PUBLIC

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Domestic Homicide Review Overview Report in respect of:

Chloe

Age 34 years

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Independent Overview Author

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1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Chloe in Derbyshire in 2015. It examines agency responses and contact with Chloe, aged 34 years, and Carl, aged [redacted], prior to the point of Chloe's death. In order to protect the identity of the victim and the perpetrator in line with national guidance, the names Chloe and Carl are given as pseudonyms having been agreed with the mother of the victim. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways 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 upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

1.3 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on 13 April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being assaulted by her partner at their home. The Home Office criteria for reviews includes "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 or she was related or with whom he or she was or had been in an intimate relationship."

It is recognised that a domestic abuse incident which results in the death of a victim is often not a first attack and is likely to have been preceded by psychological, emotional abuse, coercive control and possibly other physical attacks.

1.4 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies for their contribution and for their significant time, openness and

commitment. Also to Chloe's mother for her input and willingness to share information about her daughter at this difficult time.

1.5 Domestic Homicide Review Panel Members

HDCNH/ 15 Panel Members	
Tony Blockley	Independent Chair of the Review Panel
Marion Wright	Independent Overview Report Author
Chief Inspector Malcolm Bibbings	Public Protection –Derbyshire Constabulary
Lisa Morris	Commissioner of Domestic Abuse Services- Derbyshire County Council
Bev Baker	Derby Teaching Hospital Foundation Trust
Bill Nicol	Southern Derbyshire Clinical Commissioning Group
Sandra Marjoram	National Probation Service Derbyshire
Kerry Hodges	Substance Misuse Commissioner Derby City
Christine Flinton	Head of Community Safety Derbyshire County Council
Zoe Rodger-Fox	East Midlands Ambulance Service
Lorraine Poyser	Erewash Borough Council

1.6 To reinforce the impartiality of this report it is confirmed that the Independent Chair and the Independent Overview Author are not employed by Derbyshire agencies in any other capacity and have not previously had any direct involvement in this case. Neither have they had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair is a retired Detective Chief Superintendent of Police who had responsibility for all major and serious crime including homicide. He has widespread experience in reviewing homicides, in commissioning Serious Case Reviews and has previously chaired and written Domestic Homicide Reviews. The Independent Overview Author is a retired Assistant Chief Officer of Probation with 33 years' experience. She had strategic lead for Public Protection including Domestic Abuse. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and Domestic Homicide Reviews.

1.7 Both the agency review panel members and the Individual Management Review (IMR) report authors who have provided agency evidence considered by the review are

independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.8 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake a DHR once it was concluded that Chloe had died as a result of an assault. The Home Office were notified of the decision on ██████. The first full review panel meeting took place formally within a month of that decision on ██████. Given that the alleged perpetrator, at that stage, denied the charge of manslaughter, the review process was temporarily paused until after the conclusion of the criminal trial. This eventually took place in ██████ and the outcome was that Carl was found guilty of manslaughter and sentenced to 10 years imprisonment on ██████.The review process was immediately resumed. The prosecution in the case appealed against the length of sentence and the appeal was heard on ██████. The sentence was increased by 5 years to recognise the abuse that Chloe had been subject to prior to the incidents that resulted in her death. A total of 15 years imprisonment was the final sentence.

1.9 The view of the review panel was that to interview the perpetrator and family members prior to the conclusion of the legal proceedings was inappropriate. However, any lessons to be learnt by agencies regarding practice which required immediate attention were to be taken forward by the agencies without delay.

1.10 Following the conclusion of the criminal proceedings which resulted in Carl being sentenced to 15 years imprisonment for manslaughter, contact was offered to the perpetrator and identified family members, friends and neighbours who may wish to have their voice heard within the process and who could provide insight and information.

1.11 Parallel processes included the criminal trial and the Coroner's Inquest. Liaison took place throughout the criminal proceedings and the Derby Coroner's Office was contacted by the Police IMR author and it was confirmed that there will be no further Coroner's proceedings following the conviction for manslaughter.

<u>Circumstances that led to the review being undertaken</u>

1.12 On ██████ 2015, the couple, Chloe and Carl, had been at home all day. Chloe had complained of feeling unwell and asked Carl to ring for an ambulance which he did at 21.36 hours. He reported Chloe was pale, cold and being sick.

1.13 Chloe was found by the ambulance at 21.47 semi-conscious slumped over the toilet vomiting. She was taken to hospital with Carl in attendance. Chloe went into cardiac arrest on arrival at the hospital. Sadly, all attempts to resuscitate her were unsuccessful and she was pronounced dead at 22.54.

1.14 A routine post mortem was commenced on [redacted]. This examination was halted upon the discovery of a large amount of blood in Chloe's stomach. A Home Office pathologist was appointed to carry out a post mortem which identified that death was not due to natural causes but due to trauma to the abdomen and internal structures.

1.15 Carl was arrested on suspicion of the murder of Chloe. He was interviewed and subsequently bailed pending the outcome of further pathological investigations. The findings of the Home Office Pathologist were that the fatal injuries to Chloe were consistent with her having been assaulted. Carl was subsequently charged with manslaughter.

Scope of the review

1.16 The scope of the review will include information available on Chloe the victim, Carl the perpetrator/victim's partner between 01 January 2001 and [redacted] which is the period covering their relationship. Information in relation to Carl's previous partner is to be considered only so far as it relates to her association with Carl and any previous concerns re domestic abuse. However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their IMR. As well as the IMRs, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR), whether internal procedures were followed, whether on reflection they were considered adequate, arrived at a conclusion and, where necessary, made a recommendation from the agency perspective. Quality assurance was provided for IMRs by individual commissioners and within the review panel by the Chair and Report Author. The review panel analysed the IMRs for themes and issues which were discussed in a meeting.

Terms of Reference

1.17 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed:-

1) Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?

2) Was the victim subject to a MARAC?

3) Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)?

4) Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)?

5) Did the victim have any contact with a domestic abuse organisation or helpline?

6) Did anyone in contact with the victim know whether or not the victim was aware of domestic abuse services available locally? If yes but not used, were there any barriers to the victim accessing these services?

7) How should friends, family members and other support networks and, where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

8) How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for this?

9) Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult'. The term vulnerable adult was subject to change under the Care Act 2014 and is now termed Adult at Risk.

10) How will the Review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

11) How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

12) Were there any issues in communication, information sharing or service delivery, between services?

13) Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

14) What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator. What was the quality of any multi-agency assessments?

15) Was the impact of domestic abuse on the victim recognised?

16) Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

17) Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

18) Could the homicide have been anticipated or prevented?

Methodology

1.18 The Review Panel was convened by the Derbyshire Community Safety Partnership (CSP) and included representatives from the relevant agencies and the Independent Chair and Overview Report Author. The Review Panel commissioned a chronology and IMRs from each agency. Family members, friends and neighbours together with the perpetrator were contacted to make a contribution.

1.19 A total of four meetings were held with the Review Panel. The first was to consider information available and agree that a DHR was appropriate, to agree the Terms of Reference and commission the IMRs. The second was to consider the information contained in the IMRs, to identify gaps, and to seek further information as appropriate. The third meeting was also attended by the IMR authors and enabled agencies to present their information and give time for others to ask questions and make comment. The fourth meeting considered the draft overview report and ensured that it fairly and accurately represented the information of those agencies that contributed.

1.20 In order for agencies to prepare their contribution they were asked to consider contact and practice in providing a service measured against agency policy and procedures and to identify any shortfalls or indeed where current policies or procedures required improvement. Agencies sourced and reviewed a range of information from a variety of systems and interviewed some staff shown to have had direct involvement with Chloe and Carl.

1.21 The agencies completing IMRs and the profile of their involvement with the individuals were as follows:-

Organisation	Author	Involvement
Derbyshire Constabulary	Lloyd Young/ Tony Webster Regional Review Unit	Responded to 999 calls on 22 occasions many of which related to initial allegations of assault of Chloe by Carl.
National Probation Service Derbyshire	Sandra Marjoram	Responsible for preparing court reports and supervising Carl and Chloe on Community Orders and Carl on post release licence from prison.
East Midlands Ambulance Service	Clair Henley	Responded to emergency calls made in relation to Chloe or Carl on at least 19 occasions.
Nottingham University Hospitals NHS Trust	Bella Furse	Queens Medical Centre provided a service to Chloe relating to 5 different incidents, the 5th, sadly, being the occasion on which she died.
Derby Teaching Hospital Foundation Trust	Bev Baker	Provided services to Chloe during the scoping periods in relation to 9 overdoses, various injuries as a result of assaults or alleged falls. Medical concerns relating to

		poor liver function and alcohol related illness.
South Derbyshire Clinical Commissioning Group	Ed Ronayne	Provided GP services for both Chloe and Carl for scoping Period.
Derbyshire Healthcare NHS Foundation Trust Specialist Community Alcohol Misuse Service	Helen Pooley	Provided specialised Community Health Misuse services Feb 2007 - Nov 2007 Oct 2011 - April 2013
Addiction Dependency Solutions	Chris Judge / Gary Oulds	Regular attendance and engagement in services by Chloe 18/10/2010 - 15/09/2011.

A Summary Review Report was received from:-

Derby Homes : property owned by Derby City Council	Graeme Walton	Provided housing accommodation from 17/09/ 2001 - 15/03 2015
Erewash Borough Council	Lorraine Poyser	Area in which couple resided when death occurred

Chronological and Verbal Review from:-

Women's Work Derbyshire Ltd	Caroline Baker	Provided health support services June 2011- June 2012
HM Prison Nottingham	Maria Melbourne	Verbal report regarding 8 months prison sentence October 2013.

1.22 Whilst it is recognised that there were incidents of domestic abuse, no domestic abuse agencies were referred to or had any contact with Chloe or Carl.

1.23 In preparing the Overview Report the following documents were referred to:

1) The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and Revised Guidance 2016.

2) The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Authors.

3) Call an End to Violence Against Women and Girls HM Government published 25th November 2010.

4) Barriers to Disclosure –Walby and Allen 2004.

5) Incidents of Abuse before Domestic Abuse is reported to the Police – Jaffe 1982

6) Home Office Domestic Homicide Reviews –Common Themes Identified and Lessons Learned November 2013.

7) Links between Alcohol Abuse and Domestic Abuse –World Health Organisation.

8) Substance Abuse and Women Abused by Male Partners –Larry W. Bennett 1997

9) Agency IMRs and Chronologies.

10) Individual agency Internal Operational Policies and Procedures.

11) Borderline Personality Disorder. NHS Choices and Mind Mental Health Charity.

12) Alcohol and Victims of Domestic Abuse. Scottish Women's Aid.

1.24 Where confidential information has been detailed in relation to Chloe and Carl, it has been gathered and shared in the public interest and in line with the expectation of the National Guidance for the conduct of DHRs.

1.25 The victim's parents and friend were contacted offering them the opportunity to contribute to the review and the perpetrator and his parents were also written to in relation to contributing to the DHR process; four neighbours were also written to. Once the draft Overview Report was completed, the families and the perpetrator were contacted again to offer the opportunity to consider the Overview Report and comment on the content prior to publication. As a result, interviews were undertaken by the Independent Overview Report Author with the victim's mother.

1.26 Subjects included in the scope of the DHR:-

Victim Chloe – Partner of the perpetrator.

Perpetrator Carl – Partner of the victim.

Previous partners of the perpetrator only in relation to relevant domestic abuse information.

Family Involvement

1.27 [redacted]

1.28 The Panel would like to thank Chloe's mother for her contribution to the review and for her help in achieving a greater understanding of the nature of the relationship between Chloe and Carl and also greater insight into Chloe's life.

1.29 Her mother confirmed Chloe's behaviour was difficult to manage when she was in her mid-teens and following increased family disruption she was asked to leave home. She went to live with her friend and her family who lived next door to her step grandparents so her mother was able to maintain an awareness of Chloe's situation.

1.30 Chloe's mother referred to Chloe's ability to care for others and her particular skill in caring for the elderly and infirm. Chloe was a carer in the local hospital where she was well respected. Her alcohol use leading to increasing ill health prevented her from continuing to work.

1.31 Whilst her mother was not aware of the extent of DA that was present in Chloe's life, on reflection, she had identified the presence of Carl's controlling behaviour. Examples of this included Carl persuading Chloe not to take her mood controlling drugs even though they improved her feeling of wellbeing as Carl had convinced her they would poison her body.

1.32 Her mother visited her at home with Carl on one occasion. The front door was locked and the back door was inaccessible. Chloe had to get Carl to use his key to unlock the front door. With hindsight, her mother felt Chloe was not free to come and go at will. Her view of Carl's controlling behaviour was reinforced as when Chloe asked her Mother for a lift to the shops Carl insisted on accompanying her, possibly to monitor and control the conversation.

1.33 When Chloe intimated she could not continue to live in her flat due to the disturbances, her mother had wanted her to move into independent accommodation near her and not to move in with Carl. Chloe was reluctant to ask Derby Homes for a transfer feeling they would be unsympathetic as she felt she was an unpopular tenant.

