissioning a Serious Case Review with respect to this case.

The Chair of the Doncaster Community Safety Partnership established X's homicide met the criteria to be subject of a DHR by applying the definition set out in paragraph 3.8 of the guidance.

The panel also considered that Y, the suspected perpetrator, had been arrested and charged, and a decision was made that, because of the potential delay in learning lessons from the review, the DHR should be commissioned and not delayed by pending legal action. Agencies and interested parties were notified of the requirement to secure any records pertaining to the homicide to inform the subsequent overview report. The court proceedings related to the death of X took place in July 2012.Y was found not guilty of both murder and manslaughter.
The Crown Prosecution Service was informed that a DHR has been commissioned.
The Home Office was informed of the intention to conduct a DHR on the 20th January 2012 and the first review panel was held within a month of this date.
A specific Domestic Homicide Review Panel met which consisted of:

REP FOR:	NAME	POST
Doncaster Metropolitan Borough Council	Sandra Norburn	Crime & Re-offending Manager
Doncaster Metropolitan Borough Council	Noreen Wilkinson	Head Of Service- Care management
Rotherham Doncaster and South Humber NHS Foundation Trust	Chris Prewett	Head of Safeguarding & Standards
South Yorkshire Police	Peter Horner	Manager and Lead for Public Protection, South Yorkshire Police
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Deborah Oughtibridge	Deputy Director of Nursing & Quality

REP FOR:	NAME	POST
NHS Doncaster	Andrew Russell	Head of Quality Vulnerable Adults
NHS Doncaster	Dr Suzanne Kirby	GP Safeguarding

Sandra Norburn, Crime & Re-offending Manager, provided an expert domestic violence specialist input to the panel. She is the Manager of the Domestic Violence Service and has twelve years' experience of working as a practitioner and manager for both specialist statutory and voluntary agencies. This was supported by other members of the panel who also have significant experience of this area of work.

Professor Pat Cantrill was independent chair of the panel meetings.

The DHR Panel, at the meeting on 11th January 2012, requested that the following agencies/bodies secured their records and identified if they had contact with X or Y and commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review (IMR) from six agencies:

- NHS Doncaster – Primary Care Services/General Practitioners
- Doncaster Council - Adult Services
- Doncaster Council –Children's Services
- South Yorkshire Police
- RDASH NHS Foundation Trust
- Doncaster and Bassetlaw NHS Foundation Trust.

The agencies with no record of contact and IMRs not developed are:

- St Leger Homes of Doncaster
- Doncaster Women's Aid
- Doncaster IDVA Service

Whilst the above agencies were not represented on the panel conversations were held with them and the report and the lessons shared with them. As the couple lived in private housing and there were no housing issues in the case it was felt that this was acceptable that housing was not represented on the panel. Doncaster Women's Aid has been involved in discussions about client access which have informed the report.

The authors of the Individual Management Reviews are independent in accordance with the guidance.

The Chair and author of the Domestic Homicide Review is Professor Pat Cantrill, who is a Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health. She is a qualified teacher and has considerable education experience. Pat is a Visiting Professor at Sheffield Hallam University and the University of Lethbridge in Canada. She is a company director of her own limited company and is Senior Non Executive Director of Westfield Health Scheme.

Pat has led a number of high profile serious incident reviews particularly in relation to safeguarding vulnerable adults, domestic violence, homicide and children. Pat has had no previous involvement with the subjects of the review or the case.

1.4. Time Period

This review began on 23rd January 2012 and was completed as a draft in May 2012. It had been anticipated that it would be concluded within the Home Office timescales of 6 months in which reviews, including the overview report, should be completed. Unfortunately the commencement of the trial of Y resulted in the draft report and the overview author's notes taken from interviews with family members being used as part of evidence for the trial. The Overview author was also requested to be available to be called as a witness. As a result of this and the fact that it was felt that there may be evidence given in court that might assist in identifying key issues for the report it was decided to request a delay in submitting the report to the Home Office.

1.5. Terms of Reference

The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- X and Y had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which X died was a 'one off' or whether there were any warning signs and whether more could be done in Doncaster to raise Awareness of services available to victims of domestic violence.

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

- Whether there were any barriers experienced by X or his family/ friends/colleagues in reporting any abuse in Doncaster or elsewhere, including whether he knew how to report domestic abuse should he have wanted to.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Y, the alleged perpetrator that were missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services.

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

The review will consider any other information that is found to be relevant. The terms of reference have been forwarded to and accepted by the Home office.

1.6. Individual Management Review Authors

The DH Review Panel has received and considered the following Individual Management Review Reports (IMR):

Organisation	Author name	Author title
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Pat Johnson,	Lead Professional for Safeguarding Adults,
Doncaster Council Adult Services	Noreen Wilkinson	Service Coordinator (Assessments)
Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH)	Chris Prewett	Head of Safeguarding and Standards
General Practice	Dr Suzanne Kirby	General Practitioner
NHS Doncaster- Primary Care Services.	Andrew Russell	Head of Quality for Vulnerable Adults
South Yorkshire Police	Helen Smith	Sergeant, Public Protection Unit

1.7. Development of Individual Management Reviews (IMR)

The objective of the Individual Management Reviews (IMRs) which form the basis for the DHR is to give as accurate as possible an account of an agency's original response to X and his family, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective

response to a similar situation in the future. The IMRs have also assessed the significant changes that have taken place in service provision during the timescale of the review and considered if further changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This report is based on IMRs commissioned from professionals who are independent of any involvement with the victim, his family or the alleged perpetrator. The report author has indicated whether there is confidence in the findings of an IMR. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured by Chief Superintendent Richard Tweed on behalf of the Doncaster Community Safety Partnership.

The report's conclusions represent the collective view of the DH Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The timescale of the DHR was originally identified as November 2005 when there are indications of domestic violence taking place to 18th December 2011 when X died.
The scope of the DHR was extended as a result of IMR authors identifying relevant information from records dating back to 27th January 1988.

In addition a comprehensive integrated chronology has been compiled and analysed by the DH Review panel. This document records agency involvement and significant events from the period covered by the review (January 1988 and 18th December 2011, the date of the incident) and appears at Appendix One.

In reporting the views of individuals who received services, the Review Panel is not endorsing those views as accurate or as a fair assessment of the services they were given. They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the services involved.

Consent to access medical records

During the development of the DHR a particular area of difficulty was access to the medical records of Y. Y's solicitor failed to respond to a request to access her medical records, which created an ethical and legal challenge particularly for the IMR author for General Practice and also for Doncaster and Bassetlaw NHS Foundation Trust and Rotherham Doncaster and South Humberside NHS Foundation Trust. The authors continued with their IMRs in line with opinion of the General Medical Council who recently stated that:

> *We … feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that*

this should be the principle that doctors should follow in cooperating with DHRs as well" [1]

This action was further supported by recommendation in DoH document[2] '*Striking the Balance'* 2012

Y was informed that IMR authors would access only records that were of relevance to the review. A request for Y to meet with the report author was not accepted. There was no reply to this correspondence except a request for access to the draft report and any other information in the review author's possession. A copy of the draft report was forwarded to the CPS via the disclosure officer.

Confidentiality

The findings of each review are confidential. Following acceptance of this report by the Doncaster Community Safety Partnership the report and a 'briefing note' encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the agencies that contributed to this DHR.

Dissemination

Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. The IMRs will not be published. The DHR report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

In line with section 10.0 of Home Office Guidance, as the DHR has been conducted in parallel to a criminal investigation, the disclosure officer has informed the Prosecutor and any interviews with other agency staff, documents, case conferences etc. have been made available. Copies of the notes of meetings with X and Y's family were also provided.

The content of the Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. The Report will be produced in a form suitable for publication with any Home Office approved redaction before publication.

The report was discussed with X's and Y's family who at that time did not wish to see the report. It was agreed that after the Home Office had cleared the report the author would meet with the family to discuss the content and at that time provide a copy of the report if the family had changed their mind about access. This will be prior to the publication of the report.

[1] Letter from GMC to Professor Pat Cantrill, Chair of Adult A DHR Sheffield, 6/10/11

[2] Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS. April 2012

1.8. Subjects of the review

Deceased: X. DOB [redacted] DOD 18/12/11

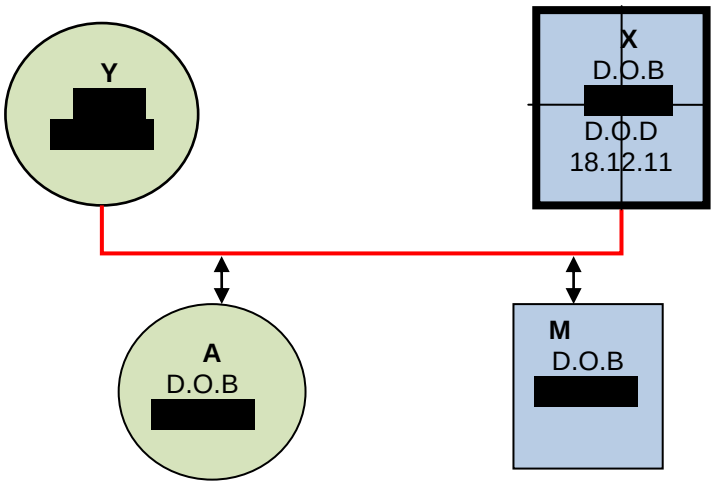
Partner Y. DOB [redacted] lived with X

X and Y have two adult children who were not living at home at the time of the incident and are not subjects of this review.

M DOB
A DOB [redacted]

All of the subjects of the review are White British.

1.9. Family genogram



1.10. Involvement of the family

In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel considered carefully the potential benefits to be gained by including individuals from both the victim's and alleged perpetrator's networks in the review process.

Extensive efforts were made to meet with family members to ensure that the maximum learning was obtained from the case.

The children of X and Y and the sister of X were contacted and two separate meetings took place with A and M (adult children) and AX (Sister), and the review author and the Crime and Re-offending Manager. The review panel had to be aware of the potential for family members to be involved in any legal action.

SECTION TWO: DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

2.1. Introduction

This review report is an anthology of information and facts from agencies, all of which were potential sources of support for X and Y. This report of a domestic homicide review examines agency responses to and support given to X and Y, residents of Doncaster prior to the point of X's death on 18th December 2011.

Whilst the DHR has at its focus the homicide of X and the contact services had with him, it is clear from the IMRs that the violent relationship that the couple had resulted in Y disclosing her abuse to services, and X did not make such disclosures. Therefore a significant proportion of the DHR examines agency responses to Y rather than X. There was recognition at the trial that Y was a long term victim of domestic violence and the homicide was accepted by the jury as an act of self-defence.

Essentially; only five agencies had records of contact with X and Y prior to his death. They are:

- NHS Doncaster – Primary Care Services- General Practitioners
- Doncaster and Bassetlaw Hospitals Foundation Trust
- Doncaster Council Adult Services (Assessment)
- South Yorkshire Police
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH)

General practitioner services in 1988/89, Doncaster Royal Infirmary Psychiatric Department (now Rotherham Doncaster and South Humber NHS Foundation Trust) in 1989 and South Yorkshire Police 2005/2006 had contact with X and Y associated with a referral or subsequent assessment and case management as a result of domestic violence. The contact was associated with the abuse of Y by X. X and Y were not known to the services of the Doncaster Community Safety Partnership and are not known to other domestic abuse support services in the Doncaster.

2.1.1 Summary of the case

X and Y were married and had lived at their marital address for at least 10 years prior to the incident. X had lived in the same village since his birth. X and Y's families identify that the couple had a volatile relationship over a long period. Y disclosed that she was experiencing domestic abuse in 1988/1989 on several occasions to her GP and also in 1989 she admitted to the GP that she had stabbed X. The GP referred Y to Doncaster Royal Infirmary Psychiatric Department where she was seen by a Consultant Psychiatrist in June 1989 in the presence of X where issues regarding domestic violence were again disclosed.
X and Y had two children born in 1989 and 1991. They lived with domestic violence all their childhood and adolescence. They were never the subjects of physical violence themselves but frequently observed the violence between their parents and had to take shelter in the bedroom with their mother or escaped to their grandparents (Ys parents).

In 2004 X had an occupational accident [redacted]
In July 2005 X reported to his GP that he felt angry all the time since his accident and was referred by the GP for an anger management course. It was not possible to determine if he completed this course. On 6th November 2005 the police were contacted by Y who stated that X was being violent and had been holding her by the throat. On 5th November 2006 a call was received from one of X and Y's children who told the call-handler that X was hitting Y. X was arrested for assault and was conveyed to the police station where he was interviewed and later cautioned. X and Y are said to have had frequent arguments which occurred particularly when the couple had been drinking. X also smoked cannabis.
On 18th December 2011 police and paramedics were called by Y who stated that she had stabbed her husband in self-defence. When they arrived at the house, X was still conscious but bleeding heavily from a wound. X was taken by ambulance to the Accident and Emergency department. X was fully conscious and alert but his condition deteriorated and X was pronounced dead later that night.
Y was immediately arrested on suspicion of assault. Later that evening police were contacted by the hospital and informed that X had died from his injuries. Y was therefore re-arrested on suspicion of murder culminating with a subsequent murder charge. At Y's trial it was accepted that she was also a long term victim of domestic violence, and the homicide was accepted by a jury as an act of self-defence and she was found not guilty of either murder or manslaughter.

