The Safe Durham Partnership

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County Durham Domestic Homicide Overview Report

DHR001 Case Reference: DS

Altogether safer

REPORT INTO THE DEATH OF:

Female DS
Aged 51 at time of death

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Date 23/05/2013

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Executive Summary

Introduction

1.1. This review examines the circumstances surrounding the death of DS.

1.2. Durham Constabulary were called to the home of DS and her husband DC following a report from a neighbour that they had witnessed an assault taking place. When the police arrived DS was found dead at the scene and her husband DC was arrested.

1.3. DC was charged with the murder of DS and pleaded guilty. He was sentenced to life imprisonment with a tariff of 13 years.

1.4. This report was prepared prior to the changes being made to NHS structures, therefore the Primary Care Trust are referred to as Independent Management Review providers. Key recommendations have been prepared based on the analysis of the Independent Management Review provided by the Primary Care Trust however these are recommended to be taken forward in line with the current structures of the National Health Service.

The Review Process

1.5. The Statutory Guidance for homicide reviews came into effect in April 2011 shortly before the death of DS. The death of DS was the first in County Durham to meet the criteria for a review to take place and at the time there were no procedures in place which had been agreed by the Safe Durham Partnership. Reviews of domestic homicides had however previously been undertaken and for the purpose of preparing this report, the existing voluntary guidance was referred to alongside the new statutory guidance. Safe Durham Partnership approved local procedures in July 2012 and the report has been written in accordance with the template advised in those procedures.

1.6. The process began with an initial meeting on 26 July 2011 of all agencies that potentially had contact with DS prior to the point of death.

1.7. Agencies participating in the original meeting were.

- Local Authority
- Social Care (Adults and Children's Social Care Services)
- Police Domestic Abuse Unit/Child Abuse Investigation Unit
- Local Probation Board
- County Durham & Darlington Foundation Trust
- Primary Care Trust
- Independent Police Complaints Commission

1.8. Apologies were received from

- Youth Offending Service
- Education

1.9. Participants at the meeting came with a summary of the information they held about the deceased DS and the accused DC. On the basis of information shared it was agreed that the case met the criteria for a review under the new statutory guidance.

1.10. Durham Primary Care Trust were asked to prepare a more detailed report of their involvement with DS. A report on police involvement was already being prepared by the IPCC. PCC and Durham Constabulary were asked to provide additional information to support this. Subsequently Durham Tees Valley Probation Trust (DTVPT) was asked to provide information about their involvement with DC.

1.11. These agencies were asked to give chronological accounts of their contact with the victim prior to her death. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family;
- What was done or agreed;
- Whether internal procedures were followed;
- Conclusions and recommendations from the agency's point of view.

1.12. Additional information was later sought from Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), Adult Services, Ambulance Trust, NHS direct, Domestic Abuse Outreach Services and Housing/Neighbourhood Services although no further involvement with DS or DC was identified.

1.13. Altogether 14 agencies were asked to search their records for information in relation to DS and DC. Of these, Primary Care Trust, Police and Probation prepared reports and County Durham & Darlington Foundation Trust (CDDFT) provided a note of their very brief involvement.

1.14. Two services had notes of brief contacts that were not relevant.

1.15. Eight services had no record of contact.

1.16. The report from Durham Tees Valley Probation Trust (DTVTP) shows that they had no contact with DS but supervised DC on a Community Order between March 2008 and March 2009.

Terms of Reference

1.17. The Terms of reference for this enquiry were adapted from the terms suggested in the statutory guidance

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

1.18. In addition to this, a separate investigation was carried out by the Independent Police Complaints Commission using a parallel terms of reference focussing particularly on the use of restorative approaches in domestic abuse.

Key Issues Arising from the Review

1.19. It emerged from the review that DS had been a victim of domestic abuse for a prolonged period of time. Despite the help and support offered to DS by her extended family she always returned to her abuser, did not seek support from external agencies and remained largely hidden as a victim of domestic abuse.

1.20. The levels of contact she had with agencies who may have been able to help her was minimal and only Durham Constabulary and the Primary Care Trust through the local GP practice held any significant records relating to her.

1.21. Both agencies along with DTVPT also had contact with her husband DC but the assessment of risk he posed to DS was never assessed as requiring urgent intervention.

1.22. The police report shows that on four occasions between January 2008 and the date of her death the police had contact with DS. On two occasions this related to allegations of assault by DC, one of which resulted in a prosecution, the other led to a restorative justice intervention. On the other two occasions the incidents are described as disturbances where both DS and DC had consumed alcohol. On both occasions the police took positive action short of prosecution, removing DC from the family home overnight.

1.23. The incident which was dealt with by means of a restorative disposal was considered in detail in an independent report prepared by the Independent Police Complaints Commission as a result of which changes were made to police policies and procedures in relation to the use of restorative approaches in domestic violence cases**.**

1.24. The report on behalf of the PCT shows that DS only attended her GP practice on two occasions with injuries from DC. She did have a variety of other health needs including anxiety and depression following the deaths of her brother and her parents. In the latter stages of her life a number of references were made to her increased use of alcohol.

1.25. At the time of her death DS was aged 51 and the review noted that while reports of domestic abuse from women in this age range were much lower than for younger women, that the majority of homicides involving intimate partners featured victims who were over 45 in County Durham and Darlington. A theme running through the review concerned the way agencies related to DS in the latter stages of her life and highlighted that there was a lack of awareness of the risks and needs associated with women in this age range.

Lessons Learned

1.26. The findings from the review highlighted some themes common to other domestic homicides:

- The need to raise awareness of domestic abuse among professionals
- To improve information sharing
- To ensure more staff are trained to ask the relevant questions
- To ensure staff know how to refer on to appropriate support services
- To ensure that victim safety is the highest priority
- Lack of professional curiosity
- Alcohol abuse

1.27. These all featured as areas that could be improved.

1.28. The new areas of learning from the death of DS however concerned the sensitivity of services to the risks and needs surrounding older victims of domestic abuse and the use of restorative approaches in domestic violence situations.

1.29. The report from the IPCC states clearly that restorative justice is not an appropriate first line response to incidents of domestic abuse. This has been accepted by Durham Constabulary who have changed policies and procedures accordingly. The IPCC and Durham Constabulary are confident that this will not be able to happen again in County Durham or Darlington.

1.30. The realisation that DS was not the only victim of domestic homicide in the over 45 year age group has been quite a significant statistic. That only women in this age group have been the recent victims of homicides by intimate partners is a cause for concern.

1.31. The review into the death of DS has highlighted the need to better understand the barriers to reporting domestic abuse in the older age group and to ensure that age is considered as a factor when assessing the risks to and needs of domestic abuse victims.

Conclusions and Recommendations

1.32. As a result of this review Primary Care Trust have identified the need to:

- Ensure training opportunities are brought to the attention of staff in general practices
- Develop a domestic abuse policy for GPs to include guidance on information sharing
- Develop a short prompt tool to support GP's on actions to take in domestic abuse cases and information to give to patients

1.33. Durham Constabulary have:

- Clarified policies on the use of restorative approaches in domestic abuse cases and issued clear guidance to staff

1.34. DTVPT have identified the need to:

Review procedures that are in place to ensure that supervising officers have proper regard for the safety and well being of victims of domestic abuse perpetrators.

- Identify and implement processes to improve the overall quality of supervision, particularly in regard to the development of an investigative approach and the tendency to accept offenders versions of events without proper challenge.

1.35. The overriding actions recommended for all agencies however are:

- To review all existing policies and procedures, as they become due for review, to ensure they are sensitive to the special risks to and needs of older women who are victims of domestic abuse.
- To ensure that all future policies, publicity campaigns, training and other planned activities in relation to domestic abuse are sensitive to the requirements of older victims and the risks of older perpetrators.

1.36. It will be clear from the above recommendations that more could have been done by agencies to support DS as a victim of domestic abuse in terms of further improvements to services. More work needs to be done on identifying the

vulnerabilities of older women, more opportunities created to encourage them to report abuse and more services designed to respond to their specific needs.

2. Introduction and background to homicide

2.1. This review was initiated following the death of DS. Police were called by neighbours who believed they had witnessed DS being assaulted by her husband DC. The neighbours who lived opposite believed they witnessed an attack on DS taking place in the upstairs bedroom of her home, looking from their own bedroom window. At 02:00hrs DS was found dead at her home and her husband DC was arrested at the scene on suspicion of murder.

2.2. DS had been beaten with a walking stick and sustained multiple injuries to her head and body including 21 blunt force injuries, 11 fractured ribs, a broken nose and a broken finger. DS was pronounced dead at the scene. DC subsequently pleaded guilty to the murder of DS and was sentenced to life imprisonment with a tariff of 13 years.

Reasons for Conducting the Review

2.3. Under these new arrangement DHR's should be carried out to ensure that lessons are learned when a person has been killed as a result of domestic violence. The guidance states:

'domestic homicide review' refers to 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 whom he/she was related or had been in an intimate personal relationship, or

(b) a member of the same household

2.4. The purpose of a DHR is to:

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

2.5. DHR's are not inquiries into how victims died and are not part of any disciplinary enquiry or process. These are matters for the individual agencies involved. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms procedures, resources and interventions.

Process of the Review

2.6. The Statutory Guidance for Homicide Reviews came into effect in April 2011 shortly before the death of DS. The death of DS was the first in County Durham to meet the criteria for a review to take place and at the time there were no procedures in place which had been agreed by the Safe Durham Partnership. Reviews of domestic homicides had however previously been undertaken and for the purpose of preparing this report, the existing voluntary guidance was referred to alongside the new statutory guidance. Safe Durham Partnership approved local procedures in July 2012 and the report has been completed and written using the structure and format suggested in those guidelines.

2.7. The Statutory Guidance for Homicide Reviews requires the Community Safety Partnership to advise the Home Office of relevant deaths. Probably due to the short time which passed between the issue of the guidance and the death of DS, plus changes in personnel, this notification did not take place within the required timescales.

2.8. As there were no child safeguarding issues at the time of this homicide it was not necessary to commission a Serious Case Review from the Local Safeguarding Children Board.

2.9. A specific Domestic Homicide Review Panel met on 26 July 2011 and was made up of representatives from the following agencies:

Agency
Local Safeguarding Children Board
Durham County Council Children and Young People's Service
Durham Constabulary
Durham Primary Care Trust
Independent Police Complaints Commission
Durham County Council
County Durham Youth Offending Service
Durham County Council Education

2.10. Durham County Council (DCC) had earlier approached DTVPT to ask if the author of this report, Hazel Willoughby could be allowed to chair the review panel as she was identified as having relevant experience due to involvement in earlier homicide reviews that had been held under the local guidance that preceded the statutory guidance.

2.11. Hazel Willoughby is a Director of DTVPT and has worked within the Probation Service for 36 years. She is currently Director of Offender Services in Darlington and holds Trust wide responsibility for Public Protection and MAPPA. She is Chair of the MARAC Board and has extensive experience of working in the area of domestic abuse.

2.12. As a result of the initial meeting the following agencies were asked to secure their records and undertake an Individual Management Review (IMR):

- County Durham PCT
- Durham Constabulary

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

2.14. The initial meeting also identified gaps in information about DS and DC and further necessary enquiries were identified. Altogether 14 agencies were asked to search their records for information in relation to DS and DC. Of these, Primary Care Trust, Police and Probation prepared reports and CDDFT provided a note of their very brief involvement.