1.34 When asked, as part of the review, what more agencies could have done to protect Chloe from domestic abuse, her mother felt Derby Homes could have assisted Chloe more with a move. However, this review has identified Chloe had not explained to Derby Homes about the noisy neighbours or asked about a tenancy transfer. She terminated her tenancy without any discussion with Derby Homes and did not leave a forwarding address.

1.35 Her mother also shared that Chloe had confided in her that she felt some of her GPs could have been much more helpful to her situation. It is unclear what prompted Chloe to feel this. Her mother felt Chloe was very sensitive to disapproval and any slight or form of rejection and once she perceived agencies as negative towards her, she would not seek their assistance. This was no doubt, in part, due to her feelings of low self-esteem and low self-confidence brought about by her personality disorder, the domestic abuse and alcohol use.

1.36 Similarly, in November 2003, when she disclosed to the Police that she had been assaulted by Carl and later retracted, she was informed by the Police that if she continued to make allegations and then withdraw she would be charged with wasting Police time. Given what we now know about domestic abuse and Chloe this was an inappropriate comment potentially serving to create an even greater barrier to disclosure.

1.37 Chloe's mother could not identify any other learning for organisations or how organisations worked together. She shared that Chloe was devoted to her cat and this may have been a barrier to her leaving and going into Domestic Abuse safe accommodation. Her mother has taken steps to publicise information about agencies that are available to help in such circumstances.

2. The Facts

Summary of the Case

2.1 From information available, it would appear Chloe and Carl began their relationship in 2001. Carl had been married previously and had ██ children from that ████████ ████████████. Chloe and Carl were both brought up in Derbyshire and continued to live in the area.

2.2 The couple had, initially, separate accommodation but clearly spent significant time together. In October 2007, Chloe wrote to Derby Homes asking to add her partner, Carl, to the tenancy. She provided evidence to show he had been resident in the property with her since January 2006. The couple became joint tenants in November 2007 until August 2013 when Carl moved to Derby and his name was taken off the tenancy. Chloe terminated her tenancy with Derby Homes on 01 March 2015 with no reason given. ████████████ ████████. Police investigations have identified that she moved to live with Carl at his address, which was a house owned by his mother. It was to this address that the ambulance crew were called on the evening of Chloe's death.

2.3 The circumstances of the homicide were that there had been a long history of domestic abuse within the relationship dating back to soon after it began in 2001. The first recorded incident being 24 March 2002, when Carl was smashing up Chloe's home, followed by an allegation of assault by Carl in December of that year.

2.4 Police were called on many occasions by Chloe reporting having been assaulted by Carl. She often later retracted the allegation once the crisis was over. Both parties then said the cause of any injuries was Chloe falling.

2.5 Chloe had a complex relationship with alcohol which impacted upon her health. Carl had also significantly abused alcohol. These circumstances were further aggravated by mental health concerns, Chloe having been diagnosed with Borderline Personality Disorder and Carl, while not having a diagnosable mental illness, had anger related issues culminating in violent behaviour and had been a patient in a residential Personality Disorder Clinic.

2.6 On the day of Chloe's death, Carl alleges the couple had spent the day together at home. In the evening, Chloe became unwell, complained of being hot and began vomiting. She asked Carl to call an ambulance as she felt she was going to die. When the ambulance arrived she was semi -conscious and slumped over the toilet having been vomiting. She was transported to hospital where she later died from cardiac arrest. Carl, who was present at the hospital, indicated that he could not understand the cause of her death.

2.7 The post mortem revealed a significant amount of blood in her abdomen. Further examination by a Forensic Pathologist confirmed that some of the injuries were fresh and that cause of death was blunt force trauma to her colon which caused her to bleed out. The Pathologist confirmed that there were two or three separate injuries which were caused 48 - 72 hours before her death.

2.8 Carl claimed that the Thursday before her death, he found Chloe being sick. They argued and he told her to leave the house. She left and went to her natural father's house who says he found her in his porch. She told him that Carl had beaten her up. Chloe was still at the house when her father went to work the next morning, but she had gone when he returned home. Throughout the day he had phone calls with Carl during which he admitted he had lost his temper. Following investigation, Carl was charged with and convicted of the manslaughter of Chloe having consistently pleaded not guilty. He was sentenced to 15 years imprisonment.

<u>The Victim</u>

2.9 Chloe was brought up by her mother and her step-father. She had one half- brother 5 years younger than herself. She experienced difficulties in her teenage years which were reflected in her behaviour. This included excessive alcohol use and playing truant from school. She became estranged from her family when she was 16 years old and went to live with a friend. She reported having used alcohol to excess from being 13 years old and this quickly escalated into dependence. She was diagnosed as suffering from a Borderline Personality Disorder (BPD) in 2001 and has spent time receiving treatment in Psychiatric Hospitals and was prescribed on-going drug therapy.

2.10 Research suggests that BPD usually begins in adolescence. The central feature of this condition is instability. Sufferers show a wide range of impulsive behaviour, particularly those that are self-destructive, including repetitive suicide attempts, in Chloe's case, overdosing with drugs on many occasions. It is recorded she suffered chronic feelings of emptiness and helplessness.

2.11 Characteristics of BPD include:-

a) Fear of abandonment with desperate attempts to maintain relationships.
b) Marked uncertainties in major life issues.
c) Emotions that can fluctuate dramatically in a number of hours.
d) Individuals acting in a self-destructive way e.g. binging on food and alcohol.

2.12 Chloe worked, briefly as a carer in a home and completed an NVQ as a carer in the Health Service where she worked in a hospital for a period. However, she was not able to maintain employment because of feeling stressed, her erratic moods and alcohol problems.

2.13 In recent times Chloe re-established contact with both her parents and reportedly become more stable. Tragically, she did not live long enough to reap the benefits of this new found stability.

2.14 Despite some significant periods of sobriety, Chloe regularly relapsed into alcohol use. She told professionals with whom she had contact that she was very isolated and rarely left her flat, only going out to buy alcohol and food.

2.15 Her physical health was deteriorating to the point she was very unwell and she was diagnosed with alcoholic liver disease. She also suffered from asthma and on occasions from related breathing difficulties.

2.16 Having been in a relationship with Carl for 14 years, there is evidence that when they were apart i.e. two periods when he was in prison, her ability to take control of her life, undertake detoxification and make progress improved considerably, only to deteriorate when Carl became a feature in her life again.

2.17 At times of crisis and intense abuse in her relationship with Carl, she would seek help from the Police. This sense of intolerance with her situation was short-lived and she succumbed, possibly, to her feelings of the fear of ending the relationship and to the power and control which is a key feature of abusive relationships.

2.18 Chloe sustained some severe facial and head injuries as a result of being beaten by Carl and reported at different times of having been stamped upon, strangled, punched and repeatedly having her head banged on the walls and floor. There were other times when she said she fell over, and required surgery on her skull to relieve the pressure caused by

trauma to the brain. There is some evidence to support the assertion that Chloe did not fall but was assaulted by Carl. He was never convicted of any crime against Chloe.

2.19 Whilst never having been referred to Adult Safeguarding as a vulnerable adult had she been, it is the view that it is unlikely Chloe would have met the threshold for services. However, her mental and physical health, her alcohol abuse, her isolation and the domestic abuse she suffered, certainly made her vulnerable and the trial Judge commented on the fact that Carl took advantage of her vulnerabilities in order to abuse her in the way he did.

Perpetrator Information

2.20 Having been brought up in the Derbyshire area, Carl maintained contact with his parents and they continue to offer him support. ██████ Carl and Chloe were renting their house in Derbyshire.

2.21 It is recorded that Carl misused substances from the age of 12 years old. There is a history of offending behaviour from his early teens, including offences against the person, property, public disorder and possession of an offensive weapon in 2013. It is also recorded that he spent 4 months in a detention centre at the age of 14 years for a Domestic crime which was an offence of grievous bodily harm against a male relative. He had been subject to both community and custodial sentences during the scope period of this review.

2.22 He was married in 1997. ██████

2.23 The marriage ended in 2001. ██████

2.24 Carl met Chloe in the same year as his marriage ended and it would appear that his new relationship followed the same pattern of his abusive behaviour. The first recorded Police involvement being in December 2002 when Chloe telephoned the Police to report damage and then assault.

2.25 There is a long history of Carl's involvement with Mental Health Services. Probation records in 2005 refer to him having been diagnosed with a Personality Disorder. He had anger related issues and demonstrated hostile and violent behaviour. However, he was

assessed, on a significant number of occasions since 2006, as not meeting the threshold for Mental Health Services and as not having an identifiable mental illness. There are several occasions when he took an overdose and was reassessed but still was not seen as having a discernible condition amenable to treatment.

2.26 There is no reference to Carl having worked in recent years which would suggest he would have been dependent on benefits. There is reference to him becoming alcohol free at times, where it would appear his situation and his relationship with Chloe would improve and be less volatile. However it is not suggested that alcohol was the cause of any violence but it is recognised it may act as disinhibitor to the aggressor. During the scope period of the review Carl was subject to supervision by the National Probation Service. He was assessed at times as presenting a high risk of serious harm to others and especially to Chloe. He completed an Anger Management course in 2012 whilst on prison licence. He engaged well with the process, however it was considered he would not be able to implement the learning into practice in real life situations.

3. Chronology

3.1 The chronology of agency contact with Chloe and Carl is attached at Appendix A.

Synopsis of Critical Events

3.2 The chronology of contact and services provided to this couple from a large number of agencies reveals that both Chloe and Carl exhibited complex and problematic behaviour and needs from a relatively early age. This was marked by the involvement of Mental Health Services, Police, Substance Misuse Agencies and Medical Agencies to name a few. What is also noteworthy is that despite a history of domestic violence and abuse and individual agency involvement, there was an absence of any significant multi-agency assessment, action plan and intervention to manage the risk to Chloe by Carl.

3.3

27.12.2002 — The first physical assault was reported to the Police. Chloe stated Carl had punched her in the head whilst she was asleep on the sofa. Chloe declined prosecution. She had rung from a nearby telephone kiosk.

07.05.2003 — Telephone call from Chloe to the Police stating her boyfriend Carl had beaten her up. She went to hospital where it was reported she had been knocked out and records show she had bruising and lacerations to the upper lip, dental injury and she was kept in for observation.

27.08.2003 — A neighbour reported Chloe being beaten up by Carl. Police marked the case - Complainant declined to prosecute.

15.09.2003	Chloe reported assault. Carl was arrested and warned next time he would be charged. Chloe was referred to the Domestic Violence Unit. When attending hospital, Chloe alleged her head was repeatedly banged on the floor and wall. She suffered blurred vision and vomiting. Also it was alleged "he tried to throttle her ". Due to head injuries and possible dangerous discharge, she was kept in overnight. Consideration was given by the hospital to a place of safety for Chloe, however she declined Domestic Abuse team input.
01.11.2003	999 Call. Chloe said she had been beaten up by partner. She retracted and was advised by Police that she was wasting their time and could be charged.
08.01.2004	Police were called. Chloe had a knife in the bathroom. Alleged she had fallen over and hurt herself. This was used often, from this time onwards, to explain injuries and avoid implicating Carl when the Police were called.
Between February 2004 and April 2013	There were at least 16 incidents of domestic abuse where the Police were called or Chloe attended the hospital and disclosed abuse. There were also 14 incidents of Police involvement due to overdoses or suicide threats or conflict with neighbours. Most overdoses also involved hospital attendance.
08.04.2004	Chloe appeared in Court for Affray and having a bladed article and received a Community Punishment Order.
15.09.2005	Carl assaulted a constable. Received 12 Month Community Rehabilitation Order.
06.03.2007	Carl appeared in Court and was sentenced to 24 Weeks imprisonment for Affray.
18.07.2007	Chloe appeared for assault and was given a Conditional Discharge.
01.08.2011	Carl appeared at Derby Crown Court, was found guilty of Grievous Bodily Harm and sentenced to 16 months custody.
22.05.2013	Carl is arrested for Affray following running around naked with a meat cleaver. Later Chloe is found in the garden with a serious head injury which required neurological surgery. On this occasion Chloe insisted she fell upstairs. Neighbours suggested she had been assaulted by Carl. He was never charged with assault.
21.10.2013	Carl sentenced to 8 months custody for affray and possession of an offensive weapon.

███	Chloe is taken by ambulance from the home she shared with Carl to hospital and tragically dies following cardiac arrest. Following the post mortem Carl is charged with Manslaughter and convicted on ███.

Analysis of Involvement

Individual Management Reviews (IMRs)

In this section, practice is analysed and evaluated against agency policy and procedure via the IMR of each agency. Further analysis takes place in the next section directly answering the TOR questions.

4. Derbyshire Constabulary

4.1 The Police review was undertaken by the East Midlands Special Operations Regional Review Unit. In conducting the review, research was undertaken within a range of Police systems to identify incidents and contacts and to gather information. The research identified that there were 22 domestic incidents involving Chloe and Carl of varying severity, and many other events including overdoses, suicide threats, conflicts with neighbours, offences of assault, affray and malicious wounding. The reviewing officers have examined all the domestic incidents, the first dating back to December 2002.

4.2 The force operates a system of graded response in dealing with incidents. The grading given and the response provided depends upon seriousness. Information provided demonstrates incidents were generally graded appropriately and response times were good.