2.1.2 The context of service involvement

The purpose of this section of the report is to provide an overview of the context in which the domestic homicide of X happened and to identify changes that have occurred in the provision of domestic abuse services during the timescales of this domestic homicide review. It will enable assessment of the provision of services to take place with an understanding of the environment in which practitioners worked: the policy frameworks, organisational structures and professional practice from 1988 to 2011. It also addresses some of the DHR terms of reference and an analysis of the performance of Doncaster's domestic abuse services is made and action taken considered.

2.1.3 National context

Domestic abuse of women has been in the public eye for many years. Many studies have examined its nature and extent, shelters for abused women have been set up, and legislation and police charging policies have evolved in response to the growing appreciation of the extent of the problem. The extent of the comparable issue of domestic abuse of men is not as well known and understood by the general public. However, recent findings contribute to a better understanding of domestic or intimate partner abuse of men. *Domestic Violence: The Male Perspective*,[3] states: "Domestic violence is often seen as a female victim/male perpetrator problem, but the evidence demonstrates that this is a false picture."

As many as four per cent of men have been victims of domestic abuse according to crime statistics for England and Wales, and charities say an increasing number of victims are beginning to come forward. Help lines report an increase of 35% in the number of calls they

[3] Domestic Violence: The Male Perspective, Parity 2010

receive from men. More men are being referred by hospitals and by the police to support centres, and many men are beginning to acknowledge they are being abused and refer themselves.

British Crime statistics in 2010/2011 show that:

- Domestic violence accounted for 14% of all reported violent incidents
- Women were the victims in 77% of incidents
- 17 per cent of men in England and Wales have experienced domestic abuse since the age of 16 (Chaplin, Flatley, Smith 2009 and 2010[4]).
- According to the 2010/11 British Crime Survey , seven per cent of women and five per cent of men experienced domestic abuse in the last year, equivalent to an estimated 1.2 million female and 800,000 male victims.
- Home Office statistics show similar or slightly larger numbers of men were subjected to severe force in an incident with their partner, according to the same documents. The figure stood at 48.6% in 2006-07, 48.3% the next year and 37.5% in 2008-09, the 2008-09 bulletin states: "More than one in four women (28%) and around one in six men (16%) had experienced domestic abuse since the age of 16. These figures are equivalent to an estimated 4.5 million female victims of domestic abuse and 2.6 million male victims."
- In addition, "6% of women and 4% of men reported having experienced domestic abuse in the past year, equivalent to an estimated one million female victims of domestic abuse and 600,000 male victims".

Additional statistics

- Some Campaigners such as Parity claim that men are often treated as "second-class victims" and that many police forces and councils do not take them seriously. Their situation is said to be largely overlooked by the media, in official reports and in government policy, for example in the provision of refuge places – 7,500 for females in England and Wales but only 60 for men.
- The official figures are said by some to underestimate the true number of male victims because culturally it's difficult for men to bring these incidents to the attention of the authorities. British Crime Survey identifies that twice as many male victims (41 per cent) as women (19 per cent) do not tell anyone about the domestic abuse they are experiencing.
- Crown Prosecution Service identified that in 2011 nearly 4,000 women were successfully prosecuted for domestic violence, compared with fewer than 1,500 in 2005. Females as a proportion of all men and women convicted rose from five per cent to seven per cent.

- Domestic violence has a significant impact on children:

  - At least 750,000 children a year witness domestic violence (Department of Health, 2002).

[4] Risk of being a victim of crime Rupert Chaplin, John Flatley and Kevin Smith**.** 2009/10 and 2010/11 BCS

- Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life (Stanley 2011) [5]
-
- 52% of child protection cases involve domestic violence (Farmer & Owen, 1995)
- 40% to 70% of men who assault their wives or partners are also directly physically or sexually violent to their children or abuse or threaten the children to increase their control over their mother (Hester and Pearson, 1998, Humphreys, C. and Mullender, A, 2000) [6]

Whilst the Government's strategic vision and action plan centres on women and girls[7] many of the key issues identified equally apply to men. It places prevention and awareness-raising, early identification and early intervention as crucial service involvement and contains measures for central government to:

- Prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it.
- Provide adequate levels of support where violence does occur.
- Work in partnership to obtain the best outcome for victims and their families.
- Take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice.

Issues of prevention and awareness-raising, early identification and early intervention are of significance in the case of X and Y.

There is evidence to suggest that in the case of X and Y situational couple violence[8] may have been present. This is supported by comments made by the family of X and Y, evidence given during the trial of Y and the information provided in particularly the Health and Police IMRs. There is research that indicates that situational couple violence is the most common form of intimate partner violence[9]. It is the sort of violence that enters a relationship when a disagreement turns into an angry argument and escalates into violence. The violence can be mild or severe, and although often this is an isolated incident in a relationship, some couples have a recurring pattern of such violence that is extremely dangerous. This type of violence is almost as likely to be perpetrated by women as by men.

[5] Children experiencing domestic violence: A research review. Research in practice 2011
[6] Hester, M., Pearson, C. and Harwin, N. (2000) Making an impact: A reader, London, Jessica Kingsley. Humphreys, C. and Mullender, A. (2000) Children and domestic violence, Research in Practice Series, Dartington, Devon

[7] Home Office (2010) Call to End Violence to Women and Girls. London: Home Office

[8] Differentiation among types of intimate partner violence: research update and implications for interventions. Joan Kelly and Michael P. Johnson 2005

[9] Differentiation among types of intimate partner violence: research update and implications for interventions. Joan Kelly and Michael P. Johnson 2005

2.1.4 Domestic abuse and Domestic Abuse Services in Doncaster

Domestic abuse

Domestic abuse as in many other cities and towns is a significant issue in Doncaster. It makes up 26% of total recorded violent crime in Doncaster, with South Yorkshire Police recording 6523 incidents of domestic abuse in Doncaster in the year April 2011 to March 2012. Doncaster has for many years had significantly higher levels of reported domestic abuse than other towns in South Yorkshire, and reporting has increased dramatically over the last three years. The average monthly incidents in 2009 were 390. In 2012 the average monthly incidents were 543, over 150 extra incidents per month. Locally this increase is attributed to a combination of increased reporting, due to publicity and awareness raising work, and more effective identification of cases by the police. The number of domestic violence crimes has remained fairly static over the same period. Nationally, 44% of adult victims of domestic violence are involved in more than one incident whilst in Doncaster it is presently 32%.

'High' risk cases which pose a continued significant threat to the victim are referred to MARAC (Multi Agency Risk Assessment Conference). MARAC data identifies that there was a consistent increase in the number of referrals up until February 2011 when the number of incidents increased dramatically; the four highest monthly figures have occurred from August 2011 to November 2011. This increase represents a 117% increase in a four month period when compared to the same period the previous year. There are 2 domestic abuse homicides in Doncaster each year on average.

Monthly performance information for a variety of metrics for the period April 2011- October 2011 identifies that the percentage of DV crimes has decreased slightly throughout the year whilst the number of high risk cases heard at MARAC has increased. Referrals to the Independent Domestic Violence Advocacy Service (IDVA) service have also increased mainly due to the increase from police referrals with low levels of referrals from Children's Services and health.

The number of referrals to Children's Social Services as might be expected has as a result risen steadily in line with the increase in Domestic Abuse incidents. A rating system to identify cases where there are significant risks (red referrals) to the children associated with the incident was introduced in January 2011. The number of red referrals has increased throughout the year mirroring the increase in the number of referrals to children's services overall.

If a domestic incident as detailed in this report occurred now where children are present, there is an additional tier of risk assessment undertaken which should address the level of risk posed to any children. This level is set by Domestic Violence Officers receiving the CMS 11 forms after a domestic incident has taken place. There are three levels: blue, amber and red. Blue generally refers to those children who are present in the house when an incident occurs but did not witness it. Amber generally refers to those children that did witness and incident and red for those that actually became involved in the incident itself and perhaps called emergency services. Where the family situation is already known to be one of risk to the children, for example they are already on a Child Protection Plan; they would be referred as red regardless of the nature of the individual incident. Once this level is set by the officer, it is sent through to Social Care with the additional level of risk attached. Red and Amber cases are prioritised. Whilst a child may not see an incident there may be a number or

pattern of incidents that make them at higher risk and therefore it is recognised that there is a need to respond appropriately to those cases assessed as Blue.
Whilst the original protocol requires that once received by children's social care services, the referral may then be referred further to the Blue Group Panel which is made up of Children's Social Care Services, Education, providers of health services, Women's' Aid and Police the significant number of weekly referrals approximately 100 make it difficult to review all cases . The intention is that the group looks at the referrals received and decides what additional action or services may be required to target particular children. The blue group deals only with cases that don't reach the threshold for child in need/child protection and therefore would not normally have social care involvement. The Blue Group Panel would agree to Integrated Family Support Service or School involvement, or other universal services such as health visitors to raise their Awareness and for them to observe and consider completion of a Common Assessment Framework.

Domestic abuse services in Doncaster

Safer Doncaster Partnership was established to reduce crime and disorder in Doncaster's communities. The Partnership involves members of the Police, Council, NHS and a range of other public sector and voluntary agencies.Safer Doncaster Partnership now has domestic and sexual abuse as one of its four key priorities, with a dedicated Theme Group. Until 2011 domestic and sexual violence was part of the remit of the Violent Crime Theme Group.

In December 2007 Safer Doncaster Partnership commissioned a report reviewing services for victims of domestic and sexual violence in Doncaster. The review identified gaps in services and made recommendations to improve services provision.

This led to the development of the Doncaster Domestic Violence Strategy 'Don't Cover Up Domestic Violence ', and to some improvements in the way domestic and sexual abuse was managed. However, it highlighted a general lack of capacity, lack of a strategic commissioning plan, and over-reliance on short term funding as weaknesses.

The structural changes that have taken place over the last few years have resulted in recognition that statutory services would be more effective working more closely together at a strategic level and by jointly commissioning services. Doncaster Council on behalf of the Partnership has commissioned an independent review of services to inform a new domestic and sexual abuse strategy and joint commissioning arrangements. Safer Doncaster Partnership links with Doncaster Safeguarding Children Board and Doncaster Safeguarding Adults Board, through key members sitting on each Board

Services in Doncaster

Early intervention

The Safer Doncaster Partnership strategy encourages reporting at the early stage to offer appropriate support to reduce the risk of further abuse.
Specific actions include:

- Communications strategy for reaching teenagers due to the prevalence of abuse within teen relationships. A national government publicity campaign targeting teenagers has already been launched in 2011. There is a need to improve recognition and encourage reporting of teen relationship abuse in line with the Governments Call to End Violence Against Women and Girls [10]action plan. Four out of ten Domestic violence crimes are against females aged 26 and under and this increases to half of all crimes against females under the age of 30. This has influenced the services and marketing campaigns that have been organised in Doncaster. There is no significant age distribution for male victims.
- Gender neutral publicity campaigns, to support national activity, and around specific times of year for example such as Valentines Day, International Day to End Violence against Women, Christmas and New Year, and key sporting events.
- A range of information and training to build public Awareness and the capacity and skills within services to respond.

Protection and Enforcement in Doncaster

The next area identifies services provided in Doncaster to protect those at the higher levels of risk, and bringing perpetrators to justice where possible. It includes:

- The implementation of the South Yorkshire Police Domestic Abuse Policy across all services.
- The Doncaster Domestic Violence Unit which actions all reported incidents to police. All incidents are risk assessed and high risks are referred to MARAC and IDVA service. All high risk victims receive a visit from a DV Officer. All medium risk victims are contacted by phone and may be visited – then may be raised to high risk level following contact. This provides a second opportunity to assess circumstances, and if necessary to re-assess the risk level.
- A specialist DV Court Programme which was established in 2006, this South Yorkshire wide agreement resulted in significant investment in the criminal justice processes and in support provision to victims. This includes the development of provision of a perpetrator programme (IDAP) for convicted domestic violence offenders, delivered by the Probation Service.
- The MARAC is one of the components of the SDVC, established to manage cases at the highest level of risk. The Administration of the MARAC is the responsibility of South Yorkshire Police, and it operates to the agreed MARAC Operating Protocol, and to CAADA guidance**.** The MARAC is well attended by a range of statutory and voluntary agencies. Referrals to MARAC are overwhelmingly from the Police however, this reflects the higher level of reporting to the police, as agencies often find that cases they are considering referring have already been reported to the Police and referred.