2.15. Two services had notes of brief contacts that were not relevant.

2.16. Eight services had no record of contact. Significantly this included outreach services whose only contact was to receive a referral following the incident the previous month. Despite several attempts to contact her, DS did not respond.

2.17. It was agreed at the initial meeting that the primary focus of the review would be between 01/09/09 and 17/05/11. These dates were chosen on the basis of information provided regarding call outs by the police to the family home.

2.18. It later emerged that this excluded an incident when following a call to the family home DC was arrested and charged following an assault on DS. He was subsequently convicted of common assault in 2008 and made subject to a period of community supervision. It is unclear how this oversight occurred but it is an error that is also reflected in the IPCC report.

2.19. Had this information been clear from the outset then the start date for the review would have been 01/01/08. The key reports provided by the Police and Primary Care Trust do provide information covering this additional period and earlier. A report was subsequently requested from DTVPT covering the period of DC's supervision.

2.20. The enquiries made of agencies which identified no knowledge of DS and DC were not limited to a time period so I am satisfied that their responses were not affected by the initial confusion.

2.21. All legal processes in relation to the death of DS have been concluded and DC was convicted of her murder and sentenced to life imprisonment.

Time Period

2.22. The review began on 26 July 2011 and was concluded when it was approved by the Safe Durham Partnership on 26th November 2013.

2.23. The delays in completing the report first of all came about due to difficulties in obtaining access to GP records. It was not until January 2012 that the IMR author was able to secure access to the relevant records. This was the first experience the Practice had of involvement in a Homicide Review and there were issues concerning consent, the fact that legal processes had not been concluded, confidentiality and payment for copying the relevant materials.

2.24. The second set of delays related to the unavoidable absence from work of an IMR author.

2.25. It was not until late December 2012 that all of the relevant material had been collected together and work could begin on the overview report.

2.26. I am sure that the guidance which has now been approved by the Partnership will assist greatly in unblocking some of the difficulties encountered in securing the full cooperation of agencies who have little or no experience of Homicide Reviews.

2.27. We do need to consider what actions are to be taken in the future when key staff have lengthy unavoidable absences from work. On reflection it might possibly have saved some time if the work could have been reallocated to a new person although this is by no means certain.

Confidentiality

2.28. The findings of each review are confidential, information is available only to participating officers/professionals and their line managers.

Dissemination

2.29. The following have received copies of this report:

- Chief Superintendent Paul Goundry of Durham Police
- Diane Richardson Designated Nurse Safeguarding Children County Durham and Darlington NHS Trust
- Safe Durham Partnership

2.30. A copy of the final report will be provided to family members following quality assurance by the Home Office.

Terms of Reference

2.31. The terms of reference adopted for the main review were adapted from the statutory guidance.

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

2.32. In addition a separate set of terms of reference were drawn up for the investigation by the IPCC, these were:

1. To investigate Durham Constabulary's response to the report of Domestic violence and in particular:-
2. To examine the previous and current Restorative Justice Policy (Level 1) to determine whether or not it is/was suitable for dealing with incidents involving domestic violence.
3. To consider the supervisory decision to sanction the restorative justice response to this incident.
4. To examine Durham Constabulary's Domestic Violence policy to identify whether or not it conflicts with the Level 1 Restorative Justice policy.
5. To assess the training and guidance given to front line staff when considering Level 1 disposals via the restorative justice process.
6. To liaise closely with the Domestic Homicide Review and Durham Major Investigation Team when obtaining and sharing information throughout the investigation process.

7. To assist in fulfilling the states' investigative obligation arising under the European Convention of Human Rights (ECHR) by ensuring as far as possible that :-
8. The investigation is independent on a practical as well as an institutional level;
9. The full facts are brought to light and any lessons are learned.
10. To identify whether any subject of the investigation may have committed a criminal offence and if appropriate make early contact with the relevant prosecuting body.
11. To identify whether any subject of the investigation may have breached their standards of professional behaviour. If such a breach may have occurred, to determine whether that breach amounts to misconduct or gross misconduct and whether there is a case to answer.
12. To consider and report on whether there is organisational learning for the appropriate authority, including:
13. Whether any change in policy or practice would help to prevent a recurrence of the event, incident or conduct investigated.
14. Whether the incident highlights any good practice that should be disseminated.

2.33. I am satisfied that these terms of reference taken together have provided a comprehensive overview of the circumstances of the death of DS.

Individual Management Review Authors

2.34. The following Individual Management review Reports (IMR):

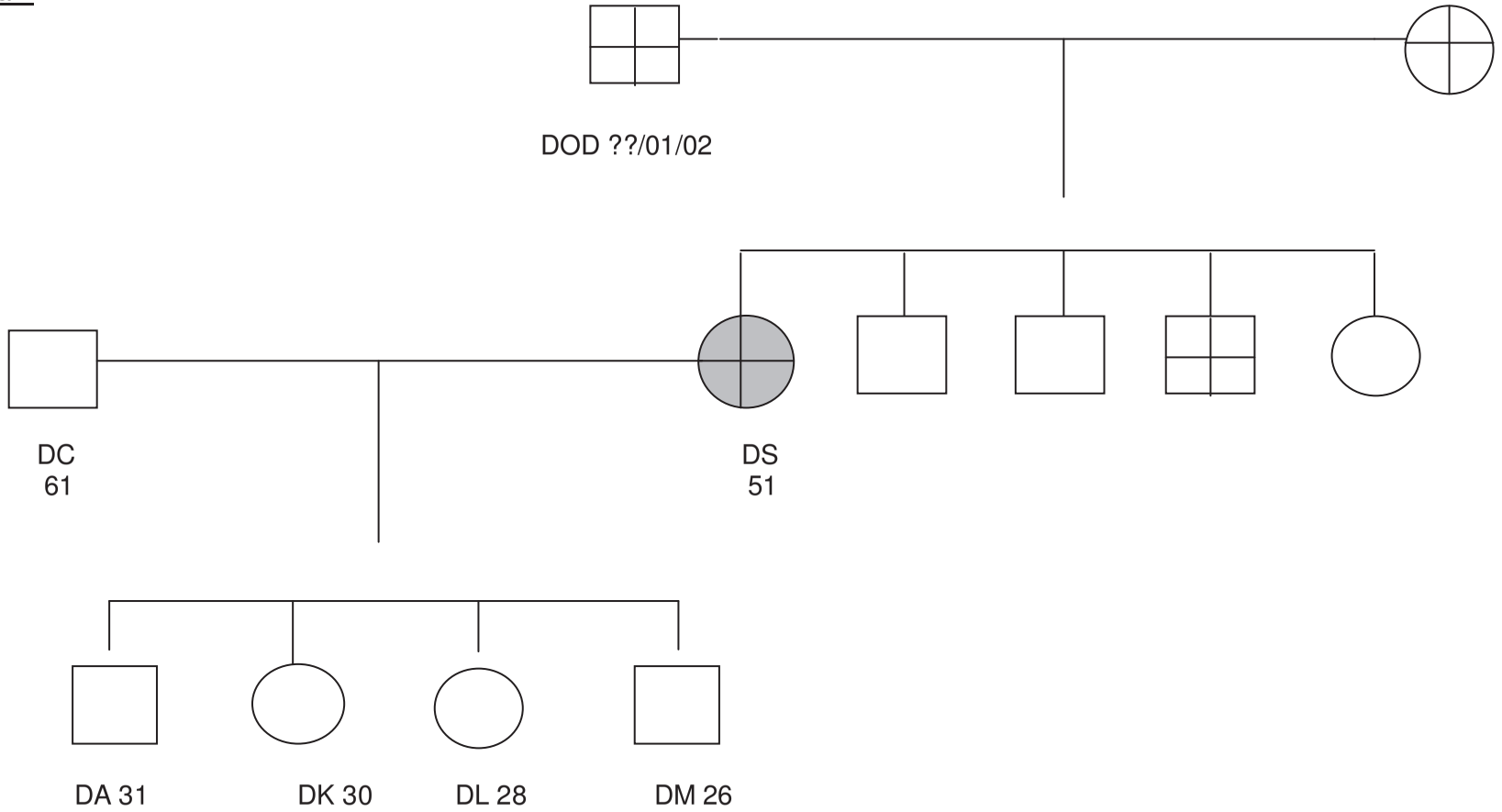
Organisation	**Job Title**
Durham Constabulary/ IPCC	Inspector IPCC/Durham Constabulary lead domestic abuse
County Durham PCT	
DTVPT	Lead Manager Public Protection

Subjects of the Review

Description	**Reference**	**Additional Information**
Deceased	DS	Age 51 at time of death
Perpetrator (Husband of deceased)	DC	Age 61 at time of offence
Son of deceased	DA	Age 31 at time of offence. Married no children. Living independently.

Daughter of deceased	DK	Age 30 at time of offence. One child age 10. Living independently
Daughter of deceased	DL	Age 28 at time of offence. Living independently
Son of deceased	DM	Age 26 at time of offence. Married no children. Living independently.

Family Genogram



Involvement of Family Members, Friends & Colleagues

2.35. The family have been supported throughout by the Police Family Liaison Officer and by the Victim Liaison Officer. They have also had separate contact with the IPCC for the purpose of their enquiry. DA has assumed the role of spokesperson for the family and is the first point of contact for agencies. I have met with DA and DK but DL and DM have declined contact. They have also declined contact so far with the VLO.

2.36. The family have reflected that at times they have found the process of dealing with the aftermath of their mother's death quite intrusive and have needed time for themselves to grieve and to begin the healing process.

3. Domestic Homicide Review Panel Concluding Report

Introduction

3.1. This review report is an anthology of information and facts from three agencies, all of which were potential support agencies for the victim. This report of a domestic homicide review examines agency responses to and support given to the victim, a resident of County Durham prior to the point of her death.

3.2. Durham Constabulary, the GP practice and DTVPT had relevant and significant records of contact with the victim prior to her death.

3.3. Durham Constabulary had attended incidents at the victim's home.

3.4. The GP practice had offered health care to DS for many years including two occasions where she attended with injuries. They also offered health care to the perpetrator DC.

3.5. DTVPT supervised DC on a Community Order in 2008 following a conviction for an assault on DS

Summary of the Case

3.6. DS and her abuser DC had been married for 30 years and had 4 adult children. She died at home following an assault by her husband DC.

3.7. DS and DC were living together at the time of her death and although there were periods of separation, including in the latter stages of her life, usually following incidents of abuse, there was a well established pattern of DS returning to DC within a very short space of time.

3.8. In the period covered by this review DS was seen by clinicians in her general practice on two occasion with injuries, attended hospital on one occasion after a fall in the street and on two other occasions having attempted to take her own life.

3.9. Medical records and information from the family suggest that DS had a significant alcohol abuse problem in the latter stages of her life as well as suffering from depression linked to family bereavements. Likewise DC also had an alcohol abuse problem which is confirmed by the family, police and probation records.

3.10. There were three attendances at her home by Durham Constabulary, two of which involved positive action short of prosecution and one occasion where a restorative approach was taken. This latter incident has been the subject of an investigation by the IPCC.

3.11. The review also includes information from DTVPT concerning the supervision of DC following a conviction for assault on DS in 2008.