4.3 Eleven of the domestic abuse incidents occurred before the first Domestic Abuse Policy was introduced in May 2006.There was, already, an established pattern of domestic abuse within Chloe and Carl's relationship by this time. Prior to the Domestic Abuse Stalking Harassment and Honour based Violence (DASH) model being introduced in 2011, the Form 621 was used as a Domestic Abuse Risk Assessment Tool, designed to identify the level of risk to the victim. The 621 was electronically submitted to the Central Referral Unit where a computer risk level was generated. All risk assessments were then reassessed by trained risk assessors and risk levels could be both upgraded or downgraded.

4.4 A feature of Chloe reporting incidents of domestic abuse would be her retracting the allegation once the initial crisis was over and she then refused to make a complaint. Often Chloe was drunk when the Police arrived and Carl was often waiting outside, calmly, to give his version of events. His plausible facade was commented upon by several of the agencies who had contact with the couple.

4.5 Several of the early incidents of assault on Chloe were marked by Police as Complainant Declines to Prosecute (CDP), even those where Carl had been arrested and the Police considered prosecution for Actual Bodily Harm. In September 2003, Police were advised by the Crime Section Law Clerk that it would not be in the public interest to pursue the complaint even though Carl admitted slapping her; however, he also claimed that Chloe had assaulted him. On this occasion, the custody sergeant gave Carl a warning that he would be charged next time and the case was marked Complainant Declined Prosecution.

4.6 In August 2004, Carl was again arrested for assault on Chloe. Once the crisis had subsided she did not wish to pursue matters. The Police consulted with the Crown Prosecution Service (CPS) regarding pursuing the matter regardless of Chloe's stance. However, the decision in liaison with the CPS was not to proceed with the assault on Chloe. Instead, Carl was charged with an assault on a Police Officer by spitting.

4.7 The first form 621 was completed in January 2006 in line with the introduction of the first DAP and the risk was considered to be standard. Of the following twelve incidents, ten, correctly had Form 621 assessments completed. One incident had no assessment and one incident had a Form 621 completed but with no risk assessment. Seven had standard assessments which was defined as" The current evidence does not indicate the likelihood of serious harm being caused". Three were considered medium risk which was defined as "There are identifiable indicators of the risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances e.g. failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol abuse.

4.8 Between September 2005 and September 2006, Carl was subject to supervision by the Probation Service on a Community Rehabilitation Order for assaulting a constable by spitting. The Probation Service was concerned about the risk Carl presented to Chloe and others. They called a risk strategy meeting with the Police and he was assessed by OASYS, the Probation Assessment System, as being high risk of serious harm to Chloe and the public. He was subject to high risk meetings until September 2006. Despite the high risk assessment, the two incidents where Police were called during this period, the risk to Chloe using the Form 621 was considered as standard. There is nothing in the IMR that suggests that the Police making the assessment were aware of the risk strategy meeting and its concerns. Risk strategy meetings were a forerunner of Multi Agency Public Protection Arrangements (MAPPA). Systems have improved and the MAPPA status would now be flagged on the Police system and brought to the attention of Police responding to calls.

4.9 Multi Agency Risk Assessment Conferences (MARAC) were introduced in 2008 where only high risk assessments are referred for multi -agency consideration and the

formation of a protection plan. The three medium risk assessments were recorded in line with policy as being referred to the Safer Neighbourhood Team (SNT) for follow up and signposting. This would have involved a visit to Chloe. However, before 2013 there was no mechanism in place to record further action taken by the SNT. There is no evidence available that this follow-up occurred in line with expectation. Investigations in connection with this case identified the process to ensure the SNT take action improved after 2013 and there is now a tasking system in place. However, this requires attention to make it more robust and a clear process needs to be developed that can be subjected to audit to ensure all medium referrals are visited prior to the incident being closed.

4.10 The incident of 22 May 2013, where Carl was convicted of Affray, after running around the neighbourhood, naked, with a meat cleaver was a missed opportunity to also charge him with assault on Chloe. She received facial injuries and a serious head injury that required two operations. Chloe said she fell upstairs, but two separate witnesses reported that she was seen at the door with no injuries. Carl barged past her after which she could be heard screaming from inside the house and appeared a short time later with facial and head injuries. This incident was not graded as a domestic incident which was an omission. Had it been, it may well have received a high risk DASH assessment leading to a multi-agency MARAC referral where information and concerns could have been shared.

4.11 There was evidence during the review process that investigations done by the Police, following the reporting of a crime by Chloe, lacked robustness and a determination to try and protect her. Each event appears to have been viewed in isolation without the accumulative picture being recognised. Alcohol use and mental health concerns were allowed to blur the picture and detract from the domestic abuse in the form of the serious beatings that Chloe was subject to. It is likely that there was much more violence than was reported and neighbours told the Police undertaking the Manslaughter enquiry, that there were disturbances at Chloe's address on a regular weekly basis.

4.12 On occasions when Carl was arrested and showed signs of mental instability, the Police did refer him on for a mental health assessment. However, he was assessed as not showing signs of any identifiable mental illness and therefore no treatment was offered. Whilst Chloe's alcohol use was recognised as a problem, there does not appear to have been any referral on or liaison with alcohol abuse agencies by the Police.

4.13 As the Police failed to recognise the severity of the domestic abuse and Chloe's vulnerability, it was not considered that information needed to be shared with others with a view to protecting her and taking steps to try and break the cycle of abuse in which she was caught.

Further analysis of Police involvement is covered under the TOR headings provided later in the report.

5. Derby Teaching Hospital Foundation Trust (DTHFT)

In preparing the IMR, medical files were viewed along with the DTHFT record systems and Emergency Department Information System. This process was supported by the Trust's Information Access Team.

5.1 Chloe received services from the acute trust over the period from 2001 - 2014, across a range of services as an in-patient and out-patient but predominately from Emergency Department (ED) and the Gastroenterology Service. Chloe attended the ED on 25 occasions during this period, was admitted on 16 occasions and was transferred twice to the Queens Medical Centre for care and surgery for a head injury.

5.2 Whilst medical care was provided as expected and in line with policies and procedures, the safeguarding issues of domestic abuse and the risk this presented to her life were not recognised or responded to appropriately.

5.3 Research indicates that risks of domestic abuse in relationships are increased where mental health issues exist and also in relationships where alcohol abuse is a feature. It must, therefore, be considered that all patients accessing services with such needs are a high risk group for domestic abuse and steps should be taken to ask the question about their safety and, where necessary refer to other agencies with a view to taking some action to protect.

5.4 Chloe was admitted to hospital on nine occasions during the scope of the review following overdoses or self-harm. On five occasions, visits to the hospital specifically related to domestic abuse incidents. There were several other occasions when Chloe attended hospital complaining of pain and she identified that this followed an argument with Carl. With hindsight it is likely the pain was due to physical assaults by him during the argument. However, the presenting problem was the focus and possible domestic abuse was not recognised, considered or explored.

5.5 Recurrent suicidal behaviour is recognised as a feature of the BPD she suffered and her frequent overdoses were indicative of the state of emotional chaos she must have suffered. The frequency did diminish which may have been due to the suggestion that borderline pathology tends to burn out as sufferers approach middle age. Whilst Chloe was referred to Mental Health Services and prescribed drugs for her mental health condition, there was little evidence of services or on-going support. Psychotherapy is considered the mainstay treatment. She was referred in 2014 by the Specialist Alcohol Services psychiatrist

but did not keep the appointment, suffering agoraphobia at the time and rarely leaving the house.

5.6 Of the four disclosures of domestic abuse by Chloe to hospital staff, two were responded to by considering her safety and offering her input by the Domestic Abuse team and providing domestic abuse support group information. She declined both offers. There was no formal domestic abuse risk assessment in 2002 - 2004 when this occurred. On the two other occasions, there was little consideration given, past the immediate medical concerns, with no questioning about the abuse or her immediate safety. The information about the assault on 20 August 2004 was shared with her General Practitioner (GP) via a letter.

5.7 Chloe's excessive use of alcohol impacted upon her health and she increasingly suffered the effects of alcohol liver disease, becoming very unwell. She battled to become alcohol free and underwent in-patient detoxification on occasions. She maintained sobriety for periods of time but then lapsed. It is recognised that individuals use alcohol as a consequence of domestic abuse as it is reported to dull the physical and emotional pain. Victims of domestic abuse are seen as less likely to access support services which may be able to accommodate them due to alcohol use. Chloe became increasingly isolated, in part, due to her alcohol and domestic abuse. The more isolated she became the more vulnerable she was.

5.8 Often Carl would accompany Chloe to the hospital and is reported to have witnessed Chloe overdosing, but there is no evidence he took steps to prevent the overdose. This had the effect of increasing her vulnerability and, in turn, increased his power and control in the relationship. From 2009, Carl began to be seen by the hospital as a supportive feature and protective factor when Chloe presented with issues.

6. Nottingham University Hospitals NHS Trust (NUHT)

In preparing the IMR, NUH case notes were reviewed including both electronic and hard copy records. The Domestic Abuse Specialist Nurse working in the Emergency Department (ED) and two nurses, working on the ward at the time of the patient's admission, were spoken to.

6.1 There were four admissions to the Queens Medical Centre NUHT. The first, on 5 September 2010 involved Chloe presenting to the ED with her sister, who was later found to be her best friend. She had multiple bruises to her face and body and is described as being very distressed. She alleged she had been assaulted one week ago but would not name her alleged attacker. Staff recognised that this was likely to be domestic abuse and referrals were made to the Domestic Abuse Specialist Nurse and the Alcohol Liaison Team, which is good practice. Staff also encouraged her to report the assault to the Police but she declined to do so. There was no DASH risk identification completed. The Domestic Abuse Specialist

Nurse had been in post less than a year and despite a referral, there is no documentation by the nurse to evidence that the patient had been reviewed.

6.2 On 7 September 2010, Chloe presented, by appointment, to be reviewed by a facial specialist. In the hospital notes it is recorded "the patient assaulted by partner 12 days ago, multiple blows to the head including being stamped upon ". There was no evidence of any further exploration or professional curiosity.

6.3 The next contact with NUHT was on 23 May 2013 on transfer from the Royal Derby Hospital. The history given by Chloe was that she fallen upstairs and hit her head. She was diagnosed with a subdural haematoma and required specialist neurological care. The ambulance crew stated "told crew she had fallen on stairs? assault". She had bruising to the left eye and blood around mouth and lips. This was the only entry where assault was mentioned.

6.4 The safeguarding question in the transfer letter had been left blank, and the referral information recorded by the Neurosurgical Registrar clearly states the injury was sustained following a fall and was alcohol related. This was in keeping with the explanation Chloe had given the Police but it was in contradiction to evidence from a neighbour who had witnessed the role Carl had played in the injuries and referred to in the Police analysis as a missed opportunity.

6.5 A full assessment was undertaken on 29 May 2013 by the Occupational Therapist (OT) on the ward. No disclosures of any concerns were recorded in relation to home circumstances. A further admission was necessary on 8 June 2013 due to deterioration and the necessity for a repeat operation to relieve the pressure on her brain.

6.6 The final time that Chloe was seen by NUHT was on [redacted] when she, sadly, died. Carl was present at the time of her death as he went into resus whilst resuscitation was still in progress.

6.7 Other than the initial contact in 2010 where Chloe volunteered the information that she had been assaulted, there is no evidence that staff questioned Chloe around the possibility of experiencing domestic abuse. There seemed to be a lack of professional curiosity and a willingness to accept the explanation at face value. After the first occasion, Chloe did not pass through ED where domestic abuse concerns and clinical enquiry have been part of the induction for staff since 2009. It is considered that where patients present with a history of alcohol abuse and alcohol related injury, this may influence decision making and the making of assumption and, in turn, reduce the likelihood of further clinical enquiry.

7. East Midlands Ambulance Service (EMAS)

The IMR was prepared following a review of the services provided to the individuals named using a variety of service records and information systems. Also the addresses were checked which is the most accurate way to locate information. A range of policy documents were also referred to.

7.1 From April 2008 EMAS are aware of nineteen 999 calls received, thirteen conveyances to hospital and six attendances where the patient remained at home after being seen by EMAS.

7.2 Documentation shows that the ambulance service was called for a range of medical complaints including alcohol, depression and overdose, asthma and domestic incidents where it was recognised Chloe was a victim of violence and abuse and that Carl was the perpetrator of such abuse. Where staff were aware that there was domestic abuse, there does not appear to be any action to share this information with other agencies or to trigger a safeguarding referral. The IMR identifies the missed opportunity to take action.

7.3 It is recognised that the first Domestic Violence and Abuse Policy was ratified in 2012 and was rolled out during safeguarding training to all front line staff during 2012 - 2013. This was after the domestic abuse incidents identified in this review took place. However, it would have been expected that the crews would have raised concerns and discussed with the safeguarding team the event of 22 May 2013.