- The Safer Doncaster Sanctuary Scheme was set up to help victims of domestic abuse who want to stay in their home following the break-up of an abusive relationship, but are worried about their abusive partner being able to gain access to the property. The multi-agency scheme involves a free security assessment of a

[10] Call to End Violence Against Women and Girls November 2010. HM Government

victim's property and advice about any work that needs to be done to ensure that their home is secure. This might include additional or replacement locks, bolts, window locks, repairs to damaged doors or windows.

- Forced Marriage and Honour Based Violence Polic**y** (SYP**)** Cases of potential forced marriage and honour based violence are some of the highest risk situations and require specialist and sensitive handling to identify cases and protect the individuals. Cases are managed by the Public Protection Unit of the Police.
- Sexual Assault Referral Centre (SARC) – reception point for all victims of Sexual Violence in South Yorkshire is based at Rotherham NHS Foundation Trust.
- The Apollo Unit is a dedicated police team dealing with sexual violence victims
- The Children's Multi- agency Referral and Assessment Service, consisting of the children's social care services and Police Public Protection Unit, responds to incidents of child abuse, many of which are related to Domestic Abuse.

Supporting Victims in Doncaster

The next group of services are provided for victims. They can be both immediate and short term protection and longer term emotional support to recover from the effects of domestic abuse. They include:

- Independent Domestic Violence Advocacy and Independent Sexual Violence Advocacy. (IDVA and ISVA) are two Independent Advocacy Services in Doncaster, providing specialist support and advocacy to victims of domestic violence and sexual violence. Doncaster IDVA service is based within the Community Safety Team, and provides support to anyone who has been assessed as high risk of further harm from domestic violence. The IDVA service works on behalf of the victim, working with a wide range of agencies to reduce the risk of further abuse, and increase their safety. The IDVA service is currently engaging with around 75% of referrals. The IDVA service had 26 high risk male victims referred to their services in 2011-12. There have been two cases involving men being stabbed by women, where the women had previously been high risk victims.

- Doncaster Women's Aid provides an Advice Service, refuge, helpline and floating support service. They also deliver the Freedom Project a 12 week programme for women who have experienced domestic abuse.
- Whilst there are no refuges for men in Doncaster emergency and temporary accommodation is provided usually via St Leger Homes.
- Victim Support provides contact and offers support to all victims including males who are referred to them by police. It also includes Court based witness support service.
- Doncaster Rape & Sexual Abuse Counselling Service is a specialist counselling service for people affected by sexual abuse including historical, and Independent Sexual Violence Advocacy (ISVA) service.

Data collection and monitoring

The community safety team at Doncaster Council collates data from a range of agencies, including the Police, IDVA, St Leger Homes, Women's Aid and ISVA. In addition the

performance report from the South Yorkshire SDVC is a comprehensive summary of performance of courts, CPS, Probation as well as Police and IDVA.

The Council's performance management system Covalent enables all of this data from across the council, including Children's Services and partner agencies to be collated and for performance reports and analysis to be produced. The Partnership has brought together its analysts into a Data Observatory. Monthly performance reports on key indicators are presented to the Partnership's Performance Board, and Exec. Board.

Review of provision and development of a strategy to tackle domestic and sexual abuse in Doncaster

In April 2012 Doncaster Council on behalf of the Safer Doncaster Partnership commissioned NSPCC Consulting and Kafka Brigade UK to review provision and develop a strategy to tackle domestic and sexual abuse in Doncaster. It has been useful to have access to the outcome of this review and to compare findings against the issues raised in this review. Overall the review found that there is commitment to addressing domestic violence which would be reinforced by having clear lines of accountability, an improved performance management framework, by review of MARAC, increased IDVA resource, and improved training. Key recommendations address the development of service provision underpinned by a new level of strategic oversight, and commitment to joint commissioning. The following key priorities have been identified:

- Preventing abuse and intervening early
- A seamless service for victims delivered through a coordinating Hub
- Multi agency Workforce Development Strategy
- Provision of support and care for children affected by domestic abuse
- Responding to perpetrators, voluntary programme and effective offender management
- Consolidating our response to high risk victims
- A systematic approach to refuge and housing.
- Measuring what matters, developing outcomes based performance measures
- Joint commissioning

2.1.5 Doncaster Metropolitan Borough Council – Children's Services

As referrals were made to Doncaster Council's Children's services by the police in 2005 and 2006 regarding domestic violence and the presence of children in the home of X and Y it is useful to examine the context of the service and its performance at this time. The problems facing the services at this time are well documented. In the autumn of 2005 the Children's Services were subject of a Joint Area Review. The JAR inspectors examined all aspects of work with children against the five key national priorities and found arrangements for keeping children safe adequate although the inspectors highlighted some areas of vulnerability. Issues identified were:

- The lack of agreed intervention thresholds was identified as a cause for delays in providing access to services for some children.
- The quality of assessment, planning and record keeping for individual children was inconsistent with some being very poor.

- At the time of the JAR the council had made progress in reducing vacancies of social workers but this remained an issue.

At the time it was felt that the planned re-organisation of services would address these issues and would result in positive change in delivering better coordinated services in local areas. Within two years following the JAR the quality of services for children had declined to the extent that by 2008 the APA judged that arrangements for safeguarding children were inadequate. There has continued to be concerns about the quality of children's services and the consistency of front-line child protection services.
Changes in assessing children referred to Children's Services as a result of domestic violence, if implemented and resourced adequately, should reduce the risk of this happening again. This is described in detail on page 15 and includes an additional three tier of risk assessment (red, amber and blue) that is undertaken to address the level of risk posed to any children. The number of referrals being made for assessment has increased significantly since this was implemented and Doncaster Safeguarding Children Board should assure themselves that this process is reviewed to ensure it remains responsive and that increasing referrals do not result in delays.

2.1.6 National Health Service Context

Organisational changes

Like many other public services, the NHS since 2008 has been through a considerable amount of change with Government initiatives influencing legislation, policy and structural changes. A major issue for partnership development and interagency planning, working and service delivery is the frequent reorganisation and mergers of organisations and in some instances resultant changes in functions and responsibilities and key personnel. The present Government is reorganising the NHS again. The result of this in Doncaster has been:

Hospital and Community Services

- NHS Doncaster presently commissions health services for the population of 308,000. In 2010/11 they had a resource allocation of £575 million. NHS Doncaster is responsible for planning and delivering health services and ensuring that local hospital services and specialist treatment are available for local patients who need them. NHS Doncaster also commissions a number of services from GP practices, opticians, pharmacists, hospital trusts, and mental health care services, independent and voluntary providers. As the Government reforms expect PCTs to contract in size before they eventually disappear in 2013, a new structure has been established called NHS South Yorkshire and Bassetlaw cluster.

- NHS South Yorkshire and Bassetlaw oversees and accounts for the delivery of services on behalf of the five primary care trusts – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. This is to ensure that each individual PCT continues to meet its legal, financial and performance responsibilities and obligations until the Clinical Commissioning Groups assume full responsibility for budgets in April 2013.The Government plans to remove PCTs in 2013 and replace them with GP Commissioning

Groups as part of the Government's plans set out in the NHS White Paper 'Liberating the NHS: Equity and Excellence. Annual Health Check of NHS Doncaster identifies performance ratings from 'weak' for quality and 'weak' for use of resources in 2007/8, to 'good' and 'good', respectively, for 2009/10.

- The Doncaster Clinical Commissioning Group (DCCG) is a formal sub-committee of the NHS South Yorkshire and Bassetlaw board. The DCCG is a clinically led committee, which is working alongside NHS Doncaster to effectively and efficiently commission health services for the people of Doncaster. DCCG does not have a legal standing but has been given delegated responsibility for budgets, by NHS South Yorkshire and Bassetlaw that pay for healthcare for around 300,000 people in Doncaster. The DCCG will be solely responsible for allocating over £550 million each year from April 2013.

General Practitioner Services

Since April 2004, Primary Care Trusts have had a statutory duty to work with other local agencies to reduce crime (in Crime and Disorder Reduction Partnerships under the Crime and Disorder Act 1998).They are the organisation that has responsibility to assess compliance of GPs but this will change with the implementation of Doncaster Clinical Commissioning Group and the responsibilities of Care Quality Commission. By April 2013 GPs have a legal requirement to register with the Care Quality Commission and comply with the essential standards, which cover quality and safety. They will be expected to self assess their performance against key standards including safeguarding children and adults.

NHS Doncaster

NHS Doncaster has worked with its health providers, including GPs to develop a Domestic Abuse Policy (2011). The Policy was developed in assist health professionals to comply with: the Crime and Disorder Act 1998, Race Relations Act 1976 (as amended), recommendations made by the Domestic Abuse and Pregnancy Advisory Group in 2005. and the Home Office document; 'Multi Agency Guidance for Addressing Domestic Violence (2000)'.

The domestic abuse policy covers employees of NHS Doncaster and the community provider at that time. There is a statement in the policy that promotes the policy to GP practices.

Key Principles

The key principles outlined in the policy are underpinned by the DOH publications 'Responding to Domestic Abuse – A Handbook for Health Professionals' and 'Improving safety, Reducing Harm-A practical toolkit for frontline practitioners.

NHS Doncaster presently assesses performance against the key Indicators which are reviewed by the Assistant Director of Quality and Governance on an annual basis and used to inform the development of future procedural documents. They have in place a well developed training strategy and programme.

2.1.7 Disability and Relationships

Disability can change relationships substantively, and where the cause is an accident this change is sudden and unexpected. Changes in relationship functioning includes a reduction in activities people engage in with others, social space, and discomfort in having to use support processes and services. Inevitably, the quality of relationships is affected and relationships have to be renegotiated as a result of constraints produced by illness and disability. In the case of X and Y there were already problems in their relationship which must have been exacerbated following [redacted] in 2004.

Given that caring for a person with a disability can be stressful, it is important that professionals and services examine family resilience and their ability to adapt to changes in relationships. The construct of "adaptability" is particularly relevant to understanding the ways in which a family member having a disability affects families and the stress experienced by them. Part of the stress of caring is due to changes in roles, and the need to adapt to the new roles.

Whilst Y and X had a history of domestic violence prior to [redacted] X [redacted] was more likely to get depressed and angry and he in fact admitted this to his GP in July 2005. Major depressive disorder is the most common co-morbidity followed by anxiety disorders. This situation would have put more pressure on X and Ys relationship

2.1.8 Conclusions about domestic abuse services in Doncaster

Doncaster Community Safety Partnership provides a mechanism to enable a broad range of statutory and voluntary partners to work together to improve strategy, this leadership role is vital to ensuring that strategy evolves in line with changing needs of adults and developments continue to be implemented and assessed. There is a requirement for Doncaster Community Safety Partnership to keep their vision clear and to maintain the determination to achieve the culture and key targets required. The impact of financial constraints and reconfiguration of services could influence the implementation of the required changes and it is important that Doncaster Community Safety Partnership is supported by all partnership organisations to meet the required level and quality of safeguarding services.

It is therefore important that the strategic element of the partnership continues to be developed. Commissioning is a central feature of local government and public service reform. Councils have been challenged to shift away from narrow service delivery functions and adopt a more strategic commissioning role. This means stepping back from traditional service delivery and focussing on understanding the needs of the community and leading activity to secure improved outcomes. It means being open to using the best way of securing

service outcomes and thinking creatively about how to get the most from available resources.

As identified in Section 2.1.4 (page 19) the review of provision and develop a strategy to tackle domestic and sexual abuse in Doncaster identifies a number of key development requirements which would impact on those areas identified by the DHR.

2.3. ANALYSES OF INDIVIDUAL MANAGEMENT REVIEWS

The focus for this section of the report is an analysis of the response of services involved with X and Y, why decisions were 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.

First and importantly this DHR was commissioned as a result of the death of X who was stabbed by his wife. During the review what has become apparent is that X and Y were both experiencing domestic abuse as a result, it appears, of situational couple violence. There is greater evidence of X's abuse of Y in the IMRs but this may be as a result of X not disclosing abuse against him to any agencies.
It is important that the findings of the review are set in the context of the internal and external factors that were impacting on delivery of services and professional practice during the period 1988 to 2011.

The IMR authors and the Domestic Homicide Review (DHR) 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. It was obvious to some IMR authors following completion of chronologies that there might be significant information from an earlier period and so a review of records extended back to 1988.

In order to manage an account of agencies' involvement the DHR author has described separate involvement of each agency. The accounts of involvement of services with X and Y cover different periods of time prior to his death. Some of the accounts have more significance than others. All five agencies responding with information indicating some level of involvement with X and Y had extremely limited knowledge of both parties and of their relationship. There are indications in records that there was some knowledge by agencies of domestic violence in 1988 ,1989 ,2005 and 2006.

There has been difficulty gaining access to information which would inform the review because although records are only normally kept for 25 years records related to health visiting and school nursing are not accessible.

The majority of the contact of services by X and Y has been with universal services, health and education. As identified earlier appropriate information provided by their family has been incorporated into IMRs.