The Context of Service Involvement

3.12. The interim Safe Durham Partnership Domestic Abuse Strategy 2011-12 and the Safe Durham Partnership Joint Commissioning Strategy for Domestic Abuse Services 2011-14 identifies the environment in which practitioners work, the policy frameworks and organisational structures. These documents were referred to by the Review Panel whilst undertaking the review.

Analyses of Individual Management Reviews

3.13. The focus for this section of the report will be an analysis of the response of services involved with DS or DC, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

3.14. In order to manage an account of agencies involvement, the domestic homicide review author has described separate involvement of each agency below.

4. **Review of IMR Prepared by Primary Care Trust**

4.1. The report provided detailed factual information about the care DS and DC received from their general practitioners. The report gives a detailed breakdown of contact during the review period and a helpful summary of contact pre 2009. The only other health information provided was a note from CDDFT of an attendance at A&E by DS in 2010 following an overdose which is included in the chronology.

4.2. The IMR author helpfully reminds us that :

4.3. *"one of the most common problematic tendencies in human cognition.is our failure to review judgements and plans - once we have formed a view as to what is going on, we often fail to notice or to dismiss evidence that challenges that picture. (Fish et al 2008)"*

Summary of Involvement of DS and DC with health services

4.4. During the review period from September 2009 to May 2011 DS was seen 13 times by the GP practice, 9 times of which she was seen by a GP and 4 times a practice nurse. In the same period DC was seen 8 times.

4.5. The average attendance by a patient is described as 5.5 times per annum of which 4 would be GP visits and 2 practice nurse visits.

4.6. Overall, from the start of electronic records in 2001 until her death in 2011 DS attended the practice on 58 occasions - the majority of times for minor health issues, common ailments and routine screening. She had frequent periods of stress anxiety and depression and in the last 3 years of her life, there were several references to concerns about her alcohol consumption.

4.7. DC also suffered periods of depression and had a series of chronic physical health problems which affected his mobility and necessitated the use of a walking stick.

4.8. In the latter stages of her life DS identified concerns about DC's health as contributory factors to her own depression. DS was referred for counselling in

2008 following the assault by DC and again in 2010. On both occasions the service was discontinued after a short time due to failure to attend appointments.

4.9. From the records the IMR author was able to identify 4 occasions when DS attended accident and emergency and 2 occasions when DC attended accident and emergency from 2004 onwards. These occasions are summarised below.

4.10. With the addition of the item in italics these are the only reports of DS or DC receiving medical treatment for injuries.

4.11. None of the hospital attendances required inpatient treatment and the table below summarises the history of hospital attendance and reports of injuries.

Attendances at A&E and Reports of Injuries

Date	DS	DC
Redacted	A&E letter to GP reveals DS attended with a bruised chest which was recorded as having fallen down stairs	
Redacted		A&E letter to GP attended following an alleged assault injured left arm and right hand and blow to head from heavy object
Redacted		Attended A&E under police arrest suffering chest pains (this followed an assault on DS)
Redacted	*Attends GP as a result of injuries from assault on 01/01/08*	
Redacted	Letter from A&E. Attended following deliberate overdose	
Redacted	Taken to A&E by ambulance suspected to have fallen in street no obvious injuries but showing signs of alcohol misuse	
Redacted	Letter to GP from crisis team following A&E visit	
Redacted	*Attends GP as a result of injuries following assault by DC*	

4.12 Other than the above, DS attendance at her GP practice was in relation to specific physical and emotional health concerns. DS had periods of anxiety and depression dating back to 2002 which were managed by her GP and some general health issues requiring specialist treatment including surgery. From early 2008 she was intermittently recorded as abusing alcohol, misusing prescription medication and self harming.

Relevant DS Interaction with GP Practice 2008 – 2011

2008

4.13 DS was seen at the GP practice for injuries following an assault by her husband DC. These injuries were a bruise to the right cheek and a bruise to the right chest wall but no fractures. The incident was noted in the records using a read code which indicated assault. In the following months she was noted as being depressed and having multiple problems, however she did improve. She was referred for counselling, but attended only for the assessment and was therefore discharged. It is noted that at the time she was caring for a terminally ill parent. There is no note of further questions in relation to the assault. The GP practice was aware of the involvement of the police on this occasion as they were requested to provide a statement relating to injuries.

2009

4.14 There were no significant contacts identified by the IMR author during 2009.

2010

4.15 In April 2010 DS attended hospital following what was recorded as a deliberate overdose where she was seen by a liaison psychiatric nurse. CDDFT have provided a note of this attendance which is included in full in the chronology. DS disclosed that over a period of hours when her husband was out she drank ½ litre of vodka and consumed medication which had been prescribed for DC. This was as a result of thinking about her dead brother who had also taken an overdose. She was found by a friend who accompanied her to hospital. DS told medical staff this was an impulsive act and that she felt foolish and regretted her actions. There was no history of involvement with mental health services and DS denied a history of self harm or overdose.

4.16 There is no evidence she was asked about domestic abuse. In follow up appointments with her GP she stated that she had been thinking about "losses in her life". At the time she disclosed she was drinking about 30 units of alcohol per week and was advised to cut down. She was prescribed antidepressants and self reported an improvement over a period of two months. She failed to keep appointments that were made through the practice with a counsellor and was subsequently discharged from that service.

4.17 In July 2010 DS was taken to hospital by ambulance after apparently having fallen over while drinking heavily. There was no note of any injuries. She failed to attend her GP for follow up appointments.

2011

4.18 DS was seen by the mental health crisis team in early 2011 when she was considered to be experiencing unresolved bereavement issues in relation to her deceased parents as well as drinking excessively. She was also reported to be concerned about DC who required surgery. She had a follow up appointment with her GP two weeks later when she was noted to be drinking heavily, living with her daughter and suffering "acute situational disturbance". There was no reference to domestic abuse but she was referred for counselling and prescribed anti depressants. Again she failed to attend for counselling appointments and was discharged from the service.

4.19 DS last appointment with her GP was 12 days after the assault in April 2011. She did disclose that she had been assaulted and was looking for her own accommodation as DC was still living at home. She was given information

about outreach services although no code indicating domestic abuse was entered on the system.

Relevant DC interaction with GP practise 2008-2011

4.20 All of DC's interactions with the GP practice were related to the range of chronic health issues from which he suffered. There was nothing reported by the IMR author in relation to domestic abuse.

Conclusions from Primary Care Trust IMR author

Training

4.21 While all of the GP's in the practice had attended Level 2 Safeguarding Children training, which includes some reference to domestic abuse, none had attended specific domestic abuse training. A short session had taken place at the surgery in 2010 in relation to MARAC, which had been established in 2009, but none of the GP's had attended formal Multi Agency Risk Assessment Conference (MARAC) training.

4.22 The IMR author concluded that a greater knowledge and awareness of domestic abuse and MARAC may have enabled the practice to carry out a fuller risk assessment and be more sensitive to the victimisation of DS.

Policies and Procedures

4.23 GP's are independent contractors within the health community and as such are responsible for their own policies and procedures. During the period of the review the practice did not have a specific domestic abuse policy in place. Policies in relation to vulnerable adults and safeguarding children were in place and did include references to domestic abuse but these were not helpful to GP's in developing their response specifically to the domestic abuse.

4.24 In relation to policies and procedures on risk assessment and management, MARAC and the associated information sharing protocol had been implemented in 2009 and a briefing had been delivered to the practice which included an overview of the risk assessment tool and referral process. The briefing was only meant as an introduction to the subject and because the full training had not been undertaken the GPs had not identified that it included a risk assessment tool which they could use in known or suspected cases of domestic abuse. This gap in knowledge meant the practice did not take further action on the two occasions when domestic abuse was disclosed by DS on the basis that the police were already involved. The IMR author highlights Director of Health Guidance from 2006 which states that health professionals should

never assume that someone else will take care of domestic abuse issues

4.25 The IMR author concludes that there were a number of opportunities for risk assessments to be carried out by the practice following disclosure of domestic abuse or the presentation of issues which are recognised as indicators of abuse, however due to gaps in knowledge and understanding and a lack of policies and procedures specifically in relation to domestic abuse, no action was taken.

Information sharing

4.26 The IMR author considered in depth the sharing of information both within and external to the practice. There was no domestic abuse related information in either DS or DC's medical record from the police or other non-health organisations.

4.27 In terms of other health professionals, there was also no evidence that GP's shared or received any information relating to DS being a victim and DC a perpetrator of domestic abuse. The letters from A & E previously referred to did not identify any of the injuries or overdoses as having been a result of domestic abuse and it is not possible to establish whether any disclosures or enquiries were made.

4.28 Concerning communication within the practice DS disclosure of 2008 was recorded. Following the introduction of electronic records the system introduced by the practice included the facility to add "read codes" to records, highlighting areas of concern for GP's. The RCGP guidance is referred to by the IMR author as stating:

4.29 *"whenever there is a disclosure of a domestic violence incident this is recorded using appropriate read codes in children's medical records as well as (both) the adults medical records"*

4.30 At the time the IMR author was conducting her enquiries it is stated there were 13 different potential read codes in relation to domestic abuse although none were applied to either DS or DC records. It is clear from the report that there was uncertainty and some disagreement within the practice about how and when read codes should be applied e.g. concerns about whether allegations of abuse were sufficient to justify a case being flagged. The guidance from the Royal College of General Practioners (RCGP) was not particularly helpful as it was only guidance and did not give clarity to GP's about how codes should be used.

4.31 It is clear that the necessary discussions had not taken place locally at the time as to how the systems were to be introduced locally and therefore neither the records of DS or DC contained any read codes in relation to domestic abuse. The record of DS did have a read code in relation to the 2008 incident, but the code used was the code for "assault". The person who added the code felt this was helpful as one or more assault codes added would have prompted other GP's to review the patient's record further. However the IMR author is clear that the assault code is not applicable in cases of domestic abuse as domestic abuse does not always involve physical violence or assault.

4.32 The absence of read codes meant that it was not easy for other health professionals who accessed the records to pick up on the domestic abuse issues. While there were quarterly practice meetings in relation to safeguarding, there was no similar formal opportunity to discuss patients who were victims or perpetrators of domestic abuse although concerns were stated to be shared "informally over coffee".

4.33 The IMR author is clear that in general the information and guidance available to GPs from the Department of Health in relation to information sharing and domestic abuse was confusing and contradictory and this is evidenced clearly in the report. Although not specifically stated the conclusion is clear that busy GP practices with only a short time allocated for each patient need clearer guidance and a quick reference point for information and guidance in relation to domestic abuse.

4.34 The key conclusions drawn up by the IMR author are summarised by her under two headings:

a. Guidance for GPs:
GPs need concise and easily accessible information and guidance on responding to domestic abuse. In this case improvements could be made by the practice in terms of the identification of victims and the follow up arrangements for their care, also with regard to information sharing both

internally and externally with other disciplines of staff. The IMR author also highlighted that in view of the lengthy delays in obtaining access to records for the purpose of completing this report, that information and guidance about the preparation of DHR's should also be provided to practices.

b. Education and Training: The IMR author states:
A better understanding of domestic abuse is the key to implementing new ways of working effectively and safely. The GP's clearly had some understanding of domestic abuse but have not had formal training hence their knowledge was limited and in some instances not entirely accurate.