7.4 EMAS was called at 20.28 on 22 May 2013. They found Chloe in the garden of the property with head injuries. The crew completed physical observation and recorded that the collapse was after a domestic incident. The fact that the crew questioned whether there had been an assault, was recorded in the records held by Derby ED. However, there is no evidence that this was raised as a concern with either the Police or the Safeguarding Team at EMAS, which is recognised as a missed opportunity to intervene.

7.5 At all attendances the crew had made the appropriate decision to transport the patient to hospital for further assessment or treatment, or if not taken to hospital, gave appropriate information should the patient's condition worsen.

7.6 There is more general learning in relation to supporting individuals with mental health and alcohol problems. EMAS staff will receive mental health workbooks to complete in 2016 - 2017 and there is now a Head of Mental Health Services for the Trust and a key part of

their role is to develop pathways for ambulance crews so that there is alternative care pathway for mental health patients rather than just taking them to the emergency department.

8. Southern Derbyshire Clinical Commissioning Group

The IMR was prepared following a review of records of the Primary Care Services for services provided to Chloe and Carl. A visit was made to the General Practitioner's (GP) practice and close scrutiny of the victim's and perpetrator's patient notes was made. Both attended the same GP practice. The practice operates an open appointment system which means the patient can choose which GP or Practice Nurse they wish to see. As a result Chloe and Carl were seen by several different Doctors and Nurses.

8.1 Chloe attended her GP practice regularly for medication and consultation on her suicidal thoughts brought on by low mood, depression and alcohol dependency. There is reference in April 2003 "that her boyfriend physically abused her for the third time, put hands around her neck and she fell to the floor ". Examinations identified small fingertip bruising to her neck. There was apparently no professional curiosity applied in relation to this disclosure and no exploratory questions about her safety or advice or referral on to domestic abuse services. It is considered by the IMR author that, if this disclosure was made today, it would be marked as domestic abuse and a referral would be considered.

8.2 There is evidence in the information received from DTHFT that they wrote to the GP in May 2003 concerning an alleged assault on Chloe by her partner which resulted in her being knocked unconscious and admitted to hospital. However, there is no reference to this in the GP's notes. I understand letters are kept separately in some practices which may explain the absence of information.

8.3 Records indicate Chloe was offered support with her alcohol dependency but there was a pattern of sobriety and relapse. Her physical health deteriorated as a result and she was very unwell prior to her death.

8.4 Both Chloe and Carl were treated for injuries from time to time linked, they stated, to Police arrest and assault by others. e.g. Chloe had an injury to her knee and Carl had been hit on the head by another.

8.5 Carl had a history of drug use in the past and of alcohol abuse in recent times. He also attended for on-going dermatitis and anxiety which included Obsessive Compulsive Disorder related to cleaning and hygiene. He also attended to seek support for symptoms of

depression. There does not appear to be any links made that the individuals were in a relationship with each other.

8.6 Much of patient contact is reliant upon what the individual chooses to disclose to the health professional. This makes the sharing of information between agencies and the use of professional curiosity and exploratory questions crucial in undertaking a holistic assessment of the individual's situation and needs. There was a missed opportunity in 2003 to refer Chloe for help and advice in relation to her domestic abuse disclosure and to consider what action could be taken to improve her safety.

8.7 There does not appear to have been any information sharing between the hospital and the GP when attendance took place that hinted to abuse and her head injuries from alleged falls. This lack of information sharing detracted from agencies developing a full understanding of the dangerous situation Chloe was in and contributed to an absence of a multi-agency response to intervene with a realistic safety plan.

9. Addiction Dependency Solutions (ADS)

In preparing this IMR, the case management system that was used to record events and contacts with service users and subsequently to also record case notes and correspondence was reviewed. Electronic case note recording commenced in 2014 and prior to that all notes were kept in paper files. Due to a transition to new contracts for delivering services from 1st April 2015, there was only limited access to paper files.

9.1 Chloe had four episodes of contact with ADS which were characterised overall by a lack of attendance, apart from a period from 18 October 2010 to 15 September 2011, when there was regular and consistent attendance, albeit interspersed by missed appointments. She attended 11 out of a possible 22 appointments. Chloe reported abstinence from alcohol for much of this period. Chloe was discharged from the service on 15th September 2011 which coincided with her involvement with SCAMS as recorded below. Through them, she underwent detox and enjoyed a significant period of absence from alcohol use. It is recognised that Chloe had complex physical and mental health needs at the time of her involvement. The input she received included psychosocial interventions, harm reduction and extended brief advice.

9.2 Chloe was again referred to ADS on 17 January 2014 by the Hospital Alcohol Liaison Service at Derby Royal Hospital. At that point Chloe, having relapsed into alcohol use some months earlier, was undergoing a further in-patient detoxification. With the benefit of hindsight, it would seem her relapse followed the head injury she sustained following the incident of 22 May 2013 which, evidence would suggest, was as a result of being beaten by Carl. He was on bail and then sentenced to 8 Months imprisonment on 21 October 2013 for

affray and possession of a bladed article relating to that incident. A pattern emerged that when Carl was in custody or had bail conditions, Chloe appeared to be able to take more control of her life and seek treatment to gain stability.

9.3 ADS made an appointment to see Chloe on her discharge from hospital on 20 January 2014. She did not keep the appointment and was therefore discharged from the service. The analysis undertaken by the IMR author showed that rather than have been given an office appointment, she should have received a home visit due to the fact information indicated that she was socially isolated, suffered severe ill health and did not leave her home other than to buy alcohol from the local shop. On reflection, this was considered a missed opportunity to further engage Chloe in services.

9.4 The final referral to ADS was on 8 May 2014 which was a self- referral. Records show two home visits were attempted but no contact was made despite telephone calls and letters sent.

9.5 Throughout ADS contact with Chloe there was no indication of any concerns in relation to domestic abuse, either from referral information or from Chloe herself. The main risk factors were physical and mental health concerns.

10. Specialist Community Alcohol Misuse Service (SCAMS)

Derbyshire Healthcare NHS Foundation Trust

10.1 Chloe was in treatment with the Specialist Community Alcohol Misuse Service (SCAMS) between February 2007 and November 2007 and between October 2011 and April 2013. She had a long history of alcohol misuse and dependence from the age of 13 years. She had previously been diagnosed with an emotionally unstable personality disorder and had had a number of admissions to psychiatric hospital prior to 2008, presenting with self - harm and intoxication.

10.2 In the risk assessment completed in 2007, it was noted that she considered her boyfriend was supportive although he was in prison at the time. It was recorded that the relationship had previously been volatile and the Police had been involved. She was also assessed by a Clinical Psychologist in 2007 who recorded that her boyfriend had previously been violent towards her. Chloe also stated that she would like support with anger management as she became volatile when under the influence of alcohol and even sometimes when not.

10.3 In October 2011, Chloe was referred to SCAMS following a hepatology out-patient appointment to assess whether she was appropriate for an in-patient alcohol detoxification. At the beginning of her treatment episode, she was exhibiting signs of alcohol gastritis and liver disease. She also reported that her partner was being released from prison in a month

and that she had been alcohol free for 18 months. She described the relationship as currently very good and her partner was supportive. During this time, she was unemployed and lived with her partner. She also had a support worker from Women's Work (WW).

10.4 From October 2011 to March 2012, she was seen weekly for alcohol counselling until admitted for Residential Alcohol Detoxification. She underwent detox for 1 month, being discharged in April 2012. She remained alcohol free until a brief relapse in February 2013. She continued to see a worker from SCAMS during this time. On 6 February 2013, Chloe attended an assessment with a Psychiatrist from Alcohol Services who referred her to the Psychotherapy Service. She was discharged alcohol free in April 2013. She did not keep the appointments that were offered her for psychotherapy and was therefore discharged.

10.5 In December 2011 her partner reportedly was released from prison and resumed living with her in spring 2012. The records state he was alcohol free at this time and was supportive in Chloe achieving abstinence. From this time until her discharge in 2013, Chloe maintained her partner was supportive and it was not stated by Chloe or identified by professionals involved, that domestic abuse was a current or present issue. It was acknowledged in the risk assessment that there was a previous history of domestic abuse but this was not assessed as a current issue.

10.6 At the point of discharge in March 2013, a letter was sent to the GP stating that Chloe was maintaining abstinence and her partner remained sober and supportive of her.

10.7 It is worthy of note, that both times Chloe commenced alcohol treatment, Carl was in custody and only having limited contact. In December 2011, when he was released from prison, he commenced attendance on an accredited Anger Management Programme delivered by the Probation Service. This appears to have been a stable period for both Chloe and Carl but ended in May 2013 when Carl was charged with Affray and Chloe received a serious head injury.

11. National Probation Service

The IMR review is based upon a review of existing Electronic Probation Records. Probation records have to be destroyed after 6 years if there is no involvement. In addition, there have been national database changes which have resulted in some data loss.

11.1 Chloe had been known to the Probation Service in 2005 and reported that Carl had been violent towards her. This was noted in the risk strategy meeting relating to Carl on 28 February 2006.

11.2 Carl was known to the Probation Service over a number of years having been sentenced for violent behaviour. Risk to partners was identified from the outset. There was reported domestic abuse in his marriage and then within the relationship with Chloe. The reported incidents of domestic abuse in the latter relationship appeared to be characterised by allegation, the victim withdrawing the allegation, together with substance misuse and mental health issues.

11.3 Carl was subject to the forerunner of MAPPA in 2005 - 2006, which involved liaison with the Police in order to manage the high risk of serious harm he presented to Chloe and others. He was still considered high risk of serious harm when the period of supervision ended in 2006. Whilst Police attended the risk strategy meetings, the risk Carl presented to Chloe did not appear to be communicated to or understood by the Police in the community who dealt with front line services and the reports of abuse made by Chloe and the neighbours. Had they been, Carl may have been charged with the assaults made upon her. Whilst the two services recognised the risks involved within the relationship, there was a missed opportunity to share information with other agencies involved e.g. health and Alcohol Services and to ensure there was a safeguarding plan to protect Chloe who was clearly vulnerable and isolated.

11.4 Reports of that time indicated that Carl had a history of psychiatric involvement which included residence at Arnold Lodge Secure Unit in Leicester. There appear to be various assessments ranging from Obsessional Compulsive Disorder, Personality Disorder through to Psychopathic Disorder. Whether there was any formal diagnosis is unclear. What was clear was that Carl was unable to manage close relationships, conflict or challenge and his reaction was often violent. Any control he did have was severely compromised through his substance misuse. Records also suggest Carl struggled to cope with Chloe's alcohol misuse.

11.5 Having completed an Accredited Violence Programme whilst under Probation Supervision in 2011 - 2012, Carl appeared to have gained a degree of learning. However, it would seem that the depth and complexity of his emotional and behavioural issues were such that this intervention would not have been sufficient to prevent aggressive or violent behaviour emerging in the future. The case was reassessed as Medium Risk of Serious Harm, as he had completed and engaged with the violence programme to an unexpected level and had strategies in place to manage himself. He was alcohol and drug free and had a relapse plan and was seeking intervention to manage his emotional vulnerability through Cognitive Behavioural Therapy. There is no record to confirm that he accessed such therapy.

11.6 Probation Supervision formally ended in November 2012. Whilst the risk assessment was deemed to be Medium Risk of Serious Harm to the public, known adults and staff, it

clearly indicated this would increase when Carl misused substances, was in conflict, there was a deterioration of mental health and had arguments with his partner.

11.7 There was a further incident in May 2013 where Carl was running around naked, with a meat cleaver. It would appear, with hindsight, all the triggers for increased risk to High Risk of Serious Harm were met i.e. substance misuse, conflict, deterioration in mental health and aggression towards Chloe. However, before Carl was sentenced to 8 months custody on 21 October 2013, the Probation Service was not given an opportunity to undertake a full reassessment of risk, being required by the Court to only prepare a 'same day' report before sentence. This was a missed opportunity to reconsider the risk assessment and management in this case. Had a more detailed report and assessment been undertaken, a recommendation may have been made for a sentence that involved some sort of supervision and control by the Probation Service and the on-going possibility of multi-agency information sharing. Offenders under National Probation Supervision can now be screened for Personality Disorders and staff have access to advice from a psychologist in relation to how to support an offender and best manage any identifiable Personality Disorder traits.

11.8 As the sentence was only a period of 8 months custody, this did not involve the Probation Service during sentence and did not attract post custody supervision. If Carl was sentenced now, he would have been released under supervision. The Offender Rehabilitation Act 2014 provides for a period of Licence Supervision for those sentenced to a term of imprisonment under 12 months.

12. Women's Work (WW)

This analysis is based upon the Chronology and telephone discussions with the Manager of the project.

12.1 A referral was made to Women's Work Derbyshire by ADS in June 2011 with whom Chloe was working in relation to her alcohol misuse. Woman's Work undertook an initial assessment on 06 September 2011 which included a risk assessment. At the time, Chloe confided her partner was in custody. A plan of contact was put in place which focussed on support needs in relation to reducing her alcohol consumption for December, when her partner would be released, engaging in education to improve job prospects and building self-confidence and self-esteem.

12.2 At that time, Chloe suffered from anxiety and found it difficult to leave the house on her own. Contact took the form of 12 face to face meetings, either home visits or to support Chloe with attending appointments, together with 19 telephone contacts. It was planned that interim intensive support would help Chloe overcome barriers to attending and engaging at the centre where there was group work on offer.