2.3.1. Information from Family

It became obvious to the panel that the IMRs would not identify some of the keys areas of learning on their own because of a lack of information as a result of agency records being destroyed and it was impossible to establish without the Family's input if there had been agency involvement and if so what that consisted of. The DHR author and Crime and Re-offending Manager met with family members who were able to confirm that the relationship between X and Y had been volatile and that domestic abuse had taken place with both partners inflicting injury on one another. The key observations were those of the Adult children of X and Y who confirmed that they did not experience abuse and that Children's Social Care services were never involved with them. They did not discuss when they were children the domestic violence that was taking place at home with anyone apart from Y's family and in 2006 with the police. Further information and analysis is provided at section 3.2.

2.3.2. Health services

Universal services have an important role to play in the prevention and early recognition of domestic abuse. All health professionals need to be Aware of domestic abuse, the signs and symptoms, the co-occurrence of child protection issues, and how to identify and raise the subject with patients. Appropriate referral routes and pathways need to be clear. The need for improved multi-agency links with health agencies is supported by a recent report commissioned by the Department of Health (DoH) and the Department for Children Schools and Families (DCSF) entitled "Responding to Violence Against Women and Children" (Alberti 2010); as well as the Coordinated Action Against Domestic Abuse (CAADA)'s own analysis which indicates that hospitals are the most effective locations to place Independent Domestic Violence Advocates to identify high risk victims of domestic abuse who may not be visible via the criminal justice system.

The Royal College of General Practitioners (RCGP) has produced guidance for GPs: 'Domestic Violence: The Role of the GP' which recognises that in many cases general practice is the first formal agency to which victims of abuse present for help.

The DoH announced the introduction of routine enquiry in all health settings within an agreed framework in 2005 (DoH), suggesting all Trusts should be working towards this goal. Many professional and governmental bodies recommend 'routine enquiry' about domestic violence for all women; for example, the British Medical Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Psychiatrists (National Collaborating Centre for Women's and Children's Health, 2008). Screening is likely to increase the number of women identified as experiencing domestic violence (ibid.).

2.3.3. NHS Doncaster – General Practice

The General Practitioner service is a universal service that provides primary medical care to families twenty-four hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death. GPs are the most common contact point for victims of domestic abuse [11]
General practitioners are not directly employed by the NHS. Rather, they provide services to their local NHS commissioning organisation, under the terms of a national contract. There is very limited discretion to vary the terms of this contract. General practitioners employ their own staff e.g. practice nurses, receptionists etc. As a result Primary Care Trusts and their predecessor organisations have limited powers in relation to the management of performance of GPs and their practice staff as they are independent providers of services and not employees of the PCT. Involvement in safeguarding and domestic violence protection does not form part of the contract with GPs and therefore does not attract the same incentives as the provision of other areas of care.

General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. However, General Practice has changed significantly in the last decade. The traditional practice where one or two practitioners know all their patients, and their extended families, is disappearing. Moves towards larger practices with part-time and/or salaried clinicians, and a range of service providers (e.g. GP Out of Hours Services, Walk-in Centres, and GP-led Health Centres), have tended to fragment the knowledge base and continuity of care. It is therefore critical that communication and record-keeping is robust and meticulous.

Summary of Involvement of General Practice from 1988 to 2011

Review of Y and X records has identified the following contact:

X

The IMR author establishes that from the GP records X had regular contact with healthcare professionals throughout the period of the terms of reference. The chronology predates the terms of reference because in the IMR authors opinion significant events relating to the case occurred following X's serious occupational injury [redacted]
Following this injury X had numerous consultations. The injury also led to X consulting a GP in 2005 to ask for help with anger management resulting in a referral to mental health services. There is no record in the notes indicating whether he attended the anger management course. There was no mention of domestic abuse by the perpetrator during routine GP assessment and no mental health issues.

Analysis of X contact with General Practice

[11] The report of the Taskforce on the Health Aspects of Violence Against Women and Children G Alberti 2010 DoH.

The IMR author identifies that X had several recent contacts with health professionals which would have provided an opportunity to discuss any problems or concerns about his relationship with Y. There was also opportunity for professionals to routinely enquire regarding domestic abuse but as he was not consulting with relevant symptoms that would have indicated domestic violence it was unlikely that the subject would have been raised by the GP or surgery staff. If this was asked it is not recorded. There is no mention of anger issues or mental health problems since X raised the issue in July 2005, and it is not possible to determine from the records whether he attended an anger management course at the time. There was no feedback from RDaSH that he completed the course and no record of a GP specifically enquiring whether his anger issues had resolved. During the consultation in 2005 regarding anger management there is no record of whether questions were asked regarding domestic abuse or the effects of the anger on the children, it would have been appropriate to ask these questions at the time. It is not possible from the information in the notes to determine whether there were any child protection concerns or contact with other agencies.

Y

GP records identify that Y disclosed that she was experiencing domestic abuse in 1988 and 1989 on several occasions to her GP. This included:

- 27/1/88 Y disclosed she had been punched on the left side face of her face and kicked on the right knee.
- 23/12/88 after a fight with X the night before Y had periorbital bruising. Her left eye and her left temporal region was tender.
- 3/1/89 Y presented with depression stating that she could not cope. She also disclosed that she had stabbed X 2 days previously.
- 10/2/89 Y had been beaten by X that morning who had punched her in the face with the resultant injuries of a small cut under her left eye , periorbital bruising and tenderness right eye tender upper part of stomach.
- 2/12/89 Y presented with anxiety symptoms and marital problems with her husband. Her baby would have been 2 months old.
- Following Y's referral to a Consultant Psychiatrist there were no further disclosures at the GP practice although she did mention feeling stressed in 2007 to the Smoking Cessation Adviser. It was recorded that Y's alcohol consumption increased from 1 unit per week in 2007 to 14 units per week in 2011.
-

Analysis of Y contact with General Practice

Y

It is clear from the medical records of Y that she was a victim of domestic violence on more than one occasion and she had disclosed this information to her GP in 1988 and 1989. The abuse occurred before and during the early stages of pregnancy and she also experienced

symptoms of depression and anxiety at this time. 40% to 60% of women experiencing domestic violence are abused while pregnant.[12]. Y also reported violence towards X on 1/1/89 when she admitted stabbing him. There were no records in X notes at that time indicating that he had sought medical advice for this injury. Y was referred to a consultant psychiatrist in January 1989 but there is no documented advice regarding referral to domestic abuse agencies.

The current guidance and expectation would be to advise victims of domestic abuse of the specialist services available and assess the requirement for referral under the MARAC process.

There was another recording of Y feeling stressed in 2007 disclosed to the smoking cessation adviser who is a receptionist at the practice, but it is unclear from the records whether this was explored further. There is also reference to Y's increased alcohol consumption which does not appear to have been followed up.

Analysis of General Practice involvement

The IMR author correctly identifies that with the introduction of computer-only records the disclosures in Y's handwritten records would not be available. Whoever had summarised the notes had not seen the information about domestic violence as significant as the information had not been summarised onto computer records and highlighted as an issue. There was no record on Y's computer records of domestic abuse and the practice does not use flags similar to those used in child protection. Documentation and flagging of past information of domestic abuse should be improved.

The IMR author has analysed the records of X to establish if there were any indications that could have signalled X's underlying distress regarding domestic violence as described in RCGP guidance. As identified X never raised the issue of being abused or that there were any concerns with his relationship with Y. Y however disclosed in 1989 that she had stabbed X and that he had required hospital treatment at Accident and Emergency. There does not appear to have been any cross referring of information and there is no record in X's files of him attending hospital for treatment.

Y had also been a victim of domestic violence but following disclosure she did not mention abuse to the practice again, this may be because the previous disclosures of abuse were not acted upon.

The practice is village-based and most of the staff members live in the village which may lead to reluctance for patients to report domestic abuse. This explanation was given by GP as a reason for the patient's reluctance to explain in more detail the stress disclosed in July 2007 at a smoking cessation appointment. As previously reported incidents were not acted upon Y may have felt that there was little value in reporting abuse.

General practice often provides the one setting where victims feel able to disclose, and Y felt able to disclose the violent relationship she had with X and it is therefore imperative that GPs are Aware of the need to provide safe spaces for this to happen. Many victims want the GP

[12] British Medical Association (1998) *Domestic violence: a health care issue?*

or practice staff they confide in to be able to do something to help and Y should have got that help. The GP made a referral to a Consultant Psychiatrist related to Y's anger management but she was not given any support regarding domestic violence even though she presented on more than one occasion with facial injuries. This is not usually because health professionals do not want to help; often they do not know what to do or do not have the confidence to respond effectively. At that time domestic violence services were not as well established, for example MARACs were not commenced until 2007 and most GPs would not have known how to make a referral.

There is a lack of documented risk assessment in the records and risk of further harm to X, Y and the children following disclosure of domestic violence to Y and X. There were clearly difficulties and anger issues within this family and may have been at risk since 1988. Opportunities for early agency intervention were missed. There were opportunities to ask those questions and act on the information and follow up previous consultations which were missed. There is a need to undertake risk assessment when domestic abuse is reported and where anger issues are identified. There are full detailed records of all consultations and evidence of a supportive Doctor-Patient relationship in the case of the general medical care of both X and Y who had been registered at the practice for many years but this is not reflected in relation to the GP's handling of disclosures of domestic abuse.

It is important when making comment on standards of practice the reviewer recognises the impact of hindsight and present practice on making judgements about past practice. Using the Bolam test it is likely that in 1988 and 1989 given that the local infrastructure, training and professional knowledge related to domestic abuse was not as developed that most GPs would have responded in the same way. The question is given a similar situation is the outcome of disclosure of domestic violence more likely to result in an effective assessment and referral to an appropriate agency now. The IMR author identified most of the above issues are still present at the GP practice

The IMR author's view is that there is still a lack of knowledge of services and confidence in referring patients because of:

- a lack of knowledge and confidence in handling patients who disclose that they are experiencing or recognising the indicators of domestic violence. In line with many other parts of the country the issue of female abuse against male abuse would not be so readily considered. There should be a raising of Awareness of guidance on Domestic Abuse and Services available for practice staff.
- a lack of knowledge about risk assessment and the MARAC referral process.
- GPs are uncertain about what services are available if a patient were to disclose domestic violence. GPs must have confidence in their ability to intervene and to know the process of accessing expert help. If a practitioner is unaware of what services are available for a particular problem that individual is less likely to pro-actively seek to identify patients with these problems. The issue of males experiencing domestic violence would not be as readily considered during a consultation because of the emphasis being on female victims.
- Significant Event Analysis in practices not identifying domestic violence as an area for training or to discus significant cases.

- GPs not being Aware of NHS Doncaster Domestic Abuse workbook, or the partnership website www.doncasterdomesticabuse.co.uk .
- GPs not Aware of RCGP advice to ask the question and the RCGP guidance on Domestic Abuse,
- A reluctance regarding referral to MARAC without the patient's consent in known cases of domestic abuse, as it is felt this may lead to a deterioration in the Dr-patient relationship.

Locally General Practitioners in Doncaster are now encouraged to routinely enquire about domestic violence when a patient attends the practice and there are indications that there may be relationship difficulties. A review of NHS Doncaster's website identifies that there is information about domestic abuse and policies but no link to Domestic abuse services or to the domestic abuse website.

In the past, general practitioners have often failed to respond because of lack of confidence in their ability to intervene effectively, sharing the sense of helplessness of the victims in the face of society's apparent ambivalence. However, attitudes have altered considerably and society is now beginning to make clear its determination to treat domestic violence as seriously as any other form of violence.[13]

If a practitioner is unaware of what services are available for a particular problem that individual is less likely to pro-actively seek to identify patients with these problems.
There is no mention in the guidance of exploring with men who present with mental health problems, whether they are experiencing aggression which is difficult to control.

The Royal College of General Practitioners (RCGP) has produced guidance for GPs: 'Domestic Violence: The Role of the GP'. This report aims to raise Awareness of this issue amongst GPs and encourages GPs to be proactive in raising the issue in certain situations. It recognises that in many cases of domestic violence, general practice is the first formal agency to which patients present for help and that whilst they are unlikely to raise it directly the contact with the GP can be '*used as a 'calling card': an apparently unimportant physical symptom to seek help indirectly'.* [14]

The RCGP curriculum[15] includes a statement on domestic violence which states that a GP should, at exit from GP specialty training, be able to:

'Recognise the prevalence of domestic violence and question sensitively where this may be an issue.'

This curriculum has been in use since 2007. Prior to 2007 a curriculum covering every area in depth did not exist, so GPs trained prior to this may not have covered the topic in training.

---

[13] Heath, Iona RCGP Policy: Royal College of General Practitioners - Domestic Violence-The GPs role

[14] Heath, Iona RCGP Policy: Royal College of General Practitioners - Domestic Violence-The GPs role
[15] RCGP Curriculum 2011: http://www.rcgp-curriculum.org.uk/PDF/curr_10_1_Womens_Health.pdf

The RCGP has recently appointed two Clinical Champions to increase Awareness of the GP's role in identifying women who are experiencing domestic abuse and signposting them where appropriate to local services. To aid an online learning module for GPs has been produced[16]. This describes the HARKS screening questions which are suitable for use by staff in primary care.