Recommendations from IMR Author

1. A system needs to be established to ensure training opportunities are brought to the attention of staff working in General Practices

2. A domestic abuse policy to be developed as a partner to the existing domestic abuse and safeguarding children policy. This policy will also include guidance on information sharing, the use of read codes to facilitate this and the requirement that all departments / practices identify a person to take a lead on domestic abuse.

3. Given the limited appointment times within which GP's work they would benefit from a short guide which would prompt them on actions to take and information to give to the patient

4. The delay in obtaining records in order to commence this review was primarily due to staff at the practice not understanding the nature and purpose of a DHR. Information needs to be disseminated to all local practices to ensure timely engagement in the event of future DHRs.

5. Review of IMR Prepared BY IPCC/ Durham Constabulary

Summary of police contacts with DS and DC

Date	Incident	Outcome
Redacted	DC charged Drunk and Disorderly. No other information available.	Conditional Discharge 6 months.
Redacted	DC charged common assault. Police records refer to this as a drunken altercation. Victim daughter DK.	Conditional Discharge 12 months
Redacted	DC charged common assault. Police intelligence states drunken altercation. Victim DS was punched and kicked.	12 months Community Order
Redacted	Police called to disturbance at family home. DC and DS both drunk.	DC made to leave property and warned he would be arrested if he returned that night. No further action.
Redacted	Police called to drunken verbal disturbance at family home. DC and DS both drunk.	DC arrested to prevent Breach of the Peace. Released NFA the following day.

Redacted	Police attended following call from DK. DS confirmed she had been assaulted by DC on 16/04	Incident dealt with by way of restorative justice. Subject of investigation by IPCC.
Redacted	Police attended family home following report from neighbour. DS found dead at scene.	DC charged with and convicted of murder.

5.1 DS has no previous convictions.

5.2 Prior to 2000 DC had appeared before the Courts on 8 occasions going back to 1967. Other than one assault charge in 1971 the offences involved were motoring matters, petty thefts, a Public Order Offence in 1982 and Bail Act Offences.

Detail of Police Involvement

5.3 As can be seen from the above information, alcohol featured heavily in all the police call outs post 2000 and involved both DS and DC. The offences charged in 2005, when the victim was DK (26 Years) and 2008 when the victim was DS were both Common Assault. This was the most serious relevant charge faced by DC but is the lowest level of charges relevant to an assault.

5.4 The circumstances of the 2008 offence were a drunken altercation between DC and DS in the early hours of New Years day following a separate argument between DC and his daughter DK. The assault took place in the presence of DK and involved DC punching and kicking DS in the face and chest. DS indicated to the Probation Officer who prepared reports on the matter that on this occasion she was willing to co-operate with the police because DC “has got away with this too many times “.

5.5 The Police were called to the family home again in September 2009 after a complaint from DS that DC had threatened to throw her down the stairs. Both parties were drunk at the time and DC was instructed to leave the property and warned he would be arrested if he returned that evening. This was a standard level of intervention and no further action was taken by the domestic abuse unit. There were no reports of injuries.

5.6 A similar situation arose in June 2010 and on this occasion DC was arrested to prevent a breach of the peace. He was released the following day and no further action was taken. This was in line with the national process to deal with breach of the peace arrests. The incident was originally graded at medium by the officers attending but this was reduced to standard by the sergeant in the domestic abuse unit. Again there were no reports of injuries. There were no reports of injuries on either occasion.

5.7 In relation to the call outs in 2009 and 2010 both of these were assessed using the DASH model. This is a widely used risk indicator for Domestic Abuse Stalking and Honour Based Violence developed and recommended by CAADA (Co-ordinated Action Against Domestic Abuse). Incidents are graded standard, medium and high, dependant on the victims answers to a series of questions and taking into account the officers professional judgement, knowledge of victim, perpetrators and children who may have been involved with the police over a period of time. The table below identifies what is indicated by each of the grading.

Standard	Current evidence does not indicate likelihood of causing serious harm.
Medium	There are identifiable indicators of 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, for example failure to take medication, loss of accommodation, relationship breakdown drug or alcohol misuse.
High	There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm (Home Office 2002 and OASys 2006): 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

5.8 In Sept 2009, the incident was graded standard which means that on the basis of the answers DS provided to the DASH questions and the known intelligence, plus the officers judgement that at the time the evidence did not indicate a likelihood of risk of serious harm. What was known at the time was only that there had been an incident in January 2008 which had resulted in a prosecution. There had been no police call outs since then which was a period of 21 months and there were no reported incidents or injuries although this does not mean that DS had not been assaulted during that period.

5.9 In June 2010 the incident was originally graded as medium but was reduced to standard on review by the supervising officer as part of police standard operating procedures. Positive action was taken in as much as DC was arrested to prevent a Breach of the Peace although he was released the following day and allowed to return home. On this occasion there had been a gap of 9 months since the police were called to the home.

5.10 The intelligence which informed this decision was again DS answers to the Domestic Abuse (DASH) questions plus intelligence of the incidents of 2008 and 2009. On neither occasion, Sept 2009 or June 2010, are there reports of any injuries. Under these circumstances the decisions reached by the officers involved were appropriate given the information that was available at the time. Clearly however from information provided by the family, domestic abuse was and had been an ongoing feature of the life of DS and DC although the extent of this did not emerge from enquiries made at the time.

5.11 The assessed levels of risk of harm did not meet the threshold for referral into MARAC.

5.12 The next police call out was in April 2011 and this was the incident which was investigated by the IPCC.

<u>Detail of Events on April 2011 from IPCC Report</u>

5.13 The IPCC report tells us that police were called to the family home by DK who believed her mother had been assaulted by her father a few days prior and she was concerned that he might not be letting her out of the house. She disclosed at this stage that her father had previously been violent to her mother.

5.14 When the police attended they were let into the house by DC but spoke to DS alone. She disclosed that she had been injured in an argument with her husband four days earlier when he pushed her over in an argument causing her to bang her head and exacerbate a back injury. DS was tearful in interview and said she

was depressed. She was not willing to make a complaint and was clear that she would not assist the police or attend any future court appearance.

5.15 The officer spoke to DC who accepted what he had done to his wife, appeared remorseful and stated the cause of the argument was that he had consumed excessive amounts of alcohol.

5.16 As DS was so determined not to make a complaint the officer decided to explore a restorative justice approach as a way forward in this incident which would allow a resolution acceptable to all parties. DS and DC both supported this course of action and the officer got both DS and DC to sign a notebook entry to this effect. The decision to adopt this approach was further endorsed by the officer's supervisor after consideration of the history of call outs to the address which showed that since the assault in January 2008 there had been only two call outs to verbal altercations as previously identified, September 09 and June 2010.

5.17 The officer attending and their supervisor had both attended training in restorative justice delivered in February 2011 aimed at neighbourhood policing teams, response officers and PCSO's.

5.18 The report by the IPCC looked in detail at the decision to adopt a restorative approach, the restorative justice training that had been recently rolled out in Durham Constabulary as well as local and national policies and procedures in relation to both domestic abuse and restorative justice.

Findings from IPCC Report

Restorative Justice Training

5.19 Restorative Justice training had commenced in Durham Constabulary on 14/2/11, although at that time the force policy on the issue had not been finalised. The training was based on the ACPO Restorative Justice and Minimum Standards Guidance Level 1 together with a draft Restorative Justice Policy produced internally by the constabulary.

5.20 Level 1 Restorative Justice is defined as :

"An instant on-street disposal where police officers or PCSO's use restorative skills to resolve conflict in the course of their duties, which allows staff to deal with minor crimes and disputes quickly and proportionately. Offenders are diverted away from the criminal justice system."

5.21 The ACPO guidance was published to assist police forces in their introduction and management of restorative justice processes although it was always intended that forces would eventually produce their own local procedures to compliment the ACPO guidance.

5.22 The ACPO guidance did contain a gravity factor decision matrix based on a traffic light system. Within this matrix domestic abuse was a "red" i.e. most risky type of offence for which it was suggested caution was necessary and advice should be sought from supervisory staff or other agency experts before proceeding with a restorative approach.

5.23 The matrix was developed to assist officers in making charging and cautioning decisions for adults with Level 1 and Level 2 on the matrix being suitable for an on street disposal or formal caution. It does not mention domestic violence as an offence but identifies "assaults " at Level 3 or Level 4 on the matrix and

considered domestic abuse as an aggravating factor. This would mean that under the matrix domestic abuse would not qualify for an on street disposal.

5.24 The draft force policy on restorative justice which was in place at the time the training took place contained a list of excluded offences but domestic abuse was not on the list. It did however state that for offences to be suitable for a restorative disposal they must be low-level minor offences at Level 1 or Level 2 in the gravity matrix.

5.25 Prior to the training being delivered a validation event took place where the question of domestic abuse and restorative justice was raised. The answer given, according to the IPCC report, was that domestic violence should not normally be subject to restorative justice, however at no time in the training was it suggested that restorative justice could not be used for domestic abuse cases. The response officer attending the home in April 2011 and their supervisor had both taken part in this training.

5.26 The response officer told the IPCC investigator that they believed from the training that restorative justice was:

"an additional tool to enable them to deal with any offences other than serious assaults, murder rape and similar serious crimes. It could be used actively and positively to help deal with incidents and crime in a victim focussed manner, obtaining the best results for the victim within the given circumstances."

5.27 The supervisor told the IPCC investigator that their understanding of the course was that:

"when officers were asked to attend to a report of a crime they were advised to consider restorative justice as the first way of dealing with the incident if the victim agreed to this course of action and the offender admitted the offence"

5.28 The supervisor believed that the training had not stated that restorative justice could not be used on domestic abuse incidents, which was correct.

<u>Restorative Justice Force Policy (Draft)</u>

5.29 According to the IPCC, at the time of the death of DS the force policy was still under development and various versions were in circulation. Consideration had been given to postponing the training until the policy was finalised although operationally this was not possible. The draft policy was very similar to the ACPO Guidance already referred to and additionally contained a list of excluded offences. Domestic abuse was not on that list although the draft policy did suggest that for offences to be suitable they must be low level offences at Level 1 or Level 2 on the gravity matrix previously referred to. The final version of the force policy was not agreed until shortly after the death of DS.

<u>Domestic Abuse Force Policy</u>

5.30 The IPCC reports the key features of the forces domestic abuse policy in place at the time of the death of DS which stipulates that the following actions must be taken:

- the officer attending must gather all available information and record all details in their pocket notebook

- officers should separate parties in order to speak with the victim on their own so they are more able to speak freely without fear of the perpetrator overhearing them.
- the officer must gather evidence of potential offences.
- a pro-active stance should be taken regarding arrests and officers should be making arrests even if the victim refuses to give a statement but there is other evidence to substantiate that an offence has taken place
- the officer should assist in the risk assessment process by completing the vulnerable adult concern form and following the domestic abuse stalking and honour based violence model.
- officers should grade the risk they feel is appropriate and inform their supervisor of their reasoning.
- the supervising officer should ensure that the officer has dealt with the incident appropriately and they have adhered to their responsibilities.