12.3 As part of the initial risk assessment, Chloe was asked about domestic abuse. She said there had been abuse in a previous short term relationship about 11 years ago. However, she did not disclose any abuse in her current relationship with Carl. Had WW been aware of domestic abuse, they have a clear policy to follow and would have worked with Chloe towards recognition of the abuse she was suffering and building her confidence to do something about it. Staff are MARAC trained. There were no domestic abuse incidents recorded during the time Chloe was in contact with WW. Unfortunately, contact stopped soon after Carl moved back into the home in April 2012. The last contact was a telephone call in June 2012 where Chloe confided she had been alcohol free for 9 weeks following her detox at The Elms.

13. Derbyshire Healthcare NHS Foundation Trust Mental Health Review

Information Relating to Chloe

13.1 Prior to the period covered by the scope of this review, Chloe had contact with the Child and Adolescent Service following a series of overdoses. It is recorded she had difficulties in her childhood which had a negative impact on her thinking, feeling and behaviour. She drank to excess when feeling depressed and suffered from low self -esteem and confidence. Her family took her to Accident and Emergency (A and E) in February 2001, as she was behaving strangely and hearing voices. She was admitted as a psychiatric in-patient in March 2001 and stayed for 2 weeks. There were no signs of a major depressive illness and she was referred to the out-patients department having been prescribed anti-depressants and other mood changing drugs.

13.2 From 24 April 2001 to 20 July 2001, she was again an in-patient at the Mental Health Unit in Derby and was diagnosed with an Emotionally Unstable Personality Disorder. Again she was prescribed medication with follow up in out-patients.

13.3 Chloe was seen on several occasions in Psychiatric Out-patients and A and E following overdoses. She was offered Community Psychiatric Nurse (CPN) support but declined the offer of input at this stage.

13.4 In May 2003, she reported to out-patients and the CPN that her boyfriend is physically violent towards her, later when admitted to hospital. She reasserts that her partner has physically assaulted and attempted to rape her. She was contacted by the Police during the in-patient admission with regards to these allegations.

13.5 There were a further 7 mental health interventions with 2 periods of in-patient treatment. In July 2003 at out-patients, she refers to the fact her boyfriend has been

aggressive and she is frightened of him. She also reported her family have cut her off as they are unhappy she continues the relationship with him.

13.6 Chloe was seen twice in 2004, twice in 2005 and twice in 2006. In 2006, she was referred to The Elms Clinic for treatment for her alcohol misuse. She often failed to attend appointments and in March 2008 was discharged from the Mental Health Out-Patient Department due to failing to attend a number of appointments. She was discharged from the Alcohol Team for the same reason in December 2007.

13.7 Due to further incidents of overdoses in October 2009 and May 2012 and due to alcohol related illness in June 2014, Chloe was reassessed by the Mental Health Team. As there was no evidence of mental illness, no further services were offered. She was referred to the Community Alcohol Team, and pursued treatment for her alcohol dependency.

13.8 Whilst Chloe was engaged with the Mental Health Services, information was shared between A and E, the Liaison Team, In-Patient and Out-Patient Departments, DTHFT and Alcohol Services. It is recorded on a number of occasions in 2003, when Chloe was in treatment with Mental Health Services that she was subject to and at on-going risk of domestic abuse. However, although this was acknowledged and she was given appropriate support when talking about the abuse, there is no evidence that further information was given regarding services and support she could access regarding domestic abuse in the community to keep herself safe. There was no evidence of a referral into the safeguarding process which may have been appropriate given her vulnerability due to her alcohol abuse, mental health, isolation and the nature of the domestic abuse that she suffered.

14. Mental Health Services Information relating to Carl

14.1 Carl is recorded as having misused substances from the age of 12 years. He was seen by a number of mental health teams over the years. He was assessed on a significant number of occasions as not meeting the threshold for mental health services and not having a diagnosable mental illness. He clearly had anger related issues and his behaviour could be very hostile and raised concerns which were reflected in assessments of risk. On the occasions where he was referred to Mental Health Services and attended appointments, he would present well and therefore would not meet diagnostic criteria. On other occasions, he failed to attend appointments and did not respond to letters inviting him to attend. On occasions where he presented in A and E following overdoses and was assessed for suicidal ideation there was found to be none apparent. The review panel discussed whether the approach to providing services to an individual with Carl's mental health presentation would be different now in 2016. The view was that it is unlikely to have changed and he would still not meet the criteria.

14.2 There are references to episodes of violence and anger towards Police Officers and his ex-partner and a reference by a GP in a letter dated 26 June 1989 to a diagnosis of "Explosive Psychopathic Personality Disorder ", but there is no record of who made this diagnosis and there is no further reference to it. He often referred to suffering from a Personality Disorder or Psychopathic Disorder when he was in crisis or being held accountable for his actions.

14.3 The relationship between Chloe and Carl was described as being supportive and volatile at different times. He was known to have been violent to his previous partner

14.4 During his relationship with Chloe, there was substance misuse by both parties for prolonged periods of time and contact with a range of services. Despite the overlap of service contact, there is little evidence of recognition, consideration and communication about the links between this couple and no evidence that domestic abuse was considered. Each episode of contact with health, police or substance misuse services was treated as a separate occurrence responding to the specific presenting issue but failing to see the toxic cumulative picture of their behaviour.

15. Derby Homes Summary IMR

15.1 Chloe signed for her tenancy on 17 September 2001 which was a flat owned by Derby City Council and managed by Derby Homes. She was the sole occupant of the property at the time. In October 2007, Chloe wrote to Derby Homes asking if she could add her partner to the tenancy. She provided evidence to show that he had been resident at the property with her since 06 January 2007. They became joint tenants in November 2007. On 06 August 2013, Chloe notified Derby Homes that Carl was moving away and his name was later taken off the tenancy. Chloe terminated her tenancy on 01 March 2015 but no reason was given and no forwarding address was supplied.

15.2 During the tenancy there were a number of incidents involving neighbours on the street. These were as follows:-

In September 2006, Chloe complained about a neighbour's girlfriend kicking the door and screaming.

In July 2007, a neighbour reported Chloe for racist language and smearing an unknown substance on her partner's face.

In March 2009, Carl reported he had been attacked by the partner of a neighbour and sustained a broken jaw and head wound. It became clear there was an on-going feud and counter allegations were made against Chloe and Carl.

In May 2009, the neighbour left the area and all cases were closed.

15.3 In July 2010, Carl was charged with a section18 wounding of another neighbour who had been his drinking partner. He was bailed to his parents' address and banned from the area. Carl was sentenced to 16 months imprisonment for this offence in August 2011. He returned to live at the address in April 2012.

15.4 Incidents of anti-social behaviour appear to have started when Carl joined the household with a clear escalation in severity. However, there was no evidence or reports of domestic abuse and Derby Homes were not aware of an abusive relationship between Chloe and Carl. They referred to a close working relationship with the Police, however the Police did not inform them of the incidents of abuse. This is possibly as the Police focussed on the issues of alcohol in terms of Chloe and only saw the domestic abuse as one off incidents rather than the cumulative picture of repeated severe beatings, isolation, power and control.

16. Her Majesty's Prison (HMP) Nottingham Verbal Report

16.1 HMP Nottingham provided information they had recorded in relation to the last prison sentence that Carl served in 2013. This was an 8 month sentence; he served 4 months and was released, without supervision on licence, in line with legislation. Due to the short nature of the prison sentence, no work on his offending behaviour was undertaken whilst he was in custody.

16.2 The risk assessment, completed as part of the presentence report, whilst acknowledging he had previously presented a significant risk to others, had assessed his risk of harm as medium despite many of the indicators for increased risk being present. However, given the short length of sentence, even if the assessment had been high risk it is unlikely any specific offending behaviour work would have been provided.

Analysis of Involvement relating to the Specific Terms of Reference

17. Are there any specific considerations around equality and diversity issues such as ethnicity, age and disability that may require special consideration?

17.1 Records indicate that Chloe was diagnosed with an emotionally unstable Personality Disorder in 2001 (this can also be referred to as a Borderline Personality Disorder (BPD). She was also dependent on alcohol for much of her life since her mid-teens. The impact and the stigma of the Personality Disorder diagnosis and the need for adequate service provision

to be made available to support and assist in addressing the specific and significant difficulties is well understood and demonstrated in research. Patterns of behaviour of someone with BPD could include:-

- Overwhelming feelings of distress, anxiety, worthlessness or anger.
- Difficulties in managing such feelings without self –harm e.g. abusing drugs, alcohol and taking overdoses.
- Difficulties in maintaining stable and close relationships.
- Sometimes having periods of loss of contact with reality.
- In some cases, threat of harm to others.

17.2 It is very likely Chloe would have been very worried about people abandoning her, resulting in her doing anything to stop this happening. This factor, combined with the dynamics of power and control exercised by the perpetrator of domestic abuse and the disabling effects of alcohol abuse may explain why she stayed in such a dangerous relationship.

17.3 Chloe was treated with drugs for both conditions. Attempts were made to engage Chloe in psychotherapy but she failed to keep appointments and was discharged from services. She declined the offer of Community Psychiatric Nurse involvement. She did accept support from ADS, SCAMS and Women's Work at times when Carl was not in close proximity or when their alcohol use was under control and they were sober e.g. in 2010 when he had bail conditions to live elsewhere or when he was in custody or released on licence. Domestic abuse is often accompanied by stigma and shame and is in itself disabling. The presence of alcohol adds an additional dimension and has the effect of blurring the understanding of blame, and increased blame is attributed to victims.

18. Was the Victim Subject to a MARAC?

18.1 There was never a referral to MARAC in this case which was a missed opportunity for multi-agency involvement to develop a coordinated action plan to reduce the risk to Chloe. It would appear Chloe did not meet the criteria for MARAC referral of being assessed high risk of serious harm, as only the highest risk cases are referred into the MARAC process. I understand there is also an opportunity to refer complex medium cases.

18.2 From the inception of MARAC in 2008, Chloe was subject to 6 domestic abuse assessments by Police, with four standard and two medium risk outcomes. It is unknown if the two medium risk assessments were followed up by the SNT as there is no record of this.

18.3 There was a missed opportunity in May 2013 (evidence would support the fact that Carl assaulted Chloe and Police, Ambulance and two hospitals were involved) to complete a DASH assessment which may have been high risk or the very least complex medium risk.

Given the repeated incidents of abuse and significant injuries, it may have been likely a MARAC referral would have been thought appropriate.

19. Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)

19.1 Whilst Carl was not subject to MAPPA in recent times, he was subject to multi agency risk strategy meeting in 2005 - 2006; these were the forerunner to MAPPA. There were meetings between Police and Probation while he was a subject of supervision on a 12 month Community Rehabilitation Order from September 2005 to September 2006 for the assault of a Police Officer. The concerns were his violence, his substance misuse, his mental health and his apparent unwillingness to take responsibility for his behaviour and his blaming of Chloe for domestic abuse incidents. When supervision finished, the Police were the single agency involved to manage the case.

19.2 There appears to have been little or no communication between the Police represented at the Risk Strategy Meetings and the Police on the front line responding to the incidents in which Carl and Chloe were involved. The front line Police did not appear to have the same concerns about the risk to Chloe as the strategy meeting.

19.3 When there was a reassessment of the risk of harm by the Probation Service in July 2011, following a further offence and court appearance, the outcome was Carl was considered to be Medium Risk of Serious Harm. It would appear this assessment was somewhat flawed in that it was based on inaccurate information. Records indicate that relationship and domestic abuse issues were highlighted in the assessment but stated that the last Police call out in relation to domestic abuse was in 2006. During the review, this has been found to be inaccurate information. There were 6 domestic abuse call outs, 1 in 2007, 2 in 2009 and 3 in 2010.

19.4 Given the passage of time, it is difficult to ascertain how or why this error occurred. Gathering such information is routine and there are now well established systems for the process. Had the correct information been obtained, it is impossible to know whether the assessment of risk would have been higher. There was an escalation of Carl's violent behaviour around this time and a high risk assessment may well have triggered multi agency discussion and possible action.

20. Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)?

20.1 Carl was never subject to a DVPP. However, he successfully completed a general violence programme, Controlling Anger and Learning to Manage (CALM), when released on licence. This release followed a sentence of 16 months imprisonment for section 20 wounding. It was for this assessment, at the time of sentence, that there was missed information about the six domestic abuse call outs. Whether this information would have made a difference to the type of programme Carl was referred to is only conjecture.

20.2 He completed the programme having appeared to gain a degree of learning, however it was felt by his Probation Officer that the depth and complexity of his behavioural and emotional issues were such that this intervention would not have been sufficient to prevent future aggressive and violent behaviour emerging.

20. Did the Victim have any contact with a Domestic Abuse organisation or helpline?

and

21. Did anyone in contact with Victim know whether or not the Victim was aware of Domestic Abuse Services available locally. If 'yes but not used ' were there any barriers to the Victim accessing those services.

Given the overlap in these two terms of reference, to avoid repetition, the author has amalgamated the response.