The Department of Health have recently published a guide for health practitioners [17]which clarifies the application of Caldicott Guardian principles to Domestic Violence and MARACS.

In May 2012 CAADA produced guidance [18] for general practices to assist them to respond effectively to patients that are experiencing abuse. The guidance supports the:

- Identification of a designated person.
- Finding out what existing domestic violence services are available.
- Engaging with local domestic abuse services – and the Domestic Violence Coordinator – to develop an effective working partnership.
- Commissioning training for the practice team.
- Establishing a simple care pathway for patients disclosing domestic abuse.
- Ensuring that the practice's response to disclosure always adheres to its information sharing protocols.

By 2013 all GPs and other primary medical services have a legal requirement to register with Care Quality Commission. and comply with the essential standards, which cover quality and safety. The standards include safeguarding children and adults. This provides an opportunity for CCGs and NHS Doncaster to monitor and influence practice performance.

Conclusions

Women and men come into contact with the health system throughout their lives. This makes the health care setting an important place where individuals experiencing abuse can be identified, provided with support and referred if necessary to specialised services. Existing interventions in health care settings focus on training health care providers to identify and respond to abuse victims and drawing up guidelines for the proper management of abuse. On average, victims of partner violence experience more operative surgeries, visits to doctors and hospital stays throughout their lives than those without a history of abuse.[19]
Y raised the issue of domestic abuse by X, and by herself on X, opportunities to conduct an effective risk assessment were missed as were those to refer the family to appropriate agencies.

[16] Violence Against Women and Children, RCGP 2011 http://elearning.rcgp.org.uk/course/category.php?id=8

[17] Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS. April 2012

[18] Responding to domestic abuse: Guidance for general practices © 2012 CAADA and IRIS.
[19] Intimate Partner Violence WHO 2002

2.3.4 Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH)

Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) provides a range of mental health, learning disability, substance misuse and community services across Rotherham, Doncaster, North and North-East Lincolnshire and in Manchester. RDaSH in 2008 was awarded **'**Excellent' for Quality of Services, having achieved 'fully met' in both the Government's core standards and existing national targets and again scored 'Excellent' in the new national targets in the Care Quality Commission's performance ratings for NHS Trusts in England. The CQC took over from the three health and social care regulators (the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission) on 1 April 2009. In April 2009, the Trust received unconditional registration under the Health and Social Care Act.

On 1st April 2011 Doncaster Community Healthcare (DCH), moved to RDaSH, and the DCH's long-term conditions and children and family services are being delivered via a partnership between RDaSH and Doncaster Council. This has provided an opportunity to integrate services across acute, mental health and community care proving coherent care pathways.

The IMR author has conducted an extensive search of RDaSH records including mental health, and community services. The only record of contact with either X or Y was with Y in 1989 when mental health services were provided by Doncaster Royal Infirmary Psychiatric Department.

The records identify that in January 1989 Y attended her GP with anxiety and depression and disclosed a recent history of domestic violence incidents involving X. Y admitted to having stabbed X in the shoulder and that he had attended Accident and Emergency. The IMR author has not been able to establish which A&E department was attended. There is no record of him attended Doncaster and Bassetlaw NHS Foundation Trust (at that time it would have been Doncaster Royal Infirmary).
The GP referred Y to Doncaster Royal Infirmary Psychiatric Department where she was seen by a Consultant Psychiatrist in June 1989 in the presence of X. [redacted]

[redacted]

It identifies in the notes that X confirmed much of what Y had said. It is interesting to note that Y would have been five months pregnant at this time.
The IMR author identifies that the Consultant Psychiatrist opinion was that Y did not have a mental illness and advised the couple to pursue marital guidance. No further appointments were made.

Analysis of contact with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

There are a number of issues regarding RDaSH contact with Y and X. The Consultant knew that Y had stabbed X and that Y was experiencing domestic violence herself and expecting them to seek marital guidance for what were significant episodes of domestic violence was not an adequate response. There was not the level of curiosity required regarding children and fact that Y was pregnant. Given that this consultation took place in 1989 there are a number of issues that should be handled differently today which includes:

- Providing a safe environment to consult with the victim of domestic abuse and recognising the risks of interviewing them with the perpetrator in the room.
- Using a systematic approach to assess risk factors and having detailed knowledge of the process of referral to appropriate agencies. Health professionals need to work with other agencies in supporting, and providing options for, victims of domestic violence.
- Recognising that responding to domestic violence is a process rather than an act.
- Routine and selective enquiry has been introduced in some health services. Asking all patients who are using the service direct questions about their experiences, if any, of domestic violence regardless of whether there are signs of abuse or whether violence is suspected.

Given the close correlation in some patients of mental health issues and domestic violence it is surprising that the Royal College of Psychiatrists do not offer more advice and information to Psychiatrists.

RDaSH have improved information to staff since 1989 and have worked with NHS Doncaster and other NHS providers to establish a Domestic Abuse Policy, which was implemented in January 2011.
The key principles of the policy are underpinned by the DOH publications 'Responding to Domestic Abuse – A Handbook for Health Professionals' and 'Improving safety.

Developments in the Trust include:

- Identification of a Lead Professional for Adult Safeguarding- They are responsible for attending the scheduled MARAC, soliciting and disseminating information in support of the process and offering appropriate advice to Staff regarding disclosures of domestic abuse that may form the basis of a MARAC referral.
- Identification of a Domestic Abuse Champion
- Development, implementation and evaluation of training in line with agreed policy.

The Trusts performance in relation to patient safety and safeguarding is also monitored by Care Quality Commission.

Conclusions

Domestic violence is a major public health problem because it is common and associated with physical and mental health morbidity. It is more common in mental health patients but is

under detected by mental health professionals. Routine enquiry increases detection but needs to be introduced in the context of comprehensive training, and only where referral and care pathways have been developed. High-risk patients should be referred to multi-agency risk assessment conferences for multidisciplinary assessment and safe management.

2.3.5 Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBFT)

Doncaster and Bassetlaw Hospitals NHS Foundation Trust is a first-wave foundation Trust, being one of just ten Trusts in the country awarded Foundation Trust status in 2004. It provides services at five hospitals and in a number of community locations, for a population of over 410,000 people in the areas covered by Bassetlaw District Council and Doncaster Metropolitan Borough Council, as well as from parts of North Derbyshire, Barnsley, Rotherham, and north-west Lincolnshire.

The Trust has achieved Three Stars each year since the introduction of the Government's "star ratings" system and has featured consistently in the list of the Top 40 Hospitals. In 2011 following new ratings by the Care Quality Commission (CQC), the Trust was classified as excellent for quality of services and good for use of resources. The Trust is represented on the Safer Doncaster Partnership Board, the Domestic and Sexual Abuse Theme Group and at the Multi Agency Risk Assessment Conferences (MARAC). The Trust Board is provided with assurance with respect to Domestic Abuse policies and procedures via the annual safeguarding adults and safeguarding children and young people reports.

Summary of Involvement of Doncaster and Bassetlaw Hospitals NHS Foundation Trust - November 2005, to 18 December 2011.

The IMR author examined records for Adult X from 1994 to December 2011. The records identify X accessed health care provided by Doncaster & Bassetlaw Hospitals NHS Foundation Trust both before, and during the period covered by this review, though contact throughout the review period was minimal. All previous contact with X pre-dated 2004.

Service provision and involvement with X and Y

X

For the purposes of the IMR, the records have been carefully reviewed by the IMR author and the following contact established.

- Attendance at A&E in July 2009 with shoulder pain following a fall. X himself gave the history, but it is not documented how the fall had occurred.

[redacted]X had no further contact with the Trust for 2 years, until August 2011 [redacted]

- X's final contact with Doncaster & Bassetlaw Hospitals NHS Foundation Trust was on 18.12.2011. He arrived by ambulance in the Accident and Emergency department at 23.16 hours. A&E records indicate that on arrival in the department, X was fully conscious and alert. Despite being given appropriate intervention and treatment, his condition deteriorated and died.

Y

Y accessed Health Care provided by Doncaster & Bassetlaw Hospitals NHS Foundation Trust both before, and during the period covered by this review. Contact throughout the review period was minimal and all previous contact pre-dated 2002.The IMR author being Aware that Domestic violence can start, or escalate during pregnancy examined Y's maternity records to establish if there was any indication or disclosure of domestic violence or concerns.
For the purposes of the IMR, the records have been carefully reviewed by the IMR author and the following contact established.

[redacted]

[redacted]

[redacted]

[redacted]

Analysis of involvement

The IMR author's opinion is that from information contained within the health records and from review of expected policy and procedure at that time that the agency's involvement was in line with regional and national expectations.
The IMR author identifies that there is no indication that domestic violence was identified as a feature of the family's experience with any contact with the Trust services. The records do not include any indicators that should have resulted in suspicions of any domestic violence issues such as repeated attendances to A&E with injuries, disclosures of violence or suggestions that there were control issues between the partners, during any of the contacts for X or Y.

Service issues and developments

The IMR author has examined procedures and practice at the Trust at the time of Y's pregnancies in 1989 and 1991, and identified that it was unlikely that routine questions would have been asked about domestic violence as part of ante natal care at that time. Whilst Y it is felt would have opportunity to disclose any such abuse, the question would not have been directly asked of her. Knowledge regarding Domestic Violence at that time was also said to be limited.
There is now a greater awareness of the increased risk of Domestic Abuse starting, or escalating during pregnancy and current policy within the Trust includes routine questioning relating to domestic violence of pregnant women at three points throughout the pregnancy. This happens initially at the first booking appointment, then again at 28 weeks and 36 weeks gestation.

There have been various ongoing awareness raising and educational initiatives within the Trust aiming to improve staff knowledge and practice since that time. There is a commitment within the Trust to develop best practice relating to Domestic Violence.

With respect to improving the public's knowledge of the role of health staff in supporting victims of Domestic abuse, information about Domestic Abuse and how to report it is on display in several areas across Trust's hospital sites including A&E, Maternity wards and Outpatients, Antenatal Clinics, and General Outpatient areas.

A&E department

The IMR author established that X and Y made a number of visits to A&E during the review period. Their records all indicate that the injuries were consistent with the explanations given by them, and A&E staff raised no concerns of inconsistencies. It is recognised that people who experience domestic violence can access health care more often than those who do not. However neither X nor Y demonstrated an excessive number of contacts and the accounts of events were consistent with the injuries sustained. The frequency of the visits, (3 attendances in 3½ years for Y, and 2 within 18 months for X) was not excessive, and would not have raised any concerns with Accident and Emergency staff. Therefore, the author proposes opportunities to undertake risk assessments were not missed as they did not present. Equally, as X and Y did not present with indications of domestic abuse, there was nothing to trigger signposting them to other supporting agencies.

Currently most UK emergency departments (including Doncaster and Bassetlaw Hospitals NHS Foundation Trust) conduct screening on the basis of an index of suspicion (selective enquiry) – they only ask about domestic abuse if the health care professional identifies factors that are suggestive of domestic abuse. However, routine screening of patients within a set criteria (e.g. over 16 and female) has been shown to significantly increase detection rates (Olive, 2007).

A&E is expected to respond to allegations of domestic abuse from men as well as women and children. They are taught and expected to question people if it is suspected that the injury/reason for attendance at A&E is related to domestic abuse. They are expected to provide information and signposting to relevant support services and to safeguard children and vulnerable adults according to Local Safeguarding Children and Safeguarding Adults procedures

Training

The Trust's Safeguarding training programme includes Domestic Abuse training at level 1 and level 2 training, and this is also included within corporate induction. Staff are informed that training at level 3 can be accessed via the Local Safeguarding Children Boards and staff groups such as midwives, A&E staff and other staff groups working with adults, children and families are encouraged to access other relevant training, such multiagency risk assessment and MARAC training.

There was no indication throughout the review period that there were issues relating to staffing supervision, nor that there was a need for involvement from Senior Management relating to the care of X & Y.

During the period of the review and currently, staff within the Trust work to the guidance stipulated within the National Domestic Violence Guidance, relating to input with individual domestic abuse cases, routine questioning within midwifery services and care of children living in families where domestic abuse is a factor. *(Responding to Domestic Abuse: A Handbook for Health Professionals* DoH, Dec 2005). An internal Trust policy in respect of Domestic Abuse is currently being written and it is anticipated that it will be circulated for final consultation during April 2012. The content will meet requirements outlined within the Local Safeguarding Board procedures for Doncaster and Nottinghamshire for both adults and children

During the period of this review, the Trust has contributed to relevant Domestic Violence forums within the catchment areas covered in order to develop practice and knowledge. At the current time, the Trust has a Named Midwife for Safeguarding, who has the Lead role for Domestic Violence. Her role is to ensure that training and practice relating to Domestic Violence meets relevant standards and guidance.