Conclusions of IPCC Report

5.31 The report of the IPCC identifies 7 key conclusions from the investigation.

1. Other than the failure to adopt a proactive approach, the officer attending the incident in April 2011 complied with the force domestic abuse policy.
2. Given what the officer understood from the restorative justice training they had attended, the decision to adopt this approach was understandable given that the assault had been committed some days previously and there was no immediate threat to DS. The supervising officer's decision to endorse the approach was similarly understandable.
3. The decision not to take a proactive approach and not to arrest DC is however the subject of some criticism. The report says:
   "The proactive stance on domestic abuse must not be undermined and the omission of reference to domestic violence in the draft force policy (on restorative justice) and lack of clarity during the training of restorative justice may be perceived as a serious flaw".
4. The report concluded that at the time there was a conflict between the force policies on restorative justice and domestic abuse, the first seeking to divert offenders from the criminal justice system, the second promoting positive action against offenders.
5. The training on restorative justice was confusing and lacked clarity.
6. The decision to proceed with the restorative justice training prior to a final force policy being in place added to the confusion.
7. The decision to resolve the incident on April 2011 by way of restorative justice had no direct correlation with the incident the following month.

Actions from IPCC Report

5.32 Durham Constabulary accepted the findings of the IPCC report in full and as a result carried out a review of their policy on restorative justice.

5.33 That policy is now unequivocal in relation to domestic abuse. The policy states:

"Under no circumstances should restorative justice principles be applied to the initial attendance at any domestic violence incidents"

"Positive action must be taken i.e. the arrest of the perpetrator and the recovery of evidence as per the domestic violence policy"

"Restorative justice disposal may only be considered as a resolution to such incidents only after positive action has been taken in the first instance and only with the expressed permission of (named senior officer) who must be consulted with first"

5.34 This wording was agreed with the IPCC who were satisfied that this would ensure that incidents of domestic abuse would never be diverted away from the criminal justice system or disposed of by way of on-street disposals without accompanying consultation with a Senior Officer.

6. Review of IMR Prepared by DTVPT

6.1 Following errors already identified in terms of information provided to identify the victim and the perpetrator a full IMR was not commissioned from DTVPT at the outset. This was later corrected and a report has been provided about the period of supervision between 06/03/08 and 06/03/09 which was the only time DTVPT had contact with either the victim or the perpetrator.

6.2 This report has been produced entirely independently of myself and I can confirm that I had no dealings with the case prior to conducting this review.

Summary of Contact with DC and DS from Review Report

6.3 Durham Tees Valley Probation Trust had no contact with DS.

6.4 On 06/03/08 DC was made subject to a supervision order for 12 months for the offence of Common Assault on DS committed on 01/01/08.

6.5 A Pre Sentence Report (PSR) was prepared for the court hearing which outlined the circumstances of the offence including the statement from DS that her decision to prosecute was based on the fact that "he has got away with this too many times", indicating that the offence was not an isolated incident but part of a pattern of abuse. The author did check with the police domestic violence unit but did not identify any previous incidents reported to the police which is consistent with the information in the police IMR.

6.6 DC was identified as a medium risk of harm to a known adult using the OASys (Offender Assessment System) which is the nationally used system across Probation Trusts for addressing risk and criminogenic need. Medium risk of harm is defined as:

"There are identifiable indicators of risk of harm. The offender has the potential to cause harm but is unlikely to unless there is a change in circumstances"

6.7 The factors assessed as contributing to offending were, in ascending order of seriousness, accommodation, relationships, attitudes, emotional well being, alcohol misuse and thinking and behaviour. An initial score of 63 was noted following the initial OASys assessment out of a maximum possible 168 which supported the assessment of medium risk of harm. A reduction in OASys scores over the supervision period is viewed as a positive indicator in terms of likelihood of re-offending.

6.8 The Pre Sentence Report author correctly identified that alcohol was a major factor in DC's offending, identified health issues and reported that DC had said he was struggling to cope with financial issues and concerns around family issues concerning his children. The author was sceptical of DC's account of the offence and identified a degree of minimisation around his offending.

6.9 The Court had indicated it wished to consider a medium level community penalty focussed on punishment and rehabilitation and after evaluating a number of options the PSR author recommended a community order for 12 months with a supervision requirement. Consideration was given to including a programme requirement but DC was not considered suitable due to his mobility problems. It was felt that his offending could be appropriately challenged through completion of the Citizenship Programme which is a structured programme of supervision delivered on a one to one basis and designed to challenge the criminogenic factors underpinning offending.

6.10 Given that this was DC's first court appearance for an offence against DS and given his history of previous convictions this was a proper recommendation to put before the court.

6.11 Post sentence the case was further assessed using OASys including development of an OGRS score. OGRS stands for Offender Group Reconviction Scale and is a predictor of reoffending taking into account only static factors e.g. number of previous offences, type of offences, age at first conviction. DC was identified as having a 10% likelihood of reoffending in 12 months and 19% in two years using OGRS. This was considered alongside the OASys assessment which includes both static and dynamic risk factors to identify the tier the case was to be managed at and the level of risk of harm. The tier indicates the level of resources to be allocated to a case, Tier 4 being the highest level of resources and Tier 1 the lowest.

6.12 The case was correctly identified as a Tier 2 medium risk of harm using the existing national guidance at the time and was allocated to a Probation Officer.

6.13 A sentence plan was drawn up which identified work around victim awareness, alcohol and violence using the established work in the Citizenship programme. From the outset however it was noted that DC's entrenched attitudes and alcohol misuse were factors that might inhibit change.

6.14 During the period of supervision a total of 21 appointments were offered to DC of which 16 were kept. Acceptable reasons were noted for the missed appointments and no enforcement action was necessary. The pattern of reporting was that DC was seen more frequently at the commencement of the order reducing to monthly in the latter half of the order. This was in line with local standards and expectations.

6.15 OASys was scored at the PSR stage (63) and again on 13/03/08 (score 63), 30/06/08 (score 60), 17/08/08, (score 42), 17/10/08 (score 42) and finally on 06/02/09 (score 45). The reviewer from DTVPT has raised issues about the reduction in these scores and has noted that the text of the records kept does not provide clear evidence to support these reductions. In particular the reviewer could not identify evidence of changes in attitudes. The increase in score between October 2008 and February 2009 was due to reports from DC of increased alcohol usage. The OGRS score did not change and would not have been expected to change.

6.16 The reviewer notes that there is evidence on the file that work from the Citizenship programme was completed and that DC's attitudes toward his offending and toward his partner, DS, were challenged. The file notes that there was clear evidence of victim blaming and while there was some expression of remorse by DC this was not backed up by explanations for or accounts of the offence.

6.17 Although the overall OASys score was reduced during supervision there was no reduction in the risk of harm which remained at medium throughout.

IMR authors Analysis of Community Order

6.18 In their analysis, the reviewer identified seven areas of concern in relation to the management of DC:

1. Historical Information and Analysis

The reviewer felt there could have been more analysis of family dynamics and previous offending at PSR stage which would have better informed risk assessment and risk management planning

2. Liaison with Safeguarding

At the time the offence occurred that led to the community order being made the grandson of DS and DC was asleep in the home and his mother DK was also present. The initial risk management plan in OASys identified this and also that there may have been a need to liaise with Safeguarding if appropriate. While there was nothing to suggest this was necessary the actions themselves appeared to disappear from the planning from the case without any justification, the implication being that this was oversight rather than an assessed decision.

3. Task focus v risk focus

The reviewer is critical of the way in which Citizenship has been completed by the Offender Manager. The view is expressed that the Citizenship tasks were carried out and work sheets completed but without a proper focus on what the implications of the responses were for management of risk in the present time. An example of this related to a file comment about "victim blaming" but a lack of detail about exactly what was said and a lack of evaluation of whether this represented an increase in level of risk.

4. SARA Procedures

Spousal Assault Risk Assessment (SARA) is a specialist tool for assessing risk in domestic abuse cases. It was introduced in 2005 and in 2008 existed as a paper exercise which was expected to be carried out in relevant cases and placed on the file. It was meant to be reviewed alongside OASys on a quarterly basis. SARA was not completed in this case.

5. Disguised Compliance

The reviewer observes that the Offender Manager appeared to accept DC's explanations for absences at face value without attempting to investigate them further or determine any potential implications for the victim. There was a lack of an investigative approach and a failure to check with other agencies that the victim was safe.

6. Victim Focus

The reviewer felt that the overall management of the case lacked an appropriate focus on victim issues. Given that DS and DC were living together there was a lack of detail recorded in relation to DS and a failure to explore how problems raised e.g. financial and health issues impacted on her.

7. Criminogenic Factors

The reviewer identifies that factors that were believed to contribute to the likelihood of reoffending were not properly addressed during supervision, particularly alcohol usage and debt problems. There was no referral

made to specialist alcohol services and DC's claims to have reduced levels of drinking were not verified.

6.19 On the basis of the information available the case was however correctly identified as a Tier 2 medium risk of harm and was supervised by a Probation Officer. As such it did not require specific manager oversight and only if there had been an increase in risk would there have been an expectation that a manager would have become involved.

6.20 Work on the Citizenship induction module was completed as required, this involved work on victim issues and challenging the reasons around DC's offending. 15 appointments were kept and 6 were missed. This level of contact is within the expectations for a community sentence of this type. The reasons given for the missed appointments were related to DC's health, including problems remembering appointments and family bereavement.

DTVPT Policies and Procedures 2008

6.21 The time this supervision was current was prior to the merging of the County Durham and Teesside Probation Services in 2010. It is difficult to establish retrospectively, therefore precisely, what local policies and procedures were in place at the time as when the services merged there was a full scale review and revision of policies procedures and guidance so that they were fit for purpose in the merged Trust. There were however policies and procedures on risk of harm, SARA , MARAC and OASys.

6.22 National guidance in the form of Probation Circular 54 of 2005 had been issued to all Trusts in 2005 and formed the standard to which the County Durham Service was expected to work. It was available to all staff.

6.23 Central to that policy were the following requirements :

- Give high priority to the safety of victims (adults and children) of domestic abuse and their protection from physical, sexual, emotional and mental harm by perpetrators.
- Reduce re-offending by providing perpetrators with attitudinal and behavioural strategies to reduce the potential for harm and by limiting their offending behaviour.
- Enhance the quality of risk assessment and risk management action plans through the effective use of OASys and the Spousal Assault Risk Assessment (SARA); and through obtaining collateral information and inter-agency information exchange by communicating clearly, promptly and effectively with partners in other public protection agencies.
- All NPS staff who come into contact with offenders and victims and the managers of those staff will be appropriately trained in domestic abuse awareness. In addition, relevant specialist staff will be trained in the use of risk assessment tools and good practice and equipped to assess and intervene effectively. Staff will be alert to the possible presence of domestic abuse in all cases with which they have to deal, including those cases that come to their attention for other purposes.

6.24 Training had been provided for staff in relation to the use of SARA and all staff were trained in risk of harm.

Recommendations from IMR author

6.25 Review procedures that are in place to ensure that supervising officers have proper regard for the safety and well being of victims of domestic abuse perpetrators.

6.26 Identify and implement processes to improve the overall quality of supervision particularly in regard to the development of an investigative approach and the tendency to accept offenders' versions of events without proper challenge.