21.1 There was no specific contact by Chloe with a domestic abuse organisation or helpline. This will be expanded upon below.

21.2 It would appear Chloe stopped seeing herself as a victim of abuse and, together, Chloe and Carl seemed to have a ready-made fabricated explanation for injuries related to Chloe falling when drunk. This was often used to counteract any suspicions there may have been. Agencies appeared content to accept the presenting story without exploration. It is unclear the level of coercive control that Carl used to ensure Chloe would maintain the facade. However, it is recorded that he was often present when she was interviewed by agencies post a domestic crisis. On her final day, he accompanied her to the hospital and was present in resus when she actually died.

21.3 There is evidence that the Police provided Chloe with a DA support telephone number in 2007. DTHFT records indicate Chloe was given domestic abuse numbers by hospital staff in September 2003 and August 2004.

21.4 During the period of treatment with SCAMS and ADS between 2011 - 2013, Chloe was referred to Women's Work, an organisation who support women with a range of issues

including domestic abuse. She was initially referred for support with health and financial issues. However, throughout the course of her engagement with them, she stated she would like to engage in both counselling and group work. Unfortunately, she had not disclosed she was a victim of domestic abuse currently, but only referred to abuse in the distant past. Sadly, Chloe withdrew from contact before she was at the point she felt she was ready to access the services that could have assisted her in understanding and possibly taking action to stop the abuse.

21.5 In terms of barriers to her accessing support, these were significant and were likely to be a combination of her alcohol use, feelings associated with low self-esteem and worthlessness, fear, shame, her BPD and the power and control exercised over her by Carl.

22. How should friends, family members and other support networkers and where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement.

22.1 The parents of Chloe and Carl, Chloe's closest friend, 4 neighbours and Carl himself have all been written to, by the author, with a view to contributing to the review.

22.2 [redacted].

22.3 [redacted], the author contacted the Senior Investigating Officer from Police who has been in regular contact with the individuals identified above. As a result, he made contact with Chloe's mother and she contributed to this review as recorded earlier in this report.

23. How should matters concerning family and friends, the public and media be managed during and after the review and who should take responsibility for this.

23.1 Family, friends and neighbours have been contacted to inform them of the review and seek their contribution. It is recognised that those who knew the individuals well, and were not either Statutory or Voluntary Agencies, may have information and a perspective on the relationship that could add key information and assist in the learning by agencies. Contact will be made again when the draft report is complete and again before publication, to provide an opportunity for communication.

23.2 The report will be published on the Safer Derbyshire website, once agreed by the Home Office, and will be available to the public. The Community Safety Partnership will seek the services of the Council's Public Relations Manager in planning for and managing any media attention.

24. Consideration should also be given to whether either the victim or the perpetrator would be assessed as a Vulnerable Adult / Adult at Risk.

24.1 Due to the time frame of this review, 2001 - 2015, both the "No Secrets" definition of a vulnerable adult and the Care Act 2014 definition of an Adult at Risk apply.

" No Secrets" states that

- " A vulnerable adult is defined as a person aged 18 years and over who is or, maybe, in need of community care services by reason of mental or other disability, age or illness and who is or, maybe, unable to protect him or herself against significant harm or exploitation".

The Care Act 2014 describes an adult at risk as an adult who:-

- has needs for care and support (whether or not the local authority is meeting these needs) and
- is experiencing or at risk of abuse, neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of or the experience of abuse and neglect.

24.2 There were vulnerability factors associated with both the victim and the perpetrator in terms of mental health, dependence on substances, physical health in relation to Chloe and domestic abuse. Both had capacity, but decision making was clouded by alcohol and mental health issues and potentially Chloe's fear of abandonment. It was considered by the Panel that although the couple had increased levels of vulnerability and complexity, they would not have met eligible criteria for Adult Social Care intervention.

24.3 Derbyshire Agencies work together to implement a Vulnerable Adult Risk Management process (VARM). The adults referred are those that are deemed to have mental capacity but are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. Chloe was not referred into this process as most agencies considered the main issue latterly was alcohol abuse and specific services were available to respond to this issue. The toxicity of the combination of alcohol, domestic abuse, mental health, poor physical health and her isolation was not recognised, nor was the serious risk she was at from Carl.

25. How will the review take account of a coroner's enquiry, and (if relevant) any criminal investigation relating to the homicide, including disclosure issues, to ensure

that relevant information can be shared without incurring significant delay in the review process?

25.1 Liaison took place between the panel and the Senior Investigating Officer throughout the criminal proceedings which finalised in October 2016. Disclosure issues were considered. The Coroner's Office was contacted by the Police and informed of the review. There are no on-going proceedings identified.

25.2 The initial meeting of the review panel was on 24 August 2015. Whilst the agencies were asked to undertake Individual Management Reviews (IMR) forthwith, the next meeting of the panel was postponed until [redacted] 2016 until there had been a finding of guilt in the case and any risk that the DHR process may undermine the prosecution case was eliminated.

26. How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

26.1 The Independent Review Author has looked at a range of relevant research, previous DHRs and has read the Home Office Domestic Homicide Reviews - Common Themes Identified, and Lessons to be Learned November 2013 and November 2016. Also, many of the panel members have now, sadly, been involved in previous reviews together with various individual agency internal reviews of practice, where learning has been identified.

26.2 Specific research which appears relevant in this case, is cited in paragraph 1.23 and relates to areas including barriers to disclosing abuse, accessing services, the role of alcohol in cases of domestic abuse and the implication of suffering a BPD. A qualitative study by a team of scientists from the Institute of Psychology was undertaken into the barriers and facilitators of disclosing domestic abuse by mental health service users and appeared in the British Journal of Psychiatry in 2011. It found service users described barriers to disclosure as being a fear of the consequences including fear of Social Services involvement, fear that disclosure would not be believed, fear that disclosure would lead to further violence, and issues of self-blame, shame and embarrassment. There were also barriers to staff asking questions: the dominant issues were to do with whether to enquire about domestic abuse was part of their role and also within their competence. Disclosure is a key but complex issue and one with which all agencies have to continue to work on to improve practice.

26.3 Research would also suggest women experiencing domestic abuse sometimes use alcohol or drugs as a response to or an escape from abuse. In some cases, individuals can be introduced to the use of alcohol by their partner as a means of increasing vulnerability and control, alcohol can be an additional weapon of domination. Research shows women experiencing domestic abuse are up to 15 times more likely to misuse alcohol than women

generally. What is crucial is that where there is domestic abuse, alcohol should not blur or detract from the issue of abuse.

26.4 Scottish Women's Aid reports victims of domestic abuse are less likely to access support services which, they fear, may not be able to accommodate them due to alcohol misuse.

27. Were there any issues in communication, information sharing or service delivery between services?

27.1 It would appear from hospital records and the behaviour of the other agencies that the issue of Chloe as a victim of domestic abuse became lost to view and that it was not included as a significant issue as part of a holistic assessment and diagnosis. For the hospital, a medical model became the dominant narrative, dealing with her alcohol related illness.

27.2 Even when Chloe disclosed abuse to the Police, hospital and her GP and on occasions to the Ambulance Service, it did not necessarily prompt this information to be shared or responded to. There were pockets of communication and information sharing but, largely, agencies did not share the concerns about domestic abuse in any way that enabled a rigorous risk assessment and risk management plan.

27.3 There was information sharing between the Police and Probation Service as part of a risk strategy meeting in 2006 / 2007 but the focus was on Carl's violent behaviour rather than specific input to protect Chloe. The risk management plan of January 2006 stated that should risk increase, Carl should be moved into Approved Premises where his behaviour could be monitored and more closely controlled. Although there were further incidents in 2006, including one during the course of supervision, it is not apparent what action was taken and there is no evidence Carl was moved to Approved Premises as planned.

27.4 Whilst Police attending the risk strategy meeting were aware of the risk presented by Carl, information did not appear to be communicated internally to officers responding to 999 calls in the community, who were charged with assessing the risk to Chloe.

27.5 When Chloe disclosed to her GP, in 2003, she had been assaulted 3 times and, on the last occasion, strangled until she dropped to the floor, this was recorded but no exploration about the incident, no information sharing with other agencies or action taken about the disclosure. The hospital did, in 2004, share information with the GP that Chloe had disclosed she had been assaulted by her partner. Chloe was offered Domestic Abuse Support Service information by the hospital but declined it.

27.6 The Queens Medical Centre, in 2010, did encourage Chloe to report the serious assault that led to her presenting there but she declined. Referrals were made to the Domestic Abuse and Alcohol Liaison Team but no DASH risk assessment was completed. Had it been, it may have triggered a referral on for multi -agency consideration. There is no record of Chloe being seen by the Domestic Abuse Nurse. Information was passed to the facial specialist she saw about the cause of the injuries to her face but no action was taken by that department perhaps assuming another department would be taking action.

27.7 There was evidence that Mental Health Services information was shared between A and E, the Liaison Team, In-Patient and Out-Patient Departments and Alcohol Services. Also from SCAMS with the GP and Women's Work but this did not involve information in relation to domestic abuse.

27.8 There were at least 14 different agencies involved with the couple during the scoping period. However, there was a lack of holistic assessment that joined up all the information available to enable service delivery to attempt to break the cycle of abuse.

28. Was the work in this case consistent with each organisation's policy and procedures for safeguarding and promoting the welfare of adults and with wider professional Standards?

All agencies have policies and procedures for safeguarding and promoting the welfare of adults. These have changed and developed over the 14 years covered by the scoping period.

28.1 Derbyshire Constabulary's first Domestic Abuse Policy was introduced in May 2006 and involved the use of form 621 to record and assess the risks of domestic abuse. In October 2011 the form 621 was replaced by the DASH model where, like the form 621, a number of specified questions were asked of the victim by the attending officer. The completed forms would then be forwarded to the Central Referral Unit (CRU) where a computer generated risk level is created based upon the information provided. All risk assessments are then reassessed by trained risk assessors within the CRU. One risk assessment relating to Chloe in June 2010 was increased from standard to medium risk which seemed appropriate. All but two of the Police risks assessments were made, in line with policy, using form 621, one had the risk assessment missing and one had the form 621 missing. There was only one relevant Police incident post the introduction of the DASH risk assessment. On this occasion, the Police accepted the presenting explanation of injury to Chloe as a result of a fall and did not use professional curiosity to explore the incident further. They did not, therefore, complete a DASH risk assessment. This was a missed opportunity.

28.2 There were many occasions when Chloe had made a complaint of abuse and then retracted. There was an opportunity to gather information and pursue a prosecution without

her consent. This positive action process was not utilised and had it been, it may have given a clear message to both Chloe and Carl that his behaviour was inappropriate, being monitored and would not be tolerated by agencies. The Police response to Chloe in November 2003, threatening she would be charged with wasting Police time if she made allegations and then withdrew, was inappropriate and may have influenced whether she made complaints subsequently.

28.3 On one occasion Chloe was provided with useful domestic violence telephone numbers in 2007 and on each Medium Risk Assessment occasion was referred to SNT for follow up in line with policy.

28.4 Several agencies including Women's Work, SCAMS, ADS and housing were not aware, during their contact, of any current concerns about domestic abuse. However, SCAMS were aware there was a history of domestic abuse and that the Police had been previously involved.

28.5 In terms of DTHFT, there was no Trust Wide Domestic Violence Policy in place until 2012. It would appear that this policy was not followed in the last 2 years of her life as no one had concerns about domestic abuse. Since 2012, the Trusts have required a routine enquiry of all patients to be undertaken on admission and domestic abuse training has been in place since 2014. A Safeguarding Adult Policy has been in place from 2004 but a copy was unobtainable, the first available was from 2008. Previous practice in the Trust, led by the previous Adult Safeguarding lead was that any domestic abuse disclosures were dealt with by focussing on the immediate safety of the individual and offering specialist domestic abuse Services contact details. Advice was given to Chloe on two occasions in 2003 and 2004 about domestic abuse services which she declined. Later incidents E.g. 19 May 2010 where Chloe was hit 5 times with a rolling pin, there was no discussion about domestic abuse services or referral to Safeguarding by the Police or hospital.

28.6 The EMAS Safeguarding Team was established in 2010 and includes an Adult Safeguarding lead. All staff have 24 hour access to the safeguarding referral line at EMAS which links into the Local Authority and Social Care Teams.

28.7 There were missed opportunities for all agencies who were aware of domestic abuse to refer into safeguarding for multi-agency consideration and action. Although individual policies and procedures were followed, what was missing was putting all the elements of abuse together to gain a holistic picture of accumulating incidents of violence. It required a multi-agency approach to put all the pieces of the jigsaw together.

29. <u>What were the relevant points / opportunities for assessment and decision making in this case in relation to the victim and perpetrator? What was the quality of any multi agency assessments?</u>

29.1 Every attendance by the Police and Ambulance at hospital, health related appointments and by Carl with Probation was a potential opportunity for assessment and decision making in relation to the victim and perpetrator. However, it would appear agencies in the main, focussed upon their individual areas of intervention and domestic abuse was not always recognised as a priority to be responded to E.g. DTHFT identified that the medical model dominated their approach.