The Trust is represented at the MARAC (Multi- Agency Risk Assessment Conference) within Doncaster and has a named contact for MARAC within Bassetlaw. Doncaster and Bassetlaw Hospitals NHS Foundation Trust has signed up to the Information Sharing Protocol. This ensures that relevant information is shared between the Trust, and other organisations within

the MARAC process in order to protect and maintain the safety of victims of domestic abuse and their families.

Additionally, the Trust has representation at the local MAPPA (Multi -Agency Public Protection Association) meetings and is committed to information sharing with this forum as required.

Based on the information contained within the health records, the author
believes neither individual appeared to have specific vulnerabilities and there are no equality and diversity issues raised.

Conclusions

This review has demonstrated that there was no indication of domestic abuse by either of the subjects of this review, nor was domestic abuse suspected at any stage during the contacts with Doncaster & Bassetlaw Hospitals NHS Foundation Trust. Equally, whilst information obtained does not particularly demonstrate areas of good practice, nor does it highlight are there any specific lessons to be learned relating to domestic violence practice.

2.3.6 Doncaster Metropolitan Borough Council – Adult Services (Assessment)

Doncaster Council Adult Services (Assessment) undertakes a Community Care Assessment for anyone in Doncaster who presents with physical care needs and assessment for home adaptations or equipment. Any individuals over the age of 18 years can make a self referral to the service via the Adult Contact Team. Anyone requesting equipment or adaptations to their home can be seen by an appropriate team of Occupational Therapists and other trained workers. Following discussions about their concerns or difficulties the individual will be offered an assessment via a district team, or signposted to the appropriate service. There are 5 district assessment teams in Doncaster and additionally teams based within the Doncaster hospitals.

Service provision and summary of involvement with Doncaster Council Adult Services (Assessment)

In July 2004 X had [redacted] following an accident. He visited the Doncaster Council Adult Services offices in August 2004 to request assessment for a walk in shower and something to make the stairs more accessible. His mobility problems were impacting on his ability to climb stairs when his leg was painful. X was advised by the duty officer that the request would be forwarded for assessment and he collected an application form for a blue car badge and was having contact with DIAL to assist him in claiming DLA Mobility. He was issued with a radar key to enable access to public toilets for people with disabilities.
The next contact was in August 2006 two years after his initial contact when he was visited by an Occupational Therapist to assess his present care needs. He is described as [redacted] who is fully independent and mobile over long distances. X had privately adapted his property but informed the OT that he would find a downstairs toilet useful. The Occupational Therapist assessed X was able to climb the stairs independently.

The Occupational Therapist was informed by X that he was due to have further surgery and would be wheel chair dependent for several months following discharge but should become fully independent again. After discussing the case with colleagues it was decided that X was not eligible for home adaptation.
There are no further recorded contacts with X. There is nothing to suggest any family issues were discussed or signs for concerns or that Y was involved in decision making.
There has been no contact with any other member of the family between the stated dates to present day.

Analysis of Doncaster Council involvement

The Doncaster Council Adult Services had limited involvement with X and from the information reviewed by the IMR author it would appear that the workers followed the correct policy and procedure for the request X made to the department. It is not the purpose of this review to make comments about service provision that is not related to DHR however a two year waiting list for access to services to address the care needs of an individual with disabilities is not acceptable. Major changes are said to have been made to reconfigure and improve this position. The IMR author identifies that there is no evidence to suggest that the service had any suspicion or knowledge of any untoward incidents occurring in this household.

Conclusions

The IMR author identifies that whilst procedures and guidance for safeguarding vulnerable adults and a robust training plan for these procedures exist there is a requirement for further training and Awareness around Domestic Violence issues for staff.
In section two of the report issues associated with the impact of disability on relationships are described. [redacted]. Assessment by Doncaster Council Adult Services should consider the impact of disability on relationships from both the disabled person's perspective and the carer

2.3.7 Doncaster Metropolitan Borough Council – Children's Services

Summary and analysis of Involvement of Children's Services from November 2005 to December 2006.

There are indications from the South Yorkshire Police IMR that referrals were made to the Children's Services in 2005 and 2006 as a result of contacts with X and Y where incidents of domestic violence had occurred and children were present in the house. It has not been possible to trace the records of the children who would have been 16 and 14 in 2005. Conversations with ALW and MW indicate that they were never seen by a social worker or anyone else to discuss the domestic violence that was occurring or about their own personal safety. The Ofsted assessments of the Children's Services at that time are described at section 2.1.5. It is within the context of a service that at the time was assessed as poorly performing that it has not been possible to find any records of the referral made by the Police being actioned which is supported by the interview with the children. Discussions with

professionals who worked in the service at the time or in partner organisations identifies that it would have been unlikely that the service would have responded given the high level of domestic violence referrals and assessment of low risk of the incident by the police. The fact that the children were 16 and 14 is also thought to be a reason why the referral would not have been actioned. X and MW were children and required their case to be risk assessed in the same way as younger children.

The risks of harm to children caused by domestic violence are recognised in the amended definition of harm in the Children Act 1989 which includes 'impairment suffered from seeing or hearing the ill treatment of another' (Adoption and Children Act 2002).Significant and growing numbers of children living with domestic violence are being referred to statutory services, along with concerns about child abuse and neglect. However, children's experiences of domestic violence are more than a child protection issue and require effective identification and action form professionals across education, health, welfare, civil and criminal justice.

2.3.8 South Yorkshire Police

Summary of Involvement of South Yorkshire Police from January 2008 to June 2011

The IMR Author has conducted an extensive review of police records for the identified period and returned to review them further as chronologies from other IMRs were presented. Throughout the DHR chronological period the police had a number of contacts with the X and Y. There were three significant contacts:

- On 6th November 2005 when the police were contacted by Y. She told the call-handler that her husband was being abusive and had held her by the throat. Shouting could be heard before the line was then cleared. The caller was re-contacted and informed the call handler that she had two children in the house and that she was upstairs in the family home: her husband was downstairs. She stated that he had been shouting at the children but had not been violent towards them. She added that it had 'been going on for a lot of years but she has never reported it as she has nowhere to go'. She also stated that he had been drinking.
  Officers were dispatched to attend the property. They arrested X to prevent a breach of the peace but stated that other than this, there were no injuries to Y or other offences. A domestic violence form was submitted by the officers who attended the incident which was shared with the Public Protection Unit.

- On 5th November 2006 a call was received from one of X and Y's children who told the call-handler that [redacted] dad was hitting her mum. The line then cleared. The call-handler phoned the number back, this time speaking to Y who stated that her husband 'goes off on one every so often and it scares the children'. She told the call-handler that she had been drinking. On arrival at the incident; Y showed them red marks to both sides of her neck and redness to her chest area. She stated that X had tried to strangle her. She also showed them items of clothing that had been ripped. As a result of what Y had disclosed, X was arrested for assault and was conveyed to the police station where he was interviewed. He was later cautioned for the assault

on his wife. A domestic violence form was submitted by the officers who attended this incident, which was shared with the Public Protection Unit.

- On 18th December 2011 police and paramedics were called to Y's home address. Y told the call-handler that she had stabbed her husband in self-defence. When officers arrived at the house, X was still conscious but bleeding heavily from a wound. Y was immediately arrested on suspicion of assault. Later that evening Police were contacted by the hospital and informed that X had died from his injuries. Y was therefore re-arrested on suspicion of murder. Following the call to this incident, which was clearly serious from the outset, CID were immediately involved, Scenes of Crime were called, the scene of the incident was cordoned off and searches were carried out. This culminated with the arrest of Y and subsequent murder charge.

Analysis of involvement

The IMR author identifies that all policies and procedure were correctly followed. In all cases, the individual contacting the police was listened to and options discussed. There were no racial, cultural, linguistic or religious issues apparent in any of the reports. There was no requirement for inter-agency working in any of these contacts. The IMR assessment is that there are no lessons to be learnt from the review related to South Yorkshire Police practice.

6th November 2005

The IMR author identifies that following the report of the domestic incident in November 2005, police swiftly attended the address and took positive action in that X was arrested and removed from the property. A domestic violence form was submitted by the officers who attended the incident, which was shared with the Public Protection Unit. The domestic violence form at that time was the CID 170: this form pre-dated the current CMS 11 procedure and current risk assessment tool. In terms of the action taken with regard to the children, it is clear from records that a referral was made to Children's Social Care. There is no indication of follow up of the referral which would not have been unusual at this time.

The IMR's author's opinion is that the correct course of action was taken at this incident: there were no injuries according to Y and no other crimes committed. The option therefore for the attending officers was to remove X from the house using breach of peace powers, which they did. They ensured that they informed the PPU of what had taken place and also that the information was shared with social care in respect of the children being present in the house.

5th November 2006

With regard to this incident, a positive course of action was taken in that X was arrested for assault and subsequently cautioned. A domestic violence form was submitted by the officers who attended this incident, which was shared with the PPU. The subsequent risk assessment that was conducted set the level of risk at standard: this was due to there only having been one previous minor incident and the presence of a minimal number of risk indicators. The level set was therefore correct at this time. Police Officers noted the presence of children in the house and on the 7th November, a referral was made to Children's Social Care in relation to thirsty was sent a leaflet in relation to domestic violence:

this was to offer her support from the Domestic Violence Officers. The IMR author identifies that the incident was dealt with correctly as officers followed protocols and procedures at that time and recognised the importance of sharing information with partner agencies.

18th December 2011

Following the death of X on Sunday the 18th December 2011, resources were committed to the investigation of his death. Y was immediately arrested and officers commenced the process of securing evidence. Y was swiftly charged with the murder of her husband and awaits trial in July 2012.

In this particular case, there were incidents of domestic abuse both in 2005 and 2006. The processes of how such abuse is handled by police has changed dramatically since that time. In 2005, the risk assessment process had not been put into place and so this incident would not have been assessed to determine the level of risk that was present. The 2006 incident was assessed by the PPU using the SPECCS+ model and graded as standard risk.

The development of procedures by 2006 meant that much more focus was placed on the victim and any potential risk that they may be under. Clearly risk levels that were set higher (i.e. medium or high) meant that more safety work would be done with the victim. The IMR author's opinion is that the level was correctly set at standard. The victim was therefore sent a Domestic Abuse leaflet as a minimum detailing how she could get further support if she needed it. The higher the risk, the more work that is undertaken with the victim. For example, those set at a medium would receive a visit from a Domestic Violence Officer, those at high would have safety planning work and be referred through to the MARAC process.

In addition, as described in section 2.5 page 15 if any such domestic incidents as detailed in this report had occurred in the present day where children are present, there is an additional tier of risk assessment that is carried out which addresses the level of risk posed to any children with referral to Social care and to the Blue Group Panel which is made up of Social Care, Education, Health, Women's' Aid and Police. The group looks at those referrals received and decides what additional action or services may be required to target particular children.

Conclusions

The IMR author identifies that police attendance at the domestic incidents in 2005 and 2006 between X and Y was in line with expected practice at that time. Each report was dealt with in the correct manner and no supervision or management was required in any decision making process. In all cases, the individual contacting the police was felt to have been listened to. Y was offered support with regard to domestic violence issues. There were no racial, cultural, linguistic or religious issues apparent in any of the reports. The children present in the house were considered and information relating to this was shared with Children's Social Care on both occasions. Following police attendance at both domestic incidents in 2005 and 2006, information with regard to the children was shared with Children's Social Care.

SECTION THREE: CONCLUSION AND LESSONS LEARNED

3.1. Conclusion

The content of this section will address the terms of reference identified in the statutory guidance and the case specific terms of reference identified as part of the review. The terms of reference are identified in bold. To reduce repetition in answering the issues raised some terms of reference have been combined.

Developing the DHR provides an opportunity to analyse information across agencies, family members, colleagues, and friends of the subjects of the review. However there is a danger, in reviewing this with hindsight, of forming conclusions that were not possible for the participants to see at the time

The DHR should:

- **Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.**

In line with the terms of reference the DHR has covered in detail the period between November 2005 and 18 December 2011, the date of the incident and agencies have provided a history and context, where relevant , from January 1988.

The IMR and the DHR authors have analysed information available and identified the lessons to be learnt from the case which are identified in detail at 3.2. An analysis of the issues has been influenced by the difficulty in gaining access to some information. For example it is not possible to analyse the children's health visiting or school records to establish if there were any disclosures made to these services about domestic violence because they have been destroyed. The IMR authors have not been able to establish which hospital X was taken to in January 1989 with a stabbing injury or if X attended an anger management course in 2005 and if issues associated with domestic violence was raised by him. Discussions with family members have not enabled us to establish the position in relation to all of these issues either.

The conclusions and lessons to be learnt have informed the development of recommendations which indicate the areas of change required to reduce the risk of a domestic homicide incident like this occurring again.