7. Information from Family

Information from the family of DS and DC

7.1 DS and DC have 4 adult children all of whom live in the Northeast and two of whom live within 5 minutes walk of what was their parents' home. The eldest son DA acts as the spokesperson for the family both in relation to this report but also in relation to ongoing victim services. His sisters DK and DL and his brother DM are aware of developments and while they appear to remain a close knit unit, there are differences between them mainly in relation to their attitude to DC. At the present time DA and DM have no direct contact with their father but DK and DL have asked for information about him. I have met DA and DK but have had no contact with DL or DM who have declined to be involved. This pattern of involvement mirrors the arrangements they have established with the Victim Liaison Officer.

7.2 It is clear from contact with the family that the history of domestic abuse goes back more than 25 years. DA said he believes he was about 9 or 10 when he was first aware of DC assaulting DS. He described. as a child. being in bed and his younger siblings joining him while an argument took place downstairs between their parents. His mother later joined them and sought to give reassurance, despite having marks on her face. There were periods when DS and DC separated but DA was clear no matter what they always got back together.

7.3 In my opinion DS clearly was concerned to try and protect her children as much as she could and 25 years ago her position as a mother with 4 small children would have been a difficult one. My assumption from my contact with the family is that, it seems clear to me however that she accepted a level of abuse from DC as the price of keeping that family together.

7.4 I talked with DA about the role alcohol played in his parents abusive relationship. He could not recall his mother being assaulted when his father was sober but was open in stating that in more recent years both his father and his mother in his opinion had a significant problem with alcohol. In the latter period of their relationship this moved from being a bottle of vodka every 3 or 4 days to as much as a bottle of vodka a night. This was in addition to drinking in the local club and taking prescription medication.

7.5 At various times all family members have offered shelter to DS. DA and DK have described a situation where as adults, their mother would come and stay with them following violent arguments with DC but after a few days either DC would call round or she would go back. It was said that she sometimes went back because she knew that he would have received his benefits and that alcohol would be available. Apart from her children DS was said to have had the support of a large extended family any of who would have been prepared to help her out

and offer her shelter. Regardless of support from her family DS always went back to DC.

7.6 I did explore if the family thought there was anything that might have been done to break this pattern and their view was unequivocal that there was nothing anyone could have done. Although they cannot comprehend it, the family believe that DS did love DC. The fear was expressed by them that under the influence of alcohol that one day DS might "snap" and cause serious harm to DC.

7.7 In the last few years of her life family concerns about DS related to her depression and alcohol abuse, at least as much as it did to her abuse by DC. The family clearly feared that she would try to take her own life as her brother had and both DK and DA had attended hospital with her following incidents of overdose. DA told us that the family tried to keep medication prescribed for DC and DS with them, at their homes to prevent DS taking it but inevitably it was removed. The family saw the depression as linked to bereavement issues particularly following the death of DS parents and her brother's suicide, but also to the role that alcohol played in her life. I have never formed the impression that they made a link between the domestic abuse and depression or alcohol.

7.8 At no point has the family indicated that they were aware of the services which were available to support victims of domestic abuse. They themselves had offered strong support to DS over many years but had never sought help or support from outside agencies. It is my assumption from my contact with the family that, for them this was a family matter and with a few exceptions covered later in the report they retained it as a family matter.

7.9 In my opinion what this has meant for them now is that they have carried exceptionally strong feelings of guilt and feelings of responsibility for DS death. In my opinion the reason why DA has taken on the role of spokesperson for the family is in order to try and afford them a degree of protection which he was unable to offer his mother.

7.10 Since 2011 DK and DL have each had periods of turmoil although they have accessed support from counselling and DM has suffered marital breakdown and is moving back to the near vicinity of his siblings. However the family has moved forward considerably since I first met them and are working hard to build a positive future. They are keen that both this report and the report of the IPCC should have a positive outcome in terms of identifying changes which will help prevent future deaths.

7.11 Since his initial arrest on these matters DC has remained in custody and is now a sentenced prisoner.

8. Summary of Involvement, Analysis and Conclusions Drawn from Report of Primary Care Trust

Summary of Involvement

8.1 The report prepared by the Primary Care Trust representative gave a very detailed analysis of the contacts DS and DC had with the general practice during the period 2008-2011. It also helpfully drew together information from hospital attendances during the review period.

8.2 During the review period DS was seen 13 times by the GP practice, 9 times by a GP and 4 times by a practice nurse. In the same period DC was seen 8 times.

8.3 DS had frequent periods of stress anxiety and depression and in the last 3 years of her life there were several references to concerns about her alcohol

consumption. DC also suffered periods of depression and had a series of physical health problems which affected his mobility and necessitated the use of a walking stick.

8.4 In the latter stages of her life DS identifies concerns about DC's health as contributory factors to her own depression. They attended appointments together at the practice where supportive elements of their relationship and mutual care and concern were identified. The practice were aware that in 2008 DS had been assaulted by DC.

Overview authors analysis

8.5 The IMR author went to some lengths to explore with the clinicians involved the extent to which they linked DS anxiety, depression, self harm and alcohol to potential domestic abuse particularly in light of the reported incident in 2008.

8.6 It is clear that despite a wealth of Department of Health Guidance referred to in the IMR that the relevant links were not made and certainly the IMR author found little evidence that specific enquiries had been made with DS as to whether or not she was experiencing domestic abuse. Similarly there is no evidence DS herself raised the subject between the assault of 2008 and that of 2011, or asked for help.

8.7 The GP's however did have some awareness of local Domestic Abuse outreach and refuge services and in April 2011 provided DS with details in the form of a text message although without properly checking this was a safe way to give information. A referral was not made following the 2008 incident as the practice was aware of the police involvement and believed they were handling the matter.

8.8 Of significance in my opinion, the IMR notes that when DS was seen in April 2010 following the overdose incident she was accompanied by DC who seemed "worried" about DS and "very caring". Their relationship was certainly seen as having positive and supportive features and this may have deflected attention away from DS as a victim of domestic abuse and DC as a perpetrator of abuse.

8.9 Similarly in February 2011 DS identified concern about the health of DC as a major factor in her own low mood. The IMR states that :

> *"In interview GP1 made reference to this and commented that DS had attended appointments with her husband in relation to his health and appeared genuinely concerned about him."*

8.10 In addition the IMR report confirms that DS was identified as having unresolved bereavement issues in relation to the death of her parents and brother who took his own life. This along with other family issues not related to this enquiry more than explained why she might be suffering from anxiety and depression.

8.11 The fact remains however, that despite the range of symptoms and problems presented by DS and despite the disclosure of domestic abuse following the January 2008 incident, the potential for ongoing domestic abuse to be occurring was not considered by the practice.

8.12 The reasons why this was able to happen seem to be linked to a general lack of awareness of domestic abuse within the practice. This coupled with poor communication within the practice as shown by the lack of policies and procedures, the lack of clarity around read codes and the confusing and sometimes contradictory information available from the Department of Health and the RCGP created a situation where the ongoing risk to DS was not apparent to those caring for her health. In addition they were not aware of other police involvements and it is notable that there was no risk information from external

agencies on their files.

Conclusions from IMR Author

8.13 The key conclusions drawn up by the IMR author are summarised by her under two headings:

Guidance for GPs:

GPs need concise and easily accessible information and guidance on responding to domestic abuse. In this case improvements could be made by the practice in terms of the identification of victims and the follow up arrangements for their care, also with regard to information sharing both internally and externally with other disciplines of staff.

8.14 The IMR author also highlighted that in view of the lengthy delays in obtaining access to records for the purpose of completing this report, that information and guidance about the preparation of DHRs should also be provided to practices.

Education and training: The IMR author states:

A better understanding of domestic abuse is the key to implementing new ways of working effectively and safely. The GPs clearly had some understanding of domestic abuse but have not had formal training hence their knowledge was limited and in some instances not entirely accurate.

8.15 I fully support these conclusions.

8.16 The IMR author did not identify any particular diversity issues in this case.

8.17 It will be argued therefore that as well as the training and policy procedural gaps already identified, the Safe Durham Partnership may need to question the broader basis of our practice and thinking around domestic abuse to test out its sensitivity to issues of age.

Recommendations from IMR author to be included in action plan

8.18 A system needs to be established to ensure training opportunities are brought to the attention of staff working in general practices

8.19 A domestic abuse policy to be developed as a partner to the existing domestic abuse and safeguarding children policy. This policy will also include guidance on information sharing, the use of read codes to facilitate this and the requirement that all departments / practices identify a person to take a lead on domestic abuse.

8.20 Given the limited appointment times within which GP's work they would benefit from a short guide which would prompt them on actions to take and information to give to the patient. The delay in obtaining records in order to commence this review was primarily due to staff at the practice not understanding the nature and purpose of a DHR. Information needs to be disseminated to all local practices to ensure timely engagement in the event of future DHR's.

9. Summary of Involvement, Analysis and Conclusions Drawn from Report of Durham Constabulary / IPCC

Summary of Involvement

9.1 The number of occasions police were called to the home of DS do not reflect what we are told by the family, that there was a history of domestic abuse going back more than 20 years. In the last four years of her life Durham Constabulary attended the home of DS on four occasions and in the years prior to that there are no reports of call outs related to DS being the victim of an assault.

9.2 Of the four occasions police attended prior to her death three resulted in positive action, one prosecution and two incidents when DC was removed from the premises. On the fourth occasion a restorative approach was taken.

9.3 None of the incidents was graded at a high enough level of risk to trigger other procedures e.g. a referral to MARAC.

Overview Authors Analysis

9.4 The report from the IPCC deals in detail with the decision to adopt a restorative approach following the incident in April 2011 and is not uncritical. It is clear that there was confusion at operational level about the appropriateness of a restorative justice approach and that the training which had been delivered lacked clarity on key points. This lack of clarity is evidenced by the officers themselves in terms of the different understandings they each took away from the training they attended.

9.5 The officers had not considered and the training had not addressed the interface between restorative justice and the force policy on domestic abuse which clearly expects positive action from officers attending domestic abuse incidents.

9.6 This lack of clarity enabled a situation where the response officer and their supervision both felt that they were operating within force policies in adopting a restorative approach when they attended the incident in April 2011.

9.7 With the benefit of hindsight it would probably have been preferable for all policies to have been aligned before restorative justice training was commenced. Durham Constabulary accepted the findings of the report and worked with the IPCC to develop a clear policy statement in relation to domestic abuse and restorative justice which I have referred to in detail elsewhere. I have had sight of internal police reports which confirm this. That policy is now clear that under no circumstances should restorative justice principles be applied to the first attendance at a domestic violence incident where positive action is required.

9.8 In my view the Constabulary moved quickly and decisively to deal with the confusion and ambiguity that was around at the time in relation to domestic abuse and restorative justice.

9.9 In relation to the earlier incidents, the officers attending adhered closely to the force domestic abuse policy and guidelines using the DASH assessment model which is the nationally recognised and accredited assessment tool. The judgements they made and the decisions they reached were entirely consistent with the existing policies and guidance.

9.10 The number and type of incidents attended and their frequency is identified elsewhere and was insufficient to raise concerns above the levels assessed at the time i.e. standard or medium.

9.11 On the issue of frequency the police SOP state:

"Whilst risk to the victim is paramount there is a need to address individuals where the risk is low or medium but there are numerous incidents. Such individuals can be difficult to engage with and may be reluctant to accept or access support that is offered from the Police and other agencies. As this is not necessarily a role of the Domestic Abuse Units, such individuals should be referred by the Domestic Abuse Detective Sergeant through the BCU NIM process for allocation and action."