29.2 Police undertook assessments at relevant points in line with expectations, however the quality was limited and they failed to recognise the picture of serious and sustained abuse. The horrific levels of injuries together with the risk factors of her vulnerability and isolation from friends and family were allowed to become blurred by her alcohol use and the risk was seen as standard or at its worst medium. Also the Police bought into Carl's positive presentation on occasions which undermined recognition of his capacity to take advantage of Chloe in a most serious way. As her health deteriorated, the impact of the beatings inevitably had greater affect upon her.

29.3 The Probation Service did recognise the risk Carl presented to Chloe in 2005 / 2006. However the risk was considered to have diminished by 2011 from high risk to medium risk of serious harm. This assessment was somewhat flawed in that it appears to have been made based upon inaccurate information about Police call outs and the prevalence of on-going abuse. The decision to include an Anger Management Programme in the post release Licence was positive in managing his general risk of violence but lacked the specific focus required to address domestic abuse. There was a missed opportunity to do a full Risk of Harm Assessment when Carl appeared in Court in 2013 when the court insisted on a same day report.

29.4 The Probation and Police Services shared information at the Risk Strategy meetings and agreed on how best to manage the risk Carl presented in 2006. However, this was the only multi-agency risk assessment undertaken. There were several missed opportunities for agencies to refer this couple for further support and multi-agency assessment and input.

30. Was the impact of Domestic Abuse on the victim recognised?

30.1 In the main the impact of domestic abuse on the victim was not recognised. Often the explanation that Chloe had sustained head and facial injuries from falling over because she was drunk was accepted or at least not challenged.

30.2 The physical impact of abuse was severe with serious head and facial injuries. On occasions, Chloe was knocked unconscious. After the unreported assault in May 2013 she had to have two operations to relieve the pressure on her brain from the bleeding caused by the trauma of the assault.

30.3 Carl often accompanied Chloe to hospital appointments and it is unclear whether this was to coercively control, monitor and prevent disclosure. He was seen, lately, as a positive and supportive factor by some services, presenting very well in these circumstances. Chloe referred to him as being supportive to her even when he was not. How much this was due to his coercive control and how much it was due to him being the main person in her life is uncertain.

30.4 The emotional and physical impact of domestic abuse on Chloe must have been significant. She had become isolated from her family and friends, isolation being a recognised characteristic of the most insidious abuse. She had lost her confidence and self - esteem and had reported overdosing. She rarely left the house except to buy alcohol from the local shop. This in turn, limited the interventions she received e.g. being discharged from Mental Health Out-Patients and psychotherapy for failing to keep appointments.

30.5 The main focus of Chloe's difficulties was seen to be her problematic alcohol use. It does not appear to have been considered that her alcohol use may have been as a consequence of the abuse in order to dull the physical and emotional pain.

30.6 Chloe had been employed as a healthcare worker at Derby Teaching Hospital but had left her job in 2004 due to her alcohol misuse and associated difficulties. Reports were that she was a conscientious, caring and valued member of staff.

30.7 In 2003, when Chloe was undergoing in-patient treatment, she discussed the impact of a then recent assault at length and was given the appropriate emotional support. This was a rare occurrence as she usually retracted allegations. However, she was in hospital in a safe environment which may have enabled her to share her experiences without fear of retribution.

31. Did actions accord with assessments and decisions made? Were appropriate services offered, provided or relevant enquiries made in the light of assessments?

31.1 In terms of agencies responding to their particular area of expertise actions generally did accord with assessments and services offered E.g. In terms of her medical care, all treatment and care was in line with good practice. However, there was a general lack of professional curiosity in thinking beyond basic policy and procedures in order to respond effectively to the domestic abuse that was an on-going pervasive feature of this couple's lives.

31.2 Action was lacking in regard to holding Carl accountable for domestic abuse and recognising the dangerousness of Chloe's situation and taking action to safeguard her. Her unwillingness / inability to disclose relevant information to those who were aware of abuse E.g. Police and GP, was a hurdle to action but should not have prevented a referral for her situation to be fully considered.

31.3 Despite some knowledge and insight of the abuse, the agencies generally, did not make relevant enquiries of Chloe and Carl or of each other to refer on to provide appropriate domestic abuse services E.g. GP and Hospitals.

31.4 If it is the Police process to refer to SNT to follow up, there must be a fool-proof system to ensure action is taken and the response is appropriate.

35. Was there sufficient management accountability for decision making? Were there senior managers or other organisations and professionals involved at points in the case where they should have been?

35.1 In 2005 - 2006, when Carl was referred to the Risk Strategy Meeting by his supervising probation officer, a senior manager would have had sight of the minutes of the meeting. The focus of the meetings was to manage the risk presented by Carl to Chloe, the Police and the public.

35.2 There was evidence of appropriate involvement from other professionals at relevant points in relation to physical health, mental health and substance abuse. Whilst the specific involvement of managers is not explicit in the records of the services, it is reasonable to take the view that they were supported by clinical and operational managers. Staff were generally autonomous practitioners and accountable for their own decision making within their scope of practice. The decisions made were largely in relation to interventions linked to the presenting health needs or problem and were not indicative of any decisions or activities to reduce the risk of domestic abuse.

35.3 The Police process of generating a risk assessment following a form 621 did involve reassessment by a Domestic Abuse Officer in the CRU. On one occasion this resulted in an increase of risk from standard to medium risk. On this occasion, there was follow up from the Domestic Abuse Police Officer to Chloe, in January 2007, and she was provided with useful numbers and was encouraged to contact the officer in future. Chloe was reported to have put the problems down to alcohol and was desperate to be reunited with Carl.

36. Could the homicide have been anticipated or prevented?

36.1 There was a long history of violence and volatility within Chloe's and Carl's relationship. Both had complex needs linked to mental health and substance misuse and it is recorded Chloe's physical health deteriorated due to alcohol liver disease. Between 2011 and her death in 2015, the incidence of reporting domestic abuse calls to the Police and presenting to others when in crisis reduced. It is likely this is, in part, due to Carl's withdrawal from her life due to a period on bail with conditions, serving two prison sentences of 8 months and 16 months, and a period of supervision to the Probation Service post sentence. At these times there was some monitoring, input and control in place regarding his behaviour.

36.2 Given the history of severe beatings and injuries sustained by Chloe at the hands of Carl and her deteriorating physical health, it could have been anticipated that further assaults would have had much greater effect and potentially a more serious impact.

36.3 It is difficult to assess whether the homicide could have been prevented, however there is evidence to say that in those cases referred to MARAC for intervention and multi - agency response to domestic abuse, outcomes improve considerably.

36.4 The review highlights the fact that agencies worked individually but rarely together in relation to the domestic abuse. They did not share information sufficiently and did not work together to arrive at a shared risk identification, assessment and management. It can only be concluded that the outcome may have been different had they done so.

37. Lessons Learned

37.1 Despite all the agencies having developed comprehensive domestic abuse policies over the period covered by this review, the professional curiosity in thinking beyond the basic policy and procedures was absent E.g. failure of various agencies to recognise and respond to the abuse Chloe suffered in May 2013. Had there been greater further exploration of the presenting issue rather than accepting events on face value, a risk assessment would have been undertaken potentially leading to an assessment of high risk and multi -agency involvement and action.

37.2 Whilst there was evidence of some good information sharing between agencies e.g. Hospital and Community Health Services regarding her alcohol use, there was generally a lack of information sharing between agencies about the domestic abuse Chloe suffered e.g. the GP did not share the disclosure of abuse by Chloe with agencies that might have undertaken an assessment and offered intervention. The Police and Hospital did not share information with each other or refer on to domestic abuse Services. It must be remembered that no agency has the complete picture but many will have insights that are crucial to share.

37.3 Agencies were largely aware of the volatile and chaotic nature of this couple`s relationship. Their alcohol misuse and mental health issues were readily recognised and

were the focus of agencies. However, the persistent domestic abuse remained below the radar for recognition and intervention. The medical model regarding alcohol dominated, and appeared to blur agencies vision of the violence. It is acknowledged domestic abuse is, potentially, the underlying driver of both mental health concerns and substance misuse, and should be considered in all cases. One agency reported "The insidious tolerance to the behaviour of people who are known to misuse substances warrants further investigation by provider services."

37.4 When risk assessments were completed by the Police, the risk to Chloe was seen as only standard on most occasions and medium on others, it was never seen as high risk. This was possibly due to Chloe minimising incidents, "it is only a fat lip, there's nothing broken" and her retracting her complaints. However, at the same time, the risk presented by Carl and those who understood his capabilities was assessed as high to Chloe. The Probation Service together with the Police in 2005 / 2006 identified Carl as high risk of serious harm, however this does not appear to have been communicated to officers who responded to 999 calls from Chloe and others which would appear an omission.

37.5 It is crucial that risk is regularly and thoroughly reassessed. When Carl completed the Anger Management Programme in 2012, the risk he presented was seen as medium risk of serious harm with a clear indication of the factors that would increase his risk to high or very high. All these factors were present when he reoffended in May 2013 and he was sentenced to 8 months for affray and possession of an offensive weapon. The risk assessment undertaken by the Probation Service was limited by the fact the Court required a "same day" pre -sentence report; this limits the time available to gather historic information and liaising with the Police about domestic abuse call outs. The sentence of the Court was 8 months custody which meant the Probation Service was not involved in the sentence or in post release supervision.

37.6 There were several missed opportunities for agencies to refer Chloe and Carl on to services in connection with domestic abuse or alcohol or mental health input e.g. the Ambulance Service when they attended calls where Chloe initially alleged abuse or where she and Carl had overdosed and were clearly in a state of chaos and in need of support.

37.7 Several agencies e.g. the Police, Mental Health, Ambulance treated each presentation separately without looking at the history of the case and the accumulative picture that was developing. This led to minimal responses to domestic abuse and a failure to take a longer term view joining up the evidence.

37.8 It is reported that Chloe became increasingly isolated, a risk factor of domestic abuse. There is reference to Agoraphobia and her only leaving home to buy alcohol at the local shop. It is alleged she failed to take medication as she could not get to the chemist. Whilst there was an awareness of this, agencies continued to offer her office appointments and when she did not attend, she was discharged from services e.g. Mental Health Services

in 2008 and Alcohol Services in 2014. In such cases, home visits should be standard practice.

37.9 Whilst Chloe was considered by the review as a " vulnerable adult " due to her alcohol misuse, substance misuse, her deteriorating physical health and her increasing inability to protect herself from domestic abuse, it was felt by the panel members that a referral to Adult Safeguarding would not have met the threshold for services. Such an assumption acts as a block to making a referral and taking action. Whether Adult Safeguarding was the right pathway or not, it is crucial agencies find a way to work together effectively and systematically to provide a coordinated response to those in need when statutory thresholds are not met.

37.10 There were missed opportunities for the Police to take positive action and charge Carl with the assaults on Chloe. This was mainly due to the fact that Chloe would make an allegation and then withdraw it, desperately wanting to avoid losing her relationship with Carl. Police viewed likely prosecution as unsafe due to this. Her mother referred to the control Carl appeared to exercise over Chloe and gave examples of him influencing her not to take medicine even though it improved her sense of wellbeing. He made it difficult for her to leave the house and often insisted in accompanying her. These factors went unrecognised but interpretation would now suggest this is indicative of the coercive control he exercised. It is, therefore, possible her retractions were due to Carl influencing her following the assaults. He was plausible and potentially manipulated situations e.g. was seen by health services as a supportive and positive factor in Chloe's life.

37.11 There was a lack of connectivity in relation to the recurring theme of domestic abuse and lack of recognition that many agencies had information that needed to be put together. Not one domestic abuse assessment reached the threshold of high risk that could have resulted in a referral to MARAC. There was only limited multi agency working together by the Probation Service and the Police in 2005 / 2006 and health professionals in relation alcohol and linked mental health. In these circumstances, where thresholds for statutory intervention are not met, the Police and others completing DASH should ensure an appropriate referral to specialist domestic abuse services takes place in order to do everything possible to protect the victim.

37.12 The quality of recording was identified by some health agencies as requiring improvement. This specifically referred to the Alcohol Service Contract which has now ended and the need for GPs to make more comprehensive patient notes.

40. Conclusion

40.1 There is evidence that domestic abuse became a feature of the relationship between Chloe and Carl soon after their relationship began in 2001. It is recognised that the first incident recorded by Derbyshire Constabulary in 2002 is unlikely to be the first and research would suggest there are many incidences before victims take the step of reporting.

40.2 There was a history of unreported abuse in Carl's marriage which ended in [redacted] Carl has been convicted of a number of violent offences, the first being when he was aged 14 years which was against a male relative.

40.3 The couple had complex needs including substance misuse, mental health issues and Chloe increasingly had physical health problems.

40.4 Despite a catalogue of disclosure of abuse to various agencies including the Police, Hospital A and E, Hospital Ward Staff and her GP, the domestic abuse did not receive the recognition and response it required or deserved.

40.5 The pattern of behaviour exhibited by Chloe was that when she was being abused and in crisis, she would call the Police and report the assault. Later she would retract the allegation, often saying her injuries were caused by falling when drunk.