The first and most important conclusion from the review is that there is evidence provided in the General Practice, RDaSH and the Police IMRs of knowledge of domestic violence between X and Y dating back to January 1988 and that there were missed opportunities to intervene to work with the family to address their violent relationship and some of the issues that are felt to have exacerbated it such as alcohol and drug use. No coordinated response to the domestic abuse was triggered by any incident or involvement of social services or police.

Reviewing the involvement of X and Y with services from January 1988 there is evidence of Y disclosing that she was being abused to her GP and to a Consultant Psychiatrist in 1988 and 1989 and to the Police in 2005 and 2006 . X did not disclose at any point to agencies that he was experiencing domestic abuse even when he was stabbed by Y. However in 1988 Y disclosed to her GP that she had stabbed X and then in 1989 X was with Y when she told the Consultant Psychiatrist that she had stabbed him.
X and Y had no known contact with any specialist domestic abuse agencies or services.

Information known to agencies included:

GP

- 27/1/88 Y disclosed she had been punched on the left side face of her face and kicked on the right knee.
- 23/12/88 after a fight with X the night before Y had periorbital bruising. Her left eye and her left temporal region was tender.
- 3/1/89 Y presented with depression stating that she could not cope. She also disclosed that she had stabbed X 2 days previously.
- 10/2/89 Y had been beaten by X that morning who had punched her in the face with the resultant injuries of a small cut under her left eye, periorbital bruising and tenderness right eye tender upper part of stomach.
- 2/12/89 Y presented with anxiety symptoms and marital problems with her husband. Her baby would have been 2 months old.
- Y feeling stressed in 2007 to the Smoking Cessation Adviser. It was recorded that Y's alcohol consumption increased from 1 unit per week in 2007 to 14 units per week in 2011.
- X in 2005 reported being angry since his accident and referred for an anger management programme.

RDaSH

[redacted]

Doncaster Council Children's Services

- referrals were made to the Children's services in 2005 and 2006 as a result of contacts with X and Y were incidents of domestic violence had occurred and children were present in the house

Police

- On 6th November 2005 when the police were contacted by Y. She told the call-handler that her husband was being abusive and had her by the throat.

- On 5th November 2006 a call was received from one of X and Y's children who told the call-handler that [redacted] dad was hitting her mum. Y stated that her husband 'goes off on one every so often and it scares the children'.
- X was arrested twice and removed from the marital home and cautioned about his violent behaviour.

The Family

- **Whether family, friends or colleagues were Aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.**

- **Whether there were any barriers experienced by X or his family/ friends/colleagues in reporting any abuse in Doncaster or elsewhere, including whether he knew how to report domestic abuse should he have wanted to.**

The children and extended families of both X and Y were aware of the volatile and violent nature of the relationship between them. A and M experienced this situation throughout their childhood and adolescence. They attempted in 2006 to get help by contacting the police during one incident. Discussions with them identified that they were never seen or spoken to by Children's Social Care or the Police.

The children of X and Y were able to inform the panel that:

1. Domestic violence had happened over a long period. They frequently took shelter in the bedroom with their mother Y or escaped to their grandparents (Ys parents). They were never the subjects of physical violence themselves. They never discussed it with any people other than Ys family and the police.

2. Both children had made calls to the police for help during incidents of domestic violence.

3. They were never seen by a social worker or any other service to discuss the domestic violence between their parents. They would not have wanted to be removed from the family but wanted help to resolve the situation. They wish that someone had intervened earlier to help them as a family.

4. They never discussed it at school or with friends because they were so ashamed that it was happening.

5. Domestic violence incidents were said to be frequently fuelled by alcohol and in the case of X cannabis. M felt usually X started the violence and A felt that it was 50:50.

X's sister met with the review author and Crime and Re-offending Manager she identified that :

1. X was the youngest of 4 children. He was 25 when he got married to Y. He was liked by everyone and enjoyed life. He worked all of his [redacted] Following [redacted] he had some difficulty adjusting but adapted very well.
2. X and Y always went out together.
3. X's family felt more isolated from him as it was difficult for them to visit their home. Y was very close to her own family. X's sister reflected that there were social differences between the families which made it difficult for them to socialise together.
4. She never saw any physical violence between X and Y but witnessed the arguments that could arise particularly when the couple had been drinking. Most of arguments she feels were fuelled by alcohol. X also smoked cannabis.
5. She is aware of injuries to X that occurred she believes as a result of violent episodes which included:

    - 1989 when her father took X to hospital after being stabbed by Y.
    - X's arm being cut by a knife by Y.
    - X's was hit in the face by Y [redacted].
    - Scratches to his arms.
    - Windows smashed and furniture broken.
    - Tension being created between the two as a result of the behaviour of M.
    - Alcohol triggered aggression.
    - X's sister never saw any injuries on Y.

It is clear that the families were aware of the violent relationship between X and Y and were not aware of what to do to get help. They were also aware that neither Y nor X would have contacted domestic violence services. The children both said that they did not tell anyone because they were ashamed. Xs sister also said that X would not have sought help as he would have been too ashamed to admit that he was being abused by a woman. [redacted]

- **Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.**
- **Whether there were opportunities for agency intervention in relation to domestic abuse regarding Y, the alleged perpetrator that were missed.**

The GP and Consultant Psychiatrist did not recognise the severity of the incidents at the time of their consultation with Y and X and did not make appropriate referrals and the police categorised the incidents in 2005 and 2006 as standard. Y and X were long term victims of

domestic violence and Y made disclosures that should have been referred to the specialist domestic violence service available at that time for her to receive required support.
If their situation had been assessed at higher risk, then more support would have been provided for them. For example, those set at a medium would receive a visit from a Domestic Violence Officer, those at a high would have safety planning work and be referred through to the MARAC process. There were opportunities to better address anger management and alcohol issue both individually and for them as a couple.

The question is would the disclosures made by Y result in the same level of response now and there are indications from the IMRs that they would.

If the Police and Children's Social Care had been Aware of the history of domestic violence then it should have resulted in a higher risk scoring. The only situation after that that would have resulted in higher scoring is further incidents or one that resulted in greater physical harm.

If X had have survived then the IDVA service was likely to have become involved and the level of intervention that had been required over many years provided. There are many factors that will cause a case to be categorised as high risk. On occasions these factors may be present in isolation and in other cases multiple factors may be present, but each case must be taken on an individual basis and its own context

Doncaster, as identified earlier and in common with many areas across the country, and CAADA nationally, has taken a high risk approach to domestic violence which as a result makes it more difficult to intervene earlier in cases. It would be preferable for there to be a single point of referral that provides a multi agency consistent systematic risk assessment determined by need to promote earlier intervention and a common basis for action. The implementation of a multi-agency co-located team would represent a significant step forward in Doncaster's response to domestic abuse and continue to transform outcomes for domestic abuse victims.

Most of the contact that X had with agencies was with universal services: mostly health services and mostly related to his occupational injury. There is no evidence that X was experiencing domestic violence in his relationship in his GP records. There were opportunities to explore if X had been experiencing domestic violence but from the information that is available it is likely they are not significant in this case. Nonetheless, they should inform changes in service policy and procedures and practice.

- **The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation**

The family are all white British. All of the IMRs considered issues associated with equality and diversity, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
There were issues associated with Xs disability and the lack of consideration of its impact on relationships.

Doncaster has undertaken publicity campaigns to better address the needs of male victims but as with many other areas of the country there is a lack of help and support available for male victims of domestic violence. There is a lack of understanding amongst society and emphasis in Government and local policy. The effect of this culture on male victims is that they remain invisible as they are reluctant to get help because of the humiliation and ridicule they may experience. Men are also unlikely to view their own victimisation as either domestic violence or a criminal assault, and so are unlikely to seek help.

This lack of recognition for male victims of domestic violence means they have to cope without any help, support and guidance. This links back to the taboo nature of the subject where men do not want to be identified as victims of domestic violence this results in repression.

Family concerns

Discussions with family members also identified some consistent issues regarding the support they required following the death of X. They are concerned by the lack of consideration of them in relation to:

- the police's handling of informing them of X's death.
- delayed access to view his body
- access to information.
- support services.
- taking of statements from them whilst they were shocked.
- feeling of intimidation at court hearing

Doncaster Safeguarding Children Board. (DSCB)

There are issues that arise from the DHR which need to be considered by Doncaster Safeguarding Children Board. They are associated with the referral made by the police in 2005 and 2006 which did not result in contact by the Children's Social Care leaving the children at risk potentially and resulting in a missed opportunity to talk to the children and to work with the family. Doncaster Children's services have undertaken as described earlier a number of significant reviews and reconfigurations to improve performance. The service is left with a legacy of cases that were misjudged and poorly case managed. The previously described changes in the process of risk assessing referrals of children in domestic violence cases should have addressed this issue for the future. However as identified there is evidence that the significant numbers of referrals are resulting in delays in assessing referrals. DSCB should assure themselves that this issue is reviewed and addressed.
The changes that are taking place in Children's Social Care Services as a result of the introduction of initiatives such as Integrated Family Support Service and Multi Agency Safeguarding Hubs provides an opportunity to establish a coordinated response to children experiencing domestic violence.

- **The review should identify any training or Awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services.**

Local policies and procedures generally reflected National Guidance. The picture is mixed in relation to organisations applying them and working effectively with other agencies. A major issue appears to have been embedding policies into practice and leading and managing change. Some of these issues relate to staff having in place appropriate education and training and others to auditing practice. Current Department of Health guidelines state that the successful implementation of policy and guidelines for domestic abuse relies on a comprehensive education and training programme. All staff who have contact with patients should be trained in domestic abuse issues – this includes administrative and reception staff (DoH, 2005) [20].The Home Office in its guidance for health professionals suggests that given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post registration on-the-job training for all health professionals (Taket, 2004) [21].

There is evidence to suggest that there are issues associated with staff, particularly in the health services, not receiving the required domestic violence training. As identified in Section 2.3 of the DHR, Doncaster Metropolitan Borough Council and NHS Doncaster has developed a training strategy and is in the process of implementation. There are also indications that partner organisations need to review the position in their own organisations and some IMR authors have identified this and made recommendations to address the issues.

3.2 Lessons to be learnt

- **Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.**

- **Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working**.

1. Inquires such as Pemberton[22] and Government reports[23][24]have identified the importance of governance structures in the development of effective domestic violence service. Without a strong governance structure policy developments are not implemented, commissioning gets stuck in historical arrangements and services become disjointed with additional services added on to existing provision, more from convenience than actual

[20] Responding to domestic abuse: a handbook for health professionals. Department of Health. December 2005

[21] Should Health Professionals Screen All Women for Domestic Violence? Ann Taket, C. Nadine Wathen, Harriet MacMillan 2004

[22] A domestic homicide review into the deaths of Julia and William Pemberton. November 2008

[23] Call to End Violence Against Women and Girls November 2010. HM Government

[24] Responding to violence against women and children – the role of the NHS The report of the Taskforce on the Health Aspects of Violence Against Women and Children March 2010

planning. Domestic violence structures will need to re-configure with changes in both commissioning and provider structures taking place in Doncaster. Difficult decisions will need to be made if services are to continue to develop, funding used wisely and integrated pathways developed. The fundamental elements of commissioning domestic violence services are to ; analyse need, to have a clear strategic vision , specify what is required and to carry out an options appraisal regarding how best to achieve the required objective and to be clear about how performance is going to be managed and assessed. This is the critical strategic activity, without which it is highly likely that what is provided will not achieve the required outcome(s). Commissioning is a central feature of public service reform and the fact that there was not a clear multiagency commissioning vision in Doncaster impacted on the planning and delivery of all services during the years that X and Y were involved with services. The commissioning vision still requires clarity not least because of significant organisational restructuring and financial constraints.
Doncaster Community Safety Partnership will be challenged to adopt a more strategic commissioning role. This means understanding the needs of the community in relation to domestic violence services and leading activity to secure improved outcomes. It means being open to using the best way of securing outcomes and thinking creatively about how to get the most from available resources. The whole domestic violence structure needs to see itself not as different parts but as a whole system, working from a shared vision in which services are equitable, integrated and robustly managed. Doncaster Community Safety Partnership needs to provide strong leadership across the whole structure and all statutory accountable bodies must help articulate the vision and ensure the right direction of travel.

2. The Review[25] of current provision of services and development of a strategy to tackle domestic and sexual abuse in Doncaster has made a number of recommendations which when implemented will address most of the key issues identified in this DHR . As they relate to this case this should include:

    - A single point of accountability at strategic level and clear lines of reporting from operational to strategic groups.
    - A single point of coordination for all specialist domestic abuse work with a collocated multidisciplinary team.
    - Staff trained in *Signs of Safety* to assist professionals to work with families where domestic abuse is present.
    - Developing and maintaining front line staff's knowledge of available services, new initiatives, local challenges and sharing good practice.
    - Development of a performance management and metrics framework that will better inform operational management.
    - Addressing the high risk based approach to domestic abuse to better address early intervention and support and hard to reach groups.