9.12 Had the case been assessed at any point as high using the DASH assessment, this would have triggered a referral into MARAC which would have led to the sharing of information that was known at the time and an exploration of how DS could have been protected. Although it is by no means certain this would have changed the eventual outcome it would have provided an opportunity for a multi agency perspective to be developed which is otherwise missing from this case.

9.13 It is worthy of note however from a diversity perspective that none of the assessments, policies or procedures referred to in the reports from Durham Constabulary/IPCC is weighted for age and that age related considerations do not feature in any domestic abuse training that officers will have attended.

9.14 Had there been a greater awareness of the age related concerns around domestic violence then the combination of age, alcohol and reports of depression may have raised the rating on the DASH score and increased the assessed level of risk. It may also have alerted officers to make additional enquiries about the onset and duration of the abuse of DS including enquires of other agencies.

9.15 This will be referred to further later in this review.

Conclusion & Recommendations for Durham Constabulary

9.16 All issues arising from the IPCC report have already been actioned and there are no additional recommendations in relation to restorative justice.

9.17 There are no recommendations from the Constabulary about further actions that need to be taken.

9.18 Neither the force DA policy and standard operating procedures, nor the advice given by CAADA in relation to the application of the DASH model makes any allowance for consideration of the victim's age as a factor related to risk. This matter will be considered at a later stage in this review.

10. Summary of Involvement, Analysis and Conclusions Drawn from Report of DTVPT

Summary of Involvement

10.1 DTVPT had no contact at all with DS but supervised DC for 12 months from March 2008. During that time DC complied with the conditions of his supervision and there were no additional reported incidents of domestic abuse or further convictions of any type.

10.2 Work was carried out with DC to look at challenging his attitudes and beliefs in relation to his conviction for assault on DS as well as work focussed on raising his awareness around victim issues.

10.3 It was noted at an early stage that DC's entrenched attitudes to his offending plus his alcohol misuse were factors likely to inhibit change. During the course of his supervision it was noted that there was clear evidence of victim blaming and that while DC expressed remorse for his actions these were not backed up by his account of the offences. DC maintained he could not remember details of the offence because of the effects of alcohol.

10.4 Over the period of supervision there was a reduction in his OASys score but the risk of harm remained medium throughout.

Overview Authors Analysis

10.5 Although the management of this case was carried out within the technical requirements of the national standards for probation supervision at the time in terms of assessment of risk and levels of contact, it will be clear that there are some issues around the quality of that supervision and particularly the failure to ensure the victims safety and well being through the process. In this respect DTVPT did not follow its own policies and procedures in terms of key aspects of the case.

10.6 The supervision which was delivered focussed on challenging DC's attitudes to his offending and trying to increase his awareness of the impact on the victim. This was the correct thing to do but not the only thing. Given that DS and DC continued living together throughout there should have been an equal regard for the safety of DS, the case should have been assessed using SARA, and best practice would have suggested that a home visit should have taken place and there should have been proactive and regular liaison with local police.

10.7 With the benefit of hindsight, had a SARA assessment been completed then this would not have impacted on the level of risk of harm that was assessed. The meaning of medium risk of harm in relation to OASys is exactly the same as the definition contained in the DASH documentation and given DC's lack of previous convictions this was the correct assessment at the time.

10.8 In terms of other actions to protect DS, this supervision took place during 2008/2009. It was only at the end of this period that MARAC was established in the area and the assessments which were in place would not have triggered a referral to MARAC. Nor were there any serious incidents during supervision which would have triggered an elevated level of risk.

10.9 The issues raised in terms of the failure of the supervising officer to adopt an investigative approach and the tendency to accept at face value the offenders version of events, e.g. in relation to health issues and alcohol use are familiar

themes nationally in terms of serious further offences that are committed by offenders subject to probation supervision.

10.10 When looking for reasons as to what were the key factors that determined how supervision was delivered and why other actions were not taken to oversee the safety of DS a key factor emerges from the assessment of DC within OASys.

10.11 In section R8.3.1 the assessor is asked to identify any concerns about the vulnerability of the offender and the answer given was:

vulnerable due to age and health.

10.12 In my opinion this factor was key in determining the responses of the Offender Manager to DC throughout the supervision period. Although the Citizenship intervention was delivered, it has been commented elsewhere that there was a lack of focus on what the implications of responses were for the management of risk in the present time. If the predominant view of DC was that he himself was vulnerable due to age and health then it is possible that there was an underestimation of his potential to cause serious harm.

10.13 As with risk assessments and policies and procedures within health and police, there was no reference to age considerations in any of the probation documentation. In this case we might have looked for a reminder that age ***is not*** a factor that decreases likelihood of offending in relation to perpetrators, however age ***is*** a factor that potentially increases risks to victims.

Conclusion & Recommendations for DTVPT from IMR author

Review procedures that are in place to ensure that supervising officers have proper regard for the safety and well being of victims of domestic abuse perpetrators.

Identify and implement processes to improve the overall quality of supervision particularly in regard to the development of an investigative approach and the tendency to accept offenders versions of events without proper challenge.

10.14 I fully support these recommendations.

Recommendations from Overview Author

10.15 I return to the issue of the ages of DC and DS. None of the assessment systems referred to that are used by DTVPT have any weighting for age either in terms of victims or perpetrators.

10.16 It is therefore recommended that a review is carried out of all policies, procedures and training in relation to domestic abuse to ensure that age is recognised as a risk factor in domestic abuse/homicide.

11. Diversity Considerations

11.1 None of the individual agency information and reports identified diversity considerations in relation to race, religion, disability, sexual orientation or age.

11.2 However during the process of preparing this report I became aware that in County Durham and Darlington between 2011 and 2012, 5 female victims died as a result of actions by an intimate partner. The age range of those women was between 40-61, specifically, 40, 47, 48, 51 and 61 including the subject of this review. This led me to consider whether or not there might be diversity considerations in relation to age that needed to be taken into account when considering the death of DS.

11.3 I began by looking at the age profile of reports of domestic abuse.

11.4 Figures provided by Sexual Violence Co-ordinator Durham Constabulary tell us that incidents of domestic abuse are most frequently reported by women in the 18-29 age range ; victims aged 18-29 make up 45% of reports of domestic abuse but only 16% of the population; victims aged 30-44 make up 38% of referrals and represent 19% of the population.

11.5 Women aged 45+ make up 17% of reports and represent 46% of the population and also represent the lowest number of cases referred to MARAC

	Reported age of DA victim **Age 18-29**	**Reported age of DA victim** **Age 30-44**	**Reported age of DA victim** **Age 45+**
Population of County Durham and Darlington 2011-2012	16%	19%	46%
Reported incidents of domestic abuse 2011-2012	45%	38%	17%
Cases at MARAC 2011-2012	45%	40%	15%

11.5 It is therefore the case that in Durham Constabulary area in recent times all of the domestic abuse related homicides involving intimate partners appear to have occurred among the group of victims who most infrequently report abuse.

11.6 Similar age related patterns were reported in other parts of the country and this suggested to me that there were issues to be considered in relation to the age profile of domestic abuse victims which needed to be taken into consideration when looking at the circumstances of the death of DS.

11.7 Two possible explanations were that either DA is less common in an older age group or that there is significant under reporting in the older age group.

11.8 Research in the USA [1] suggested that older and younger women experience domestic abuse to a similar extent but that there are significant differences in the barriers to reporting and the sensitivity of professionals to the issue which explain the differences in frequency of reporting

[1] Mouton C.P et al(2004)"Prevalence and three year incidence of abuse among post-menopausal women."

11.9 Research from Australia [2] suggested that one third of current victims of domestic violence are older women but over 60% of them did not seek help.

Prior to reviewing the case of DS who was 51 at the time of her death it was therefore, in my view, worth considering whether or not there are special factors related to this victims age group which we needed to be aware of in order that we can better understand what happened to DS.

Domestic Abuse in Older Women

11.10 This is not a widely researched area of public policy so in preparing this section I have relied heavily on two pieces of work and summarised their findings.

Older Women and Domestic Violence. A report by Women's Aid 2007

Older Women and Domestic Violence in Scotland. A report prepared for Health Scotland by the Centre for Research on Families and Relationships. 2004

11.11 Unless otherwise stated all material is drawn from these reports which are the only two large scale pieces of work on the subject relating directly to the UK. Most of the research has been conducted in USA or Australia and is referenced where used. The growing body of knowledge in this area is however remarkably consistent in its findings.

11.12 Writers generally agree that there are three basic categories which describe a typology of domestic abuse among older victims:

- **Domestic abuse grown old** - This related to cases where domestic abuse has started at an early stage in life and has persisted over time.
- **New abuse in later life** - Here the perpetrators are new spouses or intimate partners**.**
- **Late onset domestic violence** - Here DA commences in old age perhaps as a result of a strained relationship or emotional abuse that has got worse as partners have aged.

11.13 Each typology suggests different support needs for the victims involved and different barriers to reporting.

11.14 The definition of "old age" does vary considerably over studies, however there is some common ground between studies in that they are generally all talking about women over 45. There is a measure of agreement that precise age alone is not the defining characteristic in terms of policies and procedures relating to domestic abuse in older women. The significant issues seem to be more those of life history and life stage than age alone and includes consideration of physical and mental health issues, loss of confidence over time and ages of children.

11.15 Research rejects the notion of the stressed care giver as the predominant explanation for abuse and argues that the same power and control issues underpin abuse of older as well as younger women.

11.16 It is the barriers to reporting for older women, not the intent of the perpetrator or the frequency of occurrences that explain the differences in reporting.

[2] Morgan Disney and associates 2000, Two Lives-Two worlds :Older People and domestic Violence

Barriers to Reporting (from Women Aid)

11.17 The report from Women's Aid provides a helpful list of the sort of barriers to reporting that affect older women. Some of the areas suggested are :

- Older women may have different understandings of abuse and may not identify themselves as abused. This may particularly be the case where TV, films and magazines show abused women as younger women with children and may convey the impression that domestic abuse doesn't occur in mid or later life. I would add to this that campaigns about domestic and sexual violence, including our own, also predominantly use images of younger women.
- Older women may find it more difficult to disclose abuse and feel trapped by a culture and set of attitudes which dictated that they were expected to keep quiet about such problems, particularly if it involved family members. Alternatively they may have given up seeking support after years of getting negative reactions.
- Older women may feel ashamed they have tolerated abuse over a long period of time and in later life see divorce or separation as socially and financially impossible.
- Older women may themselves be carers for an abusive partner or alternatively be dependant on the abusive partner for care.
- Older women may have a mutual physical and emotional dependence on the abusive partner which it is difficult to contemplate changing in view of life stresses such as e.g. death of a friend, birth of a grandchild, retirement and fear of isolation.
- Older women may be uncertain of the reaction of children who may have tried to keep parents together or alternatively begged the victim to leave for many years.
- Professionals may lack awareness of the needs of older women :

  [3] *health and social work professionals tend not to consider domestic abuse as an issue for older women and therefore rarely ask about it: and they may assume that injuries, confusion etc are the results of age related conditions. They may assume older men are not a serious threat and/or that domestic abuse lessens with age. One study suggests that professionals may inhibit disclosure because they are unsure how to respond or are under pressure to get things done quickly."*

11.18 The report from Women's Aid goes on to consider the different kinds of services older women may require, from different kinds of refuge provision to drop in and outreach services being available at places older women feel more comfortable. It also makes the important point that the long term effects of abuse e.g. permanent physical damage, disability, self harm, self neglect, loss of confidence and mental health problems may be more severe in older women due to the extent of the abuse they may have suffered and their increased frailty.