40.6 Alcohol abuse and mental health concerns, manifesting in repeated overdoses, was seen as the presenting issues and there was a lack of professional curiosity regarding the potential underlying domestic abuse. Agencies allowed the domestic abuse to be eclipsed from view.

40.7 Over the years Chloe's health deteriorated and she became very unwell, suffering alcohol liver disease. This fact increased her vulnerability and the danger she was in from severe beatings. There is evidence of coercive control and of Carl taking advantage of her vulnerability.

40.8 Incidents both within agencies E.g. Health and across agencies were seen in isolation as "one offs", and no agency made the connection between events and arrived at a holistic assessment where the cumulative picture was recognised.

40.9 Where Carl's contact with Chloe was limited between 2010 - 2013 due to bail conditions and two periods of custody and supervision by the Probation Service, she was able to take more control of her life and seek help for her alcohol problems. To her credit, she managed abstinence for many months, relapsing prior to leaving her own independent accommodation and moving to live with Carl in January 2015.

40.10 Tragically, Chloe died following a severe beating from Carl in [redacted]. He denied manslaughter but was convicted following trial. The Prosecution took the case to the Appeal Court where the sentence was increased from 10 years to 15 years imprisonment as a punishment for all the assaults Chloe had suffered prior to the events that caused her death.

41. Relevant changes in policy already made

Derbyshire Constabulary

41.1 In December 2013, Derbyshire Constabulary introduced a Domestic Abuse Scrutiny Panel. Primarily this panel assesses the quality of the domestic abuse investigation and shares good practice and any learning.

41.2 In May 2014, Derbyshire Constabulary introduced a Serial and Repeat Domestic Violent Perpetrator Management Plan. A monthly list of serial and repeat perpetrators is recorded on the guardian intelligence system database. Those on the list are then prioritised and those considered to be at risk are subject to a tasking process. Had this procedure been in place earlier, (three recorded incidents in 2010) both Chloe and Carl would have been identified under this scheme and further action would have been taken.

41.3 Since June 2014, a Domestic Violence Investigative Toolkit has been created which officers use as a template for their investigations. This provides information regarding the key objectives of prevention, intelligence gathering and enforcement. There is also an action plan which records the date an action was raised through to its completion. The actions incorporate legislation introduced in June 2014 concerning Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) schemes which provide an alternative method of dealing with on-going domestic issues.

41.4 Following HMIC inspection all domestic abuse incidents are subject of a quality check by the Sergeant of the attending Officers. Also the command and control incident cannot be closed until the work has been completed. This came into force in January 2014.

41.5 All front line staff who are likely to be involved in domestic abuse cases are undergoing refresher training; this is showing improvements in the quality of the DASH forms submitted by attending officers.

41.6 An Escalation Policy has been developed. Work is ongoing to introduce both a MARAC case management system and improve the new NICHE crime recording system which will enable the full introduction of The Escalation Policy within the MARAC process. This policy relates to the identification of repeat medium risk victims i.e. those that have not

previously been assessed as high risk on any one occasion. Such a policy will set parameters E.g. three medium risk referrals within twelve months escalates the victim to MARAC for review.

41.7 In Chesterfield, Buxton and Amber Valley currently all medium risk referrals are referred back to the originating officers who seek to visit, reassure and where necessary offer additional target hardening or victim support. In Derby South, Derby and Erewash currently all medium risk referrals are dealt with by the Vulnerability Unit who provide the same service as the above. Whilst the service is consistent irrespective of where the victim lives it is the aim of the police to seek a common approach to the process.

41.8 The latest HMIC inspection (2016) considered the Force`s effectiveness. The report grades the force`s effectiveness as "good" in:

- Preventing crime, tackling anti-social behaviour and keeping people safe.
- Investigating crime and reducing re-offending.
- Protecting the vulnerable and supporting victims.

In reaching the above conclusions the force`s current position in relation to the investigation and prevention of domestic abuse formed part of the inspection.

42. National Probation Service (NPS)

42.1 In June 2016 a new Information Exchange Protocol was implemented between the Police and the NPS to enhance information exchange including Police domestic abuse call out information.

42.2 When Carl was sentenced to 8 Months custody in [redacted], there was no provision for him to be subject to post-custody supervision by the Probation Service. However, The Offender Rehabilitation Act 2014, provides for a period of Licence Supervision for those sentenced to term of imprisonment under 12 months. There are two distinct periods of Licence: the initial period contains powers to control, the later part of the Licence Supervision focuses on rehabilitation.

42.3 Offenders under the supervision of the NPS can now be screened for Personality Disorders and officers can receive access to advice from a psychologist in relation to how to support an offender and best manage any identified Personality Disorder traits.

43. DTHFT

43.1 A Trust Wide Domestic Abuse Policy was introduced in 2012. Since 2012, the Trust has required a routine enquiry of all patients be undertaken regarding their safety on admission. The Trust also undertook an audit of response to domestic violence in the AED in mid-2016. Results demonstrated identification of domestic violence and required response in terms of undertaking CAADA-dash and MARAC referral in well over 90% of cases.

43.2 Domestic abuse training has been in place since 2014 and from March 2016 is mandatory for all staff in urgent and unplanned care settings, midwifery and for gynaecology and paediatric staff. Gastroenterology services are now included in level 3 target audience for mandatory training in safeguarding including domestic violence.

44. Nottingham University Hospitals NHS Trust

44.1 Since 2009, a Domestic Abuse Specialist Nurse has been in post within the Emergency Department (ED), and as a result, the completion of DASH RIC within ED has greatly improved.

44.2 Domestic abuse awareness and clinical enquiry have been part of local mandatory induction for all ED staff since 2009.

44.3 In May 2013, the Trust recruited a Domestic Abuse Specialist Nurse and training has been delivered to wards and departments outside ED since 2013.

45. Clinical Commissioning Group

45.1 GP practice has improved and should a patient disclose domestic abuse it would be recorded and a referral to an appropriate domestic abuse agency considered.

45.2 It should be noted that steps have been taken by the Derbyshire CCGs to facilitate improved communication between GPs and MARAC. The CCGs have invested financially in the MARAC administration team in order to have a resource specifically to promote GP contact and information sharing prior to MARAC meetings.

45.3 The Derbyshire CCGs are also exploring the feasibility of having a consistent 'Read Code' on relevant patient GP records. This will alert GPs to the fact that there is a history of Domestic Abuse associated with the patient

45.4 A Safeguarding Adults phone App has been developed for GPs. This includes an easy to use Domestic Abuse pathway and contains information to enhance GP awareness of domestic abuse services and referral options

45.5 There is a now Safeguarding Adult Lead GP in every Derbyshire Practice. They have the offer of attending an annual bespoke training event to enhance understanding and awareness

46. East Midlands Ambulance Service

Individual staff members involved in attendances where there were missed opportunities to refer patients on have reflected on their practice.

46.1 A Safeguarding Team was established in 2010. Since that time, training has been provided for all staff. Staff have received face to face training on Domestic Violence and Abuse during 2013-2014 and Safeguarding training since then has included a section on domestic violence and abuse and when to refer. The team includes an Adult safeguarding lead and Child and young person's safeguarding lead who provides the Trust with knowledge and expertise regarding the safeguarding agenda.

46.2 Domestic violence and abuse and its associated agendas have been rolled out as part of safeguarding training to all front line staff during 2012 and 2013 as a core subject and has been repeated each year since then.

46.3 96% of staff have received level 2 safeguarding training in the last 3 years.

46.4 The EMAS Domestic Abuse policy was ratified and disseminated across the agency in April 2012 and was reviewed again in 2016. EMAS secured Care for Quality and Innovation (CQUIN) funding for the period 2015 - 2017 for a Mental Health Specialist Nurse and a Mental Health lead for the Trust. This is to build on work already commenced to further develop specialist mental health education for frontline staff.

46.5 During the educational year 2016 / 2017 a safeguarding workbook has been compiled for completion by all staff members. This will be quality assured in 2017 / 2018.

Recommendations

47. Derbyshire Constabulary

47.1 Continue to remind staff of the importance of professional curiosity and of using exploratory and probing questions to gather full information. Guard against accepting presenting issues at face value in cases where domestic abuse is an issue.

47.2 Continue to remind staff that past behaviour is the best indicator of future risk and the importance of using historical information. Liaise with others to arrive at a full and holistic assessment, especially in domestic abuse cases.

47.3 Continue to remind officers to guard against complacency in relation to alcohol abuse, it is not the cause of domestic abuse and must not undermine a positive and robust response.

47.4 Continue to remind staff that where there is evidence of mental health and alcohol abuse officers should be alert to the potential for domestic abuse to occur.

47.5 Continue to remind staff that where there is a pattern of domestic abuse, share information with other domestic abuse agencies.

48. DTHFT

48.1 The Trust to explore the requirement for a Domestic Abuse Specialist Support Service in the ED and Out-Patients.

48.2 Remind staff that the risk of domestic abuse is increased when mental health and alcohol misuse is a feature of attendance at hospital.

49. Mental Health Services

49.1 Share learning from DHR and remind staff of the importance of responding to disclosures of domestic abuse by referral on to the appropriate person within the organisation and to domestic abuse Services.

49.2 Remind staff of the importance of looking at patterns of behaviour and the accumulative picture rather than only focusing on the presenting problem as a "one off " incident.

50. The National Probation Service

50.1 To continue to consider where there is police call out information indicating a history of DA whether practice can proceed to a safe sentencing proposal via a same day report. Where it is considered that an adjournment is necessary the probation court team to ask the

court for an adjournment for a full and detailed assessment. However this would ultimately be a court decision. The increased drive to same day sentencing is linked to The National Court Agenda of Transforming Summary Justice (magistrates Court) and Better Case Management (Crown Court)

50.2 Remind staff of the importance of gathering full and accurate call out information from the Police in order to arrive at a full assessment of the risk of domestic abuse.

51. South Derbyshire Clinical Commissioning Group

51.1 In cases where there is a history of domestic abuse, staff should seek opportunities to ask the patient if they are safe within the relationship and what can be done to make them feel safer.

51.2 Look to signpost patients to relevant agencies in the community if a pattern of behaviour, that requires intervention, is identified. In this case, domestic abuse and Alcohol Services could have been an appropriate referral pathway.

51.3 Improve quality of patient notes to make them more comprehensive.

52. Derby Homes

52.1 Remind staff of the importance of being alert to and aware of the possibility of domestic abuse within tenancies.

53. Nottingham University Hospitals NHS Trust

53.1 Mandatory safeguarding adults training to include reference to this DHR.

53.2 The DHR learning to be presented to the Safeguarding Adults Committee and Safeguarding Champions Forum.

53.3 Lessons learned and recommendations to be shared at Divisional Governance meetings via the Serious Case Review Subgroup of the joint Safeguarding Children, Young People and Adults Committee.

54. SCAMS

54.1 Remind staff of the fact that where a client presents with a cluster of complex issues E.g. alcohol misuse, mental health concerns and poor physical health that this should act as an alert for current domestic abuse. Domestic abuse can potentially be the underlying drive for both mental health and substance misuse.

55. ADS

The ADS contract to provide Alcohol Services in Derby City has now ended.

55.1 Adopt home visits as standard practice for cases where there are emotional and physical needs which restrict a person's ability to attend office appointments.

55.2 Share learning from this DHR with all staff for ADS.

55.3 Ensure all staff has up to date safeguarding training.

56. EMAS

56.1 Staff to be reminded of the importance of recognising domestic violence and abuse, and the importance of referring on to other services for support. The need for accurate recording will also be highlighted. (This will be done by the EMAS E News process).

56.2 A workbook containing information on Domestic Violence and Abuse will be provided to all staff during January and February 2016. From April 2017, all staff will be expected to complete an online assessment around Safeguarding and its associated agendas which includes Domestic Violence and Abuse. Themes will be identified from this DHR and used in the assessment during 2017 - 2018.

57. GENERAL

57.1 All agencies to ensure relevant staff are aware of the process for referral to VARM. In considering referrals all staff to utilise professional curiosity and exploratory questioning in order to gather full information to establish the level of vulnerability of the individual and the sum of the risks rather than assessing each element in isolation.

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10. Glossary of Terms

ADS	Addiction Dependency Solutions
BPD	Borderline Personality Disorder
CALM	Controlling Anger and Learning to Manage
CCGs	Clinical Commissioning Groups
CDP	Complainant Declined to Prosecute
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CRU	Central Referral Unit (Police)
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Honour Based Crime
DHR	Domestic Homicide Review
DOH	Department of Health
DTHFT	Derby Teaching Hospital Foundation Trust
DV	Domestic Violence
DVA	Domestic Violence and Abuse
DV PP	Domestic Violence Perpetrator Programme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
ED	Emergency Department
EMAS	East Midlands Ambulance Service
GP	General Practitioner
HMP	Her Majesty's Prison
IMR	Individual Management Report
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
NPS	National Probation Service
NUHT	Nottingham University Hospital Trust
OT	Occupational Therapist
SCAMS	Specialist Community Alcohol Misuse Service
SNT	Safer Neighbourhood Team (Police)
TOR	Terms of Reference
VARM	Vulnerable Adult Risk Management
WW	Women's Work