[25] Review provision and develop a strategy to tackle domestic and sexual abuse in Doncaster.2012

- Review of MARAC roles and to address development needs.

- The availability of an IDVA or specialist nurse in accident and emergency department during known risk periods.

- Proactive Doncaster Alcohol services that recognise the link between alcohol and domestic violence and work to reduce risk and increase safety.

- The development of programmes to support the victims and children who have been subjected or witnessed domestic abuse.

4. The Government's action plan 'Call to End Violence against Women and Girls' 2011 identifies the importance of prevention and early intervention. Whilst the focus is on women and girls the issue equally apply to male victims of domestic violence. The action plan identifies four key outcomes:

   - *Society believes violence against women and girls is unacceptable and is empowered to challenge violent behaviour.*
   - *Fewer victims of sexual and domestic violence*
   - *Frontline professionals (e.g. teachers, doctors, police and prosecutors) are able to identify and deal with violence against women and girls*
   - *Employers recognise and support victims of domestic and sexual violence*

   There has been considerable advancement in services for people experiencing domestic violence with a emphasis being placed of people who are assessed as high risk. The action plan requires an approach that also focuses on prevention and early intervention and a coherent domestic violence service. This is different from the high risk focus in Doncaster. There is also a need to develop a model that meets the needs of male victims.

5. As identified in the DHR domestic violence is often seen as a female victim/male perpetrator issue. There is evidence to suggest that an increasing number of male victims are beginning to come forward. Help lines are reporting an increase in the number of calls they receive from men, more men are being referred by hospitals and by the police to support centres, and many men are beginning to acknowledge they are being abused and refer themselves. There remains a challenge for society and services to provide the right support to enable men to seek help without concern that they will be made to feel inadequate, humiliated or ashamed.

6. There was opportunity in the case of X and Y to evaluate their situation more effectively and to differentiate their situation from others in that they were both violent towards one another. Incidents of violence were usually fueled by alcohol. There is a value in differentiating amongst types of domestic violence in that appropriate assessment and case management processes can be developed that more accurately meet the cause of the partner violence, the context, and the consequences. Referral to Drug and Alcohol services would have enabled X and Y to be provided with additional support. In 2007 Y identified at her GP practice that her intake of alcohol had increased substantially. This can lead to better decision making, appropriate interventions and treatment programmes tailored to the different characteristics of partner violence for example the role of alcohol.

7. Recognising that responding to domestic violence is a *process* rather than an *act*, professionals need to work with other agencies in supporting, and providing options for, survivors of domestic violence. The universal services alone cannot meet all the needs of individuals experiencing domestic violence but services like GPs and the health service are uniquely placed to help change public attitudes to domestic violence, and ensure that men and women experiencing domestic violence can access services to help them change their situation. There needs to be the same rigorous and systematic approach to domestic violence as has been applied to other areas of work for example coronary heart disease. There is exactly the same need for high-quality care, early intervention and evidence-based research and practice.

8. The NHS often provides the one setting where adults or children feel able to disclose, and it is therefore imperative that the services are Aware of the need to provide safe spaces for this to happen. This applies just as much to services that do not specialise in treating adults and children who have experienced violence and abuse (e.g. primary care) as to those that do. Commissioners and providers of healthcare need to build in the time and the space for disclosure across services, paying particular attention to the privacy and safety of the relevant parts of their premises, including the need to see people who may wish to disclose violence or abuse alone. There also needs to be coordinated action by all the trusts to ensure that all staff are able to access the appropriate level of domestic abuse training.To enable robust early identification and prevention of domestic abuse there needs to be a focus on the perpetrators of domestic abuse. Health professionals are well placed to refer perpetrators to appropriate services, there needs to be acknowledgement of this in the planned development of the Health Based Domestic Abuse Services in Primary Care. The proposed restructuring of the NHS presents further challenges. During and following the transition process it is imperative that Domestic Abuse commissioning remains a priority issue within the NHS.

9. General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. As stated on page 31 this is becoming increasingly difficult because of changes to the traditional practice. It is of increased importance that GPs ensure that record keeping and clinical assessment enable the recognition of factors which, particularly in combination, may indicate that someone is experiencing or could potentially be harmed as a result of domestic violence is very important. As the contact time that GPs have with patients is limited it is important that they have a trigger list of indicators in the same way that they have for assessment of illness. These factors would include clinical matters e.g. disability, chronic health problems, mental health problems, stress, threatened suicide; and social issues e.g. recurrent non-attendance for appointments, recurrent injuries, frequent changes of address and/or GP. Systems to enable the flagging of identified victims of domestic abuse should be established.

10. Legislation in the United Kingdom requires that children are consulted about any decisions that will affect their lives (DoH 2001).Children who live with domestic violence face increased risks: the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these may lead to negative outcomes for children and may affect their well-being, safety, and stability and increased tolerance for and use of violence in adult relationships. (Carlson,

2000; Edleson, 1999; Rossman, 2001). Children's risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resilience while others show signs of significant maladaptive adjustment (Carlson, 2000; Edleson, 1999; Hughes, Graham-Bermann & Gruber, 2001). Social workers should ensure that in cases of referral associated with domestic violence that they listen and consider the situation from the child's perspective. In this case they did not see the children and talk to them to find out what they thought and felt about the issues; and take action based on this information. It is just as important to work with teenage children as with babies and young children.

11. There is professional concern about the disclosure/confidentiality of patient/client information leading to litigation. Added to this feeling of professional vulnerability is a perception of a lack of organisational support causing practitioners to feel that they are 'on their own' which escalates the feeling of risk. This can be identified from the comments made by the GP that they would not know what to do if they identified domestic violence. Having agreed policies and procedures in place assists professionals in their practice. Information about the services available to victims of domestic abuse should be included in NHS Doncaster's website and other ways of disseminating this to GPs explored.

12 Given that caring for a person with a disability can be stressful, it is important that professionals and services examine family resilience and their ability to adapt to changes in relationships. The construct of "adaptability" is particularly relevant to understanding the ways in which a family member having a disability affects families and the stress experienced by them. Part of the stress of caring is due to changes in roles, and the need to adapt to the new roles. Professionals involved in services for people with a disability should have an increased Awareness of the increased risk of domestic violence. As there was already a history of domestic abuse between X and Y before Xs amputation it should have been anticipated that their relationship would be under increased pressure.

13. Raising public Awareness of domestic violence is an on-going issue. Doncaster is well aware of this and they need to not only increase awareness for victims but also to establish collective community responsibility. The role that partner organisations, both statutory and voluntary, can play is crucial and the professionals that work in them need to act as champions to provide information to individuals and communities. Changing social attitudes challenging the norm of abuse is fundamental to prevention Evidence suggests that campaigns that target how people feel they should act are most effective. Social media also offers opportunities to campaign cost effectively.

14. Since October 12th 2009 Doctors in the UK are now required to inform the police whenever they treat a suspected victim of serious gun or knife crime. The guidance from the General Medical Council (GMC), extends the previous policy of mandatory reporting of gunshot wounds. Accidental knife injuries or those related to self-harm are not required to be reported, except in minors, when child protection issues are raised.

Overall conclusion

There is frequently an issue when examining past actions of services in recognising that some findings are a legacy of past policy, practice or organisational structures at that time. The question that has to be asked is if this situation occurred now would it be handled differently and there is evidence to suggest that in some services it would not. Universal services need to apply the same rigorous and systematic approach to this agenda as to other areas of work. There is exactly the same need for high-quality care, early intervention and evidence-based practice and for systems to be in place to identify areas of risk and to safeguard adults and children. Commitment, increased Awareness, training and education are critical for shaping attitudes and providing skills.

Doncaster has produced a number of high profile gender neutral campaigns which have impacted on the rates of referral from both professionals and the public. Changing social attitudes challenging the norm of abuse is fundamental to prevention This case demonstrates that there remains an issue about societal acceptance of domestic abuse and that there is a particular issue for men recognising they are being abused and having the confidence to make contact with services to assist them.

SECTION FOUR: RECOMMENDATIONS

Doncaster Community Safety Partnership

1. Doncaster Community Safety Partnership needs to review existing priorities for domestic violence and develop a new strategic plan which encompasses commissioning as well as delivery of services.

2. The Review[26] of current provision of services and development of a strategy to tackle domestic and sexual abuse in Doncaster has made a number of recommendations which when implemented will address most of the key issues identified in this DHR .This should include:

    - A single point of accountability at strategic level and clear lines of reporting from operational to strategic groups.
    - A single point of coordination for all specialist domestic abuse work with a collocated multidisciplinary team.
    - Staff trained in *Signs of Safety* to assist professionals to work with families where domestic abuse is present.

[26] Review provision and develop a strategy to tackle domestic and sexual abuse in Doncaster.2012

- Developing and maintaining front line staff's knowledge of available services, new initiatives, local challenges and sharing good practice.
- Development a performance management and metrics framework that will better inform operational management and practice.
- Addressing the high risk based approach to domestic abuse to better address early intervention and support and hard to reach groups.
- Review of MARAC roles and to address development needs.
- The availability of an IDVA or specialist nurse in accident and emergency department during known risk periods.
- Proactive Doncaster Alcohol services that recognise the link between alcohol and domestic violence and work to reduce risk and increase safety.
- The development of programmes to support the victims and children who have been subjected or witnessed domestic abuse.

3. It is recommended Community Safety Partnership should provide information to the public about domestic violence against men and couple violence and the appropriate action to take if they have concern about the risk of domestic violence against an individual, to enable the police or other agency to positively intervene or develop a risk management plan when they have the information to inform it.

4. The Community Safety Partnership should review the process of communicating with and interviewing procedure for the family of homicide victims particularly at the time of the death of the individual to provide consistency, support and compassion.

Doncaster Council – Adult Services, Assessment.

4. To ensure that Doncaster Council – Adult Services, Assessment have a robust and up to date training plan around Domestic Violence and ensure the workforce to have the skills and knowledge to not only identify issues around family dynamics, but how to report such findings in an appropriate and timely manner.

5. To ensure Adult Services are included in any new developments around future pathways/training/partnership working in Domestic violence.

6. To ensure the attendance of an appropriate representative to attend any future IMR Meetings.

Doncaster Council and Doncaster Safeguarding Children Board

7. Doncaster Council and Doncaster Safeguarding Children Board should assure themselves changes in the process of risk assessing referrals of children in domestic violence cases are fit for purpose.

8. Doncaster Council and Doncaster Safeguarding Children Board should ensure that the introduction of initiatives such as Integrated Family Support Service and Multi Agency Safeguarding Hubs provide an opportunity to establish a coordinated response to safeguarding children experiencing domestic violence

Rotherham Doncaster and South Humber NHS Foundation Trust

9. Rotherham Doncaster and South Humber NHS Foundation Trust having introduced the changes required to address the issues raised by the DHR have not added further recommendations.

NHS Doncaster and Doncaster Clinical Commissioning Group

10. Review current provision and knowledge and initiate appropriate training for primary care professionals to raise Awareness of domestic abuse and the current NHS Doncaster policy on risk assessment, referral and MARAC. This may need to incorporate the latest guidance on domestic abuse from RCGP ISIS and CAADA. Also included in this training would be information for practices on the Domestic Homicide Review process. Within this review there is a need to ensure that priority is given to protected education and training of primary care staff despite funding pressures. For GPs there is a recommendation that the IRIS model should be considered to provide the required level of advocacy, support and education.

11. Review current policy of feedback and monitoring of significant events in Primary Care and implementation of local policies by primary care staff to ensure that clinical governance is maintained. This could include domestic abuse, safeguarding children and adults, clinical care and interagency referrals.

12. All health service providers should be encouraged to consider the development of IT systems to enable the flagging of identified victims of domestic abuse.

13. Information about the services available to victims of domestic abuse should be included in NHS Doncaster's website and other ways of disseminating this to GPs explored.

14. DCCG and NHS Doncaster should monitor and influence practice performance of all GPs and other primary medical services in relation to Care Quality Commission essential standards covering quality and safety and safeguarding children and adults.

15. The findings of this review should be communicated to the RCGP clinical champions

Appendix 1 – Chronology – not published

Appendix 2 Glossary

A&E Accident & Emergency

ACPO Association of Chief Police Officers

BCS British Crime Survey

CAADA Coordinated Action Against Domestic Abuse. CAADA is a national charity supporting a strong multi-agency response to domestic abuse. Our work focuses on saving lives and saving public money. CAADA provides practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those at risk of murder or serious harm.

CPD Continuing Professional Development

CPS Crown Prosecution Service

DV Domestic Violence

DWP Department for Work and Pensions

IDVA Independent Domestic Violence Adviser

MAPPA Multi-Agency Public Protection Arrangements is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" of the MAPPA include the National Probation Directorate, HM Prison Service and England and Wales Police Forces. MAPPA is coordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003.

MARAC Multi-Agency Risk Assessment Conference A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

NHS National Health Service

Ofsted Office for Standards in Education, Children's Services and Skills

PCT Primary Care Trust