[3] Mullender, Audrey, 1996 Rethinking domestic violence

Melissa Westerhof

11.19 Melissa Westerhof in a study, "Transitions and changes affecting older women survivors of domestic abuse" *Grand Valley State University 2011,* suggested that there were a range of increased risks for physical and psychological problems for older women victims including:

- depression
- variety of chronic health problems
- injuries relating to trauma
- deficient in self esteem
- burdened by shame

11.20 This in turn led to increased risks of marked signs of aging among older victims, specifically

- need of physical care
- need of mental care
- care for abuser
- feelings of loneliness.

Conclusion

11.21 Rather than suggesting a phasing out of incidents of domestic abuse as individuals move to later life, research would seem to suggest that the difference in reporting rates are explained by specific barriers relevant to age. Writers identify characteristics which are common to victims in this category and to which professionals may not be fully attuned. Researchers are agreed that there is a massive under reporting of domestic abuse in the older age group.

11.22 In relation to the death of DS, then using the typologies set out earlier, she would seem to fit the profile of "Domestic abuse grown old". Certainly information provided by her children include recollections from their own childhood of violent incidents between their parents which would seem to support this view.

11.23 Some of the suggested barriers to reporting (page 62) also feature in this case. DS was a carer for an abusive partner. She seemed to be in a mutually physically and emotionally dependent relationship with him and in the latter stages of her life identified concerns about his health as contributing to her own depression. Information provided from the GP practice suggested that DS and DC attended appointments together and that supportive elements of their relationship and mutual care and concern were recognised.

11.24 DS herself displayed many of the characteristics identified as occurring in older victims of abuse, she suffered from depression, had a variety of health problems, appears to have had problems with alcohol and as far as we can tell seemed to need a level of care herself which was over and above what might have been expected for a woman of her age.

11.25 Referring back to the quote from Audrey Mullender previously referred to

[4] health and social work professionals tend not to consider domestic abuse as an issue for older women and therefore rarely ask about it: and they may assume that injuries, confusion etc are the results of age related conditions. They may assume older men are not a serious threat and/or that domestic abuse lessens with age. One study suggests that professionals may inhibit disclosure because they are unsure how to respond or are under pressure to get things done quickly."

11.26 In this case the Probation Offender Manager assessed DC as "vulnerable due to age and ill health" and at the same time did not follow the agencies own procedures in relation to ensuring the safety of victims. There is no evidence that any of the professionals involved with DS asked about domestic abuse.

11.27 The background reading I have done around domestic abuse and older victims, together with the details of this case and the figures related to the age profile of recent homicide victims leads me to the conclusion that there are significant diversity issues related to older victims of domestic abuse which are currently not being properly attended to in policy, procedures or practices in County Durham and Darlington as demonstrated by the circumstances of the death of DS.

12. Conclusions and Lessons Learned

Conclusions

12.1 The content of this section will address the terms of reference identified in the statutory guidance which in this case were also the specific terms of reference identified as part of the review. The DHR aimed to

"Establish the facts that led to the incident, whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family".

12.2 In line with the terms of reference the DHR has covered in details the period from September 2009 until May 2011 and agencies have provided a history and context, where appropriate, from 2000. An independent review of the police actions in relation to restorative justice has also been completed by the IPCC.

12.3 Agencies have identified for themselves areas where their practice needed to change or develop and have identified appropriate actions to address this.

"Identify what those lessons are, how they will be acted upon and what is expected to change as a result"

12.4 As overview author there appear to me to be a number of key themes arising from this report, two of which lack an investigative approach, and the significance of alcohol abuse are familiar findings from case and offence reviews while age as a diversity issue is less well explored.

12.5 In relation to an investigative approach or lack of professional curiosity none of the agencies involved in this case were sufficiently curious in their dealings with DS and DC to ask them other than the most superficial questions in relation to domestic abuse. DTVPT refer in their report to this as a lack of an investigative

[4] Mullender, Audrey, 1996 Rethinking domestic violence

approach and highlight this as an organisational issue. This is a recurrent theme in many DHRs, Serious Case Reviews and other investigations. Traditionally the response to this is through improved training and supervision of staff, none of which appear to have significantly impacted on the issue. My suggestion would be that the partners set time aside to look at this issue and to try and identify some new approaches to an old problem which continues to be linked with harm to victims of all ages.

12.6 In relation to alcohol it is clear that in this case as with many others, alcohol has been a significant dishibitor and its use has increased the risk to the victim. In the information from the family DA recognised this when he stated that he could never recall his father assaulting his mother when he was sober. I do not propose to make any specific recommendations in relation to alcohol and domestic violence. All agencies cover alcohol abuse issues in their risk assessments and awareness of alcohol as a risk factor in domestic abuse is very high.

12.7 In relation to restorative justice and domestic abuse the IPCC made clear recommendations which were accepted in full by Durham Constabulary and have been implemented in full. The policy is now quite clear in relation to domestic abuse and restorative justice and to the actions which must be prioritised when officers attend a domestic abuse incident and to how they must proceed if they believe a restorative approach might be appropriate.

12.8 In my opinion the key new learning from this review relates to the need to develop a better understanding and awareness of the risks to and needs of older women who are victims of domestic abuse. The recent age profile of women who have been killed by intimate partners in County Durham and Darlington is difficult to ignore and difficult to dismiss as coincidence. This has already led to older women being identified as a priority group in the Safe Durham Partnership Domestic Abuse Strategy.

12.9 It remains the case however that we do not look at age when we are delivering training, we do not target campaigns at older women and we do not have specialist resources for older women who are victims of abuse.

<u>As a result of this review Primary Care Trust have identified the need to:</u>

- Ensure training opportunities are brought to the attention of staff in general practices.
- Develop a domestic abuse policy to include guidance for GPs on information sharing and the use of read codes.
- Develop a short prompt tool to support GPs on actions to take in domestic abuse cases and information to give to patients.

<u>As a result of this review Durham Constabulary identified the need to:</u>

- Clarify policies on the use of restorative approaches in domestic abuse cases and issue clear guidance to staff

<u>As a result of this review DTVPT identified the need to:</u>

- Review procedures that are in place to ensure that supervising officers have proper regard for the safety and well being of victims of domestic abuse perpetrators.
- Identify and implement processes to improve the overall quality of supervision particularly in regard to the development of an investigative approach and the tendency to accept offenders' versions of events without proper challenge.

12.10 Many of these actions are already under way but will be part of the overall action plan from this review. (Appendix 2)

12.11 The overriding actions recommended for all agencies however are:

- To review all existing policies and procedures, as they become due for review, to ensure they are sensitive to the special risks to and needs of older women who are victims.
- To ensure that all future policies, publicity campaigns and other planned activities in relation to abuse are sensitive to the requirements of older victims and do not minimise the risks from older perpetrators.
- For the Domestic Abuse Forum Executive Group (DAFEG) to table a discussion about "professional curiosity " to explore options for tackling this persistent problem.

12.12 As a result of this review we have already seen changes in the way police officers manage the interface between restorative justice and domestic violence.

12.13 We are looking for changes in the way GP practices recognise, record and share information about patients who are victims of abuse.

12.14 We are looking for changes in the way DTVPT acts to protect the victims of violent partners.

12.15 We are looking for changes in the way all partners understand the significance of age as a factor in domestic abuse in terms of both victims and perpetrators.

Establish whether the agencies or inter agency responded were appropriate leading up to the time of the incident

12.16 The IMR's which have been conducted as part of this review have been honestly and openly undertaken and have identified gaps and shortcomings in the provision of services to DS. These have been documented elsewhere in this report.

12.17 There were clearly missed opportunities to offer support to DS although it is noted that when services were offered including outreach and counselling she failed to take them up.

12.18 In this case it is by no means certain that had there been a clearer multi agency strategy that it would have prevented the death of DS.

Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

12.19 The agencies involved in this review have extensive policies around domestic abuse and each suggested changes to their own policies and procedures as a result of the reviews they have undertaken.

12.20 In addition the review points to a need for all agencies to review their policies and procedures to ensure that the age of the victim and perpetrator is taken into account when assessing the risks in any given incident of domestic abuse.

12.21 I am firmly of the view that as a result of their age particularly in combination with levels of alcohol abuse, in this case, the risks and vulnerabilities surrounding DS were underestimated as was the potential for DC to cause serious harm. This has important implications for the delivery of domestic abuse services across all agencies, not just those involved in this review.

13. Changes proposed as a result of this review

Clinical Commissioning Group Recommendations

13.1 A system needs to be established to ensure training opportunities are brought to the attention of staff working in General Practices

13.2 A domestic abuse policy to be developed as a partner to the existing domestic abuse and safeguarding children policy. This policy will also include guidance on information sharing, the use of read codes to facilitate this and the requirement that all departments / practices identify a person to take a lead on domestic abuse.

13.3 Given the limited appointment times within which GPs work they would benefit from a short guide which would prompt them on actions to take and information to give to the patient.

Durham Constabulary Recommendations

13.4 To fully implement the new policy guidance on restorative justice and domestic abuse i.e.

- Under no circumstances should restorative justice principles be applied to the initial attendance at any domestic violence incidents.
- Positive action must be taken i.e. the arrest of the perpetrator and the recovery of evidence as per the domestic violence policy.
- Restorative justice disposal may only be considered as a resolution to such incidents only after positive action has been taken in the first instance and only with the expressed permission of (named staff) who must be consulted with first.

13.5 Neither the force DA policy and standard operating procedures, nor the advice given by CAADA in relation to the application of the DASH model makes any allowance for consideration of the victim's age as a factor related to risk. The recommendation is therefore that a review is carried out and that all policies procedures and training in relation to domestic abuse are reviewed to give consideration to age as a risk factor in domestic abuse/homicide

DTVPT Recommendations

13.6 Review procedures that are in place to ensure that supervising officers have proper regard for the safety and well being of victims of domestic abuse perpetrators.

13.7 Identify and implement processes to improve the overall quality of supervision particularly in regard to the development of an investigative approach and the tendency to accept offenders versions of events without proper challenge.

Recommendation for all Agencies

13.8 To review all existing policies and procedures, as they become due for review to ensure they are sensitive to the special risks to and needs of older women who are victims.

13.9 To ensure that all future policies, publicity campaigns and other planned activities in relation to abuse are sensitive to the requirements of older victims and the risks posed by older perpetrators.

Concluding comments.

13.10 The premature death of any individual as a result of a homicide is always a tragedy and in this case a double tragedy for a family who have lost both their mother and arguably also their father.

13.11 The agencies who have participated in this review have done so in a spirit of openness and wanting to learn and improve so that services to victims of domestic abuse can continue to develop and improve.

13.12 Even with the changes that have been proposed there is no certainty that the death of DS could have been prevented.

APPENDIX 1 (a)

Chronology of historical information

Redacted.